

A Mixed-Methods Investigation of a Rape Crisis Line Volunteer Counselling Program

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Thesis submitted to the
Faculty of Graduate and Postdoctoral Studies
in partial fulfillment of the requirements
for the Doctorate in Philosophy degree in Experimental Psychology

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Abstract

Rape crisis counsellors play a central role in frontline service delivery to sexual violence (SV) survivors, yet their training has received scarce research attention. To fill this gap, this dissertation presents three studies that sequentially examine a volunteer-based rape crisis line (CL) training program. The first study is an evaluability assessment (EA) that assesses the readiness of a community CL training program for research; the second study quantitatively examines the outcomes of the CL training program; and the third study qualitatively investigates the rape crisis counsellors' training and practice experiences.

Data was gathered from a local Rape Crisis Centre (RCC), and a total of 52 women participated in the research. Two-way mixed factorial ANOVAs were used to analyze the quantitative data, and a general inductive approach (Thomas, 2006), informed by a feminist, empowerment perspective (Nagy Hesse-Biber & Yaiser, 2004) was used to analyze the qualitative data.

The EA demonstrated that the CL training program was primarily intended to develop volunteers' basic counselling skills, suicide intervention skills, and feminist attitudes and beliefs. Based on analyses of the EA data, the program was determined to be evaluable. The second study indicated that following the training, the volunteers' counselling self-efficacy improved, whereas their suicide intervention skills did not change. Volunteers had strong pre-existing feminist attitudes and beliefs that also did not change. The third study revealed several themes that elucidated the program's processes and outcomes, such as the volunteers' perception that after the training they gained basic counselling skills, and an increased knowledge of feminism, yet felt unprepared to respond to suicidal callers. Due to their routine interactions with SV survivors and systems, the volunteers also began to perceive SV as a widespread, systemic

problem. A thematic analysis of results across studies, and implications of the findings on anti-violence practice and policy are discussed.

Acknowledgements

I would like to express my gratitude to the people who supported me during the course of my doctoral studies. A great many thanks are owed to my academic supervisors, Dr. Stephanie Austin and Dr. Tim Aubry, for allowing me to pursue a project I am passionate about and steadfastly supporting me to its completion. I appreciate their encouragement, academic rigour, and for the integral ways they embody the values of Community Psychology. I will carry these lessons with me. I would also like to thank Dr. Holly Johnson for her kindness and support and for sharing some of her vast expertise on the subject with me. I also want to express thanks to each of my committee members – Dr. Charlene Senn, Dr. Susan Farrell, and Dr. Mythili Rajiva – for the diverse ways they have contributed to my research. A thank you goes out to Dwayne Schindler for his statistical consultation, encouragement, and humour. Thanks as well to my fellow students and lab mates for being wonderful colleagues.

I thank the remarkable women of the Ottawa Rape Crisis Centre for their strong partnership. Special thanks to Sunny Marriner and Josephine Basudde for championing the project and for welcoming me into their community as a researcher. Most importantly, a big thank you to the Crisis Line counsellors, Centre staff, and comparison group participants who generously and candidly shared their experiences, insights, and time with me. I hope these studies will help support your important work and the efforts underway at Rape Crisis Centres across Canada.

Thank you to my fabulous, funny, feminist friends for introducing me to Community Psychology and for many yoga dates, lab hangouts, and conversations in the park. Lastly, I thank my family, and especially my sister and my mother, for your love and understanding and for being there every step of the way.

TABLE OF CONTENTS

Abstract.....	ii
Acknowledgements.....	iv
Introduction.....	1
Research Context.....	4
Literature Review.....	14
Research Rationale.....	24
Feminist Perspective.....	25
Methodological Approach.....	28
Research Questions and Objectives.....	30
Study 1: An Evaluability Assessment of a Grassroots Rape Crisis Line Training Program.....	31
Evaluation Rationale.....	33
Description of Organization.....	35
Methods.....	40
Results.....	43
Discussion.....	56
References.....	59
Study 2: A Quasi-Experimental Study of the Effectiveness of a Volunteer Rape Crisis Line Counsellor Training Program.....	64
Abstract.....	65
Research Context.....	67
Literature Review.....	68
Methods.....	78
Results.....	90
Discussion.....	100
References.....	110
Study 3: Insider Perspectives: A Qualitative Investigation of Rape Crisis Line Workers' Training and Practice Experiences.....	118
Abstract.....	119
Introduction.....	120
Methods.....	129
Results.....	134
Discussion.....	155
References.....	170
General Discussion.....	179
References.....	193
Appendix A Semi-structured Interview Guide - Key Informants.....	203
Appendix B Semi-structured Interview Guide - Centre Staff.....	205
Appendix C Program Fidelity Checklist.....	207
Appendix D RCC CL Training Protocol.....	208
Appendix E Semi-structured Interview Guide - ORCC Volunteers.....	209
Appendix F The Counsellor Activity Self-efficacy Scale - Helping Skills Subscale.....	211
Appendix G The Suicide Intervention Response Inventory.....	214
Appendix H The Short-form Feminist Perspectives Scale.....	221
Appendix I Demographic Questions - ORCC CL Training Program Survey.....	228

LIST OF TABLES

Table 1. RCC CL Training Protocol	39
Table 2. Evaluation Questions and Corresponding Methods Undertaken for the EA	41
Table 3. ORCC CL Program Logic Model	53
Table 4. Demographic Characteristics of the Survey Sample	92
Table 5. Demographic Characteristics of the Interview Sample	131
Table 6. Frequency Distribution of Work hrs/wk	132

LIST OF FIGURES

Figure 1. CONSORT: Enrollment, Allocation, Follow-Up, and Analysis of Participants	80
Figure 2. The mean counselling self-efficacy scores before and after training for the experimental and comparison groups.	96
Figure 3. Mean suicide intervention scores before and after training for the experimental and comparison groups.	98
Figure 4. Mean feminist attitudes and beliefs scores before and after training for the experimental and comparison groups.	99

Introduction

In Canada, violence against women (VAW) continues to be a widespread problem that negatively affects the realization of women's fundamental freedoms and human rights (Sinha, 2013; Johnson, 2006; Status of Women Canada, 2016). In 2013, Canada was ranked 20th on a gender equality index, largely due to the presence and severity of violence in the lives of Canadian women; in 2016, this ranking dropped to 35th in the world (World Economic Forum, 2013; World Economic Forum, 2016). The annual cost of intimate partner violence in Canada is estimated to be \$7.4 billion, and that of sexual assault (SA) is \$546 million (McInturff, 2013). Speaking to the severity of the issue, the United Nation's Population fund (2005, p. 65) states: "Gender-based violence is perhaps the most wide-spread and socially tolerated of human rights violation. It both reflects and reinforces inequities between men and women and compromises the health, dignity, security and autonomy of its victims."

Higher levels of SV occur across women's lifespans, as compared to men. Indeed, the World Economic Forum (2016) reported that Canadian women's lifetime prevalence of gender-based violence is six times that of men's (World Economic Forum, 2016), and Canadian police-reported data indicated that women are exposed to sexual offenses at a rate eleven times higher than men (Benoit et al., 2014). As children, females are four times more likely to be sexually abused than male children, and often a father or stepfather perpetrates the offense (44% of incidents) (Senn, 2010). During adolescence, females are ten times more likely to experience dating violence than are males – most commonly, SA and sexual interference, and often by older dating partners (Mahony, 2010). In Canada SA is defined as "all incidents of unwanted sexual activity, including sexual attacks and sexual touching (Brennan & Taylor-Butts, 2008), and it includes a range of violations (Criminal Code, Sections 271, 272, 273). Sexual interference is the

crime of touching a child for a sexual purpose (Criminal Code, Section 151). SV is a broader term that refers to: “any sexual act, attempt to obtain a sexual act, unwanted sexual comments or advances, or acts to traffic, or otherwise directed, against a person’s sexuality using coercion, by any person regardless of their relationship to the victim, in any setting...” (Krug, Dahlberg, Mercy, Zwi, & Lozano, 2002, p. 149). Lastly, the terms VAW and gender-based violence refer to violations that are perpetrated against females by males that cause sexual, physical, or psychological harm to women and that continue to occur due to systemic gender inequalities (Benoit, Shumka, Phillips, Kennedy, & Belle-Isle, 2014).

Over half of Canadian women (16 years of age and over) have experienced one or more occurrences of physical violence or SV (Statistics Canada, 1993); and 29% of married women have experienced SV perpetrated by their spouse (Statistics Canada, 1999). The recent GSS found that women were at a 20% higher risk of violent victimization than men, due to a higher incidence of SA. It also found that only 5% of victims report SA to police (Perreault, 2015; Conroy & Cotter, 2017). Women are “three times as likely to be the victim of criminal harassment (stalking)”, as compared to men (Statistics Canada, 2013, p. 8), and in 80% of offences against women, the stalker is male (Johnson, 2006). Intimate partner stalkers (21% of cases) may be the most high-risk type of stalker (Johnson, 2006), and stalking is a predictor of “attempted or actual murder of female partners” (Johnson, 2006, p. 30). Internationally, when women are murdered, in 38% of instances it is by an intimate partner (World Health Organization, 2013). In Canada, 76 women were murdered by intimate partners in 2011 (Perreault, 2012), and this number does not reflect instances of attempted murder, or cases misclassified as suicide, missing, or natural causes.

These statistics reveal the gendered nature of sexualized violence, which runs like a current through every facet of society. In seeking to address this issue and bring about social change, inspiring efforts have been made by feminists working in diverse fields. A centrally important effort was the development of grassroots Rape Crisis Centers (RCCs), which were initially put in place during the early 1970s, in response to a gap in the resources available to survivors. Services made available to survivors were volunteer operated 24-hour Crisis Lines (Campbell, Baker, & Mazurek, 1998). They were designed to provide survivors with emergency crisis counselling and guidance in utilizing legal and medical services (Ullman & Townsend, 2007). Since their establishment nearly forty years ago, few attempts have been made to evaluate these programs. Therefore, their outcomes have not been adequately measured and described, making it difficult to account for their strengths and limitations. Given the important role that volunteer counsellors play in the delivery of direct RCC services to survivors, research is strongly needed to fill this gap.

This dissertation explores the experiences of volunteer rape crisis counsellors as they undergo training, and subsequently, as they work directly with survivors. Despite their importance, impact, and central role in service delivery, the research on VAW has largely failed to investigate rape crisis counsellors. In order to provide high quality services to survivors of sexualized violence, it is vital to evaluate how rape CL training programs function and prepare CL counsellors for their role. This is the primary goal of the current research project. A secondary goal is to explore counsellors' insights and perspectives on sexualized violence in society. Crisis counsellors work closely with both survivors and emergency service providers, and thus, develop rich knowledge about both worlds. Crisis counsellors occupy a unique social location, and as such, have original insights to share about this social phenomenon. In order to

situate the research within the current social context, the scope and impact of SV in Canada and literature on recent and historical legal reforms will be reviewed next.

Research Context

This section begins with an analysis of the prevalence and correlates of SV victimization and perpetration, and then describes the legal reforms that were designed to respond to this ongoing social issue in Canada, as well as limitations of the justice system response to SV.

Prevalence and Correlates

In Canada, both self-reported data and police data have been used to estimate SV in the population. The General Social Survey (GSS) uses self-reported data, whereas the Uniform Crime Reporting survey (UCR) uses police reported statistics. In the early 1990s, improvements were made to the GSS in terms of how it measured SV. The Violence Against Women (VAW) survey was the first large-scale survey in Canada to address limitations of the GSS and its handling of data collection on SV victimization. Limitations of the GSS related to: its lack of sensitive and detailed questions, lack of sufficient training for interviewers, use of male interviewers, lack of safety mechanisms for respondents, single screening questions, orientation to think about crimes in public rather than in private spheres, and relatively short reference periods that overlooked the long-term impacts of SV (Johnson and Dawson, 2011). In contrast, the VAW survey took steps to address these limitations through bringing in the use of detailed, expert-informed questions and affording greater privacy to respondents (Johnson, 2015). Using such methods, the 1993 VAW survey found that 39% of Canadian women experienced SA, 29% experienced intimate partner violence, and 50% experienced at least one incident of sexual or physical violence (Johnson, 1996). Since then the GSS has reverted to using more limited and generic crime survey questions that tend to underestimate prevalence in the population (Johnson,

2015). (However, in 2014 the GSS was enhanced through its addition of a question to measure SA while unable to consent.) Currently, prevalence detected by the GSS may be further underestimated because it does not capture information about people who are institutionalized, homeless, or do not speak an official language, or refuse to divulge very traumatic experiences to survey researchers (Benoit et al., 2014; Pelot, Allan, Brzozowski, & St-Cyr, 2011).

Despite these limitations, the GSS offers more reliable estimates of SV in the population than do police data, as only a minority of such crimes are reported to the police: roughly 5% of SA (Perreault, 2015; Conroy & Cotter, 2017), and 36% of incidents of spousal abuse (Johnson, 2006). Additionally, police unfound a large percentage of SA complaints, with national police statistical records from 2010-2014 showing that 19.4% of such cases had been classified as unfounded (Doolittle, 2017). When SA complaints are unfounded, no official actions are taken and these cases are deleted from police statistics, thus deflating rates. Such police decisions are judgment-based, and no rationale or reasoning need be produced to explain them (Doolittle, 2017; Sheehy, 2012; Tang, 1998). Furthermore, police-reported data only measures Criminal Code offences and does not capture other types of VAW (e.g., sexual harassment, psychological, financial). In comparison, self-reported data capture unreported crimes, and thus, can reflect more accurate estimates.

The recent GSS on Victimization found that for every 1,000 Canadians aged 15 and older 22 incidents of SA occurred; this equated to approximately 636,000 incidents of SA in a 12-month period (Conroy & Cotter, 2017). The report also found that approximately 50% of the offenders were known to the victims and that the majority of offenders were young men (below age 35) who acted alone (Conroy & Cotter, 2017).

Over the past 10 years there have been reductions in victimization rates for all crimes except SA, and while approximately 1/3 of all other crimes were reported to police, only 5% of SA were reported (Perrault, 2015; Conroy & Cotter, 2017). The GSS on Victimization also revealed that women faced higher levels of violent victimization than men overall, and this was attributed to the persistence of SA over time (Perrault, 2015). Survey data revealed that Aboriginal women faced much higher levels of SA than other women: 115 per 1000 women, compared to 35 per 1000 women for non-Aboriginal women (Perrault, 2015). Several other demographic variables were also associated with SA, such as being young (15-24 years of age), being single, being a student, having experienced physical or sexual victimization in childhood, having a mental/psychological disability or a learning disability, using drugs or binge drinking, engaging in a greater number of evening activities, and having a history of homelessness (Perrault, 2015).

In a report prepared for Status of Women Canada that drew on both police-reported and self-reported victimization data, Sinha (2013) identified several factors associated with gender-based victimization. The report documented that strangers were reported to perpetrate more VAW who were “young, participated in many evening activities, were single, used drugs, identified as an Aboriginal person” and who lived in socio-economically disadvantaged communities (Sinha, 2013, p. 9). Factors relating to an increased risk of violence were also elucidated in a report prepared for the UN Division for the Advancement of Women (Johnson, 2006). In it, the following factors were associated with spousal abuse and homicide for Canadian women: “being young, living in a common-law relationship, separation, alcohol abuse by male partners, controlling behaviours on the part of male partners” (Johnson, 2006, p. 2). Additionally,

Johnson (2006) reported that, “witnessing violence in childhood raises the risk of both victimization and perpetration of partner violence” (Johnson, 2006, p. 2).

Recent police data indicated that 21,500 SAs were recorded by police in 2015, representing an increase of 4% from the previous year (Allen, 2016). Police-reported data from 2011, show that among the five most frequent violent offences against women were SA level 1 (7%) and criminal harassment (7%). Compared to men, women were subjected to 11 times as many sexual offences, and 3 times more instances of criminal harassment or stalking (Statistics Canada, 2013). In 83% of cases of VAW, the accused was male, and most commonly, a current or former intimate partner (45%). Additionally, women were four times more likely to experience intimate partner violence. These incidents commonly involved assault and physical force, and roughly half of the victims were seriously injured. Rates of spousal violence were similar across genders, however, women experienced more extreme violence, such as “multiple victimizations” and more serious injuries (Statistics Canada, 2013, p. 23). It is commonly thought that strangers perpetrate SAs; however, only 18% of SAs recorded by police fit this profile (Brennan & Taylor-Butts, 2008). Mahony (2011) reported that the majority of SAs are perpetrated by men who are known to the victims; in 41% of the cases perpetrators were the victims' current or former spouses or intimate partners; and in 42% of the cases, perpetrators were family members or acquaintances of the victims (Mahony, 2011, p. 171).

Additionally, different aspects of women's identities and social locations interact to shape their level of vulnerability to SV. In particular, it is documented that Aboriginal women (Allen & Perreault, 2015; Brennan, 2011; Amnesty International, 2012); immigrant and refugee women (Benoit et al., 2014); young women (Johnson, 2006; Sinha, 2013); and women with disabilities (Perreault, 2009; Benoit et al., 2014) have a heightened risk of SV. According to the recent GSS on

Victimization, SA is experienced at higher rates by the following groups: women, Indigenous, young, LGBTQ2S, disabilities, mental health issues, histories of childhood abuse and/or homelessness (Conroy & Cotter, 2017). Since it is possible to identify with more than one of these groups, women who experience multiple oppressions are even more vulnerable to SV (Benoit et al., 2014).

Although most attempts to measure SV in the population have focused on women's SV victimization, there is a growing body of research that seeks to understand men's SV perpetration, and correlates for SV perpetration at multiple ecological levels, and which is largely driven by the goal of strengthening violence prevention (See Fulu et al., 2013; Heilman et al., 2013; Krug, 2002). This research is informed by an integrated social ecological model of gender-based violence, in which factors associated with perpetration are identified at the individual, group, community, and broader societal levels (Heise, 1998). Specifically, at the individual level, SV perpetration is associated with witnessing marital violence as a child, being abused oneself as a child, and/or having an absent or rejecting father. At the group level, male dominance in the family, male control of wealth in the family, use of alcohol, and/or marital/verbal conflict emerged as correlates; while at the community level, low socio-economic status/unemployment, isolation of the woman and the family, and/or delinquent peer associations were correlated with perpetration of gender-based violence. Lastly, the broader social correlates were identified, such as male entitlement/ownership of women, masculinity linked to aggression and dominance, rigid gender roles, acceptance of interpersonal violence, and/or physical chastisement (Heise, 1998, p. 265).

Recent research, involving several countries, has since validated and elaborated on Heise's initial findings. For instance, the UN Multi-country Study on Men and Violence in Asia

and the Pacific (Fulu et al., 2013) found that perpetration of gender-based violence was associated with several factors, such as gender inequality, low socio-economic status, early childhood abuse, physical violence against female partners, enactment of hegemonic masculinity, having more sexual partners, and/or a sense of entitlement to women's bodies. In addition, it reported that the men who raped women rarely faced any legal repercussions for their crimes. Similarly, Fleming et al (2015) conducted a study with sites in Chile, Croatia, India, Mexico, and Rwanda found that men who had experienced childhood sexual abuse, or witnessed violence against their mothers were more likely to report that they had perpetrated rape. At each site, men who reported sexually aggressive behaviours as adolescents, binge drank, held attitudes of male privilege and entitlement, paid for sex, or had multiple sexual partners also had a greater risk of perpetuating rape.

Lastly, the WHO's World Report on Violence and Health identified many of the same correlates at the individual and group levels as were previously discussed, and additionally, emphasized that the following community and societal level factors increased men's risk of committing rape: a lack of institutional support from police and judicial system, general tolerance of SA within the community, weak community sanctions against perpetrators of SV, weak laws and policies related to SV, and weak laws and policies related to gender equality (Krug et al., 2002, p. 159). Taken together, these studies suggest that individual acts of perpetration are shaped by broader social structures that normalize and maintain gender inequality, and that detailed investigations of multilevel factors are needed to develop understandings of why some men commit SV.

Impacts on SV Survivors

In attempting to understand the impact of SA, researchers have mapped out common short-term and long-term effects. Common short-term effects can include intense stress, fear, and anxiety (Benoit et al., 2015; Koss, 1993; Campbell, 2006), whereas long-term effects can include major depression, alcohol and drug dependence, generalized anxiety, obsessive-compulsive disorder and posttraumatic stress disorder (Campbell, Dworkin, Cabral, 2009; Koss, 1993; Temple, Weston, Rodriguez, & Marshall, 2007). In addition, women who have experienced SV are at a heightened risk of suicide (Briere & Runtz, 1986; Conroy & Cotter, 2017). The recent GSS on Victimization found also that following SA approximately 25% of SV survivors reported difficulties in maintaining their normal routines, and approximately 17% reported symptoms consistent with those of PTSD (Conroy & Cotter, 2017).

Physical health impacts include increased risks of physical injuries (Benoit et al., 2015) and/or sexually transmitted diseases, with 4% to 30% of victims being diagnosed with a disease (Koss, 1993). Women who have experienced SV also may report more fear of disease, view their health more poorly overall, and engage in more negative health behaviours (Koss, 1993; Campbell, Sefl, & Ahrens, 2004). Approximately one half to one third of women who are sexually assaulted are seriously physically injured during the attack (Beebe, 1991; Koss, 1993). Additionally, in the context of spousal violence, women were twice as likely to be injured, three times as likely to experience disruptions to their lives, and seven times as likely to legitimately fear for their lives (Statistics Canada, 2013). Research also documents that SV survivors can experience impacts of re-victimization by police and other service providers; and re-victimization is tied to a variety of negative consequences for SV survivors, such as depression, suicidal thoughts, and PTSD (Campbell, 2006; Campbell et al., 1999). Although this research

describes common responses, Senn (2010) suggests that it is important to acknowledge that individual responses vary greatly according to individual women's perceptions of their experience and personal coping resources.

Legal Reforms

Rape was originally treated as an extension of the common-law crime of abduction, wherein the "carrying off" of a woman was treated as an offense against her husband or father (Tang, 1998). Indeed, in the state of Massachusetts, an early statute imposed the penalty of death in cases of rape, but only if the woman was married (Allison & Wrightsman, as cited Tang, 1998). Until the Canadian legal reforms of 1983, there was spousal immunity for rape, and when women came forward and reported, they were subjected to laws that essentially, codified rape myths (Johnson, 2017, p. 9). For example, complainants were required to report immediately following an attack; their previous sexual history could be freely explored and questioned in determining whether consent had been given; a third party witness was required; and only certain acts were considered to be rape (Tang, 1998; L'Heureux-Dube, 2012). Moreover, the legal standard for affirmative consent was not yet established, and instead, the onus was on complainants to provide proof of lack of consent (Randal, 2010).

These discriminatory laws were eventually re-written through a growing recognition of SA as an equality rights issue, and the application of gendered and contextualized analyses to SA law (Randall, 2010). Legal successes were brought about by the work of feminist legal scholars and advocacy groups, such as "the National Action Committee on the Status of Women, the National Association of Women and the Law, and the Women's Legal Education and Action Fund, rape crisis centres, and others..." and by judicial rulings that drew connections between SA and broader patterns of gender inequality (Randall, 2010, p. 401).

In particular, the case of Jane Doe was significant due to its precedent setting power. In 1986, Jane Doe was sexually assaulted at knifepoint in her bed. Upon reporting the attack to police, she learned that they were familiar with the criminal profile (Sheehy, 2012). When Jane Doe questioned why she had not been warned, the police replied that they did not warn potential victims, because “women would become hysterical and the rapist would flee the area” (Sheehy, 2012, p. 23). In effect, this was an admission that the police had “used her as “bait” to catch the rapist” (Sheehy, 2012, p. 29) and in response, Jane Doe sued the Toronto police department for discriminating against her on the basis of her gender, and for failing to warn her despite the potential risk. Eleven years after initiating the lawsuit, Jane Doe won \$220 000 in damages, and received a judicial admission that the police had “violated her right to equality and had been negligent in failing to warn her” (Sheehy, 2012, p. 24).

The ruling of the Judge, Justice Jean MacFarland, was central to the precedent setting power of this case. For the first time, a judge used a feminist framework for defining SA, which she described as “an act of power and control rather than a sexual act” that derives from “the perpetrator’s desire to terrorize, to dominate, to control, to humiliate; it is an act of hostility and aggression” (Sheehy, 2012, p. 33). Additionally, Justice MacFarland stated, “male SV operates as a means of social control over women” (Sheehy, 2012, p. 33) and thus, she acknowledged the larger social context of SV. This judgment worked to implement new law, and has been cited in more than forty cases as legal precedent (Sheehy, 2012).

Following from feminist actions on multiple fronts, a number of changes were made to the *Criminal Code* of Canada (Randall, 2010; Johnson, 2017). For instance, legal definitions were expanded to reflect a wider range of offenses, and the term SA was introduced into the *Criminal Code* of Canada in 1983 (Tang, 1998; Brennan & Taylor-Butts, 2008). This reform

replaced the crimes of “rape” and “indecent assault” with three levels of SA crimes that range in severity according to the degree of violence present (Brennan & Taylor-Butts, 2008). These amendments shifted understandings of the basis of the crime to emphasize the level of violence involved, and this worked to align SA with the same legal framework used to judge physical assault. Concurrently, the Canadian legal reforms of 1983 removed spousal immunity for SA, restricted evidence regarding complainants’ past sexual history in trials, removed the requirements of recent complaint and corroborating witnesses, and resulted in affirmative standards for consent (Johnson, 2017; Randall, 2010). Affirmative standards for consent placed limitations on “mistaken” consent defences, and essentially, prohibited defences in which the accused’s belief arose from self-induced intoxication, reckless or willful blindness, or failing to take reasonable steps to ascertain that the complainant was consenting (Randall, 2010, p. 402). Crucially, affirmative standards for consent also resulted in the requirement that the accused provide evidence of having taken “reasonable steps” to establish consent when mistaken consent defences are used (Randall, 2010). The legal reform referred to as the “rape shield provisions” was introduced into the *Criminal Code* in 1992, which limited the use of evidence relating to complainants’ past sexual histories in SA trials, and prohibited the use of this evidence for undermining complaints’ credibility or implying their consent (Randall, 2010).

Despite Canada’s progressive legislation, SA remains a major source of gender bias in the legal system. As previously discussed, 99% of perpetrators are male and 90% of victims are female (Tang, 1998). Only 5% of SA are reported to police (Perreault, 2015; Conroy & Cotter, 2017), and of these, only a small fraction is successfully prosecuted. Indeed, within Ontario, data show that less than 1 percent of SAs substantiated by police resulted in convictions (Johnson,

2017). With the advancement of legislative reform on SA, how can such poor outcomes be accounted for?

Canada is one of the most advanced countries in terms of legal and judicial reforms however, there are numerous problems with how the law is implemented. Specifically, the law is undermined by pervasive police skepticism towards SA complainants and police “unfounding” of SA cases, defence lawyers’ use of discriminatory practices intended to intimate SA complainants and undermine their credibility, and judicial decisions that are influenced by sexual stereotypes and rape myths (Johnson, 2017; Randall, 2010). These “deep and systematic flaws in the legal processing of criminal SA cases” (Randall, 2010, p. 400) are based on “real rape” and “ideal victim” understandings of SA (Randall, 2010) that essentially rely on rape myths and stereotypes to determine complainants’ credibility and worthiness of justice. Supporting this, research indicates that complainants are perceived as more credible (and therefore deserving of justice) in cases involving “[W]hite women, ethnic minority and low status perpetrators, a weapon, physical injuries, vigorous resistance, recent complaint, emotional upset, forensic evidence, no prior complaints of SA, and a sober respectable women with no prior sexual relationship with the suspect and no history of psychiatric or intellectual impairment” (Johnson, 2017, p. 4). Given this reliance on irrelevant stereotypes in determining women’s credibility, it is perhaps unsurprising that levels of SV have not gone down in the past decade, and that racism, ableism, classism/respectability and other biases against women continue to prevent them from receiving procedural justice from the legal system (Perreault, 2015).

Literature Review

RCCs evolved out of feminist recognition of failures of social and legal institutions, and the need to provide counselling support, advocacy, and political activism. The next section

engages with the existing research on RCCs, and provides an overview of the studies on volunteer counsellor training programs conducted in related community contexts in RCCs, peer support models, volunteer counsellor training programs, student peer counsellors, healthcare workers, and telephone hotlines.

Rape Crisis Centres

Overall, limited research has been carried out in RCC settings. However, research has examined how RCCs have changed over time and whether they have continued to be faithful to feminist principles (Maier, 2008; Campbell, Baker, & Mazurek, 1998; O'Sullivan, & Carlton, 2001). Limited research has also focused on the efficacy of RCC services (Bennett, Riger, Schewe, Howard, & Wasco, 2004; Wasco, Campbell, Howard, Mason, Staggs, Schewe, & Riger, 2004; Westmarland, & Alderson, 2013). Research on RCC service providers has examined the experiences of social workers, counsellors, and health care workers (Clemans, 2004; Truell, 2001; Kulkarni, Bell, Hartman, & Herman-Smith, 2013; Botega and colleagues; Shim & Compton, 2010). In comparison, scarce attention has been afforded to rape crisis counsellors. This research has predominantly focused on the challenges and negative outcomes of trauma support work with SV survivors relating to burnout and other stress responses (Ullman & Townsend, 2007; Baird and Jenkins, 2003; Thornton and Novak, 2010; Wasco and Campbell, 2002; Cyr & Dowrick, 1991). Research also examined rape crisis counsellors' motivations for volunteering (Black & DiNitto, 2008; Rath, 2008); the personal changes they experience due to their work (Schauben & Frazier, 1995; Rath, 2008); and their positive impact on preventing clients' re-victimization by other service providers (Maier, 2008; Campbell, Wasco, Ahrens, Sefl, & Barnes, 2001; Campbell, 2006; Campbell, 1998). Very limited research has focused on rape crisis counsellors' training and preparation, and no quasi-experimental or experimental

outcome evaluations have been conducted in this area. The small group of studies examining rape crisis counsellors' training and preparation are reviewed, in turn, below.

Rath (2008) sought to understand how volunteers made sense of their training, and used grounded theory to identify themes emerging from qualitative interviews with RCC volunteers. Volunteers received 65 hours of instruction on topics relevant to crisis counselling and advocacy, such as "counselling skills, crisis intervention, the politics of SV, legal issues, police procedures, sexual health, social work procedures, domestic violence, abortion and contraception, sexuality, survivors of child abuse, suicide and self-harm, relationship issues, and Rape Crisis principles" (Rath, 2008, pp. 21). Volunteers had all completed training within the past 2 years at the same British RCC. Rath found that themes of change were frequently woven into participants' interviews, beginning with their tendency to join the training during times of personal upheaval. Change was discussed in terms of their own gender politics in intimate settings, and the dissolving of, or improvements to, relationships with their intimate partners. Volunteers spoke of positive changes in their confidence, communication skills, and the quality of their relationships. Themes that emerged in this study predominantly related to volunteers' growth and development as it coincided with their participation in RCC counsellor training.

Carlyle and Roberto (2007) focused on RCC CL volunteers' communication competency (based on their skills, knowledge, and motivation) and how this construct related to their communication anxiety, and counselling self-efficacy. Researchers administered questionnaires to CL volunteers, who had undergone 40 hours of training at two American RCCs within the past year. The study determined that communication competence was negatively related to communication anxiety, and positively related to all areas of counselling self-efficacy. It recommended that RCCs develop communication skills in training (e.g., building listening skills,

and reframing client concerns without giving advice) and incorporate specific examples of how to respond to different situations, in order to help volunteers deal with anxiety over uncertainty and increase confidence in their abilities.

Hellman and House (2006) administered questionnaires to RCC CL volunteers to examine correlations between different aspects of volunteers' experiences – such as training, social support, experiences with victim blaming, and volunteer self-efficacy – and their overall satisfaction, affective commitment to volunteering, and intent to remain. Results suggested that the perceived quality of their training was positively related to their overall satisfaction and intent to remain. The perceived quality of training was also positively correlated to counselling self-efficacy and affective commitment, and negatively correlated with victim blaming by service providers. These findings indicate the importance of volunteers' training to their overall satisfaction and commitment, and suggest that the variables may be interrelated, such that training could improve their self-efficacy, and help provide them with strategies to manage victim-blaming attitudes directed at survivors.

Peer Support Model

According to the Mental Health Commission of Canada, “peer support is a supportive relationship between people who have a lived experience in common. The peer support worker provides emotional and social support to others who share a common experience” (Cyr, McKee, O'Hagan, & Priest, 2016). Furthermore, peer support involves the pairing of former mental health service clients/survivors with current clients in order to both reduce stigma around mental illness, and provide hope, encouragement and support to clients from those with first-hand knowledge of their peers' struggles (Nelson & Prilleltensky, 2010). The peer support model is the basis for many self-help/mutual aid groups in community mental health, and is found in peer-

run and consumer-run organizations, workplaces, schools, and healthcare settings (Cyr et al., 2016; Nelson & Prilleltensky, 2010). Although the CL training program shares several traits and benefits of the peer support model, it also departs from it in important ways.

The CL training program differs from the peer support model insofar as volunteer counsellors do not necessarily have lived experience with SV, nor is lived experience a focus of the CL program. However, there is overlap in their shared focus on clients' strengths, health/wellbeing and recovery; the development of egalitarian, non-directive relationships between peers; and the development of skills/abilities and naturally occurring resources (Cyr et al., 2016; Nelson & Prilleltensky, 2010). In another departure from the peer support model, CL counsellors locate the source of clients' distress both in inequitable social structures that maintain gender discrimination and support SV against women, and in the actions of SV perpetrators (Senn, 2010; Enns, 1993). The peer support model does not involve such an analysis. Regardless these differences, they share several traits and may be similarly empowering to clients. Several positive outcomes of peer support have been demonstrated in the literature, relating to improved client satisfaction with services, decreased use of hospital services (and decreased associated hospital costs), fewer psychiatric symptoms, enhanced social networks, improved quality of life, and increased self-esteem and social functioning (Cyr et al., 2016).

Volunteer Counsellor Training Programs

Community psychology research establishes that volunteers have worked as effective counsellors and crisis interventionists in a variety of settings. Such settings include telephone hotlines, outreach programs, hospitals, mental health centers, and college residences (Clark, Matthieu, Ross, & Knox, 2010; Katz, DuBois, & Wigderson, 2014; Schinke, Smith, Myers, & Altman, 1979; Hart & King, 1979). While the majority of this research was conducted in the

1970-80s, recent research also suggests that such programs show promise (Banyard, Moynihan, & Plante, 2007; Moynihan, Banyard, Arnold, Eckstein, & Stapleton, 2010; Coker et al., 2011; Cissner, 2009; Clark, Matthieu, Ross, & Knox, 2010; Katz, DuBois, & Wigderson, 2014). The research in these settings is not specific to the context of RCCs, however, it sheds light on the design, implementation, and outcomes of relevant training programs, and thus, helps to inform the current research.

Student peer counsellors. Several studies have examined the effects of training programs on the counselling competencies of student volunteers. One study, focusing on dormitory residence assistants in the US, compared a group receiving training in crisis intervention to a matched control group receiving no training, on a variety of measures (Schinke et al., 1979). Participants were randomly assigned to their groups. In a single 4-hour session, experienced trainers modeled and described interviewing and helping techniques. Additionally, they taught assessment, behaviour-change, and referral procedures. As part of their training, participants discussed the material and engaged in skill building role-play exercises. Training outcomes were assessed through knowledge tests, role-play interviews, and questionnaires. Results demonstrated that the residence assistants scored significantly higher than the controls on overall crisis intervention competence, which included knowledge, interviewing skills, recall of interview content, correctness of clinical judgments, and referral suggestions. A limitation of this study was its use of a posttest only control group design.

Waaen, and Haelstromm (2003), examined the efficacy of a high school peer gatekeeper training program in suicide risk assessment. Sixty five participants on average between 15-16 years of age were sampled from schools in three different school districts on Vancouver Island. Participants were on average between 15 and 16 years of age. Participants attended two half days

of training that ran one week apart, and then attended a follow-up session after 3 months.

Training consisted of the following: active listening techniques, self-care and setting limits, crisis theory, and signals of suicide, suicide risk assessment, role-play scenarios, and community resources. Effects of the training were assessed using questionnaires on suicide awareness and risk assessment skills that were modified for use with youth respondents. Compared to pre-training, post-training scores showed significant improvements in skills, attitudes toward suicide intervention, and knowledge, and these gains were observed again at 3 months. Although no control group, or random assignment was used in this study, it nevertheless provides evidence that short-term suicide intervention training can be effective, and that it can also benefit youth volunteers.

Healthcare workers. More recently, research has focused on crisis intervention training for healthcare workers. In a Brazilian study, Botega and colleagues (2007) explored how a 6-hour suicide intervention training program influenced nurses' attitudes about suicide. During training, a psychiatrist presented information about suicide, techniques for intervention, and the nurses were encouraged to explore their attitudes and feelings. A questionnaire assessing dimensions of attitudes, including feelings toward the patient, capacity to manage situations involving suicide, and opinions regarding the right to suicide, was used. The questionnaire was administered at the start of training, at the end of training, and 6 months after training. Results showed positive changes in feelings toward the patient, and capacity to manage situations. Nurses did not endorse the patients' right to suicide, but this may relate to their values and beliefs, rather than the effectiveness of the training. The study's design was limited by its use of a proxy measure (attitudes), rather than measuring suicide intervention skills directly. In addition, no random assignment or control group was used.

A similar US study focusing on the efficacy of suicide intervention training was conducted with emergency department clinicians (Shim & Compton, 2010). During 3-hours of training, clinicians were educated about suicide, and learned crisis intervention strategies that could be implemented in emergency room settings. Pretest-posttest questionnaires, developed for the project, were used to assess training outcomes. They revealed significant gains in clinicians' knowledge, and perceived ability to manage suicidal patients. In this study, no random assignment or control group were employed.

Morriss and colleagues (1999) evaluated an 8-hour suicide intervention training program for British front-line health workers and volunteers. This program focused on suicide assessment, crisis management, problem solving, and crisis intervention skill building. To evaluate the program, the participants' interviewing skills were videotaped and assessed by trained raters. Additionally, questionnaires were administered at the beginning and end of training, which involved self-assessments of clinical skills and confidence. The training improved participants' performance on risk assessment and management skills, and confidence in dealing with suicidal patients; however, the training did not enhance their general interviewing skills.

Telephone hotlines. Several studies have focused on the impact of training on crisis hotline volunteers. In the US, Frauenfelder, and Frauenfelder, (1984) examined the impact of a brief training program on undergraduate crisis hotline volunteers' empathetic skills. The training involved role-play activities, instructor modelling, and education on counselling techniques. Two paper-based questionnaires were used to assess the effects of training; in particular they were the Empathic Listening Test (Frauenfelder, & Frauenfelder, 1984), and the Empathy Scale (Frauenfelder, & Frauenfelder, 1984). Compared to the controls, the student trainees showed marked improvements in counselling abilities, understanding, and interest at the end of training.

This study suggests that volunteer counsellors' competencies can be meaningfully enhanced through short-term training. Additionally, it provides two short questionnaires that can be used in applied settings with adults to assess specific volunteer counsellor competencies.

Hart and King (1979) evaluated the impact of a telephone counselling training program on US undergraduates' capacity to demonstrate empathy, warmth, genuineness, and concreteness in telephone counselling as measured by the Telephone Counselling Effectiveness Scale (TCES) (Morgan and King (1975). During three 2-hour training sessions, participants engaged in role-play exercises simulating typical crisis center issues including "depression, problem pregnancy, loneliness, and sexual problems" (Hart & King, 1979). Each participant provided role-plays that were tape-recorded at the onset of training, at the end of training, and again three weeks following training, and these were scored using the TCES. Notably, the results showed that, regardless of their initial level of counselling competency, volunteers had similarly high scores at posttest, and these changes were maintained three weeks later. This study was limited in that the same role-play scenario was used at all three points in time, and no control group or random assignment was used.

Whereas the aforementioned studies demonstrate the efficacy of training programs for volunteers, other studies have resulted in less favourable outcomes. For example, Carkhuff (1969) found that a training program was only effective for US volunteer counsellors who already possessed basic counselling skills. Other research projects have indicated that training does not result in the development of adequate counselling capacities in particular areas (e.g., France, 1975; Genthner, 1974).

France (1975) conducted a systematic review focusing on crisis telephone services in the US in order to understand the competencies of volunteer crisis hotline volunteers. This analysis

uncovered three primary functions of crisis line volunteers: making referrals, helping, and influencing behaviour change. According to France (1975) making referrals requires a comprehensive knowledge of community resources, and specialized knowledge about the population served. Helping involves the ability to communicate genuine warmth, empathy, and concern for the caller. Influencing behaviour change involves the application of a behaviour change strategy to a callers' concern. Findings of this review suggest that while volunteer crisis line volunteers are effective as helpers, they were less effective as referral, and behaviour change agents (France, 1975).

Bryant and Harvey (2000) evaluated the competencies of volunteer counsellors working on a crisis hotline for Australian Vietnam veterans. In this study, professional clinical psychologists made simulated crisis calls to the hotline. During these conversations, the psychologists assessed the volunteer counsellors on three dimensions including basic counselling skills, specialized knowledge of veteran issues, and suitability of advice (Bryant & Harvey, 2000). In this study, virtually all of the counsellors were rated as displaying effective basic counselling skills, which included the ability to develop rapport, display empathy, and non-judgment; this finding corresponds to France's (1975) findings that volunteers were adequate as "helpers". However, Bryant and Harvey (2000) found that counsellors were less effective at providing suitable advice, and understanding veterans' specific concerns and experiences. In particular, volunteers underestimated callers' risk of suicidality or violence, and were unfamiliar with psychopathology typical of this population.

Reviewed together, this literature indicates that while crisis hotline volunteers can effectively provide basic counselling to callers, they may require more specialized knowledge about target populations. This translates to a need for specialized training tailored to specific

populations, and to research that evaluates such training. Across several human services settings, research has shown that training programs can result in meaningful and long lasting improvements to volunteer counsellors' skills. Unfortunately, few attempts have been made in the context of RCCs. The current research will build on the methods used and discoveries made in the context of related research settings, and will focus on gathering information about how such training functions in the novel context of a Rape Crisis Centre. In particular, research on community-based training programs tends to use questionnaires to assess counselling competencies and knowledge, and this approach will be used in the current research. Given the applied context of this research, some limitations are apparent in the designs used (e.g., posttest only designs, designs lacking control groups or random assignment, and few participants). The current research will employ a more rigorous design to increase confidence in the results.

Research Rationale

RCCs have played a vital role in both influencing social change, through organizing, lobbying, and advocacy activities, and providing direct services to women since their beginning (Campbell, Baker, & Mazurek, 1998). However, the majority of these programs have not been evaluated, and thus, their outcomes are not known. Important services offered by RCCs are the CLs, which notably, are volunteer operated. Volunteers are often exposed to troubling accounts, have only short-term contact with callers (Payne, Button, & Rapp, 2008), and this makes their role extraordinarily challenging. Limited sustainable funding to RCCs means that the centres rely heavily on volunteers to stay in operation, and could not exist without committed volunteers (Rath, 2008). This underscores the importance of understanding how to retain volunteers over time and necessitates an examination of the factors that impair retention.

Crisis counsellors at RCCs serve more women than other groups of direct service providers, and due to the anonymous and confidential nature of CLs, they can reach clients who may not otherwise seek support (Colvin, Pruett, Young, & Holosko, 2016). Counsellors also perform the important role of connecting clients with other services such as healthcare, police, legal, and housing services (Colvin, Pruett, Young, & Holosko, 2016). Unlike some other direct service providers, they take a feminist empowerment approach, which can be beneficial to survivors' mental health and wellbeing as it emphasizes clients' strengths and autonomy (Ullman & Townsend, 2007). Research demonstrates that when survivors report an assault with a crisis counsellor present, they are less likely to experience re-traumatization, or "the second rape" (Campbell, 2001) and they report to police more frequently (Campbell, 2006). For all these reasons, research on this largely understudied population is required.

Feminist Perspective

The RCC collaborating on this research operates from an anti-oppression, feminist, anti-racist ideological framework, which views SV as "a direct product of a patriarchal political and socio-economic order based on structural inequalities and the systematic oppression of some of its groups" (ORCC, 2005). This analysis of SV overlaps with that of feminist scholars (Jiwani et al., 2010; Kelly, 1988; Nagy Hesse-Biber & Yaiser, 2004; Sheehy, 2012). Kelly (1988) proposed the "continuum of SV model", which contends that different forms of VAW are connected to each other, and that all forms are rooted in a larger systemic pattern of gender-based oppression. In this model, extreme, socially condemned acts (e.g., rape, SA) are represented at one end of a continuum, and banal, socially permitted forms of violence (e.g., sexual harassment, sexually violent media imagery, sexist language, pornography) are placed at the other. This model suggests that violence is present in all women's lives although its form, impact, and definition

greatly vary. It rejects the notion that some forms of SV are harmless. Consistent with this analysis, Jiwani and colleagues (2010) assert that violent attitudes, behaviours and practices, whether extreme (and criminal) or banal and accepted, are based on the same root cause. As it aligns with previous research on SV, and the perspectives of the RCC collaborating on the project, a feminist empowerment perspective will guide this research project (Reinharz, 2002).

Feminist scholars conduct research using a diversity of methods – just as there are numerous definitions and understandings of feminism, so too are there many possible feminist research methods (Reinharz, 2002). This plurality of methods allows for examination of the largest possible spectrum of inquiries, and this adaptability and scope is seen as strength of feminist research (Reinharz, 2002). After undertaking an inductive analysis of all major approaches to feminist approaches to research, Reinharz concluded,

Since feminism is a large movement without official leaders, it is not surprising that we lack a single definition of how to do feminist research. In fact, since we value working in all the disciplines and using all the methods, there has been interest in expanding feminist research as much as possible, not in narrowing it. We are likely to protest if any particular method receives short shrift in the name of feminism (p. 244).

While no single method is unique to feminist research, or uniquely defines it, the current research is characterized by several traits of feminist research that are found in different disciplines and areas of study. First, this research aims to be for women, rather than merely being about women (Nagy Hesse-Biber & Yaiser, 2004). Implicit in this distinction is the goal of improving women's social condition with respect to the issue of SV. It is intended that women will benefit from the current research, rather than serving only as "research subjects". Its potential benefits are practical and direct, and include such aides as providing an opportunity for

participants to speak and feel validated; making improvements to “on the ground” programming that positively influence women’s lives; and/or collecting evidence to support favorable policies or funding opportunities. Its potential benefits are also indirect, by contributing to and influencing research knowledge, and/or public discourse. Furthermore, the current research strives to avoid the reproduction of social inequalities in social research by aiming to include a diverse group of women with respect to race, class, ability/disability, sexual orientation, religion, and culture. This aligns with feminist research in its goal of “reflecting variations” in women’s individual characteristics, or “showing intersections” in their overlapping identities (Reinharz, 2002, p. 253), and in its intention to amplify the voices of non-dominant/marginalized groups of women. In these ways, this project is consistent with a feminist perspective on research that seeks to bring about social change to support women’s equality, and so improve the material conditions of their lives (Reinharz, 2002).

In addition, the current research overlaps with a feminist perspective in that it is sensitive to power dynamics in the research process, and it aims to minimize and address power differentials. It rejects the “expert/subject” dichotomy, and works to afford as much information, transparency, and accountability to participants as possible. This research project values experience as a legitimate source of knowledge and expertise, and this is reflected through the use of consultations and collaborations with community partners and participants during various stages of research projects. The valuing of experiential knowledge is also reflected in the use of qualitative tools. Qualitative methods are consistent with a feminist approach as they work to understand and interpret the lived experiences of others, particularly marginalized groups, and to integrate participants’ subjectivities and multiple perspectives (Nagy Hesse-Biber & Yaiser, 2004). This study’s use of quantitative methods further reflects a feminist perspective as

experimental methods are often used in feminist research to “challenge and invalidate misperceptions about women” and to pursue practical social change goals (Reinharz, 2002, pp. 244). A feminist approach to research is important because it supports the empowerment of women who are marginalized by different social structures within society. In the context of the current project, this approach is relevant because of the gendered nature of SV, the way one’s vulnerability to SV is affected by different aspects of identity, and the project’s overarching goal of social empowerment.

Methodological Approach

Together, these three studies take a sequential mixed-methods approach to the research, in which a quantitative quasi-experimental investigation of the training program is followed by a qualitative exploration of fewer cases in richer detail (Creswell, 2013). Both methods are needed in this series of studies, and their integration leads to a fuller understanding of crisis counsellor training and practice. A quantitative approach is appropriate for capturing and demonstrating the outcomes of the training, whereas a qualitative approach is best suited to reflect on the process of working directly with survivors and the various services (legal, medical, psychological). Because crisis counsellors work closely with survivors of violence, they can provide an ‘insider’s perspective’ on the human service response systems, and are in a unique position to report on any obstacles to effective and compassionate service delivery. Only a minimal amount of research exists on volunteer crisis counsellors, therefore, an exploratory, qualitative approach is appropriate for this analysis. Finally, the integration of both quantitative and qualitative methodologies supports the process of triangulation, in which the results of each study is examined separately, and is then compared and contrasted in order to identify areas of overlap

(Campbell, Patterson, & Bybee, 2011). A mixed-methods approach accommodates insights from both of these rich research traditions, and examines research questions from multiple angles.

Despite the benefits of a mixed methods approach and its suitability to the current research, tensions between the epistemological and ontological assumptions underlying quantitative and qualitative methodologies exist (Campbell, Patterson, & Bybee, 2011; Westmarland, 2001). Whereas quantitative research is grounded in positivist or postpositivist thought, qualitative research is rooted in social constructivism or postmodernism. Positivism and postpositivism posit an “objective reality” that can be accessed through empirical observation and verified by hypothesis testing. In this view, it is possible to uncover laws of human behaviour through careful experimentation. Social constructivism, in contrast, rejects the notion of an objective reality, particularly in the human sciences, and points to the cultural, social, and historical construction of meanings. Here, realities are derived from experiences, and the way they are understood are highly contextual and varied (Creswell, 2013).

Positivism and postpositivism can be said to be reductionist insofar as they strive to distill phenomena to smaller, discrete sets of ideas that can be tested. They are deterministic in the sense that they strive to identify stable cause and effect relationships between variables. Social constructivism is based on the assumption that individuals build meanings about the things they experience and people they interact with. In this tradition, researchers do not attempt to reduce phenomena to fewer categories. Instead, they formulate broad questions and attempt to interpret a multiplicity of perspectives. Additionally, rather than regarding themselves as objective observers, social constructivists aim to understand their position in relation to their research (e.g., past experiences, social location). Therefore, in many ways quantitative and qualitative research epistemologies are shown to be contradictory (e.g., assumptions of objectivity/subjectivity;

determinism/interpretation, etc.), and this debate continues to be explored in the literature.

However, today a variety of mixed-methods approaches have been established and they represent a strong and growing tradition of applied social research (Campbell, Patterson, & Bybee, 2011).

In the current study, a pragmatic approach is taken that prioritizes the research questions, and the selection of methods follow from the goal of real world problem solving (Patton, 2002). The use of numerical data is used to measure the efficacy of the training, while qualitative data is used to explore volunteer counsellors' perspectives on working with SV survivors. Consistent with a pragmatic approach, the research is understood to exist within the current social, historical, and political context and thus, aligns with a research perspective that engages with political and social justice issues (Creswell, 2013), and in particular, the issue of violence against women.

Research Questions and Objectives

This dissertation consists of three studies designed to systematically evaluate a volunteer-based CL training program. It investigates the development of volunteer counsellors' competencies following their counsellor-training, and explores their experiences working directly with SV survivors. Using a sequential mixed methods quasi-experimental design, the research addresses the following overarching primary questions: 1) is the counsellor-training program ready to be researched, and what is the program logic? 2) to what extent does the training meet its intended objectives? 3) how do the counsellors experience their training and practice? Additionally, it set out to answer the following secondary question: 4) what larger insights can the counsellors reveal about SV in society?

Study 1 is an evaluability assessment, which was conducted to prepare for the subsequent studies. The objectives of Study 1 were to determine whether the CL training program was ready

for a full evaluation, and to elucidate the program's components, processes, and intended outcomes. It was also intended to clarify the RCC's broader organizational goals.

Study 2 is a quasi-experimental evaluation of the effectiveness of the CL training program. Its objectives were to examine whether volunteer counsellors developed the intended skills and competencies over the course of the training, including increased counselling self-efficacy, crisis intervention skills, and feminist attitudes and beliefs.

Study 3 used semi-structured qualitative interviews to explore counsellors' perceptions of training, and their experiences of working directly with survivors. The objectives of Study 3 were to examine the counsellors': (1) initial motivations for volunteering; (2) training and practice experiences; (3) ongoing motivations and challenges; and, (4) perspectives on SV in society.

The use of mixed-methods is particularly well suited to this series of studies – numerical data measures the outcomes of the counsellor training, and verbal data validates quantitative findings, and helps to shed light on the experiences and insights of a largely understudied group of direct service providers.

Study 1

An Evaluability Assessment of a Grassroots Rape Crisis Line Training Program

Evaluation Rationale

This evaluability assessment (EA) was conducted in collaboration with the Ottawa Rape Crisis Center (ORCC). The Centre's objectives are to promote the development of a safe and equitable community through working to end violence against women (VAW), and to provide empowering services to women who experienced sexual assault (SA). After an initial dialogue with the Centre, the Crisis Line (CL) training program was selected for evaluation, particularly as a current strategic direction of the organization aimed to "build a sustainable core community of CL volunteers" (ORCC Strategic Plan, 2013-2016). Additionally, research on the CL training program is timely because a current priority for the organization is to improve volunteer engagement and retention in order to ensure consistent delivery of CL services to the community.

As the CL training program had not previously received external evaluation, and program evaluation was new to the organization, an EA was identified as an important first step in developing evaluation research on the CL training program. EAs are exploratory, and involve collecting information about a program from a variety of sources. They are not designed to determine whether program objectives have been met, rather, they are used to identify program goals, clarify the elements of a program, compare its theory to its reality, and assess whether the program is ready for evaluation research to be conducted on it (Wholey, 2010). In addition, EAs involve making recommendations and helping to plan program evaluation research (Wholey, 2010).

Primary research questions for the EA were developed in collaboration with the ORCC's Executive Director and the CL Program Coordinator.

The research questions guiding the EA are the following:

Program Model

(1) What is the program logic model (PLM) of the CL training program, as envisioned by the organization?

(1a) What are the goals and objectives of the training program?

(1b) How do the program's components support its goals?

(1c) Is the PLM supported by relevant research?

Evaluability

(2) Is the CL training program evaluable at this time, according to evaluability assessment criteria proposed by Wholey (2010)?

(2a) Are program goals agreed on and realistic?

(2b) Are information needs well defined?

(2c) Are evaluation data obtainable?

(2d) Are intended users willing and able to use evaluation information?

These research questions align with an EA approach to evaluation as they involve gathering and synthesizing broad information about the program, and collaborating with the organization on plans for its subsequent evaluation (Wholey, 2010). The EA will also focus on relationship-building with the organization in order to improve communication during the research process, and to improve uptake of the evaluation after its completion. In addition, the EA will provide a rich basis of information about the program, and will serve as a practical first step in ensuring the research is feasible before beginning a more extensive research project. Rather than merely assessing whether the organization is ready to be evaluated, the EA will serve as a process-oriented tool to help prepare the organization for a successful evaluation. For these

reasons, an EA is an effective and appropriate way to begin research on the CL program at the ORCC.

Description of Organization

History

Local feminist activists founded the Ottawa Rape Crisis Centre (ORCC) in 1974. At this time, they recognized that VAW was a critical issue at the community level, yet appropriate services and supports were not in place to respond to these needs. The Centre's CL services were established soon after, and have been operating for approximately 40 years. Initially, the ORCC was structured as a collective in which all members were granted equal voting rights and in which all members were expected to perform each role within the organization. (This was complicated by the fact that the organization was comprised of both paid workers and volunteers.) In the 1980s, the organization separated into the ORCC and the Sexual Assault Support Centre of Ottawa (SASC), due to differences in philosophies among members and differences in terms of how they wished to be structured and managed. A decade later, the ORCC further evolved, when its members voted to move from a collective to a hierarchical organizational model that included an Executive Director and Board of Directors. This change allowed the organization to formalize staff and volunteers' roles and responsibilities, to deliver structured services, and to increase accountability to funders. Along with the CL, the Centre now offers several services to women who have experienced violence, and also delivers public education to promote the development of a safe and equitable community.

Services and Programs

The Centre is committed to providing a range of services, and ensuring they are accessible to marginalized groups of women. For example, the ORCC facilitates regular

workshops and support groups at the Carleton Detention Centre. A peer mentorship program and the GirlsChat project, available to immigrant and refugee women and girls, are designed to offer culturally appropriate supports. The ORCC provides cultural competency training to counsellors and front-line workers at several other community agencies. In addition, the Centre disseminates public education workshops and campaigns that are designed to help prevent SV and gender discrimination as well as provide information on these issues.

Population Served

The CL program offers services to English speaking women and girls who are at least 16 years of age and survivors of recent or childhood SA. Family and friends of survivors can also access CL services. In its program documentation, the ORCC reports that the population seeking services often has health and addictions issues related to trauma. The ORCC serves more than 1500 women annually, and reaches the larger community through public education campaigns and training programs.

Organizational Structure

The ORCC is a feminist organization with an Executive Director and a volunteer Board of Directors. The main stakeholder groups include clients, paid staff, volunteers, and partnering organizations. To increase research and development capacity, public education, and advocacy efforts, the Centre collaborates with several community partners and coalitions, at the regional and provincial level. Currently, there are three full-time and eight part-time staff. There are approximately 50 volunteers who contribute to the organization by providing CL services, serving as members of the Strategic Planning Committee or Board of Directors, or engaging in public education activities. The staff and volunteers liaise with the police, medical personnel, lawyers, and other social service resources. The CL itself is currently staffed by 27 volunteers.

Funding

The Centre's annual budget is approximately \$650,000. The ORCC receives the bulk of its funding from the Ministry of the Attorney General, and smaller amounts of funding from other sources, including United Way Ottawa, City of Ottawa, project based funding from Status of Women Canada, Kiwanis Club of Canada, fundraising events, as well as private donors. Despite these sources of funding, the organization struggles with precarious funding of its programs, limited growth in funding, and uncertainty regarding how long the core funding will be available. Because of these issues, it relies heavily on the work of volunteers.

Crisis Line Program

The RCC volunteers operate a 24-hour CL service for survivors of SV and their family and friends. The CL is a well-established and long standing service at the Centre. The service offers emergency crisis intervention and feminist counselling to survivors on issues including childhood sexual abuse, recent SA, flashbacks, and suicide intervention. The CL also offers referrals to other community resources and services, such as women's shelters, legal clinics, individual and group counselling, and housing services. In addition to providing support on lines, volunteers act as advocates to survivors during accompaniment to police stations and the Sexual Assault Partner Care program at the Civic campus of the Ottawa hospital. The CL services are confidential and anonymous, and thus, no records of clients' personal or identifying information are collected. The volunteers who become CL counsellors are recruited from the community, and receive in-house training prior to working on the lines. A commitment of 20 hours per month, for a period of one year is expected of the volunteer counsellors. In a single day in Canada, 2105 women are served by RCCs (Allen, 2014), and one of the main services they offer is their anonymous and confidential crisis hotlines for survivors of SV.

Crisis Line Program Training

The CL training program was well established with it having been offered by the community-based RCC for over 40 years. It involves 30 hours of counselling training organized as 3-hour sessions over 10 consecutive weeks. Currently, three 10-week training sessions are conducted each year at the Center. This training is provided internally and is supervised by a counsellor who has numerous years of experience, and an advanced degree in social work. Sessions consist of facilitator instruction and guest presentations, supervised role-play exercises, and group discussions. Participants explore different topics each week including: understanding SV through an anti-oppression framework, crisis intervention, recent SA, suicide, coping strategies, and self-care. Additionally, participants learn about relevant legal and medical practices and protocols in order to provide support and information to survivors who engage with these social services. Table 1 presents the content of the curricula for each of the 10 sessions.

Table 1

RCC CL Training Protocol

Training Session	Curricula
1	Introduction to the Centre Volunteer Commitment / Self-care Understanding Violence Against Women
2	Sexual Violence and Oppression
3	Feminist Counselling Strength Based Framework Role Plays
4	Guest Speaker from the Outreach Program at the Royal Ottawa Role Plays
5	Recent Sexual Assault/Coping Strategies Guest Speaker from the Sexual Abuse Partner Care Program Role Plays
6	Childhood Sexual Assault and Coping Strategies Guest Speaker from the Centre for Treatment of Sexual Abuse and Childhood Trauma Role Plays
7	Suicide Intervention Role Plays
8	Role Plays
9	Role Plays
10	Role Plays/Volunteer Information

Notes. Trainees were required to attend each of these 3-hour long training sessions.

An integrated feminist approach to crisis counselling is also taught to trainees. This approach differs from other approaches to counselling in several ways. One difference is that a feminist framework attempts to avoid pathologizing survivors' responses to SV by accepting and validating their experiences, demystifying psychological language and concepts, and locating the source of the problem within the social context and perpetrators' actions (Senn, 2010). Another distinction is that counsellors intentionally enter into non-hierarchical relationships with survivors through explicitly addressing power dynamics and going beyond the expert/victim approach (Corey, 2012; Israeli, & Santor, 2000). Furthermore, value is placed on supporting clients in their own decision-making, and in emphasizing their personal autonomy, strengths, and individual differences (Senn, 2010; Enns, 1993). The need for CL volunteers to have a feminist perspective on SV is very important to the organization, as it relates directly to the organization's values, and to the volunteers' ability to carry out their crisis counselling and advocacy work in line with these values. Because of its emphasis on empowerment, a feminist approach to crisis counselling is seen as appropriate for survivors of SV, who have been through particularly disempowering events (Senn, 2010).

Methods

Research on the CL training program is relevant to the field of community psychology. It is a grassroots volunteer-operated program that serves women who have experienced a form of violence that is unequally experienced across gender, race, and class (Wasco, Campbell, & Clark, 2002). As such, the research values collaboration with non-professionals and the development of community capacity, and seeks to support a program that serves a relatively marginalized population. While the research takes an ecological perspective that recognizes

interactions between individual and system settings, it most strongly emphasizes the organizational and community setting, which is typical of community psychology research.

Diverse methods were used to assess the CL training program's readiness for evaluation, including consultations and semi-structured interviews with the agency's ED and CL Program Coordinator, semi-structured interviews with Centre staff, a review of documents and administrative data, and a literature search. The evaluation questions of the EA and methods used to explore them are depicted in Table 2.

Table 2

Evaluation Questions and Corresponding Methods Undertaken for the EA

Evaluation Question	Data Source and Method
1. What is the program logic model, as envisioned by the organization?	Consultations Semi-structured interviews Document review Literature search
2. Is the program evaluable at this time, according to established criteria?	Consultations Semi-structured interviews Document review Literature search

Consultations

As the EA was intended as being "utilization-focused" such that it would produce data useful to the CL program and the ORCC (Patton, 2012), it involved close collaboration and engagement with program stakeholders at each stage of the evaluation process. During the initial stages of shaping the project, consultations with the Executive Director and the CL Program Coordinator were carried out. These consultations worked to clarify the scope of the evaluation, gather general information about the CL program (e.g., recruitment, enrolment, and volunteer

characteristics), and generate a partnership agreement to elucidate expectations for the evaluation. While most consultations were completed in person at the Centre, communication was also conducted over email and telephone. During the latter stages of the EA, stakeholders were consulted on preliminary interpretation of findings, and future evaluation plans.

Throughout the process, stakeholder engagement and involvement was sought.

Semi-structured Interviews

Interviews were conducted with the agency's ED and CL Program Coordinator to gather information about how the objectives of training were identified, program activities were mapped out, and training outcomes were operationally defined within the organization (see Appendix A for interview guide). The interviews were approximately 60 minutes in length, and detailed notes were made during and after the interviews. These interviews were used to address evaluation question (1): *What is the program logic model, as envisioned by the organization?* The information was used as one line of evidence in creating the PLM.

A second set of interviews with Centre staff were conducted to explore the organizational context for CL volunteers (see Appendix B). Each interview took approximately 60 minutes, and 4 interviews were completed in total. Interviews were conducted with paid staff at the Centre who had experience as counsellors, and who had been with the Centre for 2-25 years. Each of the interviewees had experience performing various roles at the Centre, and was knowledgeable about the CL program. This information provided broad, contextual information on the CL training program and organization as a whole.

Document Review

A review of relevant documents and program records was conducted to establish descriptive and contextual information about the CL program. In particular, operational strategic

plans, annual reports, the CL training manual and other training materials, the organization's website and virtual material, and available program administrative data were reviewed. This documentation provided information about the program's goals, activities, and outcomes, and the linkage between them, as well as the immediate goals and priorities of the organization. The data was carefully reviewed, and was used to address evaluation questions (1) and (2).

Literature Search

Research databases, such as ERIC, Google Scholar, PsycInfo, and Academic Search Complete were used to search the literature on volunteer-based CL programs. This search was intended to provide the EA with a richer context, and to assess whether the CL program's goals and objectives are realistic and obtainable, given previous research in the field (Wholey, 2010). The literature review addressed research question (2).

Results

Findings corresponding to both of the research questions are discussed in turn below.

Research Question (1): What is the program logic model of the CL training program, as envisioned by the organization?

Evaluability assessments are conducted in order to clarify a program's logic and identify how the program's elements lead to its intended outcomes (Patton, 2002). Because PLMs map these processes, they are useful tools in evaluability assessment. Patton (2002) describes PLMs as graphically depicting the linkages between "program inputs, activities and processes (implementation), outputs, immediate outcomes, and long-term impacts" (p.162). Additionally, in the planning stage of an evaluation, PLMs are useful for identifying the available data and systems in place for data collection (Wholey, 2010; Rossi, Lipsey, & Freeman, 2004). They can be used to build stakeholder consensus on a program's purpose, activities, and objectives, or

identify discrepancies in opinion; and can demonstrate the usefulness of an evaluation to an organization. For these reasons, a PLM can assist in assessing a program's evaluability, and in planning future evaluations.

In the current evaluation, the PLM was developed based on consultations with key informants, including the ED of the agency and the CL Program Coordinator, and semi-structured interviews with 4 Centre staff, and a review of program documents, including operational strategic plans, annual reports, the CL training manual and other training materials, the organization's website and virtual material, and available program administrative data. Several draft versions of the PLM were created and revised, based on feedback from the ED of the agency and the CL Program Coordinator. These key informants were the most knowledgeable about the CL program and the organization's goals in collaborating on the research, therefore they were closely involved in the PLM conciliation process. The current PLM, which represents the CL training program, as envisioned by the organization, is included below in Table 3. Each component of the PLM is then summarized in the following section.

Table 3. ORCC Crisis Line Training Program Logic Model

Program users	Inputs	Activities	Outputs	Short-Term Outcomes	Longer-Term Outcomes
- The primary users of the CL training program are the volunteers selected for the program	<u>Staff</u> - Program Coordinator and an experienced volunteer facilitate the CL training. <u>Volunteers</u> - There are approximately 30 volunteers who work on the CLs. <u>CL Training Program Resources</u> - Administrative support - Online information - Meeting space - Training handbook and printed materials - CL binder and referral information - In-kind donations from community agencies (e.g., presentations to trainees).	<u>CL Training</u> - Each training session includes 10, 3-hour long classes. - Activities involved: facilitator instruction, presentations, role-plays, group discussions, and accompaniment training at the Civic Campus of the Ottawa Hospital. - Topics discussed were: feminist counselling, suicide assessment and intervention, recent SA, childhood sexual abuse, coping strategies and self-care, accompaniments and advocacy.	- 3 training sessions offered each year (fall, winter, summer sessions). - 30 hours of training are delivered per session. - A maximum of 16 volunteers are enrolled per session. - Approximately 25-30 volunteers complete training each year.	<u>Primary outcomes</u> - Development of basic counselling skills - Development of suicide assessment and intervention skills - Increases in feminist attitudes and beliefs about SV <u>Secondary outcomes</u> - Increased awareness of referral options - Increased knowledge of relevant medical and legal procedures related to SV victimization - Increased self-care behaviour	- CL services are consistently and reliably provided to the community - Volunteers are retained over time - Clients receive timely and appropriate referrals, emotional support, suicide assessment and intervention, and accompaniments - Clients experience improvements to their physical and mental health, and well-being

Program Users

The CL training program users are women from the community who volunteer to take part in the CL program. Before being accepted into the program, the participants are interviewed and screened to ensure that their values match those of the organization. Prior to working with the public, the participants also complete police record checks. The program is delivered in English, so participants must be fluent speakers. While there is some variation in age, the majority of volunteers are young adults, and many are post-secondary students. The participants have diverse ethnicities and cultural backgrounds. The CL program, and the volunteers working the lines, serves the broader community of Ottawa. In particular, it offers services to survivors of recent or childhood SA who are 16 years of age or older, as well as their families and friends. Because rape CLs are anonymous and easily accessible, they attract clients who may otherwise be unwilling to seek out support (Tjaden & Thoennes, 2006). Rape CL counsellors are also specifically trained to support survivors of SV, unlike providers in other sectors (Colvin, Pruett, Young, & Holosko, 2016). The CL program is therefore suitable to meet the needs of its clients.

Inputs

The CL Program Coordinator and an experienced volunteer co-facilitate the CL training; and the Coordinator works with the Center on a part-time basis. The CL Program Coordinator has delivered the training for the past nine years, while the experienced volunteer has assisted her for two years. According to the program records, there are currently 30 volunteers on the CL. The remaining program inputs are: program administrative support, a meeting room at the Centre, the training handbook and materials, CL kits that contain binders, pagers, and referral information, and in-kind donations in the form of presentations and training from community

agencies (e.g., the Ottawa Hospital, the Sexual Abuse Partner Care program, the Centre for Treatment of Sexual Abuse and Childhood Trauma, Planned Parenthood).

Activities

Training at the ORCC includes 30 hours of volunteer training organized as 3-hour sessions over 10 consecutive weeks. Currently, three 10-week training sessions are conducted each year at the Center. This training is provided internally and is supervised by a counsellor who has numerous years of experience, and an advanced degree in social work. Sessions consist of facilitator instruction and guest presentations, supervised role-play exercises, and group discussions. During training, participants explore different topics each week including: SV through an anti-oppression framework, feminist counselling, suicide assessment and intervention, recent SA, childhood sexual abuse, coping strategies, and self-care. Participants also learn about relevant legal and medical practices and protocols in order to provide support to survivors who engage with these systems.

Outputs

The program outputs include 3 training sessions per year, with each training session consisting of 30 hours of instruction. Annually, there are approximately 25-30 volunteers who complete the training, although this varies year to year. A maximum of 16 volunteers can enroll in any one session.

Short-term Outcomes

Through their participation in the CL training, volunteers are intended to develop basic counselling competencies, suicide assessment and intervention skills, and feminist attitudes and beliefs that will enable them to work from a feminist empowerment perspective. These primary

short-term outcomes were identified for the volunteer training program, in order to prepare the volunteers to provide safe and supportive assistance to callers. Secondary short-term outcomes of the program include an increased awareness of referral options, increased knowledge of relevant medical and legal procedures related to SV victimization, and increased self-care behavior designed to promote the volunteers' well-being.

Longer-term Outcomes

It is critical that clients of the Centre receive useful, high quality support when they contact the CL, and that CL services are consistently and reliably delivered to the community: these are the intended longer-term outcomes of the training program. Achievement of these longer-term outcomes depends largely on the development of volunteers' core competencies, and on volunteer retention over time. Key informants suggested in their interviews that if the volunteers felt supported by the organization, integrated into the organization, and if they had the opportunity to participate in ongoing training and professional development, it would have a beneficial effect on volunteer retention. As these areas were expected to enhance volunteers' satisfaction and retention, they were included in the PLM's longer-term outcomes. Longer-term outcomes will also be achieved for the clients as a result of the training. In particular, clients will receive timely and appropriate referrals, emotional support, suicide assessment intervention, and accompaniments from the CL counsellors. The program will also promote clients' physical and mental health and wellbeing through providing them with CL support, advocacy, and referrals.

Research Support for the PLM

Because the CL training program aims to provide training that is supported by the research literature, a search of the relevant literature was conducted. As the research in this area

is sparse, it was supplemented with research on related types of CL services, such as suicide hotlines, helplines, and distress lines. The literature search revealed that the program logic is consistent with that of other CL services that have received research attention.

The primary training program users are female volunteers who enroll in the CL training. Prior to being accepted into the program they undergo individual interviews with the CL Volunteer Coordinator to assess their suitability for the program. Some of the volunteers have had personal experiences with SV, but similar to other program approaches, if they have recovered they can participate in CL training (Rath, 2008). Overall, the primary program users are typical of rape CL programs (Rath, 2008; Hellman & House, 2006; Carlyle & Roberto, 2007).

The training program inputs, as described by the PLM, matches with other examples of rape CL programs found in the literature. In particular, the CL program is largely volunteer-operated, and volunteers are recruited and enrolled in the program several times per year (Colvin et al., 2016; Payne, Button, & Rapp, 2008; Rath, 2008). Due to limited access to resources and sustainable funding, RCCs rely on volunteers to operate the CLs (Maier, 2011; Rath, 2008; Payne, Button, & Rapp, 2008; Hellman & House, 2006).

RCCs typically provide in-house training to volunteers, as is the case with the organization under study (Colvin et al., 2016; Macy, Giattina, Sangster, Crosby, & Montijo, 2009; Rath, 2008). A part-time employee and a volunteer, who have expertise in feminist empowerment approaches to rape crisis counselling and advocacy, contribute to the CL program by co-facilitating the training. Volunteer speakers who contribute to the training include social workers, outreach workers, counsellors, and lawyers. In addition to the training, the remaining

inputs such as physical space and equipment, and in-kind donations from other community organizations also reflect those commonly found at RCCs.

The activities and outputs described in the current program's PLM closely follow those presented in the literature (Colvin et al., 2016; Macy, Giattina, Sangster, Crosby, & Montijo, 2009; Finn and Hughes, 2008; Rath, 2008). Colvin and colleagues (2016) reviewed archival data of a RCC to understand service user needs, and then described the RCCs' CL training program curricula designed to meet the needs. The curricula included training on crisis intervention, basic information about SA and types of assault, information on police services and investigative practices, medical services and forensic issues, the long terms effects of abuse, and other topics related to providing support to survivors of recent and historical sexual abuse (Colvin et al., 2016).

Finn and Hughes (2008) conducted an evaluation of a national online rape CL, and provided a detailed description of the volunteers' training. Volunteers in this program received training in crisis intervention, support skills, and referral. Additionally, they practiced online communication training in active listening online, procedures for beginning and ending sessions, managing challenging callers, and completed a simulated session. Additionally, in a review of the published and "grey" literature on relevant services in the United States, Macy et al., (2009) found agreement in the literature that rape CL providers need to be trained to offer callers emotional support, crisis intervention, information about their legal and medical options, and referrals to community resources and services. It also found that volunteers should be trained to use an empowerment-based approach that emphasized clients' coping strategies and decision-making abilities (Macy et al., 2009).

In a qualitative study exploring rape crisis counsellors' perceptions of their work, Rath (2008) described the training curricula as including, "counselling skills, crisis intervention, politics of SV, legal issues, police procedures, sexual health, social work procedures, domestic violence, abortion and contraception, sexuality, survivors of child abuse, suicide and self-harm, relationship issues and Rape Crisis principles" (Rath, 2008, p. 21). This training program ranged in length from 10-65 hours, and the training processes primarily included instruction and group discussion, external speakers, and visits to hospitals and police stations. Overall, the various components making up the PLM match with the training processes identified in the previous literature.

The primary short-term outcomes described by the PLM are also consistent with research on similar programs. Several studies have found that volunteer counsellors, who receive CL training, show gains in basic counselling skills (Frauenfelder & Frauenfelder, 1984; Hart & King, 1979; France, 1975; Bryant & Harvey, 2000; Katz, DuBois, & Wigderson, 2014; Paukert, Stagner, & Hope, 2004). For instance, Frauenfelder, and Frauenfelder, (1984) found that volunteer telephone counsellors' basic counselling competencies relating to empathy, understanding, and active listening skills were strengthened through short-term training. Hart and King (1979) reported that CL training significantly improved volunteers' abilities to express empathy, warmth, genuineness, and concreteness, as measured by external observations.

In a systematic review of the research on volunteer CL workers, France (1975) found that overall, trained volunteers demonstrated effective helping competencies, such as communicating genuine warmth, empathy, and concern for the caller. Bryant and Harvey (2000) found that trained volunteer counsellors were equipped with basic counselling skills, including the ability to

develop rapport, display empathy, and be non-judgmental. Furthermore, Katz, DuBois, and Wigderson (2014) found that helpline training significantly improved volunteers' empathic and reflective active listening skills, relative to a comparison group; and Paukert, Stagner, and Hope (2004) found that helpline training enhanced volunteers' active listening skills immediately after the training and also over the 6-9 month follow-up.

Research supports the notion that volunteer counsellors can develop suicide intervention skills as a result of short-term training (Schinke et al., 1979; Waalen & Haelstromm, 2003; Morriss & colleagues, 1999; Clark et al., 2010). Schinke and colleagues (1979) found that volunteers' crisis intervention competencies relating to knowledge, interviewing skills, recall of interview content, correctness of intervention judgments, and referral suggestions significantly improved after a brief training program. Similarly, Waalen, and Haelstromm (2003) found that volunteers' suicide risk assessment skills pertaining to assessment, attitudes, and knowledge were significantly enhanced by short-term training and remained in place 3 months later. Based on external assessments of participants' skills and self-report surveys, Morriss and colleagues (1999) found that volunteers' risk assessment and management, and confidence in dealing with suicidal patients improved following training. Similarly, Clark and colleagues (2010) found that the Samaritans of New York's suicide intervention training increased trainees' suicide intervention self-efficacy, particularly for who had previous experience with suicidal individuals and who had higher educational attainment (Clark et al., 2010).

In the literature, paraprofessionals have also demonstrated gains in feminist attitudes and beliefs following participation in related programs (Banyard, Moynihan, & Plante, 2007; Moynihan, Banyard, Arnold, Eckstein, & Stapleton, 2010; Coker et al., 2011; Cissner, 2009).

Although these studies pertain to violence prevention programs, rather than counsellor training programs, they provide support that programs with shared components increase participants' feminist sensibilities. Violence prevention programs are designed to stop the perpetration of violence before it occurs (or reoccurs).

Banyard, Moynihan, and Plante (2007) found that the Bringing in the Bystander violence prevention program enhanced female and male participants' pro-feminist attitudes and beliefs up to one year after the program's completion. Additionally, Moynihan et al., (2010) reported reductions in female and male athletes' sexist attitudes about SV following their participation in the same program. Coker and colleagues (2011) found that students who underwent the Green Dot violence prevention training were less accepting of violent and sexist attitudes than untrained students two years after the training; and Cissner (2009) found that a brief violence prevention intervention led to improvements in male and female trainees' feminist and egalitarian attitudes (Cissner, 2009).

Across services settings, the research demonstrates that short-term paraprofessional counsellor training programs result in increases to trainees' basic counselling skills, and suicide assessment and intervention skills, and feminist attitudes and beliefs about SV (Frauenfelder & Frauenfelder, 1984; Hart & King, 1979; France, 1975; Bryant & Harvey, 2000; Katz, DuBois, & Wigderson, 2014; Paukert, Stagner, & Hope, 2004; Schinke et al., 1979; Waalen & Haelstromm, 2003; Morriss & colleagues, 1999; Clark et al., 2010; Banyard, Moynihan, & Plante, 2007; Moynihan, Banyard, Arnold, Eckstein, & Stapleton, 2010; Coker et al., 2011; Cissner, 2009). Based on this literature search, the current training program's goals are found to be *realistic and attainable* (Wholey, 2010). Currently however, these outcomes are not being monitored by the

organization. To better understand the impact of CL training on volunteers, and to contribute to a limited body of literature, it would be valuable to measure and report on these outcomes.

Research Question (2): Is the program evaluable at this time, according to established criteria?

The evaluability of the CL program was assessed using the following guidelines set out by Wholey (2010, p. 84), which specify that a program can be evaluated if the following conditions are met: (1) Program goals are agreed on and realistic, (2) information needs are well defined, (3) evaluation data are obtainable, and (4) intended users are willing and able to use evaluation information. Each of these conditions was taken into consideration in determining the CL's readiness for evaluation, as discussed in the section below.

Program goals are agreed on and realistic. After mapping the PLM in collaboration with the organization, the stakeholders were found to have a shared vision of the CL training program's goals. Stakeholders agreed on the different components of the program, and the linkages to intended outcomes. Additionally, through a review of program documents and administrative data, a literature search, and semi-structured interviews, it was determined that the program's goals and objectives were clearly defined and realistic.

Information needs are well defined. Specific areas were recognized, in consultation with the organization, as representing important outcomes of the training. In particular, it was determined that volunteers would develop suicide assessment and intervention skills, basic counselling skills, and feminist attitudes and beliefs that would enable them to support survivors. Additionally, volunteer recruitment and retention were identified as processes that needed further

development. The organization expressed an interest in measuring the program's performance in these areas in the context of a future evaluation.

While there was an interest in measuring the training program's outcomes, there was less interest in recording other aspects of the program. Internal record keeping represented an area that would benefit from further attention. In particular, enhancing record keeping on certain program inputs and outputs would enable the organization to better examine and reflect on aspects of its program that it seeks to strengthen, such as volunteer retention. It is appreciated that in the context of a RCC, the need to collect information to evaluate and improve programs must be balanced with the need to protect the privacy and safety of clients (Sullivan & Alexy, 2001). Nevertheless, it would be useful to track non-sensitive data on each program input/output of interest to improve record keeping and enhance organizational reflexivity in these areas. Despite this minor issue, the training program's goals were agreed upon, realistic, and the organization's information needs were well defined overall.

Evaluation data are obtainable. It was determined that the current assessment would be followed by a fuller mixed-methods evaluation, designed to (1) measure training program outcomes, (2) explore volunteer counsellors' experiences in training and working with survivors, and (3) discuss implications on volunteer retention and longevity. Evaluation data will be obtained through collecting surveys and conducting semi-structured interviews with CL volunteers. Initial recruitment emails will be administered to participants through the Centre, and brief presentations about the research will be made to the volunteers during their training. Despite the challenges associated with collecting data within a community context, participants can be expected to support the evaluation, as it provides a further way to support the Center.

Intended users are willing and able to use evaluation information. The Center was found to be receptive to using evaluation research information. It has actively collaborated on the current EA, and has committed itself to facilitating data collection during the planned evaluation research project on the training program. As such, no barriers to using future evaluation findings and recommendations were discerned. If future evaluation recommendations are feasible and align with the organization's philosophy, it is expected that it will be *willing and able* to use future evaluation findings.

Discussion

The CL training program was designed to train volunteers to support survivors of SV, through providing an accessible and wide-reaching service to the community. As the CL training program was a core service that had not previously been the focus of research, the organization expressed an interest in investigating it. During the first stage of the EA, a logic model was generated in consultation with the organization. It provided a clear vision of the program, and described how its components led to its intended outcomes (Wholey, 2010). Consultations with staff, interviews with key informants, and a review of program documentation were conducted to provide clarification of the program. Furthermore, a literature search revealed that the current logic model matched closely with what was presented in the previous literature in the field; suggesting that the program's design and outcomes were described appropriately and realistically.

The second stage of the EA involved examining the program's goals, informational needs, availability of data, and potential utilization to determine whether it was ultimately 'evaluable' (Wholey, 2010). Through the process of mapping the logic model, the organization

was found to have a clear and agreed upon understanding of the program's goals. The organization's informational needs were also documented, such as the need for future research that would measure the primary short-term outcomes of program to gain insight on the effectiveness and quality of the training. Within the limitations of organizational practices, the availability of data was determined to be good. Data could be collected from volunteers, and it was anticipated that volunteers would be motivated to further support the RCC by participating in research. Lastly, it was determined that the organization could be expected to utilize future research findings, given its investment and collaboration in the EA process, and its interest in future research.

Based on these analyses, it was determined that a full evaluation of the program is feasible at this time, and mixed-methods research will be conducted to: 1) measure training program outcomes; 2) explore volunteer counsellors' experiences in training and working with survivors; and, 3) discuss implications on volunteer retention and longevity. Given the lack of prior research, an EA was determined to be an appropriate first step in laying the groundwork for research on the CL training program. This is consistent with Trochim's (2005) recommendation that social intervention research should occur in the broader context of exploratory and developmental studies.

Trochim (2005) proposed a multi-phased model of social intervention research involving: (1) a formative and exploratory phase; (2) a quasi-experimental phase; (3) a randomized experimental phase; and, (4) an ongoing monitoring and evaluation phase. As the current EA represents a first study that systematically describes and evaluates the CL training program, it is consistent with phase 1 research. This preliminary research is essential for building working

relationships with community partners, identifying data collection methods, elucidating program designs; and identifying appropriate populations and outcome variables, thereby increasing the construct validity of future research. It is not possible to study a training program without first clearly defining what that intervention is. To the extent that the CL training program is researched and reflected upon, the organization's efforts can be strengthened. The EA also contributes to an underdeveloped, yet important, area of community-based research by providing a foundation for future study. Building on the findings of this EA, Study 2 explores the outcomes of the CL training program in greater depth by investigating the development of counsellors' key competencies and pro-feminist attitudes.

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Study 2

A Quasi-Experimental Study of the Effectiveness of a Volunteer Rape Crisis Line Counsellor Training Program

Abstract

Within a one-year period, Rape Crisis Centres (RCCs) in Canada assisted over 80 000 survivors of gendered violence (Johnson & Dawson, 2011). A core service that RCCs offer is volunteer-operated 24-hour crisis lines (CLs). They serve as a front-line response to survivors, and perform the critical functions of crisis intervention and referral. Previous research indicates that CL counsellors can be instrumental in promoting SV survivors' physical and mental health (Campbell et al., 1999; Campbell et al., 2001). Thus, it seems imperative that CL counsellors receive adequate training and preparation to assist SV survivors. Despite the importance of these tasks, little research exists on the training and preparation of the volunteers delivering these services. The current study is intended to examine the outcomes of a volunteer rape crisis counsellor training program. Using a quasi-experimental pre-test posttest design with a control group, 52 women who were recruited from a local RCC (experimental N = 24; control N = 28) participated in the study. Findings offer preliminary evidence that CL training yields improved counselling self-efficacy in volunteer trainees, and also sheds light on other areas that RCCs can focus on to further strengthen CL training programs. Further research on this topic is needed to support the effectiveness of RCC programs and services.

A Quasi-Experimental Study of a Volunteer Rape Crisis Line Counsellor Training Program

Rape crisis counsellors play a critical role in their communities, yet their training has received minimal research attention. Volunteers are charged with carrying out front-line services, while often having limited experience in relevant areas, it is essential that research attention examine the outcomes of such volunteer training programs. This focus will support RCC services by enhancing organizational reflexivity, particularly regarding the impact of training outcomes for volunteers, and will also serve as a solid source of documentation for funders.

The aim of the current study is to measure the extent to which a community RCC counsellor-training program achieved its intended outcomes, as defined by the organization. A quasi-experimental pre-test posttest design with a control group was used to investigate changes in participants' (1) counselling self-efficacy, (2) crisis intervention skills, and (3) feminist attitudes and beliefs as a function of participation in training. To this end, participants from both groups completed pretest-posttest surveys designed to measure changes on these variables over the course of the period of training. In the initial stage of this thesis, an evaluability assessment was completed (see Study One). Through investigating several lines of evidence, it served to elucidate these intended outcomes of rape crisis counsellor training.

This study is consistent with a community psychology approach to research, as it involves analysis of a community-based program, designed to serve a marginalized group of service users who experience disproportionate harm due to their gender and other dimensions of social status (Wasco, Campbell, & Clark, 2002). The program under study seeks to enhance community capacity through the education of lay volunteers. Furthermore, the kind of organization under study, a RCC, serves the overarching social justice goal of ending SV and

promoting gender equality, and research efforts are intended to support this larger vision. All of these characteristics position the current study within the field of community psychology.

Research Context

In recent years, the problem of SV has become increasingly present in the public conversation, yet levels of SV have not declined, nor have legal outcomes improved for SA complainants (Johnson, 2017; Randall, 2010). As previously discussed, SV continues to disproportionately hurt women and girls, and to have a range of negative long-term effects on victims' families and communities (Perrault, 2015; Government of Ontario, 2013; Sinha, 2013; Yuan, Koss & Stone, 2007; DeKeseredy, & Dragiewicz, 2011; Sinha, 2013). In addition to gender, other facets of women's positionality bear on the unequal distribution of this form of social harm. For example, in Canada, Aboriginal women and immigrant and refugee women experience increased levels of SV (Amnesty International, 2012; Olive, 2012; Benoit et al., 2014). Young women (Perrault, 2015; Johnson, 2006; Sinha, 2013), and women with disabilities (Perrault, 2015; Benoit et al., 2014) are also shown to be at an elevated risk. In addition, being single, being a student, having experienced physical or sexual victimization in childhood, using drugs or binge drinking, engaging in a greater number of evening activities, and having a history of homelessness were also identified as correlates of SA in the recent GSS (Perrault, 2015). These factors become even more serious when considered with the information that women who face multiple and intersecting forms of structural violence experience even greater harm (Benoit et al., 2014).

Feminist activists first mobilized around the widespread problem of SV by organizing RCCs approximately forty years ago. Through these RCCs, activists sought to educate the public

about SV, provide empowerment-based supports for survivors, and engage in a variety of anti-violence social change activities. One important service that RCCs continue to offer are 24-hour CLs designed for survivors and their immediate support people (Campbell, Baker, & Mazurek, 1998). CL services provide callers with crisis counselling and intervention informed by a feminist empowerment perspective. CL services also provide callers with referrals to in-house and community resources and accompaniments and support in engaging with other services. In 2008, 134 RCCs were in operation in Canada (Johnson & Dawson, 2011), most of which offer CL services to their communities.

Literature Review

This literature review will begin by surveying the research that has been conducted in RCC contexts, then it will highlight studies that focus on the training of RCC volunteers, and finally, it will narrow its scope to outcome studies of other community-based volunteer training programs.

Research on RCCs

Within the active and long-standing context of community RCCs little research has been conducted. That which is available focuses on RCCs changes, and adherence to feminist philosophies over time (Maier, 2008; Campbell, Baker, & Mazurek, 1998; O'Sullivan, & Carlton, 2001). The literature available on RCC personnel has tended to focus on professional staff such as social workers, counsellors, and health care workers (Clemans, 2004; Truell, 2001; Kulkarni, Bell, Hartman, & Herman-Smith, 2013; Botega and colleagues; Shim & Compton, 2010), rather than on volunteer counsellors and advocates. Despite this, there is a small body of literature on RCC volunteers, focusing on their motivations for volunteering (Black & DiNitto,

2008; Rath, 2008), their role in preventing survivors' re-victimization (Maier, 2008; Campbell, Wasco, Ahrens, Sefl, & Barnes, 2001; Campbell, 2006; Campbell, 1998) and predominantly, the many challenges and negative consequences associated with the role, including burnout, vicarious trauma, and secondary traumatic stress (Ullman & Townsend, 2007; Baird and Jenkins, 2003; Thornton and Novak, 2010; Wasco and Campbell, 2002). Research pertaining to the efficacy of RCC services has also received limited research attention (Bennett, Riger, Schewe, Howard, & Wasco, 2004; Wasco, Campbell, Howard, Mason, Staggs, Schewe, & Riger, 2004; Westmarland, & Alderson, 2013).

RCC Volunteers in Training

The limited research on CL training for RCC volunteers, and lack of publications on measuring training outcomes, indicates a gap in the research. Volunteer counsellors are strategically positioned to have a meaningful impact on victims of SV and their communities, and thus, should be well trained and prepared. While no outcome evaluations have been conducted in this context, the small body of research pertaining to rape crisis counsellors in training is reviewed next.

Rath (2008) employed grounded theory to explore how British rape crisis counsellors' made sense of their training. The training program lasted 65-hours and included instruction on topics such as: "counselling skills, crisis intervention, the politics of SV, legal issues, police procedures, sexual health, social work procedures, domestic violence, abortion and contraception, sexuality, survivors of child abuse, suicide and self-harm, relationship issues, and Rape Crisis principles" (Rath, 2008, p. 21). Several salient themes relating to change and personal growth were reflected in the study's findings. In particular, participants reported that

they joined the training during times of personal upheaval and change, that meaningful changes occurred in their intimate relationships over the course of their training, and that they experienced positive changes in their other personal relationships which they attributed to the improvement of their communication skills.

Carlyle and Roberto (2007) administered questionnaires to recently trained American rape crisis counsellors to examine the relationships between their overall communication competency (defined as communication skills, knowledge, and motivation) and their counselling self-efficacy, and communication anxiety. Results revealed that counsellors' overall communication competency was positively correlated with counselling self-efficacy, whereas it was negatively correlated with communication anxiety. An implication of these findings is that training programs should focus efforts on developing counsellors' communication skills. This in turn, would reduce their anxiety, and increase their confidence around communicating with RCC clients.

Hellman and House (2006) used survey measures to investigate how American rape crisis counsellors' affective commitment to volunteering, overall satisfaction, counselling self-efficacy, and intention to remain with the RCC, correlated with their perceptions of the quality of training they received. Results demonstrated that volunteers' affective commitment to volunteering, overall satisfaction, counselling self-efficacy, and intention to remain with the RCC, were all positively correlated with the perceived quality of the training. In contrast, volunteers' experiences of witnessing victim blaming by service providers, was negatively correlated with the perceived quality of the training. These results may support the notion that training quality is relevant to volunteers' overall satisfaction and desire to continue volunteering. They may also

suggest that higher quality training conducted by staff with expertise prepares volunteers to manage victim blaming by service providers.

While these studies provide valuable information on different facets of RCC volunteers' training experiences, they are less informative on whether training outcomes are being achieved. Community psychology research has examined outcomes of related volunteer training contexts, such as telephone hotlines, helplines, and peer counselling programs (Clark, Matthieu, Ross, & Knox, 2010; Katz, DuBois, & Wigderson, 2014; Schinke, Smith, Myers, & Altman, 1979; Hart & King, 1979). As the methods, design, implementation, and outcomes are aligned with those used in the current study, and are conducted on similar populations (i.e., volunteers), these studies provide relevant information on its research questions and hypotheses. The current study contributes to the literature by expanding community psychology's inquiries to the context of a RCC, and by exploring whether rape crisis counsellors develop perceived counselling self-efficacy, suicide intervention skills, and pro-feminist perspectives as a result of their training. Outcome evaluations examining two of these variables (basic counselling and suicide intervention) are discussed in turn below.

Volunteer Training Programs

As previously reported community psychology research explored the effect of training interventions on crisis hotline volunteers, and even though the bulk of this research emerged in the 1970s, more recent research concurs with the notion that training programs show promise (Banyard, Moynihan, & Plante, 2007; Moynihan, Banyard, Arnold, Eckstein, & Stapleton, 2010; Coker et al., 2011; Cissner, 2009; Clark, Matthieu, Ross, & Knox, 2010; Katz, DuBois, & Wigderson, 2014). For example, in the US, Frauenfelder, and Frauenfelder, (1984) found that

volunteer telephone counsellors' basic counselling competencies relating to empathy, understanding, and active listening skills were strengthened through short-term training. Their training involved role-play activities, instructor modelling, and information on counselling techniques. Hart and King (1979) also evaluated the outcomes of telephone counselling training for American volunteers relating to their abilities to express empathy, warmth, genuineness, and concreteness. Training consisted of three 2-hour training sessions, in which participants engaged in role-play exercises simulating typical crisis center issues, such as "depression, problem pregnancy, loneliness, and sexual problems" (Hart & King, 1979). Participants completed (scored) role-plays at the start and conclusion of training, and again at a three-week follow-up. Results showed that, irrespective of volunteers' initial scores, they achieved similarly high scores at posttest, and these scores were maintained three weeks later.

In a systematic review of articles that examined the competencies of volunteer CL workers in the US, France (1975) found that making referrals, helping, and influencing behaviour change were the primary competencies CL volunteers were expected to possess. Overall, the results of the systematic review suggested that volunteers demonstrated effective helping competencies, such as communicating genuine warmth, empathy, and concern for the caller, however, they were less effective at influencing behaviour change and making appropriate referrals (France, 1975).

Assessing the counselling competencies of volunteer counsellors working a hotline for veterans in Australia, Bryant and Harvey (2000) found that volunteer counsellors possessed basic counselling skills, such as the ability to develop rapport, display empathy, and be non-judgmental. However, they were less equipped to provide referrals based on specified knowledge

of the client characteristics. They were found to underestimate the callers' risk of suicidality and were generally unfamiliar with the clients' particular risks and experiences. These findings match with France's (1975) assessment that volunteer counsellors were adequately prepared for their "helping" role, but may require more specialized knowledge with respect to target client groups.

More recently, Katz, DuBois, and Wigderson (2014) assessed the impact of a 10-week helpline training program on American undergraduate volunteers' empathic and reflective listening skills. Using pretest-posttest survey methods, the study compared communication outcomes of volunteers who completed helpline training with students who completed a service learning course (e.g., student placement at a shelter) but did not receive training. The researcher found that only the students who completed helpline training demonstrated improved active listening skills over time.

Paukert, Stagner, and Hope (2004) investigated the active listening skills of volunteers in the US who underwent helpline training by looking at both pretest-posttest surveys and supervisor assessments built into the training. Follow-up assessments were also conducted 6-9 months after the training. The training involved 45 hours of instruction on basic counselling skills, referrals, crisis intervention and suicide assessment. The researchers reported that the volunteers' active listening skills improved over the course of training, and were maintained over the 6-9 month follow-up period.

Several studies have also examined the effect of training on volunteers' suicide intervention skills. Schinke and colleagues (1979) examined whether a single 4-hour training session impacted US dormitory residence assistants' crisis intervention competencies.

Participants were randomly assigned to training and control conditions, with the training consisting of instruction on assessment, behaviour-change and referral procedures and practice with role-plays. Results suggested that the trainees performed better than controls on overall crisis intervention competence, (which was described as encompassing knowledge, interviewing skills, recall of interview content, correctness of intervention judgments, and referral suggestions).

Waalén, and Haelstromm (2003) provided evidence that short-term suicide intervention training can be effective, and that it can also benefit youth volunteers. This Canadian study documented a gatekeeper training program for high school students, designed to develop youth volunteers' suicide risk assessment skills. The training was brief, involving only two half-days of training over two weeks, and a follow-up session 3 months later. During training, student volunteers were introduced to crisis theory, signals of suicide, suicide risk assessment, and related topics. Results based on survey measures demonstrated improvements pertaining to assessment skills, attitudes, and knowledge and confirmed that these gains remained stable for 3 months. Furthermore, Morriss and colleagues (1999) evaluated an 8-hour suicide intervention training program for front-line health workers and volunteers in the US. The training focused on suicide assessment, crisis management, problem solving and crisis intervention skill building. Based on scored assessment of the participants' interviewing skills and self-report surveys, results showed that volunteers' risk assessment and management, and confidence in dealing with suicidal patients improved. However, the training was not found to enhance general interviewing skills.

Additional research has reported that even a brief intervention may improve lay counsellors' self-efficacy at suicide intervention. Clark, Matthieu, Ross, and Knox (2010) conducted an outcome evaluation on the Samaritans of New York's suicide intervention training in order to examine its effect on volunteers' suicide intervention skills. A single 3-hour training was delivered to community and school-based staff in which information about suicide myths and stigma, intervention and assessment, and active listening were presented and discussed. Results indicated that after the training, participants reported increased self-efficacy and in addition, those who had previous experience with suicidal individuals and those who had higher levels of education, reported greater improvements in self-efficacy (Clark, Matthieu, Ross, & Knox, 2010), indicating that these factors may enhance volunteers' receptivity to training.

Research on training relevant to the development of pro-feminist attitudes and beliefs, has also been conducted. The vast majority of research on RCCs documents the importance of having feminist attitudes and beliefs when assisting survivors of gendered violence (e.g., Campbell, et al., 2001; Campbell, 2006; Senn, 2010). Additionally, intervention programs have been shown to positively influence the development of participants' attitudes and beliefs in alignment with feminist values (e.g., Banyard, Moynihan, & Plante, 2007; Moynihan, Banyard, Arnold, Eckstein, & Stapleton, 2010; Coker et al., 2011; Cissner, 2009).

Banyard, Moynihan, and Plante (2007) administered a violence prevention program, *Bringing in the Bystander*, to American female and male undergraduates in either one or three 90-minute sessions of training. The training consisted of information on the prevalence, causes and impacts of SV, and exercises in which participants practiced intervention strategies and learned how to be allies to survivors. Results of the intervention demonstrated improvements on

female and male participants' pro-feminist attitudes and beliefs (in both intervention groups) up to one year after the program's completion (Banyard, Moynihan, & Plante 2007).

Moynihan, Banyard, Arnold, Eckstein, & Stapleton (2010) also examined the effects of the Bringing in the Bystander program on the attitudes and beliefs of female and male university athletes in the US. Using surveys measures before and after the intervention and at a two-month follow-up, reductions in sexist beliefs about rape were found for both genders (Moynihan, Banyard, Arnold, Eckstein, and Stapleton, 2010).

Coker and colleagues (2011) studied the effects of a mixed-gender bystander intervention program, Green Dot, on American university students' pro-feminist attitudes and beliefs and other bystander-related variables. The 6-hour long training consisted of an overview of information on VAW, discussions of the bystander role, and skill-building activities. The results indicated that students who had received training within the past 2 years were less accepting of violent and sexist attitudes than were untrained students (Coker et al., 2011). In addition, Cissner (2009) evaluated the effects of a violence prevention program designed to break down negative social norms that maintain SV. A mixed-gender group of intervention participants in the US underwent seven hours of training over the course of two days on several topics relating to SV. Results indicated that immediately following the intervention participants reported more egalitarian, feminist attitudes and an improved understanding of peer norms (Cissner, 2009).

Notably, these studies have been conducted on the practice of violence prevention, rather than on training volunteer counsellors, nevertheless they suggest that programs with components similar to the CL training resulted in the development of pro-feminist, anti-violent attitudes and beliefs. These variables have been reported as important for those who support and advocate for

survivors of SV, which would include these counsellors (Senn, 2010; Rath, 2008; Ullman & Townsend, 2007; Clemans, 2004).

Considered together, the literature indicates that while crisis hotline training improved volunteers' basic counselling skills, volunteers may still lack knowledge about target populations. This implies a need for training tailored to specific populations, and to research that evaluates such training. Volunteers' suicide intervention skills were also enhanced through their participation in community training programs, despite the relative brevity of some of these programs. Violence prevention research indicates that participants became less accepting of violent and sexist attitudes following engagement in awareness-raising activities similar to those involved in the counsellor training program studied (Coker et al., 2011). Given the applied context of this research, some limitations became apparent in several of the designs used (e.g., posttest only designs, designs lacking control groups or random assignment, and limited numbers of participants). While random assignment was not possible, the current study uses a quasi-experimental design to increase confidence in its results. The current research builds on previous research and contributes new knowledge to the research area by investigating the effectiveness of volunteer counsellor training in the unique context of a RCC.

Based on previous research, and on the findings of an evaluability assessment, the hypotheses for this study are as follows:

- 1) Individuals receiving counsellor training will report greater improvements in self-efficacy of their helping skills than individuals who are not receiving counsellor training.

- 2) Individuals receiving counsellor training will show greater improvements in the development of crisis intervention skills than individuals who are not receiving counsellor training.
- 3) Individuals receiving counsellor training will report greater development of feminist attitudes and beliefs than individuals who are not receiving counsellor training.

Methods

Study Design

This study used quantitative methods to assess potential changes in participants' perceived counselling self-efficacy, crisis intervention skills, and feminist attitudes and beliefs as a function of the CL training intervention. It used a quasi-experimental pretest-posttest design, with a control group. In this design the control group and treatment group acted as the between subject variables and the pretest and posttest measures served as the within subject variables. In order to attain a sufficient sample, data were collected during the course of 3 training sessions over a one year period.

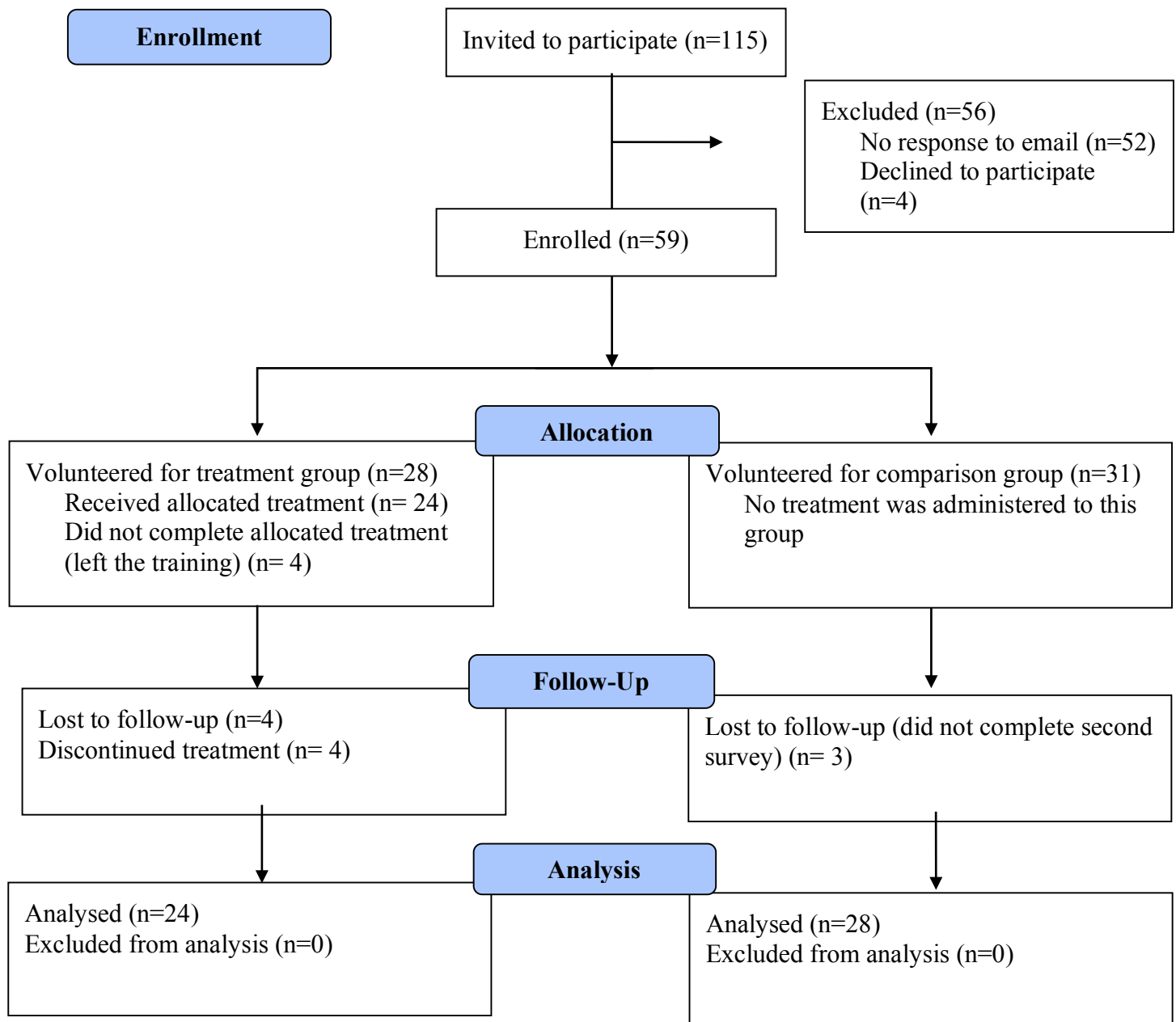
Participants

A total of 52 women participated in this study. The experimental group included 24 women who participated in the CL training, while the control group included 28 women who did not undergo the training. The initial plan was for the control group to be comprised of wait-listed volunteers who had not participated in the training, but who planned to participate in the future. However, it turned out that the Centre did not have a wait-list for the program, as interest in enrollment was lower than anticipated. Therefore, purposive sampling (Teddlie & Yu, 2007) was used to locate people of a specific population to form the control group.

Using this technique, the control group participants were contacted about the study through email lists generated by the Centre. Control group participation was restricted to women who had not completed training in CL counselling or related work, and who endorsed the views that gender equality and VAW were issues that were important to them. These criteria were used to foster comparability between groups. The recruitment for the control group participants was conducted simultaneously with experimental group recruitment (between June, 2014 and March, 2015).

Figure 1 (below) is a Consort flow diagram describing participants' intake into the 'Rape Crisis Line Counsellor Training' study.

Figure 1. CONSORT: Enrollment, Allocation, Follow-Up, and Analysis of Participants



Crisis Line Program

The RCC volunteers operate a 24-hour CL service for women, which is a well-established, long standing service at the Center. A commitment of 20 hours per month, for a period of one year is expected of the participants. The service offers emergency crisis intervention and feminist counselling to survivors, and helps survivors navigate the medical and legal systems. In addition to providing support on lines, volunteers also act as advocates to survivors during accompaniments to police stations or hospitals. In a single day in Canada, 30% of all female victim service clients are victims of SA, and 2105 women are served by RCCs (Allen, 2014). One of the main services they offer is their anonymous and confidential crisis hotlines for survivors of SV.

Crisis Line Program Training

The training program was well established and has been offered by the community-based RCC for over 40 years. It involves 30 hours of counselling training organized as 3-hour sessions over 10 consecutive weeks. Currently, three 10-week training sessions are conducted each year at the Centre. This training is provided internally and is supervised by a counsellor who has numerous years of experience, and an advanced degree in social work. Sessions consist of facilitator instruction and guest presentations, supervised role-play exercises, and group discussions. Participants explore different topics each week including: understanding SV through an anti-oppression framework, crisis intervention, recent SA, suicide intervention, coping strategies, and self-care. Additionally, participants learn about relevant legal and medical practices and protocols in order to provide support to survivors who engage with these social services. Table 1 presents the content of the curricula for each of the 10 sessions.

Table 1

RCC CL Training Protocol

Training Session	Curricula
1	Introduction to the Centre Volunteer Commitment / Self-care Understanding Violence Against Women
2	Sexual Violence and Oppression
3	Feminist Counselling Strength Based Framework Role Plays
4	Guest Speaker from the Outreach Program at the Royal Ottawa Role Plays
5	Recent Sexual Assault/Coping Strategies Guest Speaker from the Sexual Abuse Partner Care Program Role Plays
6	Childhood Sexual Assault and Coping Strategies Guest Speaker from the Centre for Treatment of Sexual Abuse and Childhood Trauma Role Plays
7	Suicide Intervention Role Plays
8	Role Plays
9	Role Plays
10	Role Plays/Volunteer Information

Notes. Trainees were required to attend each of these 3-hour long training sessions.

An integrated feminist approach to crisis counselling is also taught to trainees. This approach differs from other approaches to counselling in several ways. One difference is that a feminist framework attempts to avoid pathologizing survivors' responses to SV by accepting and validating their experiences, demystifying psychological language and concepts, and locating the source of the problem within the social context, and perpetrators' actions (Senn, 2010). Another distinction is that counsellors intentionally enter into egalitarian relationships with clients through explicitly addressing power dynamics and going beyond the expert/victim approach (Corey, 2012; Israeli & Santor, 2000). Furthermore, value is placed on supporting clients in their

own decision making, and in emphasizing clients' personal autonomy, strengths, and individual differences (Senn, 2010; Enns, 1993). The need for CL volunteers to have a feminist perspective on SV and counselling is very important to the organization, as it relates directly to the organization's mandate, and to the volunteers' ability to carry out their crisis counselling and advocacy work in line with that mandate. Because of its emphasis on empowerment, a feminist approach to crisis counselling is seen as appropriate for survivors of SV, who have been through particularly disempowering events (Senn, 2010).

Power Analysis

An a priori analysis was carried out using G*Power 3.1 Statistical Software to compute sample size (Faul, Erdfelder, Lang, & Buchner, 2007). For the mixed factorial ANOVA with two groups, a moderate effect size of .25 (Cohen, 1988), and power level of .8 were adopted. Assuming $\alpha = .05$, a total sample size of 34 is required. As the sample will be divided into two groups (the intervention group, and the comparison group), a total of 17 participants are required per group. This number was exceeded in both the experimental ($N=24$) and control group ($N=28$), indicating that there was sufficient power for the analyses.

Measures

The measures used in this study pertained to three different outcomes including counselling self-efficacy, suicide intervention skills, and feminist attitudes and beliefs. These outcomes were identified and defined as the primary short-term outcomes of the training during the evaluability assessment stage of the research. The measures were selected based on the priorities and concerns of the organization, as voiced by its executive director and CL Training Program coordinator, as well as on previous research. These studies demonstrated gains on counselling

self-efficacy and suicide intervention in similar populations who participated in comparable training programs (Bryant & Harvey, 2000; Katz, DuBois, & Wigderson, 2014; Paukert, Stagner, & Hope, 2004; Schinke et al., 1979; Waalen & Haelstromm, 2003; Morriss & colleagues, 1999; Clark et al., 2010). Therefore, the previous research offered support that similar outcomes could reasonably be expected of the CL Training Program. Although there was limited research to draw upon to identify these outcomes, the researcher, through conducting an evaluability assessment in consultation with the organization (See Study One), determined that the training program was designed to target these particular outcome variables. Items that were most relevant to the objectives of the training were drawn from existing standardized surveys corresponding to these content areas, and comprise the final survey instrument's subscales.

The Counsellor Activity Self-Efficacy Scale (CASES) – Helping Skills Subscale.

Counselling self-efficacy refers to counsellors' "beliefs about their ability to perform counselling-related behaviors or to negotiate particular clinical situations" (Larson & Daniels, 1998 as cited in Lent, Hill, & Hoffman, 2003). The Counsellor Activity Self-Efficacy Scale (CASES) (Lent, Hill, & Hoffman, 2003) includes 41 self-efficacy items in total, which are separated according to three domains of counselling competencies including: helping skills (12 items), managing the counselling process (10 items), and handling challenging counselling situations (16 items).

In the current study, only the Helping Skills Subscale (See Appendix F) was used as it measured relevant skills such as listening, attending, reflecting feelings, and providing information, which corresponded to the competencies required for work on the crisis hotlines. For each item respondents were asked to indicate their level of confidence in their ability to do

the given task effectively with most clients over the next week (e.g., “capture and understand the messages that clients communicate” and “repeat or rephrase the client’s statements with an emphasis on his or her feelings”) (Lent, Hill, & Hoffman, 2003, p. 101). A 7-point Likert scale is used to rate each item (from 0 = no confidence to 7 = complete confidence). The highest score possible on the Helping Skills Subscale is 84 and the lowest score possible is 12. Higher scores correspond to higher levels of counselling self-efficacy.

The Helping Skills Subscale has been shown previously to have good convergent validity, discriminant validity, and criterion-related validity (Lent, Hill, & Hoffman, 2003); and in addition, it demonstrated very good internal reliability and high test-retest reliability (Lent, Hill, & Hoffman, 2003). The scale has been administered to various groups of counselling trainees, such as career counsellors, rehabilitation counsellors, school counsellors, college student personnel, community counsellors, and psychologists (Lent, Hill, & Hoffman, 2003). Reliability analyses were conducted on the Helping Skills Subscale data collected in the current study. It was found to have a Cronbach’s alpha of 0.89 at baseline and a Cronbach’s alpha of 0.86 at follow-up.

The Suicide Intervention Response Inventory (SIRI-2). The SIRI-2 survey (Neimeyer & Bonnelle, 1997) measures the extent to which paraprofessional counsellors are able to “recognize appropriate responses to suicidal clients” (Neimeyer & Bonnelle, 1997, p. 59) (See Appendix G). It is comprised of several hypothetical caller statements and two possible counsellor responses are provided for each. For each item, one of the counsellor responses is considered to be facilitative of suicide intervention (e.g., “your voice sounds so sleepy. Have you taken anything?”) and one is considered to be harmful (e.g., “you sound so tired. Why don’t you

get some sleep and call back in the morning?”). The SIRI-2 includes a total of 25 items, and uses a 7-point Likert scale format for each item. Respondents were instructed to evaluate the suitability of both hypothetical counsellor responses for each item from +3 (highly appropriate) to -3 (highly inappropriate). The measure uses an absolute mean difference score. The score is simply the absolute difference between the respondent's rating on each item and the mean of the expert panel, with greater values representing poorer performance. By contrast, the hypothetical ideal score would be 0 – perfect agreement with the panel. The measure has been used on a variety of professional and paraprofessional populations, such as counsellor trainees, undergraduate students, student volunteers, paid personnel, teachers, nursing students, medical students, high school students, and college students. SIRI-2 has demonstrated good construct validity and discriminant validity, and reliability indicators for the SIRI-2 have showed excellent internal consistency and test-retest reliability (Neimeyer, & Bonnelle, 1997). In the current study, reliability analyses found the measure to have a Cronbach's $\alpha = 0.87$ at the baseline and a Cronbach's $\alpha = 0.88$ at follow-up.

The Short-Form Feminist Perspectives Scale (FPS). The Short-Form FPS (Henley, Meng, O'Brien, McCarthy, & Sockloskie, 1998) was used to measure feminist attitudes and beliefs. The scale assessed participants' overall endorsement of pro-feminist attitudes and beliefs by incorporating five theoretically derived feminist orientations into the composite score including: liberal, radical, socialist, cultural feminist, and woman of colour (womanist). The Short-Form FPS (See Appendix H) is comprised of 25 items rated on a 7-point Likert scale (e.g., “by not using sexist and violent language we can encourage peaceful social change” and “racism and sexism make double the oppression for women of colour in the work environment”).

Respondents rated their level of agreement with the statements presented from 1 (strongly disagree) to 7 (strongly agree). Possible scores ranged from 25 to 175, and higher scores indicate higher levels of feminism, as defined by this measure. The scale has been used on broad segments of the population, such as “adult, nonstudent respondents, both women and men, feminist and non-feminist, of different ethnic/racial groups” (Henley et al., 1998). The Short-Form FPS has demonstrated good convergent, discriminant, and overall content validity, and reliability indicators for the Short-Form FPS showed excellent internal consistency and a level of high test-retest reliability (Henley, Meng, O'Brien, McCarthy, & Sockloskie, 1998). Reliability analyses were conducted on the Short-Form FPS composite score data, demonstrating good internal consistency with a Cronbach's alpha of 0.83 at baseline and 0.78 at follow-up.

Procedure

The surveys were administered to participants using an online survey tool made available 1 week prior to the training. They included questions relevant to the intended outcomes of the training. Participants completed an informed consent form that was included in the beginning of the survey and were asked to complete the pretest survey prior to the beginning of training. Ten weeks later, after their final day of training, participants were invited to complete an online posttest survey, and this survey was also available to participants for a period of 1 week. Participants were also given the option of completing paper surveys, on the first or last day of training, if preferable. The researcher was present at the conclusion of training to debrief with participants and to respond to any questions about the research. The control group followed a similar procedure, completing the pretest and posttest surveys online 1 week prior to or 1 week following the 10-week long training period. The researcher was available on an as-needed basis

to debrief or answer any questions of control group participants. At the post-test phase, participants who had not completed the survey by mid-week were sent personalized email reminders inviting them to do so. In order to achieve a sufficient sample size, data were collected over the course of 3 training sessions occurring in the Spring and Fall of 2014, and Winter of 2015. At the pretest phase the response rate for the intervention group was 65.11%, whereas the response rate for the comparison group was 43.05%. At the posttest phase, the response rate for the intervention group was 85.71%, while the response rate for the comparison group was 90.32%.

Training Program Fidelity Checklist. An observation checklist was created for the study to monitor the extent to which the training was implemented consistently, and as planned at the RCC (See Appendix C for fidelity checklist). Prior to the training sessions, the researcher mapped out the training program logic and activities in consultation with the organization (See Study One). The program fidelity checklist consisted of 8 questions that corresponded to the program's identified components, and one open-ended question. Each question required a yes or no response, and space was provided for additional feedback. Training sessions were co-facilitated and the co-facilitators were asked to complete the checklists independently. Although it was initially intended for the researcher to observe the sessions, it was decided that the facilitators would complete the checklists themselves to avoid any disruptions that a researcher's presence might cause, due to the sensitive nature of the topic. Given the community context of the research, and the collaborative nature of the project, it was important to respect the organization's decision-making around data collection methods, and to limit the project's demand characteristics on program staff.

Data Analysis

Results pertaining to each of the three examined outcomes were analyzed separately, as they were designed to measure different constructs, as originally set out in the study's hypotheses. To assess changes over time, 2 (time) x 2 (group) mixed analyses of variance (ANOVAs) were conducted, using SPSS statistical software. Data were screened to assess for missing values and to determine if the assumptions of the analyses were met. Less than 5% of the data were missing on each of the variables, and the data were found to be missing at random, according to Little's MCAR test. To explore the impact of missing values (participant non-responses) on the outcome variables, single imputations were run using the Expectation Maximization (EM) algorithm in SPSS.

For each of the variables, normality was determined through visual inspection of Normal Q-Q Plots, and outliers were assessed using studentized residuals with values greater than ± 3 . Homogeneity of variances was assessed through Levene's test of homogeneity of variances, and homogeneity of covariances was determined using Box's test of equality of covariance matrices. It was not necessary to assess for sphericity as the factors each only had two levels.

Assumption testing indicated that the SIRS-2 data did not meet the assumption of homogeneity of covariances, and after further examination, it was determined that the data were positively skewed. To ensure that the results were not influenced by the skewness of the data, transformations were performed. However, results based on the transformed data did not differ from those of the original data, so the untransformed data were retained. Additionally, on the Short-Form FPS variable, assumption testing demonstrated that there was one outlier in the data. The outlier was Winsorized to the nearest value and was retained in the analysis.

In these analyses, the control group and treatment group acted as the between subject variables and the pretest and post-test measures served as the within subject variables. The alpha level, or risk of Type 1 error, was set at .05. Reliability analyses were run on each of the surveys using the Cronbach's alpha statistic, and values of .70 (or higher) were considered to be acceptable for this exploratory research (Nunnally, 1978). The analyses are designed to examine the outcomes of the training program, and whether changes occurred in the anticipated direction.

Results

Participant Characteristics

Participant characteristics are presented in Table 4. The vast majority of the participants were young, university educated women with no children. The sample showed considerable diversity in terms of participants' ethnicities. While 57.7% of the participants had European ethnicities, participants also reported African (15.4%), Arab (7.7%), East and South Asian (9.6%), Metis (3.8%), and Latina (3.8%) ethnicities, respectively. Most of the participants were single and had never been married (73.1%), however, more comparison group participants had been married or lived in common-law arrangements (35.7%), than in the experimental group (16.6%), which may correspond to the three-year age difference between groups. Furthermore, most of the participants were born in Canada (76.9%). More than half of the participants in the experimental group were students (58.3%), compared to just over a third of the comparison group participants (35.7%).

Statistical analyses were conducted to assess for differences in demographic characteristics between groups. Chi-square tests found no association of group and: educational attainment

($\chi^2(3)=4.436$, $p=0.218$), ethnicity ($\chi^2(5)=6.57$, $p=0.254$), marital status ($\chi^2(2)=3.64$, $p=0.162$), number of children ($\chi^2(1)=.01$, $p=.911$), or being born in Canada ($\chi^2(1)=.09$, $p=.761$), indicating that the groups were comparable in these areas. However, the results of an independent-samples t-test demonstrated that the comparison group was slightly older ($M = 28.74$, $SD = 5.10$) than the experimental group ($M = 25.36$, $SD = 2.59$), and this difference was significant, $t(47) = 3.0$, $p = .001$. No difference between the comparison group ($M = 28.09$, $SD = 15.14$) and the experimental group was found on work hours ($M = 21.52$, $SD = 15.11$), $t(49) = 1.55$, $p = .593$. Overall, there was good comparability between groups on demographic characteristics.

Table 4

Demographic Characteristics of the Survey Sample

Characteristics	Intervention Group N = (24)	Comparison Group N = (28)
	Mean (SD) or n (%)	Mean (SD) or n (%)
Age	25.4 (2.6)	28.7 (5.1)
Education		
High school	0 (0%)	1 (3.6%)
College	1 (4.2%)	3 (10.7%)
Undergraduate	20 (83.3%)	16 (57.1%)
Graduate	3 (12.5%)	8 (28.6%)
Ethnicity		
European	12 (50%)	18 (64.3%)
African	2 (8.3%)	6 (21.4%)
Arab	2 (8.3%)	2 (7.1%)
Asian	4 (16.7%)	1 (3.6%)
Metis	2 (8.3%)	0 (0%)
Latina	1 (4.2%)	1 (3.6%)
Marital status		
Married	4 (16.7%)	7 (25.0%)
Living common-law	0 (0%)	3 (10.7%)
Single, never married	20 (83.3%)	18 (64.3%)
Children		
No children	23 (95.8%)	27 (96.4%)
One child	1 (4.2%)	1 (3.6%)
Born in Canada		
Yes	18 (75.0%)	22 (78.6%)
No	6 (25.0%)	6 (21.4%)
Work status		
Student	14 (58.3%)	10 (35.7%)
Hours/wk	14.4 (13.5)	11.4 (10.1)
Employed	8 (33.3%)	17 (60.7%)
Hours/wk	31.0 (12.7)	36.8 (9.2)

Note. In the intervention group, two respondents did not report their age, one did not report her ethnicity, and two did not report their employment status. In the comparison group, one respondent did not report her age, and one did not report her employment status.

Fidelity of Program Implementation

Data were collected over the course of three training sessions (Spring, Fall, Winter). The program facilitators were asked to complete the fidelity checklists independently on the same randomly selected days. Two sessions of training were rated per session to keep the demands placed on the training facilitators manageable. The consistency of training program implementation for both the Fall and Winter session was 100% (32 out of 32 questions), with all four of the sessions receiving a rating at 100% (8 of 8 items). Complete agreement between raters was reported on the quantitative questions. Fidelity ratings were not completed for the Spring session (the study's first session). The only fidelity item on which there were differences related to whether the respective session had included other training program activities, not previously mentioned. It was an open-ended neutral question that was not included in the analysis above. During the Fall training, one rater responded to this question by reporting that a SA nurse examiner from The Ottawa Hospital had presented to the group, however, the other rater did not report this presentation. In the Winter training, both facilitators reported that no additional training program activities had taken place during either of the two sessions rated.

To further assess for differences between the Spring, Fall, and Winter training sessions, the Kruskal-Wallis H test was conducted on the trainees' post-test scores to compare the effect of training session on each of the training outcomes. The test was appropriate for the small, unequal groups being compared (Siegel, 1956). Distributions of CASES, SIRI-2, and FPS scores were similar across all training sessions, as determined by visual inspection of boxplots. Results pertaining to trainee's counselling self-efficacy skills indicated that CASES scores were similar between training sessions, Spring (mean rank = 63.29), Fall (mean rank = 64.64), Winter (mean rank = 63.83), and there was no statistical difference between sessions $\chi^2(2) = .24, p = .89$.

Assessment of trainees' suicide intervention scores revealed similar scores across sessions Spring (mean rank = 1.12), Fall (mean rank = 1.19), Winter (mean rank = 1.01), and no statistical difference between training sessions, $\chi^2(2) = 2.19, p = .34$. Lastly, an analysis of trainees' feminist attitudes and beliefs demonstrated that FPS scores did not differ between training sessions, Spring (mean rank = 122.57), Fall (mean rank = 124.30), Winter (mean rank = 120.33), $\chi^2(2) = .36, p = .84$. These results suggest that training delivered at each time point (Spring, Fall, Winter) had a similar effect on trainees.

The fidelity checklists also elicited descriptive comments about the strengths and challenges of each training session. Each of the activities described in the fidelity checklists' comments were consistent with the types of activities elucidated in the training program logic model (See Study One), indicating consistency with the program logic model during the various sessions. For example, the facilitators provided comments about how a feminist anti-oppression framework was applied to the training; one session dealt with mental health language and oppression, and another session addressed empowering communication strategies. The raters also described what kind of information was taught to the group, including: recent SA and reporting to the police or hospital, crisis counselling skills and feminist practice, active engagement and mental health, suicide intervention, risk factors for suicide, assessing for safety, contracting, breaking confidentiality, calling 911, and information on coping strategies and grief. Lastly, the raters' described the hands-on practice that participants received with regard to feminist counselling and crisis intervention skills. In each of the sessions, the participants were given time to put the information that was taught into practice through engaging in role-play exercises. For example, when they learned about emergency situations and calling 911, the role-play tackled

how to call 911 without disempowering the client. Overall, the fidelity checklist ratings and descriptive comments suggested that the training activities in the assessed sessions were in line with the intended activities as specified in the logic model of the program.

Testing of Hypotheses

Helping skills. A 2 (time) x2 (group) mixed ANOVA was carried out on the CASES- Helping Skills Subscale data to test the hypothesis that individuals receiving counsellor training will report greater improvements in the self-efficacy of their helping skills compared to individuals not receiving counsellor training. A statistically significant two-way interaction on Helping Skills Subscale scores was found, $F(1, 50) = 19.26, p < .001$, partial $\eta^2 = .28$, 95% CI [.09, .45] in which the experimental group reported greater improvements compared to the comparison group. Prior to the training, the mean score for the experimental group was 53.33 ($SD = 9.98$) and the mean score for the comparison group was 52.89 ($SD = 11.63$). After the training, the mean score for the experimental group was 64.04 ($SD = 9.18$), while the mean score for the comparison group was 54.32 ($SD = 9.69$). (These results are depicted in Figure 2.)

Relating these scores to the response options on the 7-point Likert scale, before the training both groups scored approximately 4 out of 7 on the scale, indicating that they had “some confidence” in their counselling abilities; whereas after the training the comparison group’s score did not change, but the experimental group’s score increased to approximately a 5 out of 7 on the scale.

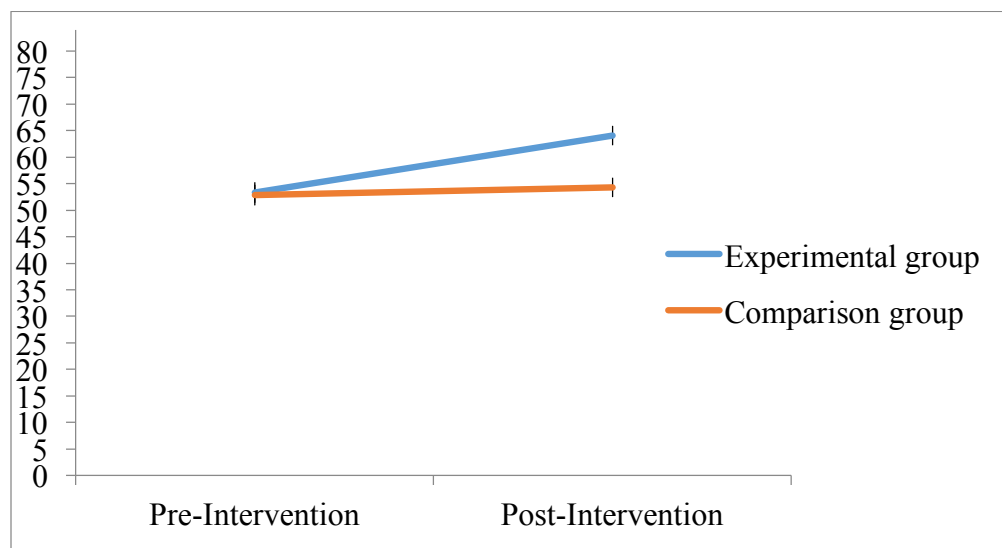


Figure 2. The mean counselling self-efficacy scores before and after training for the experimental and comparison groups.

A statistically significant main effect of time was also found, $F(1, 50) = 32.94, p < .001$, partial $\eta^2 = .40$, 95% CI [.19, .55]. It demonstrated that overall, participants' counselling self-efficacy scores were higher after the intervention than before the intervention. Additionally, the main effect of group (experimental, comparison) was not statistically significant, suggesting that there was no difference between the experimental and comparison groups' scores overall.

To explore the impact of missing values (participant non-responses) on the counselling self-efficacy data, a single imputation was run using the Expectation Maximization (EM) algorithm in SPSS. Little's MCAR test demonstrated that the values were missing at random both prior to ($\chi^2(33) = 19.49, p = 0.97$) and after the training intervention ($\chi^2(11) = 16.02, p = 0.14$). Since less than 5% of the data was missing on this measure, it was appropriate to run a single EM algorithm on the data (Schafer, 1999). A two-way mixed factorial ANOVA model was applied to the imputed CASES – Helping Skills Subscale data set. The results of the imputed

data set were similar to the original analyses, which suggests that the data were not sensitive to the missing values.

Suicide intervention skills. A 2 (time) x2 (group) mixed ANOVA was carried out on the SIRI-2 data to test the hypothesis that individuals receiving counsellor training will show greater improvements in suicide intervention skills compared to individuals not receiving counsellor training. Results demonstrated no statistical significance on the two-way interaction, $F(1,50) = .54$, $p = .47$, partial $\eta^2 = .01$, 95% CI [.00, .12]. Before the intervention, the mean score for the experimental group on the SIRI-2 was 1.21 ($SD = .29$), while the mean score for the comparison group was 1.45 ($SD = .57$). After the training, the mean score for the experimental group was 1.13 ($SD = .34$), while the mean score for the comparison group was 1.43 ($SD = .58$). As this measure used an absolute mean difference score, it was not possible to relate the scores back to the 7-point Likert scale response options.

The main effect of time was also not statistically significant, ($F(1, 50) = 2.12$, $p = .15$, partial $\eta^2 = .04$, 95% CI [.00, .18]), indicating that overall, the participants' SIRI-2 scores did not change from the first to second measurement. On the other hand, the main effect of group (experimental versus comparison) was statistically significant, $F(1, 50) = 4.62$, $p = .04$, partial $\eta^2 = .08$, 95% CI [.00, .25], with the experimental group having on average a lower score than the comparison group across the two time points. While the two-way interaction did not reach statistical significance there was a small but noticeable improvement in the experimental group's scores over time. This measure's values are based on participants' absolute mean difference scores from expert panel ratings and lower values represent closer correspondence to responses of the expert panel. These results are depicted in Figure 3.

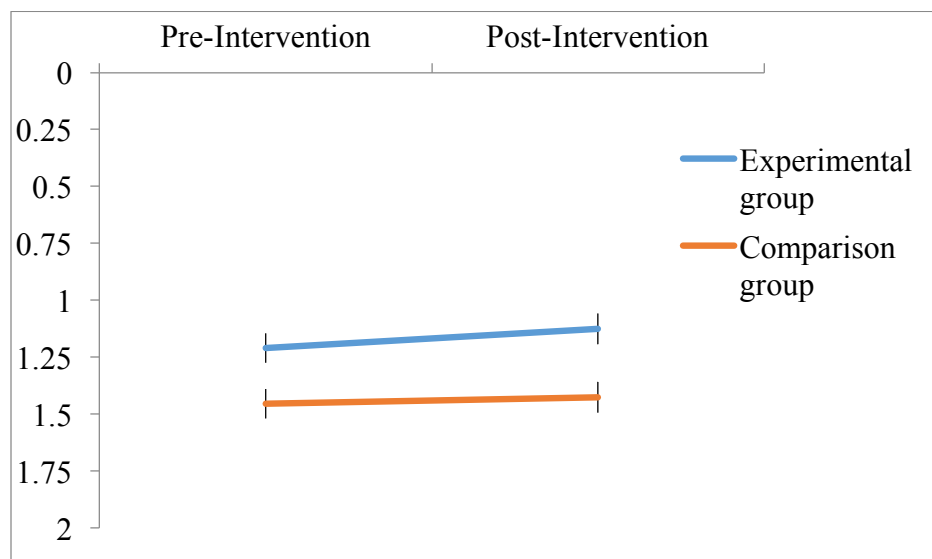


Figure 3. Mean suicide intervention scores before and after training for the experimental and comparison groups.

To explore the impact of missing values (participant non-responses) on the SIRI-2 results, a single imputation was run using the Expectation Maximization (EM) algorithm in SPSS. Less than 5% of the data was missing on this measure. Little's MCAR test demonstrated that the values were missing at random both prior to ($\chi^2(38) = 42.51, p = 0.28$) and after the training intervention ($\chi^2(111) = 122.51, p = .21$), which indicates that it was appropriate to run the EM algorithm on the data. A two-way mixed factorial ANOVA model was applied to the imputed SIRI-2 data. The results based on the imputed data were consistent with those of the non-imputed data, which suggested that the SIRI-2 data was not sensitive to missing values.

Feminist attitudes and beliefs. A 2 (time) x 2 (group) mixed ANOVA was conducted to test the hypothesis that individuals receiving counsellor training will report greater development of feminist attitudes and beliefs than individuals not receiving counsellor training. There was no interaction, $F(1,50) = .202, p = .17$, partial $\eta^2 = .04$, 95% CI [.00, .18]. Before the intervention, the mean score for the experimental group was 118.63 ($SD = 13.63$) and the mean score for the

comparison group was 122.79 ($SD = 15.72$). After the training, the mean score for the experimental group was 122.79 ($SD = 13.94$), while the mean score for the comparison group was 121.96 ($SD = 13.69$). (These results are depicted in Figure 4.) Relating these scores to the 7-point Likert scale response options, before the training both groups scored at approximately a 5 out of 7 on the scale, indicating that they “somewhat agreed” with the items. After the training both groups’ scores remained at approximately 5 out of 7.

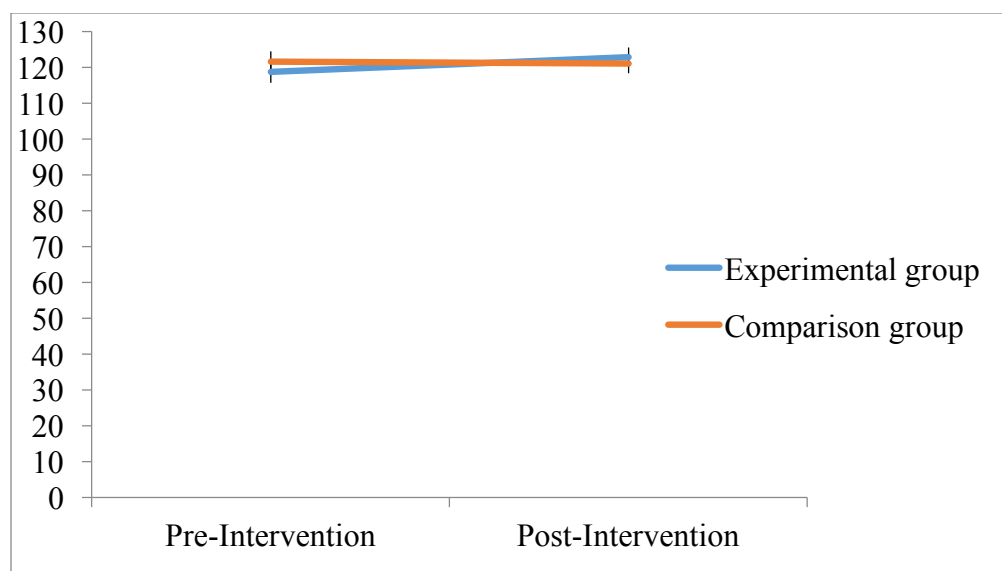


Figure 4. Mean feminist attitudes and beliefs scores before and after training for the experimental and comparison groups.

The main effect of time was not statistically significant, ($F(1, 50) = 1.38, p = .25$, partial $\eta^2 = .03$), 95% CI [.00, .16], indicating that overall the participants’ FPS scores did not change from the first to second measurement. The main effect of group (experimental, comparison) was not statistically significant, $F(1, 50) = .020, p = .89$, partial $\eta^2 = .01$, 95% CI [.00, .02].

To explore the impact of missing values (participant non-responses) on the FPS data, a single imputation was run using the Expectation Maximization (EM) algorithm in SPSS. Little’s MCAR test demonstrated that the values were missing at random both prior to ($\chi^2 (116) =$

111.05, $p = 0.61$) and after the training intervention ($\chi^2(87) = 105.10$, $p = 0.09$), and less than 5% of the data was missing on this measure. This indicated that it was appropriate to run the EM algorithm on the data. A two-way mixed factorial ANOVA model was applied to the imputed FPS data set. The results of the imputed data set were consistent with the original analysis, demonstrating that the FPS data were not sensitive to missing values.

Discussion

On the CLs, volunteer counsellors deliver services to vulnerable populations, serve large catchment areas, and act as first responders to clients after events occur. They also serve the critical function of linking clients with other services such as healthcare, police, legal, and housing services (Colvin, Pruett, Young, & Holosko, 2016). Because of the CLs' anonymous and accessible nature, volunteer counsellors have the potential to reach clients who may otherwise be reluctant to seek out support (Tjaden & Thoennes, 2006). Furthermore, CL counsellors fill a void in service delivery, as crisis intervention providers in other sectors often lack the training to support survivors of SV (Colvin, Pruett, Young, & Holosko, 2016). As such, CL volunteers have the potential to strongly impact their communities, and thus it is important that these volunteers are well trained and prepared to deliver the services that RCCs promise. This pilot study is the first research to measure the extent to which CL counsellors develop appropriate skills and competencies as a result of their training.

This pilot study found that the training intervention positively impacted the CL volunteers' counselling self-efficacy in relation to helping skills; following the intervention, participants who received training reported greater improvements in their helping skills than those in the comparison group. These findings suggest that a community-based CL training

program supported the development of volunteers' helping skills. Several studies have measured counsellor self-efficacy to assess counsellor training program outcomes (e.g., Larson & Daniels, 1998; Lent, Hill, & Hoffman, 2003), and research demonstrates that counselling self-efficacy is positively associated with counselling performance and skill level (e.g., Larson & Daniels, 1998), whereas it is negatively associated with counsellor anxiety (e.g., Barbee et al., 2003). This research would suggest that counselling self-efficacy is associated with counselling skills.

In the context of the current study, it was not possible to have supervisors complete detailed assessments of participants' counselling skills. However, at the end of training each CL volunteer completed a simulated call in which they responded to a fictitious caller and were then given a pass/fail rating by their supervisor. This rating was based primarily on the supervisor's assessment of volunteers' basic counselling skills. All of the CL trainees included in this study passed their final assessments and were permitted to continue on and volunteer on the lines. This provides further support that they attained basic counselling proficiency by the end of their training, and documents a positive outcome of a grassroots effort to build community capacity.

Although helping skills improved over the course of the training, no change in volunteers' suicide intervention skills were apparent. In particular, the results suggested that the counsellor training program did not change the level of CL volunteers' suicide intervention skills. However, the results did indicate that the intervention group scored higher than the comparison group overall on suicide intervention skills, which may imply that those who self-selected to participate in the CL program, had a greater aptitude for this intervention work than their non-volunteering peers.

The content of the suicide intervention training was based on curricula developed by other organizations doing suicide intervention work (e.g., WHO, 2000; Health Canada, 2002), and could reasonably be expected to have improved trainees' skills. However, in this instance the training was delivered as a single 3-hour session, whereas a larger amount of the training might have been needed to produce an effect. Additionally, previous research, showing the effectiveness of training of suicide intervention skills, focused on interventions that were exclusively designed to enhance participants' suicide intervention competencies (Shim & Compton, 2010; Schinke, Smith, Myers, & Altman, 1979; Botega et al., 2007). In contrast, the CL training covered a wider range of topics, and embedded the suicide intervention component within 10-weeks of training on other topics. These factors may have reduced the saliency and memorability of the suicide intervention material to trainees, relative to the interventions examined in the previous research.

Previous studies on suicide intervention training have used survey instruments to examine the development of skills in trainees (e.g., Schinke, Smith, Myers, & Altman, 1979; Botega et al., 2007; Shim & Compton, 2010). While it was desirable to use a performance measure to assess suicide intervention skills, the questionnaire was designed for generic helpline volunteers. This may have diminished the trainees' performance on this measure because the scenarios diverged from those discussed and rehearsed in the CL training. The trainees might have performed better on a context-specific measure that reflected common reactions to SA and abuse and their relation to suicidality. For example, if a hypothetical "caller" reported a sense of powerlessness towards her abuser, intense feelings of shame or self-blame over childhood sexual abuse, or distress over uncontrollable flashbacks, it might have been easier for the trainees to

identify appropriate responses with respect to suicidality, as the scenarios would have matched closely with their training.

Contrary to the study hypothesis, results indicated that participants' feminist attitudes and beliefs did not change over the course of the training. While the training intervention did not appear to impact the CL volunteers' scores on these specific items, it is notable that they scored moderately highly at both time points. These results suggest that the RCC is succeeding in recruiting individuals who have attitudes and perspectives that are generally consistent with the values of the Centre, and that the recruited control group was similar to the experimental group in this respect. However, as the measure intended to assess politicized feminist perspectives was nearly two decades old, it may have been less relevant to the study's participants, and likely did not have the sensitivity to detect potential ways the training may have further enhanced or otherwise altered trainees' relationships to feminism. Lastly, to assess the consistency of training delivery across training sessions fidelity assessments were completed. Results indicated that the training was implemented consistently during the Fall and Winter sessions. Since the CL training program is stable and long-standing, with the same instructors facilitating each of the three sessions, it is probable that the Spring session was conducted in much the same way. Notably, all of the fidelity ratings were at ceiling, and the possibility of social desirability bias in the reporting process cannot be ruled out. Also, the fidelity scale used dichotomous measures and it is possible that the level of implementation was not at maximum capacity in some of the training areas of focus. On the other hand, the training may in large part have simply been carried out as intended. The latter interpretation is supported by the fidelity ratings and descriptions of activities (and their alignment with the training logic model).

Limitations

While the current study contributed to community psychology's understanding of the effectiveness of RCC CL training, it had limitations. One limitation related to the lack of random assignment in the study's design, which results in the possibility that the non-equivalence of the two groups are contributing to findings, particularly when there are differences that might be attributed to the intervention. However, given the research context and capacity, a randomized design was not feasible because the research could only be conducted in the context of a RCC.

A second limitation of the study related to the composition of the control group. While it was planned that waitlisted volunteers would comprise the control group, in practice, interest in enrollment was low and no waitlist was formed. Therefore, control group participants were recruited via email lists generated by the Centre. As there was only a 43.05% response rate for the control group, compared to a 65.11% response rate for the experimental group there was the potential for sample bias. It is possible that those with greater affiliation to the Centre or stronger motivations to support it were more likely to volunteer for the research. Such pro-social motivations, however, could be expected to be similar to those of the volunteers enrolling in the CL training. An analysis of descriptive statistics revealed that there was equivalence between groups on all demographic variables except age, suggesting good comparability overall. There was no statistical difference between groups on pretest scores for the three outcome variables. Both groups also had low attrition from the study, which reduced the potential for bias at the post-test phase.

The self-report nature of the study's counselling self-efficacy and feminist attitudes and beliefs measures constituted another limitation, as it was not possible to remove the potential for

demand characteristics. The external assessment of staff counseling abilities by a third party can be expected to be non-biased and more accurate measure of this outcome. This also related to the fidelity ratings, such that if an external observer or recording device had been used, greater confidence could be placed in the ratings. Given that self-report measures are indirect measures; they do not measure the actual skills of participants, and in testing attitudes and beliefs they are vulnerable to social desirability effects. While the use of performance measures (such as the use of an external expert to rate basic counselling skills) would have provided greater information about the development of actual measured skills, it was not possible to use such measures in the context of the current study because of logistical issues. Nevertheless, attempts were made to limit social desirability effects associated with the use of self-report measures. In particular, participants were assured that their participation in the study would not impact their involvement with the RCC and that their responses would remain confidential and anonymous. The researcher was not involved in delivering the training intervention and did not share participants' identified data with the organization.

Another limitation was that some of the measures were limited with respect to fully operationalizing the targeted outcomes. For example, the feminist attitudes and beliefs measure was designed to test politicized perspectives, but given that it was nearly two decades old perspectives have likely changed over this time rendering the scale less sensitive to change today. Furthermore, the scale was designed to assess feminist attitudes and beliefs in the general population, rather than the specialized pro-feminist context of a RCC. A more current and sensitive measure would have been needed to fully assess this changes on this outcome. It is also notable that the screening process recruited volunteers with feminist perspectives as the research

was completed in the naturalistic setting of a feminist organization. As well, the counselling self-efficacy measure assessed participants' confidence in their counselling skills, rather than their actual counselling skills, and thus, did not fully capture the outcome of interest.

A final limitation of the research related to generalizability of results. The intervention involved a relatively small group of participants ($n=24$) who received training at a single RCC. Therefore, their responses to the training might not have been characteristic of other CL volunteers. Furthermore, RCCs are not necessarily homogenous and can differ according to their organizational structure and mandate (Colvin, Pruett, Young, & Holosko, 2016). To understand how the research generalizes to other RCCs, it would be necessary to research CL training across a variety of RCC settings. Considered together, these limiting factors suggest that the results of this pilot study, while informative, should be interpreted tentatively.

Future Research

Despite their widespread availability, little empirical research exists on RCC CL training programs. As a result, community agencies have received limited research guidance on the development and delivery of evidence-based training (Colvin, Pruett, Young, & Holosko, 2016). Future research is needed to address this gap. A consideration for future research is the need for more rigorous research methods. Randomized experiments are generally considered to be the best method for assessing interventions' effectiveness, however, as Trochim (2005) discussed, randomized experiments should be situated within a framework of "exploratory, implementation, and formative" studies (p. 4). Drawing upon medical research as a model, Trochim (2005) identified the following phases of intervention research: (1) formative and exploratory research; (2) quasi-experimental research; (3) randomized experimental research; and, (4) ongoing

monitoring and evaluation. The current study represents phase two pilot research. Future phase two research using recent and performance-based measures, specifically designed to examine feminist CL counselling skills and other SV related outcomes should follow the current pilot to further understand the effectiveness of the training in attaining its intended outcomes. Using such measures, future research should attempt to measure volunteers' actual counselling skills using behavioural measures, rather than using subjective measures such as self-efficacy, because subjective measures can be susceptible to a social desirability bias. (In the current study, however, the presence of demand characteristics would not explain why the trainees scored higher than controls only at follow-up on this variable.) However, future studies should attempt to measure actual counselling skills, rather than relevant proxy measures, to increase confidence in their results.

Future research should also examine the maintenance of intervention effects, through the inclusion of lengthier follow-ups in research designs (e.g., after 3-months). In order to have a meaningful effect, any beneficial outcomes of training interventions would need to remain in place over time. Therefore, it would be important for future research to investigate the durability and sustainability of these effects. If the intended outcomes of the training intervention were consistently demonstrated by quasi-experimental research, then phase three research could be conducted. The use of a randomized design would help to control for confounds and strengthen the internal validity of the research. Finally, future research involving client feedback on services and external observations of service delivery would be necessary to extend the evaluation to an examination of the effectiveness of service delivery and to unpack the relationship between training quality and service delivery.

Implications and Conclusion

This study took initial steps to examine an area of research that had not been previously investigated, and did so within the constraints and research limitations of the organization undergoing research. The literature suggests that CL counsellors are instrumental in promoting SV survivors' health and wellbeing as survivors reach out for support and try to navigate the social services (Campbell et al., 1999; Campbell et al., 2001). Thus, it is imperative that CL counsellors are adequately trained and prepared to assist SV survivors.

This pilot study offers preliminary evidence of the outcomes associated with such a training program. With improved counselling self-efficacy in relation to their helping skills, CL counsellors will be better prepared to serve SV survivors. While gains were not found on volunteers' suicide intervention skills, this finding highlights an area that RCCs can address to strengthen their training. Indeed, the suicide intervention results suggest the need for the organization to integrate more training on suicide assessment and intervention into the training curriculum. Options could be to provide additional suicide assessment and intervention training internally, or to provide it through a partnership with a compatible suicide intervention organization. Lastly, feminist attitudes and beliefs did not change, however, this finding likely reflects at least in part the consistency in values held by people drawn to volunteering on a rape CL and the validity of the scale.

An important step in improving services for women and girls who reach out to RCCs, is to conduct research on the services the Centres provide. One area to examine is the training of paraprofessionals who deliver front-line services. A complementary area is the impact of services on service users, and on legal and health-related outcomes. Overall, broad collaborative

and coordinated research efforts are needed to strengthen and promote secondary system responses in this area.

Recent policy recommendations also echo the need for greater research on responses to SV through calling for a federal approach that is “evidence-based and will support improved data collection and analysis to better understand gender-based violence” (Status of Women Canada, 2016). Further, they propose, “strengthening community-based and culturally responsive counselling and support services” and “adequately resourcing services for survivors and perpetrators” (Status of Women Canada, 2016). These recommendations have implications on CL practice, as they broadly support the resourcing and operations of community anti-violence programs.

SV in society is an increasingly discussed conversation that has yet to lead to meaningful change in the lives of victims/survivors of SV. Concretely, this is demonstrated by the fact that rates of SA have not declined in ten years, and that at least 20% of SA complaints are deemed to be unfounded by police (Perreault, 2015, Randall, 2010). However, increased understanding of front-line community services, coupled with adequate resourcing of RCCs, could go far in tangibly supporting SV survivors. This pilot study took an initial step in an innovative direction that supports these aims.

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Study 3

Insider Perspectives: A Qualitative Investigation of Rape Crisis Line Workers' Training and Practice Experiences

Abstract

Rape crisis line (CL) counsellors offer frontline support to survivors of sexual violence (SV), yet they have received scarce research attention. To facilitate more effective rape CL counsellor practice, it is crucial to first understand their perceptions of the effects of the training they receive and of their experiences as counsellors. This study qualitatively explores volunteer counsellors' training and practice experiences through the use of semi-structured interviews. Ten volunteer counsellors, recruited from a local Rape Crisis Centre CL program, participated in the study. Findings revealed that individuals were motivated to volunteer with the CL for career exploration, feminist advocacy activities, and altruistic reasons. After the training, volunteers perceived they had gained basic counselling skills and increased knowledge of feminism; however, they felt largely unprepared to respond to suicidal callers. In delivering services, volunteers found their work personally meaningful, but they nevertheless struggled with emotional challenges, and with certain organizational challenges. Lastly, volunteers' involvement in the CL work, and their regular contact with survivors and systems raised their awareness that SV is a systemic problem, reinforced by social structures and institutions. Due to their social location within community RCCs, rape crisis counsellors are uniquely positioned to contribute to improvement to secondary responses to violence against women (VAW).

A Qualitative Exploration of Rape Crisis Line Workers' Training and Practice Experiences

Introduction

The purpose of this study is to understand and document the experiences of women who participated in CL counsellor training, and then volunteered directly with clients for at least one year. This study set out to understand volunteer counsellors': (1) initial motivations for volunteering; (2) training and practice experiences; (3) ongoing motivations and challenges; and, (4) perspectives on SV in society. There is a shortage of research on the training and work experiences of this specialized group of direct service providers, and very limited research has been published within a Canadian context. The current study was designed to address this void in the literature.

This study was conducted using a social ecological framework (Heisse, 1998; Nelson & Prilleltensky, 2010), which acknowledges that individuals' qualitative experiences do not occur in isolation from their social environments. This framework looks at the connections between individual, and extra-individual environmental factors, such as the micro-system (e.g., immediate social groups), meso-system (e.g., community organizations), and macro-system (e.g., social norms, policies), and offers a holistic understanding of how individuals' experiences are shaped by community and social structures, as well as how changes to these larger systems can positively affect individuals. While this study takes a social ecological perspective (Heisse, 1998), its primary focus is at the intersection between individual and organizational levels of analysis, as the rape crisis counsellors' work occurs in the context of a community organization.

This research location is well suited to the discipline of community psychology, which is concerned with how community research can develop programs and policies and improve social

conditions for marginalized groups of people. As sexualized violence is a social oppression that is unequally distributed across gender and other demographic characteristics such as culture and ethnicity, immigrant status, disability, income, and age (Benoit et al., 2014; Wasco, Campbell, & Clark, 2002) the program under study serves marginalized groups of women. Because the CL training program equips non-professional community members to support this population, it builds community capacity. Due to these characteristics, this study has the potential to contribute to community psychology's understanding of an important, yet understudied group of direct service providers, and to support the population under study.

This introduction situates the current study in the context of research on RCCs, and rape crisis counsellors' training experiences. Relevant research on counsellors' motivations for volunteering, challenges of trauma support work, and personal changes associated with the work will then be reviewed. A description of the specialized CL counsellor training program will be presented last in this section.

Research on RCCs

Although RCCs have been in active in Canada for approximately 40 years, they have received limited research attention. The existing research has predominantly focused on the practice experiences of the professional staff who work with survivors of SV (Maier, 2008; Campbell, Baker, & Mazurek, 1998; O'Sullivan, & Carlton, 2001), and less attention has been placed on RCC volunteers. The research with a focus on volunteer rape crisis counsellors and advocates, examined their motivations for volunteering (Black & DiNitto, 2008; Rath, 2008), their beneficial effect on SV survivors' wellbeing (Maier, 2008; Campbell, Wasco, Ahrens, Sefl, & Barnes, 2001; Campbell, 2006; Campbell, 1998), and most often, the personal challenges and

negative psychological outcomes associated with their volunteer role (Ullman & Townsend, 2007; Baird and Jenkins, 2003; Thornton and Novak, 2010; Wasco and Campbell, 2002). Other research has examined the effectiveness of RCC services (Westmarland, & Alderson, 2013; Finn, Garner, & Wilson, 2011; Finn & Hughes, 2008; Bennett, Riger, Schewe, Howard, & Wasco, 2004; Wasco, Campbell, Howard, Mason, Staggs, Schewe, & Riger, 2004).

While there is a small body of research on CL volunteers' training experiences, which is herein reviewed, it does not retrospectively ask counsellors how well their training actually prepared them for their work, or enquire about their motivations, challenges, and insights arising from their work. This study makes a unique contribution to the literature by longitudinally following rape crisis counsellors to investigate these understudied areas.

Rape Crisis Counsellor Training

Rath (2008) conducted qualitative interviews with British volunteer rape crisis counsellors to explore their perceptions of their training. Their training consisted of 65-hours of instruction on the following topics: "counselling skills, crisis intervention, the politics of SV, legal issues, police procedures, sexual health, social work procedures, domestic violence, abortion and contraception, sexuality, survivors of child abuse, suicide and self-harm, relationship issues, and Rape Crisis principles" (Rath, 2008, p. 21). Grounded theory was used to analyze the interview data, and the results strongly reflected themes of personal change. For instance, volunteers enrolled in training during times of personal upheaval; training coincided with positive or negative changes in their intimate relationships; and volunteers reportedly gained confidence and improved their communication skills, which helped to strengthen their relationships. Overall, the study found that rape crisis counsellors reported positive personal

growth as a result of their training.

Hellman and House (2006) used survey methods to examine how American rape crisis counsellors' perceptions of the quality of their training related to their overall satisfaction, affective commitment to volunteering, and intent to stay. They found that the perceived quality of the training was positively correlated with volunteers' overall satisfaction and intent to stay with the RCC. Additionally, the perceived quality of training was positively correlated with counselling self-efficacy and affective commitment, and negatively correlated with their experiences of witnessing victim blaming by service providers. These results suggest that CL counsellors' training experiences are important to their overall satisfaction and commitment, and that higher quality training can contribute to increasing counsellors' self-efficacy, and their capacity to prevent occurrences of victim blaming by service providers.

Carlyle and Roberto (2007) examined how American rape crisis volunteers' overall communication competency (defined as communication skills, knowledge, and motivation) related to their communication anxiety, and counselling self-efficacy. Survey measures were used to examine relationships among these variables. The study's results indicated that communication competency was negatively associated with communication anxiety, and positively associated with all areas of counselling self-efficacy. Based on these findings, the researchers proposed that RCCs could help volunteers manage their anxiety and increase their confidence related to communication, by increasing volunteers' communication skill training.

The aforementioned studies predominantly focused on qualitative examinations of rape crisis counsellor training, whereas the current study explores the counsellors' qualitative accounts of their training and practice experiences. As rape crisis counsellors' motivations for

volunteering, the challenges posed by the work, and their personal changes coinciding with work are examined in the current study, the relevant research on these topics is reviewed below.

Motivations for Volunteering

Most social service agencies use volunteers, but few rely as heavily on volunteer workers as the “female enclaves” of RCCs and women’s shelters (Black & DiNitto, 2008). Indeed, many of these centers would not be able to function without the support of volunteer workers (Rath, 2008). Within these settings, volunteers engage in difficult, unrecognized work, and there is typically limited interest in enrolment. Therefore, there is a need to understand what motivates volunteers to enroll in such programs and how to retain volunteers over time to sustain volunteer-operated services.

In a review paper exploring motivations for volunteering more generally, Clary and Snyder (1999) suggest that people volunteer in order to fulfill several personal, social, and career-related goals. In particular, this model posits that people volunteer in order to “express or act on important values like humanitarianism”; “learn more about the world or exercise skills that are often unused”; “grow and develop psychologically through volunteer activities”; develop “career-related experience through volunteering”; build social relationships; or “reduce negative feelings, such as guilt, or to address personal problems” (Clary & Snyder, 1999, p. 157). Several studies with diverse groups provide support for this six factor model of volunteer motivation (Clary, Snyder, & Stukas, 1996; Clary & Snyder, 1999; Okun, Barr, & Herzog, 1998).

Additionally, research has linked volunteering that is based on career enhancement goals to lower levels of retention, as volunteers may lose their motivation to continue volunteering once their career goals are met, whereas other forms of motivation, such as values, continue to serve

as motivation over time (Garner & Garner, 2011, p. 824). In a cross-cultural study involving student volunteers, Handy, Hustinx, Cnaan, and Kang (2009) found that students who reported being primarily motivated by career enhancement goals demonstrated a lower intensity of volunteering than those motivated by altruistic or social interests.

Self Determination Theory (SDT) (Deci & Ryan, 2002) has also been used to understand volunteers' motivations (Frendo, 2013). SDT proposes that there are different types of motivations and forms of motivation regulation. *Intrinsic motivation* is the desire to engage in an activity, which is itself enjoyable and reinforcing. This form of motivation is entirely intrinsically regulated and self-determined. A volunteer, driven by altruistic goals, who volunteers solely for the pleasure of helping others would be considered to be intrinsically motivated (Frendo, 2013). In contrast, *extrinsic motivation* is driven by external factors, and is regulated through the internalization of social rules. Research supports that, in addition to intrinsic motivations, volunteers tend to be motivated by *identified* or *integrated* extrinsic processes, in which externally-oriented goals are valued, accepted as personally important, and assimilated into one's sense of self (Frendo, 2013). For example, a RCC volunteer may not enjoy accompanying survivors to the hospital, but may nevertheless be motivated by the extrinsic goal of supporting a valued cause. SDT theory proposes that the more autonomous and self-determined the motivation style, the stronger and more sustained the motivation to continue volunteering (Frendo, 2013). Combining Clary and Snyder's (1999) six factor model of volunteering and SDT's internal and external motivations, Moreno-Jiménez and Villodres (2010) found that extrinsic motivations, related to social and career-based factors predicted higher burnout and attrition in volunteers, while intrinsic factors, such as acting on personal values and

experiencing self-understanding, were related to lower rates of these outcomes. These findings suggest that motivations for volunteering can affect success and longevity in the position, and that career goals may be linked to poorer outcomes.

Other studies, however, suggest that multiple, complementary motivations drive volunteers and that retention is associated with the fulfillment of the particular volunteer's expectations (Clary & Snyder, 1999; Clary et al., 1998; Clary & Miller, 1986; Omoto & Snyder, 1995). These studies suggest that it is the match between volunteers' various motivations and their volunteer experiences that are most relevant to retention. The current study will focus on these issues – what motivates people to volunteer and how can they be retained over time – within the understudied context of the training provided by RCCs to their volunteers, and the experiences of volunteers in providing support to survivors of SV.

Challenges of the Work

Working with traumatized clients can cause secondary stress in service providers and caregivers. Vicarious traumatization and secondary traumatic stress (STS), or “compassion fatigue” are examples of secondary stress that can lead to burnout and/or attrition (Pearlman & Saakavitne, 1995). Vicarious traumatization is defined as the “cumulative, transformative effect upon the trauma therapist of working with survivors of traumatic life events” (Pearlman & Saakavitne, 1995a, p.31). Through emotional engagement with clients' harrowing stories, the worker begins to feel similar emotions to the traumatized clients, and the worker's sense of self and outlook on the world can change. STS also involves experiencing emotions similar to those of the traumatized clients, but it more closely mimics the acute symptoms of PTSD, such as “re-experiencing the survivor's traumatic event, avoidance, and/or numbing in response to reminders

of this event, and persistent arousal” (Baird & Jenkins, 2003, p. 23). STS is a temporary stress response, whereas vicarious traumatization embodies a more permanent shift in perspective. Both forms of secondary stress can be seen as risks associated with working with traumatized populations.

Secondary stress and burnout are documented in service providers who have frequent exposure to survivors of SV (e.g., Clemans, 2004; Baird & Jenkins, 2003; Kulkarni et al., 2013; Babin, Palazzolo, & Rivera, 2012; Bemiller & Williams, 2011; Ullman & Townsend, 2007; Campbell, 2002). A variety of factors have been shown to place RCC workers at risk of burnout (Cyr & Dowrick, 1991; Ullman & Townsend, 2007). Symptoms of burnout are “irritability, depression, helplessness and/or hopelessness; physical, emotional and psychological fatigue; negative attitudes towards the work such as apathy, loss of caring, alienation; and withdrawal from the work or life in general” (Cyr & Dowrick, 1991, 346). As such, burnout can have a significant negative impact on both volunteers’ work and on their personal lives.

Although it is under-researched in the context of work with rape survivors, burnout appears to be common in trauma workers. In a study involving 25 rape survivor advocates working at various RCCs in a large city, 44% of respondents reported experiencing stress and burnout (Ullman & Townsend, 2007), and in a survey study involving CL workers, 54% of workers indicated that they had experienced burnout (Cyr & Dowrick, 1991). The current study will explore the extent to which volunteers experience emotional challenges associated with their work at a RCC, as well as how the organization can support workers.

Personal Changes

As discussed above, a potential outcome of working with traumatized populations, and survivors of SV in particular is an increase in secondary stress and burnout. In a study involving female trauma workers Hollingsworth (1993) found that that over time, the workers experienced a diminished sense of safety and security in their lives due to repeatedly hearing about rape survivors' experiences. Similarly, in a study with female social workers from eight rape crisis programs, Clemans (2004) reported that due to their work, the participants experienced increased feelings of vulnerability as women, reduced trust in others, and began to question the overall goodness of society. Additionally, in her seminal research on SA survivors, Kelly (1988) discussed how secondary trauma could result in greater distrust of men, changed sexuality, feelings of vulnerability to future victimizations, and changes in worldview (Clemans, 2004).

In contrast, Schauben and Frazier (1995) discussed the positive changes that occurred as a result of RCC counsellors' work. In this study, service providers spoke about their own growth and change as positive outcomes of working with rape survivors, and reported experiencing a strong sense of accomplishment and satisfaction when they witnessed their clients recovering. Rath (2007) discussed how the reflexive, consciousness-raising rape crisis training also resulted in positive growth and development for the participants in her study. These participants experienced increased self-worth and confidence through undergoing the training.

The current study will add to this body of literature by retrospectively interviewing rape crisis counsellors about their CL training experiences, and investigating how it prepared them for the nuances and complexities of their work. The specific research questions that will guide this qualitative study are the following:

Primary Research Questions

- 1) What motivated counsellors to volunteer?
- 2) How did the counsellors experience their training and practice?
- 3) What motivated counsellors to continue volunteering? What were the challenges they faced as counsellors?

Secondary Research Question

- 4) How did the counsellors' training and practice experiences develop their knowledge about SV in society?

Methods

Crisis Line Program

The RCC volunteers operate a 24-hour CL service for women, which is a well-established, long standing service at the Center. A commitment of 20 hours per month, for a period of one year is expected of the participants. The service offers emergency crisis intervention and feminist counselling to survivors, and to helps survivors navigate the medical and legal systems. In addition to providing support on the lines, volunteers also act as advocates to survivors during accompaniments to police stations or hospitals. In a single day in Canada, 2105 women are served by RCCs (Allen, 2014), and one of the main services they offer is their anonymous and confidential crisis hotlines for survivors of SV.

Crisis Line Program Training

The training program for volunteers involves 30 hours of counselling training organized as 3-hour sessions over 10 consecutive weeks. Currently, three 10-week training sessions are conducted each year at the Center. This training is provided internally and is supervised by a counsellor who has numerous years of experience, and an advanced degree in social work.

Sessions consist of facilitator instruction and guest presentations, supervised role-play exercises, and group discussions. Participants explore different topics each week including: understanding SV through an anti-oppression framework, feminist counselling, crisis intervention, recent SA, suicide, coping strategies, and self-care. Participants also learn about relevant legal and medical practices and protocols in order to provide support to survivors who engage with these services. (Please see Appendix D for the training protocol.)

Participants and Procedure

Participants were eligible for the study if they were either current or past volunteers at the RCC and had participated in the previous quantitative study. Recruitment for the study involved contacting 24 participants via email with a request for participation. The request invited participants to participate in a follow-up study, explained the study's purpose and what participation involved, and stated that participation was optional and would not impact their involvement with the Centre. Ten participants responded to the request, and were included in the study. While the original plan was to use a maximum variation sampling technique and select participants based on demographic characteristics, this was not possible due to the limited number of potential participants. Table 5 and 6 represent the sample's demographic characteristics.

Table 5

Demographic Characteristics of the Sample

Characteristics	Interviewees N = (10) Mean (SD) or n (%)
Education	
Some undergraduate	7 (70.0%)
Some graduate	3 (30.0%)
Age	27.66 (6.42)
Race	9 (90.0%)
White	1 (10.0%)
Black	
Marital status	
Married	2 (20.0%)
Living common-law	2 (20.0%)
Single, never married	6 (60.0%)
Children	
Children	1 (10.0%)
No children	9 (90.0%)

Table 6

Frequency distributions of Work hrs/wk (N = 10)

Work hrs/wk	N(%)
0	2(20%)
15	1(10%)
19	1(10%)
24	1(10%)
30	1(10%)
37.5	1(10%)
40	3(30%)

Semi-structured interviews were conducted with participants. Participants were informed about the purpose of the study and were asked a series of open-ended questions based on a semi-structured protocol, intended to explore the evaluation study's questions. Interviews were audio recorded and then transcribed verbatim into a qualitative data entry template in Microsoft Word.

Measures and Research Questions

A semi-structured interview protocol was generated in consultation with key stakeholders at the partnering agency (See Appendix E). The measure consisted of eight open-ended interview questions and several follow-up probes, designed to encourage full responses from participants, while also anchoring the interview in the research questions. Qualitative interviews can also be useful in eliciting extensive responses from participants and in identifying unexpected program processes and effects. Therefore, participants were encouraged to respond in their own words,

rather than being restricted to pre-set responses, and this afforded them a larger role in shaping the research.

First, the interviews explored counsellors' motivations for volunteering and their expectations of what volunteering would entail. Then, the interviews inquired about participants' perceptions of their training and the extent to which they believed training adequately prepared them to deliver services to survivors. Finally, the volunteers' motivations and challenges involved in their role as crisis counsellors were investigated. Woven throughout the interviews were questions about how the experience of supporting SV survivors may have influenced their awareness and understanding of SV in society (See Appendix E).

Data Analysis

A general inductive approach (Thomas, 2006) was selected to analyze the volunteer-counsellors' interview data. This approach has been used in similar studies (Maier, 2008; Wasco & Campbell, 2002; Baird & Jenkins, 2003; Clemans, 2004; Rath, 2007; Ullman & Townsend, 2007). A general inductive approach to analysis involves synthesizing textual data into a framework that depicts themes or processes as they relate to a study's objectives (Thomas, 2006). The study objectives provide "a focus or domain of relevance" for the analysis (Thomas, 2006, p. 239). The findings, however, are based on thorough readings of the text itself and the themes and concepts found within it. This approach enables a ground-up analysis, rooted in the data, and guided by the research questions. It allows for the discovery of potentially useful, unanticipated findings that may improve understandings of the program under study, while addressing particular research questions.

Data coding was conducted using an inductive analysis technique (Thomas, 2006; Miles, Huberman, & Saldana, 2014; Miles & Huberman, 1994). First, based on a detailed reading of the interview transcripts, open codes were assigned to the transcript data. The criteria for developing open codes were that the categories should be relevant to the research objectives, distinct, and exhaustive. Once open codes were established, the data was revisited using secondary coding to: confirm that they reflected participants' responses; develop new codes if they didn't; and look for interrelationships between codes and the concepts they represented. Following this, selective coding was introduced in order to identify quotes that clearly represented important findings. Coding of interview data was completed using *NVivo version 10* data analysis software.

Trustworthiness of the analysis (Lincoln, Lynham, & Guba, 2011) was supported in several ways. During data analysis, the text was analyzed for disconfirming cases and alternative explanations (Patton, 2002) to ensure that participants' varied perspectives were reflected by the research. An audit trail was maintained to document how the research process was carried out, the research decisions that were made, and how the data was analyzed. Member validation occurred through presenting summary findings to key stakeholders at the organization and requesting their feedback and interpretations. This offered the opportunity for "negotiation of meaning" (Rath, 2008, p. 8) and allowed for further gathering and dissemination of information with those who had the most experience with the CL program. These steps were central to maintaining quality and trustworthiness during the research process.

Results

The current study's findings are organized by the following primary research questions: (1) What led the counsellors to volunteer? (2) How do the counsellors experience their training and

practice? (3) What motivates the counsellors to continue? What are their challenges?

Additionally, it was organized by the following secondary research question: (4) How did the counsellors' training and practice experiences develop their knowledge about SV in society? To ensure that the participants' voices are reflected in the analysis, and for illustrative purposes, direct quotes from volunteer-counsellors are included in the findings.

(1) What motivated counsellors to volunteer?

Participants' motivations that led to their volunteering were explored during the course of their interviews. In particular, participants spoke about three main motivations for volunteering: career exploration, engagement in feminist advocacy activities, and altruism. Each of these areas are discussed in turn below.

Career exploration. A few of the volunteers saw the CL as a way to gain volunteer experience and training in a field related to their desired future career. They explained that involvement in the program could support their career goals through exposing them to CL counselling, and thus, offering them the opportunity to 'try out' counselling-related work at an early stage, to assess whether they wanted to pursue it. Volunteers were also aware that volunteer experience could strengthen graduate school applications by offering them applied experience and an opportunity for developing relationships with individuals who could write reference letters for them. For example, one volunteer described volunteering as a mutually beneficial arrangement with the Centre, "It's given me opportunities that not only better myself as a person, but also work towards, you know, making me more appealing to those that I hope to impress when I go into grad school. You know, it's a win-win."

Engagement in feminist advocacy activities. Several of the participants expressed that they were motivated to contribute to activist efforts that would benefit women. For example, one participant who was already a volunteer with another feminist agency explained, “I wanted to complement the work I was doing there with a little bit more hands-on experience and training in terms of how to support survivors.” She explained that, although it was infrequent, she had encountered SV survivors in the context of her other volunteer work, and was motivated to take the training in order to strengthen her activist tools.

The majority of participants expressed that they were only interested in volunteering with a feminist organization. Illustrating this, one participant stated, “I don’t know that I would want to volunteer at an organization that didn’t have feminism as some part of their policy”. Although this sentiment was shared by most, a minority of participants expressed that they were simply looking for a volunteer opportunity, and were not specifically drawn to the program because of its feminist or anti-violence focus.

For example, one volunteer who was a woman of colour expressed that she had a general interest in volunteering, with no particular concern for feminism or SV. However, although she was not initially motivated to volunteer with a feminist organization, she stated that it ended up providing her with a unique social context in which she could discuss topics of importance to her, such as race and gender politics: “We talked about different oppression things, so like how women of color have come so far to be where we are. And that’s stuff I never thought about, so it was just nice to have people talk about that”. This participant’s experiences in the program caused her to change her expectations and develop new motivations for participating. Several of the participants made reference to belonging to a community with like-minded people as being a

motivating factor. Participants explained that they were looking for a way to connect with other feminist women, to make friends, and to build community. These volunteers spoke about their hope that the Centre would offer them a space for discussion, camaraderie, and belonging in a political space.

Altruism. Some participants were motivated to volunteer by their desire to help others; and they found a sense of purpose and meaning in the endeavor. As one of the volunteers expressed, “One of the things that makes me feel the best about my life, and feel the most well rounded and whole is when I am able to give back a little bit of my time”. This group of participants found volunteering to be intrinsically rewarding. It helped some of them cope with and give new meaning to their own past experiences. For example, one participant spoke about her struggles with depression and the effort she was undertaking in order to overcome and manage it. For this participant, volunteering helped her feel better about her life. Another volunteer mentioned she had been impacted by domestic violence, and it was important to her to find a way to transform her lived experience into actions that would help other women, as stated below:

I had just moved to Ottawa and I was looking for an organization – I had spent a lot of time kind of processing the trauma I had undergone and I really wanted to find a way to give back to that type of community.

At the RCC, some of the volunteers have had personal experience with SV, in these situations, if they have undergone counselling or therapy or have otherwise recovered from the trauma; they can participate as volunteer counsellors. Each volunteer's fit with the program is assessed during intake through individual interviews with the program coordinator. In this study, participants who had experienced SV stated how their lived experiences, combined with their

personal recovery/healing, served to strengthen their work as CL counsellors.

(2) How did counsellors experience their training and practice?

Participants' perceptions of the training process, their feedback on training outcomes, and the extent to which the training adequately prepared them to deliver services, were investigated in the participant interviews. These findings are discussed in detail below.

Training process. Overall, participants spoke very positively about the process of taking part in the CL training. They felt a strong sense of community, and as one participant expressed, enjoyed the weekly routine of meeting with the other volunteers, "It was a great thing to look forward to every week, to get to hang out with incredible women". Participants felt emotionally safe in their groups, and perceived the other volunteers as friendly, welcoming, and warm. The volunteers also spoke favorably about the lead training facilitator.

Several of the volunteers commented that opportunities for learning occurred because of their differences. For example, one participant spoke about how the diversity among volunteers, and learning about one another's experiences, led to opportunities to learn about feminism: "There was more diversity than I've seen in other feminist spaces, so I thought that was really cool because there were issues of race and class that intersected with feminism." Given that the Centre's clients are themselves from diverse backgrounds, and that it is imperative that service providers avoid stigmatizing or further harming them, it is important for counsellors to develop their critical awareness of how multiple grounds of identity can influence women's experiences and vulnerabilities to SV.

Lastly, speaking about the spirit of debate fostered in the training, a participant said:

I definitely enjoyed the atmosphere that they created. They would never shame anybody for their beliefs, but they would definitely encourage people to respectfully challenge each other. To create an atmosphere of discussion, rather than you know, this is the way we do things. This is right, this is wrong. It's more of a respectful discussion which I really enjoyed.

While the participants' feedback on the process of participating in the training was positive overall, a few participants commented that at times the training could be emotionally taxing or make them feel uncomfortable when their attitudes or beliefs were challenged. Additionally, one of the participants recalled that the training felt quite lengthy and intensive.

Training outcomes. Participants spoke about several areas of skills and competencies that they developed as a result of the training. The current section reviews training outcomes, as participants saw them. Overall, participants reported that their training experiences improved their basic counselling skills, increased their knowledge of feminism and a feminist approach to counselling, and made them more aware of what a woman's experience might be in interacting with the medical and legal systems.

According to the volunteers, the training improved their basic counselling skills. They were instructed on how to approach different situations that a caller may present, and learned what questions to ask in different circumstances to make sure the caller was safe. Additionally, they learned about building rapport, and practiced their active listening skills. Participants were taught about flashbacks to traumatic experiences, as well as breathing and centering techniques to help bring somebody out of a flashback. Participants were also encouraged to establish their personal boundaries, and to focus on offering callers non-directive support and referrals.

The participants also reported learning about a feminist approach to counselling and its goal of empowering the caller. They described their training as beginning with the principle that women have the personal resources to solve their own problems and find their own solutions even in difficult situations. The reasoning was expressed by another volunteer, “survivors have had control taken away from them, so in engaging in feminist counselling you’re giving them back that control and ensuring that they are empowered to make their own choices.”

A majority of interviewees stated that their volunteer experiences with the RCC served to strengthen their pre-existing feminist beliefs, even though these individuals already had robust feminist sensibilities going into the program, as illustrated below:

I’ve been a feminist and activist, I’ve been that for a long time, so it wasn’t my first immersion in a very firmly feminist space. So I don’t think I changed or was suddenly like oh my god, feminism, amazing! Because I already knew that, but it definitely taught me more specifically about SV.

While most of the volunteers were familiar with feminist thought, a minority reported that they gained a totally new perspective from the training. One stated, “honestly I would go home and look up half the words they used, because I had no idea. I was like, what’s a patriarchy? I had never heard of that. So that definitely just broadened my horizons a little bit”. Regardless of their knowledge of feminism coming into the program, all of the volunteers reported that they increased their knowledge about SV, and SV survivors, through their involvement. This experience deepened their awareness of the severity and prevalence of SV in society, and it also influenced their perspectives on the survivors themselves:

I think it helped me not look at them as victims. Because it's hard not to look at someone who has been raped, not to look at them as victims, because it is such a horrific crime. But looking at them as survivors instead. To me a victim is someone who needs to be saved, and a survivor is someone who needs support, who is stronger.

Learning about SV and SV survivors were areas that volunteers identified as strengthening their feminist views. Volunteers also reported that they became more acutely aware of privilege and oppression through their CL training. One particular exercise that volunteers mentioned involved first forming a line, and then, when different forms of oppression were named, taking a step forward if they personally identified with the form of social oppression named. This exercise reportedly heightened their understanding of how it feels to be stigmatized and the potential vulnerabilities of their callers. Commenting on this experience one volunteer said,

I felt like I could – I'm not really sure how to explain it – like I could target the exact, precise emotion that I felt in being isolated from the group. Like the emotion just became more clear to me. Like maybe I felt it in a mixed, muddy, combination of other emotions at other points in my life but this was like a very clear – oh, this is how this feels.

While a few volunteers identified this particular exercise as strongly impacting them, the fundamental topics of identity and diversity were embedded throughout the training. This critical analysis strengthened their feminist attitudes and beliefs.

Lastly, participants reported learning new information about medical and legal procedures relevant to survivors of SV in the training. They stated they gained new knowledge in terms of understanding legislation and court proceedings, and what a forensic examination involves. This

was important information for the counsellors, as they were often the first persons to explain information to callers and connect them with other services.

Crucial areas of training. Participants identified a number of areas that they thought were particularly important in preparing them for their work. One area they found especially relevant was the training on flashbacks, as these represented the majority of calls. Participants also indicated that the information on grounding techniques, and identifying callers' coping mechanisms was useful and relevant to their practice experiences. In addition, most of the participants said that the role play exercises were very useful in enabling them to develop basic counselling skills, including active listening, building rapport, responding to different scenarios and assessing risk of suicide. (Participants engaged in one-on-one unsupervised role plays as well as plenary role plays in which they were coached in front of the group, and then debriefed as a group.) One of the counsellors explained that although some of the role play scenarios initially seemed unlikely to occur, in hindsight, they closely matched what she experienced on the lines:

One thing that I found that really mirrored my experiences were the role-play exercises that we did during training. In the training I was like I don't know how we'd ever get calls like this, but they do mirror pretty closely what you actually get on the lines. So, it was really good preparation.

Several participants felt training would be strengthened through inclusion of more extensive material on supporting suicidal callers. One volunteer voiced concern over misconceptions she believed other volunteers held around suicidal callers. For example, she noticed that because few callers expressed suicidal ideation, volunteers tended to think it did not occur. Additionally, she

was concerned that repeat callers, who were frequently in distress, were not taken seriously by volunteers as being at a high risk of suicide. Describing one meeting at which the topic of suicide was discussed, this volunteer reported that the presenter had dismissively said, "This never happens, you're probably never going to use this information." However, the participant did in fact deal with a situation in which a caller had overdosed, and she had to intervene and call paramedics. Therefore, she was concerned that this representation may have inadvertently served to undermine volunteers' readiness to deal with critical situations. Participants also spoke about experiencing a great deal of anxiety around getting a suicidal caller, for example; "It's just this unknown where it can be quite anxiety provoking to think about receiving a suicidal call, and being prepared to handle that".

Additionally, several volunteers mentioned they would have liked more a stronger emphasis on repeat callers in training. As CL callers' names and personal information were not recorded, it was often difficult for participants to identify whether or not they were speaking with a repeat caller. Some volunteers expressed that having a clear set of procedures for responding to them would be helpful. The procedure currently used for dealing with repeat callers is that callers are only permitted to make one call to the line per day, and the length of their call is limited. While this process is useful, without the capacity to recognize repeat callers, (some will use fake names) it is hard to implement.

(3) What motivated the counsellors to continue? What were the challenges they faced as counsellors?

Ongoing motivation. In their interviews, participants were asked to describe what supporting survivors had been like for them after they had been involved in delivering services.

Some of their experiences in the program aligned with their initial expectations of the work. In particular, participants found that they were able to help others, and several spoke about the sense of purpose they found in believing callers who might not otherwise have received support. Volunteers also found the opportunity for political advocacy to be rewarding. Speaking of this aspect of her work, a volunteer stated: "I really appreciate the advocacy piece here. That it is a political issue and while we are just talking one-on-one with somebody, it's actually impacting. It's connected to a greater issue in society. The activist piece feels really important."

Overall, most of the volunteers spoke about their ongoing motivation for the work as being related to their sense of fulfillment in being able to support survivors, and in positively contributing to an important social issue. In addition, a few of the volunteers shared the ways in which volunteering was personally meaningful, and indeed transformational for them. These volunteers discussed how their involvement with the CL had helped them through the final stages of accepting and overcoming their own difficult SV experiences. They stated that being able to talk about their experiences within a group, and to apply a critical perspective to them was a support both in empowering themselves and in educating others. Some women who joined the CL program drew from their own personal experiences with SV, wanting to "right the wrongs" that had happened to them or to people they knew. Others sought to know more about why SV occurred, and to understand the social phenomenon more clearly, through examination and analysis.

One volunteer who was a survivor of SV, spoke about how others have appreciated her honesty and openness about her lived experiences. She attributed her capacity to share her experiences to her training involvement at the Center:

I talk about things that others might find difficult to talk about themselves. That I'm very blunt and almost straightforward when talking about, you know, having experienced SV and not shying away from talking about it, it's something that people have appreciated. I definitely think that that's a result of the training I did.

From this perspective, speaking about experiences with SV not only helps the speaker feel accepted and supported, but also helps others feel less isolated and stigmatized. Moreover, it serves to educate and build awareness around the issue. Expanding on the transformational qualities of this type of volunteer work, another volunteer said, "This is a way that I can take the things that happened to me and turn them into good actions in the world, and be part of making a better society. So that's what the volunteering has meant to me."

For these women, through helping survivors, and connecting with strong and supportive peers, volunteering became a way of transforming the meaning of their past experiences. This, in turn, amplified their motivation to continue. Other volunteers, however, spoke of encountering challenges they had not anticipated once they began working on the CLs. Some of these challenges related to their emotional responses to the work, while others related to areas for which they reported feeling unprepared or unsupported. The following will review the challenges that participants discussed, which were categorized as: emotional challenges, feeling unprepared, and feeling unsupported in their role.

Emotional challenges. In their interviews, participants spoke about how their experiences of delivering direct services to clients differed from their expectations and motivations going into the training; they described complex and dissonant emotional experiences of overcoming their

own reactions in order to provide in-the-moment support. One volunteer understood her difficulty with the work as being due to the topic:

When you hear a woman crying, you're just like, why did you have to go through this?

And, I'm so sorry! You hear what this person did to them and you want to find them and hurt them. I think the topic is the hardest part of being on the lines.

Several of the volunteers reported how they were affected by callers' level of emotional intensity, as well as their own reactions to what they had heard. It was something they described as not being prepared for and not fully understanding prior to engaging in the work. A related facet of the work, which volunteers also struggled with, were the lasting emotions that some of them experienced when away from the lines. One volunteer said:

I found I would feel pretty emotional after the conversations were over. So it triggered something in me, really a sense of empathy of trying to understand what it would be like to go through what these women described and feeling alone or scared.

Some of the volunteers ruminated about the calls. One participant described the difficulty of changing her focus after the caller has hung up.

I don't know, it's just like you're sitting on your bed and then your phone rings. And you have to go into this other space. And then you end it. And you're still in your bed, but you're kind of – I guess I was still in the conversation.

Although the volunteers valued the chance to support survivors, and to be involved in anti-violence efforts, the intense and sometimes conflicting emotional responses they had towards their work, represented an area with which they struggled.

Feeling unprepared. Volunteers also spoke about areas for which the training had not adequately prepared them. For example, they felt uncertain of their ability to offer adequate support to suicidal callers, and reported that they would have benefitted from additional training on suicidality assessment and intervention skills. Participants also spoke about requiring more training with repeat callers. The term “repeat callers” was used by the Centre to designate those callers who used the lines for unintended purposes. These callers were considered to have mental health issues, and would call the lines repeatedly – sometimes several times on a single shift – despite not being considered in immediate crisis. They seemed to call the lines primarily for companionship and attention, which was problematic as it tied up the lines for other callers. Because the CL service was intended to offer clients confidential and anonymous support, clients’ names and personal information were not recorded. Therefore, one of the challenges for volunteers was determining whether or not they were speaking with a repeat caller. Some of the participants mentioned their need for more training on managing repeat callers, as they felt unprepared for these calls. The following statement illustrates the difficulty experienced in being unable to identify repeat callers:

The caller last night was speaking in a really low voice and saying really abusive things about potentially inflicting harm on somebody else. I engaged in some contracting to make sure the caller wasn't actually planning on doing anything. After a conversation with another volunteer she let me know that this was a repeat caller and not to feel anxious because she's never actually done anything.

Most of the participants reported that interacting with repeat callers caused them emotional distress, as they did not have much training or experience to navigate these situations. Moreover,

one participant reportedly felt manipulated, emotionally exhausted, and frustrated by her inability to positively influence the caller. For example:

You know instead of using her energy on getting better, and using the help and support she gets to get better, instead she's just sucking the life of others to feed her little dramas. That's what she's doing. And I know I should be detached, but that angers me.

This interviewee stated that she would not be returning to the CL specifically because she wanted to avoid having to interact with repeat callers. She also suggested that other volunteers left the lines because of these clients: "I wouldn't be surprised if a lot of them left the CL after a year because of people like that."

Dealing with repeat callers was challenging for some of the volunteers due to the ambiguity of identifying them, the lack of progress in supporting them, and the personal attacks experienced from them. However, the volunteers who were able to perceive their role on the lines as crisis intervention and practice a feminist empowerment approach – the view that the client is in control of her own helping process and that personal agency and accountability are of paramount importance – became less emotionally invested and frustrated with the repeat callers. In these circumstances, participants accepted that they should not attempt to control the outcomes of the calls, and that their role was merely to maintain their boundaries and to support the repeat callers' self-care.

Feeling unsupported. Participants spoke about situations in which they felt unsupported and needed more supervision and support from the Centre. For example, they raised the need for more clarity around the buddy system. The buddy system involved the partnering up of new volunteers with more experienced volunteers when they first started answering calls, however, it

was not clear how well this system was implemented. Illustrating this, one participant stated, "The buddy system was a really good idea, but I didn't truly understand how it worked."

A few participants also mentioned that they were unsure of how to access supervision on overnight shifts, and some reported they were unwilling to contact their supervisor or support people because they didn't want to inconvenience them. One participant recalled feeling unprepared for and unsupported during her first accompaniment to hospital. Although she had reviewed her manual, followed its instructions, and used the counselling skills acquired in training, she still felt unprepared, "As I was there, I went into counselling mode and supported the woman as much as I could, but it became clear that she had some mental health issues I wasn't prepared for." Additionally, this participant did not know how to obtain support during her accompaniment. Following her shift, she concluded, "I didn't really hear anything from anybody after that, so I felt very unsupported in that scenario." Another participant spoke about the difficulty she had in reaching her supervisor to debrief after a difficult shift. Because she was not able to connect after a few attempts, and because she was not too distressed, she eventually decided not to debrief. However, she noted that, "If I'd had a triggering experience I might have been less inclined to stay on the lines, like I might've been inclined to leave after a couple of months, because I didn't have support readily available."

A few participants reported they had experienced difficulty in contacting their supervisor to debrief following demanding calls, and they suggested this could negatively impact retention. Similarly, a few volunteers also mentioned that they had had difficulty connecting with their supervisor when attempting to book their CL shifts, and one described an instance in which scheduling errors could have resulted in a gap in coverage on the lines. These volunteers

expressed that they found it inefficient to book shifts over email, with one volunteer describing the process as “a really frustrating thing for me”. Since the program had only one part-time staff member, it was mentioned that there were times when there would be gaps in the on-call supervision. This meant it was not always possible to debrief with a supervisor immediately after an event. This situation and the resulting stress it caused volunteers, was spoken of by one participant:

The whole organization really runs off its volunteers and if the volunteers are either stressed or feel like they can't reach out to the only one person that's available, then they might be inclined to keep it in or not debrief if it's too much of a hassle.

Similarly, a few volunteers said that they had felt unsupported while working on overnight shifts and during accompaniments. These instances appeared to occur when the on-call supervisor was not available. It was mentioned that in these situations, mass emails were sometimes sent out to the list of CL volunteers. Whoever was available would then email the volunteer. However, some of the participants said they wanted to have a more structured process in place for receiving support. It is important to note that overall, the volunteers spoke very positively about the supervision they received. They stated both being impressed with the quality of their training, and having a genuine appreciation and respect for their supervisor. Many of the challenges brought up by the participants can be linked to limited funding and capacity.

(4) How did the counsellors' training and practice experiences develop their knowledge about SV in society?

This study was intended to focus predominantly on the organizational level of analysis, and thus, focused primarily on participants' experiences with training and practice within the

organization. Despite this focus, some of the participants' responses addressed systemic issues relating to SV that stem from a patriarchal social context. These secondary research findings are worthy of mention as they point to systemic issues at play within the research area of SV.

Patriarchy is a power system that supports male authority and privilege, and which systematically treats women as inferior to men (Benoit et al., 2014). Through their involvement in the CL, the participants became increasingly aware of how patriarchy oppresses women through the normalization of SV, and the denial of the severity and impact of SV. This was reflected in the following participant quote:

After I went through a lot of the training, I would just start picking up on things within media and movies and stuff, and it definitely, it made me that much more sensitive to.. sensitive in a way that I was just picking up on a lot more. It actually instilled a lot more confidence within myself, to really stand up when I see those things being challenged. So, I've stopped watching movies halfway through because I'm just like, no this isn't working. An inappropriate joke that shouldn't have been made. I'm pulling myself away from those comedy movies that rely on that topic to try and get a laugh. It's made me notice even within topics with friends, and you know, or at school, or on the bus it's made me a lot more aware.

For this participant, the CL training increased her awareness of the routine objectification of women in the media, and the commonplace jokes about rape and sexual abuse therein. After experiencing the program, she began to reject patriarchal portrayals of women as sexually available objects in the media. The demeaning treatment of women in the media, identified by this participant, represents one way SV is socially reinforced. Another way SV is socially

supported, is through the double sexual standard placed on women in our culture. Speaking about this issue, a participant stated:

I had thought that like, if you do wear a skirt that's very short what do you want really? So I'd always kind of looked at things like that, or... I've never really taken the woman's perspective per se, because that's just what I had been exposed to all the time. So it was like.. girls shouldn't do that because guys interpret that differently, or things like that. But now after this, it just seems like no actually that's not correct at all. It's not okay for a random guy to come up and put his hands on your waist. That shouldn't be acceptable, so that's definitely changed.

This quote highlights the pervasiveness of the double sexual standards in society that imply that women can cause or invite SV through the way they dress or behave. Furthermore, it reflects how the participant's experiences in the program increased her ability to recognize and challenge social conventions that blame women for SV. It reveals how the volunteer's personal acceptance of a rape myth (i.e., that a woman's clothing makes her responsible for SA) diminished after she participated in the training. Their experiences with the program heightened volunteers' awareness of women's sexual objectification, and the double sexual standard, and how these social processes normalize and excuse SV. In addition, volunteers gained an awareness of SV as a form of social oppression that impacts all groups of women. Illustrating this one volunteer stated, "I've looked at the lopsided social order. How women and are treated, and how prevalent violence is". Another volunteer expressed:

All women have experienced some form of SV, I mean none of the stats you can really use, but there isn't any woman who hasn't been affected by SV in their life, like whether it's them directly, or somebody close to them.

Through providing support on the CL and by accompanying survivors, volunteers interacted with system personnel, and thus, gained a fuller awareness of how different systems respond to survivors. This 'insider perspective' is discussed in the following quote:

I think that we get a deeper understanding of the ways in which women who have experienced SV experience the police, the ways in which the hospital system works, you know, just things like that, that no matter how much of a feminist you were coming into the organization you may not have had the experience of understanding that this is a systemic problem.

One volunteer, speaking about her experiences on the CLs, said candidly:

I would have calls from people who had gone to the police station and they were just angry because the system sucks. And sometimes they had a friend who was sexually assaulted and they had dealt with the system and it was awful and just giving them a place to vent, and kind of normalizing what they were feeling. Like, yes the system sucks, but you're also contributing to it sucking less by having a place where women can feel supported and kind of heal from experiences that they've had.

The volunteers' involvement in the CL work raised their awareness that VAW is a systemic issue, and that systemic violence occurs when service providers are unsupportive and hostile to survivors. Along with gaining a deeper awareness of the poor treatment of survivors, the participants also spoke about the important role counsellors play in buffering some of these

effects through providing services that focus specifically on survivors' wellbeing and recovery. Although these volunteers recognized the value of their work, they still struggled when confronted with stories about abuse of power, as illustrated below:

I got a call about a woman who was assaulted by a police officer, and that really hit me hard. It was something that, you know, you hear about it on the news and it's scandalous and horrifying, but then you hear it from a real person within your city, about a police officer within your city who is supposed to protect you. And its like.. you know what? I kind of made it a part of me because it's like, well, is he still working? Is he still protecting our city?

This call brought systemic problems with the police and legal system sharply into focus for the participant, and also impacted the other CL counsellors who she spoke to about the call. As the assumed attacker in this scenario was a local police officer, there was the underlying concern that it would not be possible for the survivor to access procedural justice due to biases and barriers against her. This volunteer described how she relied on her peer network of other volunteers for support following this call:

If a certain situation really bothers me, I lean on the other women. So that time I emailed the ladies and said I need to talk to somebody, to talk through the call with them and make sure that what I said was appropriate. And then I also vented about how much the topic and everything upset me. So, having those other women within the RCC to lean on, knowing that confidentiality is fine within our group, with the other women, it makes it a lot easier.

Discussion

This study qualitatively explored diverse facets of volunteer rape counsellors' training and practice experiences in order to document an important, yet under-researched frontline service. The findings show that local women were initially motivated to volunteer with the CL program for career exploration, feminist advocacy activities, and altruistic reasons. Once in the training, the volunteers spoke positively about the process of participating in the CL training; and following its completion, perceived that their basic counselling skills, and knowledge of feminism and a feminist approach to counselling had improved. Volunteers also gained an awareness of what a survivor's experience might be in interacting with the medical and legal systems. In contrast, after the training, volunteers reported that they felt unprepared to respond to suicidal callers and repeat callers, and needed more preparation in these areas.

After working directly with clients, the volunteers experienced a sense of satisfaction in supporting survivors and contributing to anti-violence efforts, and these experiences strengthened their motivation to continue volunteering. Furthermore, a few volunteers explained that their work was personally meaningful and even transformational for them. Coinciding with these positive aspects of the work, some volunteers also struggled with emotional challenges, feeling unprepared, and feeling unsupported in their role. Feeling unprepared and unsupported were tied to a lack of motivation to continue volunteering.

Finally, the findings reflected a larger understanding that the counsellors gained through routinely interacting with survivors and systems: SV is not merely an individual-level problem, occurring as isolated incidents between perpetrators and victims. Instead, it is a systemic problem, reinforced by social structures and institutions. Therefore, counsellors were tasked with

assisting survivors not only after their initial attack or in the wake of historic abuse, but also after they experienced mistreatment by secondary systems, such as medical and police services. This finding casts doubt on the neutrality of institutions in their responses to survivors of SV.

A limitation of the current study was the potential for sampling bias because of the small sample size, and because those who remained with the program and volunteered to participate in the qualitative interviews may have been more resilient or had different attitudes about the program than those who left the program or did not volunteer for the interviews. Therefore, it is possible that the opinions of those who had a more negative perspective on the program may have been under-represented in the current study. Despite this limitation, a range of responses to the research questions were obtained, several limitations and challenges of the program were identified by participants, and data saturation of themes was reached. A second limitation is that the same participants took part in the previous study, and thus, there is the potential that participation in Study 2 may have influenced their qualitative responses. However, it was nevertheless necessary to include the same group of participants in both studies in order to examine their perceptions of how the training prepared them for their CL counsellor practice.

Feminist research strives to represent women's diversity (Reinharz, 2002) in order to avoid/reduce reproducing dominant group biases in social research (e.g., white, middle-class, heterosexual) and to include and learn from non-dominant groups. Therefore, it was intended that a maximum variation sampling technique would be used to reflect a diverse group of participants. However, as the sample was drawn from a very small potential population of interest, as there was attrition from the program over time, and as the participants self-selected for the study, the research was limited in its diversity, particularly with respect to race. As most

of the participants in this study identified with the dominant social group as white, the perspectives of non-white/women of colour and Indigenous women were under-represented in the data. This is an important limitation, as research that does not meaningfully capture non-dominant/marginalized social groups' experiences and perspectives runs the risk of reproducing dominant social groups' biases and maintaining existing social hierarchies. The study participants underwent feminist anti-oppression training, in which they critically examined their own social location and issues of race privilege, and to the extent that participants divulged their learnings on this topic, it is reflected in the findings. However, future projects should include a more diverse participant group and from that, extrapolate further on intersections of race and gender in relation to RCC CL training. In the next section, each of the study's findings will be discussed, in turn, in light of relevant research.

Reasons for Volunteering The first set of primary findings explored participants' multifaceted reasons for volunteering. While some volunteers were hoping to use the experience to try out a possible career path and to build their resumes, others wanted to engage in feminist advocacy activities, or to simply support survivors of SV for altruistic reasons. According to Self-Determination Theory (SDT) (Deci & Ryan, 2002) people volunteer in order to satisfy universal psychological needs for *autonomy*, *competency*, and *relatedness*. The extent to which these needs are satisfied by an organizational context influence one's ongoing motivation to volunteer (Frendo, 2013). The psychological need for *autonomy* is described as "the ability to decide one's own behavior and make one's own decisions" (Frendo, 2013, p. 5). With respect to volunteer work, autonomy is demonstrated by freely choosing to volunteer, gaining skills relevant to personal goals, and empowering oneself or others through one's actions. Autonomy

can be also enhanced by organizational practices that afford volunteers control and ownership over their work. The need for *competence* refers to one's perceived ability or self-efficacy to perform particular tasks. The quality of training volunteers receive and their opportunities for ongoing professional development can impact their perceived competence. Lastly, the need for *relatedness* pertains to the desire for social relationships, connection and community.

The current study found that participating in career exploration, being part of a feminist community, and providing opportunities for altruism motivated women to volunteer with the CL. These motivations correspond to SDT's universal psychological needs. Altruism, considered to be the most self-determined and autonomous form of motivation, relates to the need for autonomy (Frederickson, 2013). Career exploration relates to the need for competency at career-related skills, and the autonomy to reach one's career goals. Feminist community satisfies the need for relatedness, as participants discussed the desire to build relationships with like-minded peers, and to be part of a social justice cause that is larger than themselves.

Based on these findings, RCCs can improve volunteer retention by taking steps to address the areas in which volunteers reported requiring more training, and by providing ongoing training and skill development to support volunteers' needs for competency; to provide opportunities and platforms for community building to satisfy their needs for relatedness, and to afford volunteers control and ownership over their work and to maximize their autonomy. SDT theory also proposes that the more autonomous and self-determined the motivation (i.e., intrinsic and extrinsic motivational styles), the stronger and more sustained the motivation to continue volunteering. RCCs should therefore encourage volunteers to internalize the organizational goals and values, and should strive to meet volunteers' needs for autonomy, competence, and

relatedness. These concrete steps would help to support volunteer retention efforts within the context of RCCs (Frendo, 2013).

Volunteers' Perceptions of Training and Practice Experiences The second set of primary findings investigated volunteers' training and practice experiences. Overall, the volunteers reported enjoying the training process and learning a host of valuable skills and analysis, ranging from basic counselling to advocacy with other service providers (e.g., police, medical personnel), to having a better understanding their own personal experiences through critical analysis. These findings provide qualitative support that the rape CL training was effective at achieving several of its intended objectives from the perspective of CL trainees. In particular, the volunteers reported improving their basic counselling skills, developing their feminist attitudes and beliefs, and improving their knowledge of relevant medical and legal proceedings. Similar improvements to participants' counselling skills (Frauenfelder & Frauenfelder, 1984; Hart & King, 1979; France, 1975; Paukert, Stagner, & Hope, 2004; Katz, DuBois, & Wigderson, 2014) and pro-feminist attitudes (Banyard, Moynihan, & Plante, 2007; Moynihan, Banyard, Arnold, Eckstein, & Stapleton, 2010; Coker et al., 2011) have been reported in previous studies of intervention programs. While the training was seen as substantively successful in these areas, there were also areas that could be further improved, such as volunteers' confidence in their suicide assessment and intervention skills, and in their ability to support repeat callers with complex mental health issues.

Additional outcomes of the training also emerged, relating to the positive personal changes that the volunteers experienced. These changes resulted from the volunteers' increased awareness of structural violence and from developing their critical analysis skills. One particular

change the volunteers reported was a solidified personal commitment to feminism. Through the reflexive work that was woven into the training, and through interacting with survivors over time, they increased their knowledge regarding different forms of privilege and oppression in relation to SV. This work led them to examine and deconstruct their own prejudices to avoid further marginalizing or stigmatizing CL users.

A few volunteers expressed that the training was transformational for them. They spoke about how disclosing and discussing difficult personal experiences within a group of peers helped them to redefine the meaning of their experiences, and supported the later stages of their personal recovery and development. This finding corresponds to other research on peer support groups' potential to positively impact lay counsellors (Rath, 2008; Oulanova, Moodley, & Séguin 2014). These exploratory findings add to the limited research on CL training and practice, and its impact on volunteer rape crisis counsellors.

Although RCCs are diverse in their practices and policies, this study's findings may have implications for other RCCs who use similar training models. For example, an analysis of the Victoria Sexual Assault Centre's (VSAC) CL training program revealed that its structure and content were akin to that of the ORCC (VSAC, 2017). For instance, the VSAC training is also provided internally by senior rape crisis counsellors who have graduate level training in relevant areas. Although it is lengthier than the training offered by the ORCC (at 62 hours compared with 30 hours), it runs over approximately the same timeframe. It also covers many of the same topics – such as, suicide assessment and intervention, active listening, setting boundaries, child abuse – and includes many of the same activities, such as, presentations, group discussions, role plays/coaching, and visits to the hospital and police station. Similarly, to the ORCC, VSAC's

training on suicide intervention is limited to a single session. VSAC's CL training differs from the ORCC model in two significant ways: it additionally offers a trans-inclusion workshop, and it is attached to a newly established SA Clinic. Furthermore, VSAC also offers emergency supports to SA survivors of all genders, and its CL service is delivered in coordination with the SA Clinic, forensic nurse examiners, RCMP and police services. Future research is needed on RCC CL training programs in a variety of settings and across different models to identify the key components of such training and to formalize a set of best practices for the training of service providers in this area. The development of a community of practice involving front-line workers, programmers, and community researchers would be invaluable in this respect as it would allow for sharing of information, resources, and learnings among diverse RCCs. This form of collaboration would enable the long-standing Canadian RCCs, including the ORCC, and the more recently created RCCs, including the VSAC, to share information and models to enhance their design and delivery of CL training programs.

Volunteers' Motivation for Continuation and Challenges in Service Delivery The third area of primary findings pertain to volunteers' motivations and challenges in delivering CL services. As previously discussed, the volunteers reported that they were motivated to continue volunteering because they found satisfaction and fulfilment in supporting survivors, and in contributing to feminist advocacy efforts to end SV. A few volunteers spoke about how they experienced transformational personal changes through their involvement in the program; these volunteers perceived that the process ultimately strengthened their ability to support survivors, and increased their motivation to continue volunteering. These findings correspond to SDT's proposed universal needs for autonomy, relatedness, and competence, and suggest that the

satisfaction of these needs may enhance counsellors' motivation to continue volunteering in the context of a RCC (Frendo, 2013; Deci & Ryan, 2002).

Within the organizational setting, volunteers were also faced with the challenging task of supporting traumatized individuals, while receiving limited support themselves. Some volunteers reported that they felt unprepared to support suicidal callers and repeat callers. Along with requesting additional training in these areas, one volunteer suggested developing an internal database of instructions for speaking with individual repeat callers. Having a clear protocol in place with key messages to relay to repeat callers could alleviate stress for all parties. Using key word searches, for example, in a shared word doc, or excel file could help volunteers quickly identify repeat callers. The database was envisioned as being internal and anonymous (similar to the email updates currently sent out with directions for interacting with repeat callers). However, it would have the added benefit of helping volunteers identify repeat callers on the spot. This would help to reduce the ambiguity and uncertainty around identifying repeat callers.

Other volunteers reported feeling unsupported by the organization at times, and perceived that they did not have adequate supervision and support during overnight shifts and on accompaniments. A couple volunteers also stated that insufficient supervision and follow-up in these situations impacted their desire to remain with the organization. This relates to previous research findings that supervision and support are linked to volunteer burnout and attrition (Ullman & Townsend, 2007; Black & DiNitto, 1995; Cyr & Dowrick, 1991). At the RCC under study, the program supervisor was found to play a central role in coordinating the CL program, managing volunteer recruitment and intake, facilitating the 30-hour CL training, administrating shift bookings, and providing continuous 24-hour support and supervision to volunteers. Given

the heavy reliance on a single part-time staff member for the operation of the program, it may be useful to consider assigning volunteers (or other staff) to undertake some of the responsibility sharing.

Avenues for responsibility sharing could include strengthening the existing peer support network and affording it a greater role in providing support to new volunteers, particularly on overnight shifts and accompaniments. The process of accessing peer supports could also be encouraged and normalized. Another option for responsibility sharing is that one specific volunteer could be appointed to handle scheduling and coordinating the shifts. Alternatively, because the volunteers stated they wanted greater responsibility over their work schedules (less rigidity and a shared scheduling interface), the program supervisor could consider using a shared online calendar, or another collaborative tool to allow volunteers to sign up for their own shifts, and swap shifts with other volunteers. The supervisor could then manage or oversee the document. Changes such as these would free the program supervisor to focus expertise on training and providing guidance to the volunteers.

These efforts, combined with the further development of formal and informal peer supports could have a positive effect on individuals carrying out support work and on organizations delivering these services. Peer support groups allow lay counsellors to share coping strategies, normalize experiences, reduce isolation, and deal with the after effects of their work (Trippany, Kress, & Wilcoxon, 2004). Development of a strong peer support network would help to ensure that volunteers are supported and retained, despite the numerous and complex challenges they face. In the literature, similar challenges to those reflected in the current findings were associated with burnout in RCC volunteers. Ullman and Townsend (2007)

explored organizational issues influencing burnout by conducting qualitative interviews with RCC workers. They identified poor supervision, inadequate support, and witnessing survivors' secondary victimization among the factors leading to burnout.

Cyr and Dowrick (1991) used quantitative survey methods to assess burnout in CL volunteers, and found that interpersonal and peer relationships helped to prevent burnout. In particular, they identified that volunteer turn-over (short relationships with other volunteers); lack of contact with peer volunteers; and lack of platforms for discussion of work stresses and challenges contributed to volunteer burnout. Similarly, researchers have noted the impacts of strong, supportive relationships between volunteers and staff for preventing volunteer burnout (Black & DiNitto, 1995), and have reported that a sense of supervisor support and appreciation helped to prevent burnout (Cyr & Dowrick, 1991). To the extent that RCCs can address volunteers' sense of being unsupported and unprepared, and can implement suggestions for program changes, reductions in volunteer burnout and attrition should follow.

Volunteer Counsellors' Perceptions of SV in Society Lastly, the secondary findings revealed volunteer perceptions based on their experiences as CL counsellors that suggested that SV is systemic in scope, and that broad societal systems enact structural violence against survivors in identifiable ways. Their role as rape crisis counsellors required that the volunteers work closely with both individual survivors and within institutional systems. This put them in the position where they perceived the often poor treatment of survivors by those systems. In their interviews, the counsellors clearly expressed that institutional responses to survivors of SV were often harmful and inadequate. Thus, in addition to performing support work after incidences of SA and abuse occurred, the counsellors were also required to support survivors after their interactions

with police, legal, and medical systems. This finding – that the institutions charged with protecting and supporting SV survivors may instead cause them further harm – undermines the notion of social institutions as neutral and impartial in their treatment of survivors of SV.

Previously conducted research has documented how these institutions can negatively impact SV survivors' physical and mental health outcomes (Campbell, Wasco, Ahrens, Sefl & Barnes, 2001) and lead to the “re-victimization” of survivors (Maier, 2008; Campbell et al., 1999; Campbell & Raja; 2005) which refers to stigmatizing and blaming responses that further traumatize and harm survivors (Maier, 2008). When seeking medical care, SV survivors are vulnerable to particular negative outcomes. Campbell and Raja (2005) reported that the majority of SV survivors in their study were distressed by medical personnel's questions about their sexual histories and behavior, and by their treatment during their physical examinations. Other research has found that women often feel “depressed, violated, and anxious” after post-assault contact with medical systems (Campbell, 2006). Furthermore, research has suggested that SA survivors may face gaps in medical care, for example, in receiving information about pregnancies, STIs and STDs, and obtaining emergency contraception and other medications from health care professionals (Campbell, 2006).

Interactions with police can also be harmful to survivors, as they are sometimes questioned about their sexual histories, and their behavior leading up to and during the assault (Campbell, 2006). This suggests that there is an implicit bias against complainants in these exchanges. Indeed, recent research has revealed that, compared to other crimes, women who report SA are far less likely to receive procedural justice from police officers (Doolittle, 2017). Recently, Johnson (2017) investigated the experiences of 37 women who reported SAs to the Ottawa

police. This study found that the majority of complainants were treated with disbelief and skepticism by police, and received otherwise harmful reactions to their trauma. Of the SAs reported by these women, police laid charges in only 19% of the cases, and furthermore, this rate of charging in SA cases was consistent with that reported by the Ottawa Police Service's statistical records from 2009 to 2013 (Johnson, 2017).

The disproportionately high rates of “unfounding” of SA reports, constitutes a systemic barrier facing survivors of SV. Unfounding occurs when a crime is deemed by police not to have occurred or been attempted (Tang, 1998; Sheehy, 2012; Johnson, 2017). Police decisions to unfound are influenced by social biases such as rape myths and inaccurate assumptions about how “real” rape victims behave (Sheehy, 2012; Johnson, 2017). They may also be influenced by a lack of information and training about how memory is impacted by trauma, leading police to disbelieve the reports of traumatized SA complainants (Doolittle, 2017). When cases are officially classified as unfounded they are no longer pursued and are excluded from crime statistics, and these decisions are based solely on police officers' judgments (Sheehy, 2012; Perreault, 2015). Consequently, the rate of unfounding in SA cases are dramatically higher than that of other crimes (Doolittle, 2017).

The Ottawa Police Service's statistical records from 2009 to 2013, show that 38% of SA cases involving women were classified as unfounded (Johnson, 2017). In a recent high profile investigation by the Globe and Mail, in which police statistical records from 2010-2014 were retrieved from policing jurisdictions across Canada, it was discovered that the national rate of unfounding of SA cases was 19.4% – indicating that approximately 1 in 5 (or 5000 reports in total) were deemed baseless, and were not pursued. Between jurisdictions, a great deal of

variability in rates of unfounding was detected. For instance, in Saint John 51% of SA reports were classified as unfounded, whereas in Winnipeg only 2% received this classification. The variability was not linked to city size or demographics; for example, Toronto had a relatively low rate of 7%, while neighboring York Region had a rate of 31%. Instead, the factors that reduced rates of unfounding were police practices relating to education and supervision of officers, and the previous scrutiny of police departments' practices by local researchers (Doolittle, 2017). When women's reports of SA are frequently dismissed, it communicates to women that fundamentally, they are not likely to be believed by police and it deters them from reporting (Johnson, 2017; Doolittle, 2017).

An analysis of the legal system responses to SA cases in Canada demonstrates that, "Less than half of SAs deemed to be founded result in charges against a suspect, less than half of charged suspects are prosecuted, and just one-third of prosecutions result in a conviction for SA. When unreported SAs and unfounded cases are factored in, the overall conviction rate is less than 1 percent." (Johnson, 2017, p. 9). Taken together, this literature suggests that social institutions are not neutral in their response to survivors, and instead, exercise systematic biases against them. In the current study, the interviewees' accounts reflected structural barriers and abuses of power that survivors and their advocates face when interacting with systems that are charged with supporting survivors but are, in practice, largely unsupportive.

The organizational goal of promoting survivors' recovery and empowerment is unique to RCCs, and RCC services are beneficial to SV survivors' recovery and wellbeing (Campbell 2006; Campbell et al., 2001; Campbell, Baker & Mazurek, 1998). In contrast, institutional goals can conflict with the goal of survivors' recovery; for example, police and prosecutors' need to

present credible witnesses, and doctors and nurses' intent to treat physical injuries and collect forensic evidence (Ullman & Townsend, 2007). Because of their unique focus on survivors' wellbeing, RCCs meet the essential needs of supporting survivors post-assault, advocating for survivors during their interactions with medical, police, and legal systems, as well as responding to survivors' negative experiences with these systems. Given their valuable and unique social role, RCCs should be supported by current social policy and funding decisions.

The fact that the counsellors in the current study were unpaid volunteers illustrates both the lack of social value placed on their work, and the lack of political will to adequately fund and resource RCCs. Increased funding needs to be provided to support community RCCs. Broader social policy changes are also needed to support the anti-violence organizations and programs already operating in community settings. Based on recent national roundtable consultations, Status of Women Canada (SWC) (2016) is now calling for federal policy changes and developments to address gender-based violence. SWC (2016) has proposed recommendations that would directly support the work of rape crisis counsellors at RCCs across Canada, and would address the broad social norms and conventions that perpetuate SV. The recommendations call for the prioritization of:

- Community-based and culturally responsive counselling and support services;
- Creating survivor advocates to represent and advance survivor interests through the justice system;
- Adequately resourcing services for survivors and perpetrators;
- Supporting the women's movement through funding;
- Addressing stereotypes about who constitutes a victim and about marginalized populations;

- Providing greater oversight and accountability to ensure that cases of gender-based violence are handled appropriately by the justice system; and,
- Training justice professionals to better understand the complex needs of survivors and perpetrators.

These multifaceted policy recommendations would support community organizations in their important, ongoing efforts. They would also address problematic and prejudicial institutionalized responses to SV survivors, and would work to ameliorate the social conditions that permit and uphold SV in society. This study has explored rape crisis counsellors' training and practice experiences at a local RCC, and has shed light on findings relating to individual, organizational, and systemic processes. Volunteers' personal motivations for joining the program, as well as the factors that influenced their ongoing motivation to volunteer were examined. Outcomes of the organization's efforts to train the volunteers and adequately prepare them for rape crisis counsellor practice were explored. Lastly, secondary findings pertaining to volunteers' observations about SV in society were reflected. Through this analysis, rape crisis counsellors' insider knowledge was harnessed to contribute to an under-studied and socially valuable area of research.

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General Discussion

This dissertation consisted of three studies designed to systematically examine a volunteer-based rape CL training program. It began by evaluating the readiness of a CL training program for research by conducting an EA. It was followed by an outcome evaluation that assessed how the training was associated with the development of counsellors' key competencies and pro-feminist attitudes. Lastly, a qualitative study was conducted that investigated the volunteers' perceptions of their training and practice experiences. Prior to these studies, a literature review was conducted that showed that gender-based violence is a widespread and ongoing problem (Johnson, 2006; Sinha, 2013; Benoit et al., 2014). Consistent with previous research, a social ecological framework, informed by a feminist empowerment perspective, (Nelson & Prilleltensky, 2010; Heisse, 1998; Nagy Hesse-Biber & Yaiser, 2004) was used to guide the current dissertation (e.g., Baird & Jenkins, 2003; Hellman & House, 2006; Clemans, 2004; Rath, 2007; Ullman & Townsend, 2007). In this thesis, three studies were conducted in a logical sequence; with each building on earlier findings, and exploring different dimensions of the RCC CL training program.

Summary of Findings

Each of the studies was designed to investigate a unique set of research questions. The EA was conducted to prepare for the subsequent studies. It was used to determine whether the CL training program was ready for a full evaluation, and to elucidate the program's components, processes, and intended outcomes. The EA involved consultations with the organization, semi-structured interviews, a review of documentation and administrative data, and a literature search. These data sources revealed that the CL training program had been designed to develop the

volunteers' basic counselling skills and suicide intervention skills, and to foster their feminist attitudes and beliefs. The data also revealed the RCC's broader organizational goals. For example, the EA showed that the RCC was concerned with the retention of volunteers over time, as well as the administration of timely and appropriate referrals, emotional support, crisis intervention, and accompaniments to clients. Based on analyses of the EA data, it was determined that the RCC CL training program was evaluable, and thus subsequent studies of the CL training program were proposed.

Following the EA, a quasi-experimental study of the effectiveness of the CL Training Program was piloted to assess whether volunteer counsellors developed the intended skills and competencies over the course of the training. As there was a paucity of previous intervention research to draw upon, the research hypotheses and outcome variables were based primarily on research that had been conducted in related contexts, as well as on the knowledge and expertise of the RCC workers. Overall, the quantitative results that emerged from this study indicated that, over the course of the training, the volunteers' counselling self-efficacy improved, whereas their suicide intervention skills did not change. Volunteers were found to have strong pre-existing feminist attitudes and beliefs that also did not change following their involvement in the training.

Broadening this enquiry, a qualitative study was conducted to examine the volunteer counsellors' perceptions of how their training prepared them for their work. The findings provided a broad understanding of the CL training program's processes and outcomes. Findings revealed that volunteers were motivated to undergo the training for reasons relating to career exploration, feminist advocacy activities, and altruism. Findings also revealed that after their training, the volunteers perceived that they had gained basic counselling skills, as well as an

increased knowledge of feminism, yet they felt unprepared to respond to suicidal callers. The findings further revealed that although the volunteers saw their work as personally meaningful, they struggled with its emotional demands and also with some organizational challenges. Additionally, due to their routine interactions with survivors and systems, the counsellors developed an awareness of SV as a broad, systemic problem.

Through analysis of the findings across these three studies, four overarching themes emerged. One prevailing theme related to the volunteer counsellors' development of self-efficacy, over time. Quantitative results demonstrated that the participants who received the training scored significantly higher on counselling self-efficacy at the posttest measurement than those who did not: the qualitative interviews provided validation that volunteers viewed themselves as having developed competencies in this area, and revealed the activities that volunteers perceived as being responsible for these changes. In particular, the volunteers stated that the role play exercises, training on flashbacks, information on grounding techniques, and training on identifying the callers' coping mechanisms were particularly beneficial. The finding that trainees perceived improvements to their basic counselling skills that corresponded to their training, was consistent with the expectations of the research, and with previous qualitative studies (Rath, 2008; Carlyle and Roberto, 2007). Quantitative intervention studies on related types of training, such as telephone hotlines, helplines, and peer counselling programs, also found that relatively short-term training interventions was associated with improvements in volunteer counsellors' basic counselling skills (Frauenfelder & Frauenfelder, 1984; Hart & King, 1979; France, 1975; Bryant & Harvey, 2000; Katz, DuBois, & Wigderson, 2014; Paukert, Stagner, & Hope, 2004). Overall, the current research suggests promise in developing lay

counsellors' basic counselling skills through their participation in community-based training programs.

A second area of converging findings in the quantitative and qualitative studies was the need to further develop the counsellors' suicide intervention skills. The quantitative data indicated that the volunteers' suicide intervention skills were not enhanced over the course of the training, and the qualitative data were consistent with these results. In particular, volunteers perceived that they were inadequately prepared to support suicidal callers, and experienced a great deal of anxiety around the prospect of receiving these calls. They reported that the inclusion of more content on suicidality assessment and intervention skills would have greatly enhanced the training, and improved their confidence in this area. This finding is both inconsistent with the expectations of this research, and also with the results of several other studies that were conducted on volunteer suicide intervention trainings in related community contexts (Shim & Compton, 2010; Waalen & Haelstromm, 2003; Morris colleagues, 1999; Clark, Matthieu, Ross, & Knox, 2010). This may have been a result of the greater number of topics included in the CL training, and the larger amount of time afforded to them, which may have led participants to place less focused/intensive attention on the area. Therefore, the training content on suicide intervention may have seemed less salient to participants in the current study than to participants in previous studies that focused exclusively on suicide intervention. The EA identified that although the CL training was relatively lengthy, lasting a total of 30 hours, only one 3-hour session was allocated to the topic of suicide intervention. Additionally, in the qualitative study, a volunteer mentioned that a presenter had minimized the importance of suicide intervention skills to the volunteers, by stating that it was unlikely they would actually be

required to use them. These factors may have led volunteers to place less importance on developing their suicide intervention skills. The qualitative data generated by the volunteers provided support for the quantitative outcomes in this area, and suggested that a greater focus on suicide intervention should be included in the training program.

A third area of findings related to feminist attitudes and beliefs. Quantitative findings on this theme revealed that participants' feminist attitudes and beliefs did not change over the course of the training, however, both groups scored highly before and after the intervention. These results suggest that the RCC was successful in recruiting volunteers with values that match with their own organizational philosophy, and that the comparison group was similar to the experimental group on this measure. Notably, the quantitative and qualitative studies differed in terms of whether counsellors were found to have developed feminist attitudes and beliefs following their training. In the quantitative study, the participants did not show changes on this variable after their training, however, in the qualitative study, the participants described nuanced ways in which their perspectives had changed. For instance, the qualitative findings revealed that participants were led to explore their own biases and prejudices about different social groups, and they learned about how different forms of discrimination (such as racism, homophobia, and classism) overlap with sexism to increase women's vulnerability to SV (Olive, 2012; Benoit et al., 2014). They also reported that the training developed their sensitivity to what it felt like to be stigmatized, and helped them learn how to avoid oppressive practices when working with clients. Lastly, the volunteers became more aware of their own perspectives on women who had been harmed by SV, reporting that they began to see them as survivors rather than victims of their experiences, which represented a shift in perspective that aligned with the organization's

feminist empowerment philosophy. While this critical feminist analysis that the volunteers reported developing was crucial to their work with clients, it was not reflected in the quantitative results. This inconsistency in results can be attributed to the use of a measure in Study 2 that likely fell short of operationalizing current politicized feminist perspectives and which may have resulted in a lack of sensitivity to detect effects.

Directions for Future Research

This thesis took initial steps to evaluate a RCC CL training program. The research methods it used aligned well with the developmental stage of the program, as the program had not previously been studied, and the research area was newly emergent (Urban, Hargraves, & Trochim, 2014). Future research in this area should aim to build on this pilot research by conducting similar studies in the context of other RCCs, and by working towards using more rigorous experimental designs over time. As randomized experiments are understood to be the strongest method for evaluating intervention effectiveness (Trochim, 2005; Urban, Hargraves, & Trochim, 2014), future research in this area should aspire to use a randomized design; however, it is important that the research methods selected to conduct intervention research fit with the program under study (Urban, Hargraves, & Trochim, 2014).

Elucidating the stages of social intervention research, Trochim (2005) proposed that randomized experiments should be situated within an appropriate developmental framework including: (1) formative and exploratory research; (2) quasi-experimental research; (3) randomized experimental research; and, (4) ongoing monitoring and evaluation. As the current study aligned with pilot phase-two research, the next step would be for more rigorous, later phase-two research to be conducted in different community RCC settings. Such research should

also attempt to use more sensitive measures; include waitlisted volunteers as a comparison group; and use behavioral measures, where possible, to reduce the potential for response biases. Ideally, the research should also include longer follow-up periods to examine the maintenance of intervention effects over time. If such quasi-experimental research consistently demonstrated intervention effects, then future research using a randomized experimental design should be conducted in this area. This design would strengthen the internal validity of the research and allow for causal claims to be made about the training intervention's effectiveness (Trochim, 2005).

While quantitative research is useful in examining intervention outcomes and effectiveness, qualitative research is valuable for exploring program processes and stakeholders' perceptions, and it is appropriate for investigating new and understudied topics. Given its unique strengths and its feminist tradition (Westmarland, 2001), it is essential that future research in this area also continue to pursue qualitative lines of inquiry. Lastly, as mixed-methods approaches are useful in triangulating and validating findings, as well as providing a broad understanding of a program, mixed-methods research should also be pursued. Future research applying each of these methods will be valuable in building on this early training program research.

Furthermore, multi-pronged research efforts are needed to understand how CL training relates to service delivery quality, and to long term outcomes for SV survivors. Such research might examine client feedback on services, expert observations of service delivery, or longitudinal outcomes for RCC clients who receive CL services. It would also be critical for future research to examine the suitability of RCC CL services for diverse and/or marginalized populations. This could involve examining how clients' sociocultural characteristics may

moderate service effectiveness, or investigating ways in which different groups of women experience service delivery. Research indicates that Aboriginal women, immigrant and refugee women, women with disabilities, and women who are young are disproportionately harmed by SV (Olive, 2012; Benoit et al., 2014; Johnson, 2006; Sinha, 2013). Community services should therefore be tailored to better meet the needs of these diverse groups of women, and research is required to assess these specific needs. This research direction would further clarify how RCC's programs and services can be most beneficial to their clients.

Limitations of the Research

While this thesis had several strengths, such as being the first study focusing on a RCC CL training program; offering a broad perspective through the use of mixed-methods; and using a community-based research approach, it has some limitations. As previously mentioned, one limitation related to the quantitative study's non-experimental design. Given the applied context of the research, and the project's limited resources, it was not possible to randomly assign participants to conditions. This restricted the ability of the research to draw conclusions about cause-and-effect, as the treatment groups were not considered statistically equivalent. However, attempts were made to recruit participants who were similar, and the quantitative study's demographic statistics demonstrated equivalence between groups on all demographic characteristics except for age, which suggests the groups were largely comparable.

Another limitation of the studies related to the generalizability of findings. The research reflected the experiences of a relatively small group of rape crisis counsellors at a single RCC, therefore, the results of this research may not be generalizable to other RCC settings. As RCCs have diverse structures and mandates (Colvin, Pruett, Young, & Holosko, 2016), a range of

studies on RCC CL training programs in different organizational contexts would be needed to bolster confidence in the findings' generalizability.

Lastly, a limitation shared by the studies was the use of self-report measures and research tools, such as the counselling self-efficacy and feminist attitudes and beliefs survey measures, the fidelity assessments, and the semi-structured interviews. Given that these measures were based on participants' perceptions, rather than their behavioural responses, it was not possible to eliminate the potential for demand characteristics. However, efforts were made to reduce social desirability effects, by assuring participants of their confidentiality and anonymity, separating the researcher's role from the training itself, and informing participants that their responses would in no way impact their involvement at the Centre. Additional research limitations have been discussed within the body of this thesis.

Implications of the Research

This research was intended to examine the effectiveness of a RCC CL Training Program, explore volunteer counsellors' experiences in training and working with survivors, and discuss implications on volunteer retention and longevity. Key learnings coming out of the studies were the need for a greater focus on suicide assessment and intervention in the training curriculum, information about the factors that influenced volunteer attrition, and documentation that SV survivors were often treated poorly by service providers. This information has implications for practice on enhancing CL training, improving volunteer retention, and reexamining the larger context of service delivery; and for policy on recent governmental recommendations and investments. These avenues for change that the research supports are discussed, in turn, below.

One implication of the quantitative findings on practice, was the finding that RCCs need to provide more training on suicide assessment and intervention to volunteers during the course of their training, to support their skill development in this area. This finding was validated by the volunteers' qualitative reports. Implementing further training in this area would help lessen the volunteers' anxiety about receiving these difficult calls, and would ensure that they were equipped to respond appropriately to suicidal callers. Programmers should therefore review their training curricula, and consult with other suicide intervention agencies and experts to ensure the quality of their training on suicide intervention and assessment.

In addition to revealing avenues for improving the training, the quantitative findings also revealed training program's strengths. In particular, they indicated that the volunteers' counselling self-efficacy improved following their training. This finding represented a success of the program and supported the notion that the CL training may have better equipped volunteers to serve RCC clients. This finding was also validated by the volunteers' qualitative reports. Furthermore, the quantitative results revealed that the RCC was successful in recruiting individuals who shared the Centre's feminist values; and the volunteers' qualitative reports on this topic revealed their perceptions that the training equipped them with a critical feminist analysis of SV in society, and taught them anti-oppressive practices for supporting CL clients.

Another implication of the findings on practice, related to volunteer retention and longevity. In particular, the exploratory qualitative findings revealed that a few volunteers' reports of feeling unprepared to support suicidal and repeat callers, and being unsupported on overnight shifts and accompaniments were tied to a lack of motivation to continue volunteering. In order to support retention efforts, organizations should provide further training to support

volunteers' needs for competency; provide opportunities and platforms for community building to satisfy volunteers' needs for relatedness; and afford volunteers maximal control and ownership over their work to increase their sense of autonomy (Frendo, 2013). These findings were supported by Self Determination Theory (Deci & Ryan, 2002).

To further improve the retention of trained volunteers and remove barriers to participation, rape crisis counsellors should ideally be remunerated for their work. Community programming attempts to reduce obstacles to participation (Nelson & Prilleltensky, 2010), and thus, both higher and lower income volunteers should be encouraged to participate in programs. Compensating volunteers for their work may assist in the retention of individuals with lower incomes, who may otherwise need to prioritize paid positions. Additionally, to increase the inclusiveness of CL Training Programs, attempts should be made to recruit volunteers from a variety of community settings other than universities, particularly as feminist organizations tend to value diverse forms of experience and knowledge (Campbell, Baker, & Mazurek, 1998).

A final implication of the findings on practice is the need to reexamine the broader context of service delivery. The secondary qualitative findings reflected the counsellors' insight that SV is a systemic problem, enacted when service providers mistreat survivors. This was illustrated by the counsellors' reports that in addition to supporting survivors following their experiences of SA or abuse, they were also called on to support survivors after negative experiences with police and medical systems. Campbell (2001) refers to these re-traumatizing events with service providers as "the second rape" of SV survivors, and research documents the frequent occurrence of these events (Doolittle, 2017; Johnson, 2017).

This finding highlights the potential value of inter-agency coordination of services in preventing SV survivors' re-victimization by service providers. Coordinated care programs bring together specially trained service providers from different sectors, such as police, doctors, nurses, rape crisis counsellors, and mental health professionals to provide efficient and collaborative care to survivors (Campbell, 2001). Coordinated care programs have improved domestic violence services (Gondolf, 2004; Robinson, 2006; Salazar, Emshoff, Baker, & Crowley, 2007), and therefore, such a model may be similarly beneficial for SV services (Campbell, 2001). Although there may be barriers to building cross-sectorial collaborations (Ullman & Townsend, 2007), examples of such partnerships exist. The Victoria Sexual Assault Clinic is a recently developed coordinated care service that offers a range of services and supports, housed at one location. While it has not yet been researched to determine its effectiveness, the anti-oppressive, trauma-informed training of personnel, and the increased communication and oversight characteristic of coordinated services is likely to reduce service providers' harmful treatment of clients, reduce SV survivors' re-traumatization, and improve clients' access to necessary services.

Recent federal-level policy advancements are also relevant to this thesis, and have broad implications on the field of anti-violence research. As previously discussed, Status of Women Canada (2016) has recently called for policy changes that would include: "supporting community-based and culturally responsive counselling and support services", "adequately resourcing services for survivors and perpetrators", and building a federal approach that is "evidence-based and will support improved data collection and analysis to better understand gender-based violence" (Status of Women Canada, 2016). Such advancements would support

both RCCs in delivering services to SV survivors, and increase investment in research and evaluation in this area.

In the newly released Budget 2017, the Federal Government has responded to pressure from multiple fronts, (such as recent media attention and ongoing research and social advocacy efforts), to prioritize the issue of gender-based violence. Specifically, it proposed to invest an initial \$100.9 million dollars in a National Strategy to address gender-based violence, and to invest \$20.7 million dollars over five years in an effort to improve judicial responses to SA cases (Morneau, 2017; Zilio, 2017). The strategy will involve the creation of a Centre of Excellence within Status of Women Canada, and it stated that the Centre collaborate with the Royal Canadian Mounted Police and the Department of Defense on anti-violence initiatives (Zilio, 2017). While the specifics of the National Strategy are not yet clear, it is likely that other governmental and service sectors will also be positively impacted. Gender-based violence has not seen an investment in a long time, and the substantial investment set out in the recent Federal Budget offers promise to service providers and researchers working in the area.

Conclusion

The issue of SV is increasingly present in the public conversation, yet the important work of front-line service providers remains largely unrecognized. This thesis has provided a detailed picture of a RCC CL training program by carefully mapping it out and measuring its outcomes, and by conducting in-depth interviews with the volunteer rape crisis counsellors. Research on lay counsellor training programs has previously been conducted, but not in the community setting of RCCs. Therefore, this thesis offers a unique contribution to the literature. Community-based research is central to efforts to improve secondary responses to SV across social ecological levels

(Nelson & Prilleltensky, 2010). At the individual level, it can improve the quality of services SV survivors receive, and at the organizational level, it can support RCCs in strengthening their services. At the social level, it can demonstrate positive impacts of community services to government agencies and policy-makers. This thesis has taken initial steps to advance knowledge in an understudied area, and to support anti-violence research efforts across multiple levels of engagement.

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Appendix A

Semi-structured Interview Guide – Key Informants

1. How would you describe the objectives / intended outcomes of the program?

2. What are the main components of the training and how do they relate to the objectives / intended outcomes of the program?

3. How do recruitment and enrolment occur?

4. Could you describe the volunteers' characteristics (age, education, SES, ethnicities, sexualities, reasons for volunteering, how long they volunteer on average)?

5. Could you tell me about enrolment and the waitlisted participants?

6. How many are participants are enrolled right now? How many people do you expect to participate?

7. What is working well with the training and counsellor program? What areas could be improved?

Appendix B

Semi-structured Interview Guide – Centre Staff

Question 1. To begin, what is your role at the ORCC?

Question 2: What motivates people to volunteer with the Crisis Line?

Probe: What do they hope or expect to get out of volunteering?

Question 3. What professional development opportunities can volunteers access through the Centre?

Probe: Aside from professional development, what other benefits are there?

(e.g., Personal growth? Sense of community? Contribution to a cause?)

Question 4. What are some of the ways volunteers' needs are accommodated?

Question 5. What supports are in place for the volunteers in dealing with the emotional aspects of the work?

Question 6. How does the organization check-in with volunteers about their work?

Probe: Has there ever been a time when volunteer feedback lead to changes in how the program functions?

Question 7. How are volunteers kept up to date about the organization?

(e.g., Social media? Blogs? A webpage dedicated to volunteers?)

Question 8. Considering the volunteers' other obligations, what is their commitment level to the work?

Question 9. Aside from their role on the Crisis Line, in what other ways do the volunteers integrate into the organization?

Probe: Are they involved in social events?

Probe: Has someone ever started as a volunteer and become staff?

Question 10. How does the Centre say goodbye to volunteers when they decide to leave?

Question 11. Do the majority of volunteers stay on with the Centre? Why or why not?

Probe: What would make more people stay?

Appendix C

Program Fidelity Checklist

- Thank you taking the time to complete this checklist.
- Please have 2 facilitators complete checklists for the same 2 training sessions.
- Your answers will be kept confidential and anonymous.
- Your responses will help to document how the Crisis Line training is being implemented.

Facilitator name _____

Date _____

Question	Yes	No	Comments
1) Did the training run for 3 hours?			
2) Was a feminist anti-oppression framework applied to the training?			
3) Did the facilitator provide information to the group during this session? (If so, what topics were taught?)			
4) Did participants learn about feminist counseling during this session?			
5) Was crisis intervention discussed during this session?			
6) Did participants get hands-on practice with feminist counselling and/or crisis intervention in this session?			
7) Did the session involve group discussion?			
8) Was there a satisfactory amount of group participation?			
9) Did any other activities take place during this class (e.g., external presenters, trip to hospital or police station)?			

Appendix D

Table 1

RCC CL Training Protocol

Training Session	Curricula
1	Introduction to the Centre Volunteer Commitment / Self-care Understanding Violence Against Women
2	Sexual Violence and Oppression
3	Feminist Counselling Strength Based Framework Role Plays
4	Guest Speaker from the Outreach Program at the Royal Ottawa Role Plays
5	Recent Sexual Assault/Coping Strategies Guest Speaker from the Sexual Abuse Partner Care Program Role Plays
6	Childhood Sexual Assault and Coping Strategies Guest Speaker from the Centre for Treatment of Sexual Abuse and Childhood Trauma Role Plays
7	Suicide Intervention Role Plays
8	Role Plays
9	Role Plays
10	Role Plays/Volunteer Information

Notes. Trainees were required to attend each of these 3-hour long training sessions.

Appendix E

Semi-Structured Interview Guide – ORCC Volunteers

Question 1. What brought you to volunteering at the Centre?

Probe: What motivated you to volunteer – what did you hope or expect to get out of your volunteer work?

Question 2. How was your experience of participating in the training?

Probe: What changed for you?

Probe: Did the training provide you with new information and knowledge? If so, in what areas?

Probe: How did training influence your attitudes about feminism, and sexual violence more specifically?

Probe: How would you describe the process, the shared experience, of training?

Question 3. When you began working directly with survivors, did you feel prepared for your role?

Probe: In what ways did you feel prepared/unprepared?

Probe: What helped you to feel prepared? Why do you think you felt unprepared?

Probe: Based on these experiences, what would you say was the most crucial part of the training for preparing you?

Probe: What could be changed or added to the training?

Question 4. What has supporting survivors been like for you?

Probe: What are the most rewarding aspects of your work?

Probe: What do you like? (Tasks? People? Sense of community?)

Question 5. What are the most challenging aspects your work?

Probe: How do you cope with these challenges?

Question 6. In what ways could the Centre better support you in your role?

Question 7. Has doing this work changed you in any way?

Probe: Has it impacted your relationships? Or, led to any other changes in your life?

Question 8. What does your volunteer work mean to you?

Appendix F

The Counsellor Activity Self-Efficacy Scale (CASES) – Helping Skills Subscale

Instructions: This section asks about your beliefs about your ability to perform various counsellor behaviors or to deal with particular issues in counselling. We are looking for your honest, candid responses that reflect your beliefs about your current capabilities, rather than how you would like to be seen or how you might look in the future. There are no right or wrong answers to the following questions.

Please indicate how confident you are in your ability to use each of the following helping skills effectively, over the next week, in counselling most callers.

1. Attending (orient yourself physically toward the survivor, if meeting in person).

No confidence at all								
confidence								
1	2	3	4	5	6	7		

2. Listening (Capture and understand the messages that callers communicate).

No confidence at all								
confidence								
1	2	3	4	5	6	7		

3. Restatements (repeat or rephrase what the caller has said, in a way that is succinct, concrete, and clear).

No confidence at all								
confidence								
1	2	3	4	5	6	7		

4. Open questions (ask questions that help callers to clarify or explore their thoughts and feelings).

No confidence at all								
confidence								

1 2 3 4 5 6 7

5. Reflections of feelings (repeat or rephrase the caller's statements with an emphasis on his or her feelings).

No confidence at all Some Confidence Complete

1 2 3 4 5 6 7

6. Self-disclosure for exploration (reveal personal information about your history, credentials, or feelings.)

No confidence at all Some Confidence Complete

1 2 3 4 5 6 7

7. Intentional silence (use silence to allow callers to get in touch with their thoughts or feelings).

No confidence at all Some Confidence Complete

1 2 3 4 5 6 7

8. Interpretations (make statements that go beyond what the caller has overtly stated and that give the caller a new way of seeing his or her behavior, thoughts, or feelings).

No confidence at all Some Confidence Complete

1 2 3 4 5 6 7

9. Self-disclosure for insight (disclose past experiences in which you gained some insight).

No confidence at all Some Confidence Complete

1 2 3 4 5 6 7

10. Immediacy (disclose immediate feelings you have about the caller, the helping relationship, or yourself in relation to the caller).

No confidence at all Some Confidence Complete

1 2 3 4 5 6 7

11. Information-giving (teach or provide the client with data, opinions, facts, resources, or answers to questions).

No confidence at all			Some Confidence			Complete
1	2	3	4	5	6	7

12. Direct guidance (give the caller suggestions, directives, or advice that imply actions for the clients to take).

No confidence at all			Some Confidence			Complete
1	2	3	4	5	6	7

The Suicide Intervention Response Inventory (SIRI-2)

Please rate each response in terms of how appropriate or inappropriate you feel the reply is to the caller's comment. Be sure to respond to each helper response, and try not to leave any blanks.

			-1	0 (Neither appropriate nor inappropriate)	+1		
	-3 (Highly inappropriate response)	-2 (Inappropriate response)	(Marginally inappropriate response)		(Marginally appropriate response)	+2 (Appropriate response)	+3 (Highly appropriate response)

Helper A: You can tell me. I'm a paraprofessional, and have been trained to be objective about these things.

☐ ☐ ☐ ☐ ☐ ☐ ☐

Helper B: So some of your ideas seem so frightening to you, that you imagine other people would be shocked to know you are thinking such things.

☐ ☐ ☐ ☐ ☐ ☐ ☐

 4. Caller: No one can understand the kind of pain I've been going through. Sometimes I just feel like I have to hurt myself, so I cut my wrists..

-3 (Highly inappropriate response)	-2 (Inappropriate response)	-1 (Marginally inappropriate response)	0 (Neither appropriate nor inappropriate)	+1 (Marginally appropriate response)	+2 (Appropriate response)	+3 (Highly appropriate response)
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Helper A: It seems like you've been suffering so much that cutting your wrists is the only way you can make the pain go away.

☐ ☐ ☐ ☐ ☐ ☐ ☐

Helper B: But you're so young, you have so much to live for. How can you think of killing yourself?

☐ ☐ ☐ ☐ ☐ ☐ ☐

 5. Caller: What are you anyway? Are you a doctor? How do you know what I've been going through? You've probably always had it pretty soft.

-3 (Highly inappropriate response)	-2 (Inappropriate response)	-1 (Marginally inappropriate response)	0 (Neither appropriate nor inappropriate)	+1 (Marginally appropriate response)	+2 (Appropriate response)	+3 (Highly appropriate response)
------------------------------------	-----------------------------	--	---	--------------------------------------	---------------------------	----------------------------------

Helper A: So you're wondering if I can understand how you feel.

☐ ☐ ☐ ☐ ☐ ☐ ☐

Helper B: You're not even giving me a chance. I've had a pretty rough life too; you're not the only one who's seen some hard times.

☐ ☐ ☐ ☐ ☐ ☐ ☐

 Please rate each response in terms of how appropriate or inappropriate you feel the reply is to the caller's comment. Be sure to respond to each helper response, and try not to leave any blanks.

 6. Caller: I really need help . . . It's just . . . {voice breaks: silence}

● ● ● ● ● ● ●

-3 (Highly inappropriate response)	-2 (Inappropriate response)	-1 (Marginally inappropriate response)	0 (Neither appropriate nor inappropriate)	+1 (Marginally appropriate response)	+2 (Appropriate response)	+3 (Highly appropriate response)
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• • • • •

○ ○ ○ ○ ○ ○ ○

-3 (Highly inappropriate response)	-2 (Inappropriate response)	-1 (Marginally inappropriate response)	0 (Neither appropriate nor inappropriate)	+1 (Marginally appropriate response)	+2 (Appropriate response)	+3 (Highly appropriate response)
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● ● ● ● ● ● ●

● ● ● ● ● ● ●

12. Caller: I have to hang up now. My mother's coming home soon and I don't want her to know I've been talking to you.

		-1	0 (Neither appropriate nor inappropriate)	+1		
-3 (Highly inappropriate response)	-2 (Inappropriate response)	(Marginally inappropriate response)		(Marginally appropriate response)	+2 (Appropriate response)	+3 (Highly appropriate response)

○ ○ ○ ○ ○ ○ ○

Helper B: All right, but first I want you to promise me you won't do anything to hurt yourself, until you call and talk to me. Will you repeat that promise?

☐	☐	☐	☐	☐	☐	☐
-----------------------	-----------------------	-----------------------	-----------------------	-----------------------	-----------------------	-----------------------

 13. Caller: Is it really true that many people feel this way? I thought I was the only one who had such dreadful ideas.

-3 (Highly inappropriate response)	-2 (Inappropriate response)	-1 (Marginally inappropriate response)	0 (Neither appropriate nor inappropriate)	+1 (Marginally appropriate response)	+2 (Appropriate response)	+3 (Highly appropriate response)
------------------------------------	-----------------------------	--	---	--------------------------------------	---------------------------	----------------------------------

Helper A: No, there are many people who suffer from mental illness. But with appropriate treatment by a qualified physician, some of these patients can be cured.

☐	☐	☐	☐	☐	☐	☐
-----------------------	-----------------------	-----------------------	-----------------------	-----------------------	-----------------------	-----------------------

Helper B: It is true. You're not the only one who has suicidal thoughts. And you can be helped to get through this crisis, just as others have been.

☐	☐	☐	☐	☐	☐	☐
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 14. Caller: I'm so lonely, so tired {crying}. There just isn't anywhere left to turn.

-3 (Highly inappropriate response)	-2 (Inappropriate response)	-1 (Marginally inappropriate response)	0 (Neither appropriate nor inappropriate)	+1 (Marginally appropriate response)	+2 (Appropriate response)	+3 (Highly appropriate response)
------------------------------------	-----------------------------	--	---	--------------------------------------	---------------------------	----------------------------------

Helper A: You seem so alone, so miserable. Have you been feeling suicidal?

☐	☐	☐	☐	☐	☐	☐
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Helper B: Come on now. Things can't be all that bad.

☐	☐	☐	☐	☐	☐	☐
-----------------------	-----------------------	-----------------------	-----------------------	-----------------------	-----------------------	-----------------------

 15. Caller: {Over telephone} It's hard to talk here, with all these people ...

-3 (Highly inappropriate response)	-2 (Inappropriate response)	-1 (Marginally inappropriate response)	0 (Neither appropriate nor inappropriate)	+1 (Marginally appropriate response)	+2 (Appropriate response)	+3 (Highly appropriate response)
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Helper A: Would it help if I asked questions?

☐	☐	☐	☐	☐	☐	☐
-----------------------	-----------------------	-----------------------	-----------------------	-----------------------	-----------------------	-----------------------

Helper B: Why don't you call back some other time when you can talk more easily?

☐	☐	☐	☐	☐	☐	☐
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 16. Caller: Why should you care about me, anyway?

	-3 (Highly inappropriate response)	-2 (Inappropriate response)	-1 (Marginally inappropriate response)	0 (Neither appropriate nor inappropriate)	+1 (Marginally appropriate response)	+2 (Appropriate response)	+3 (Highly appropriate response)
Helper A: I've been trained to care about people. That's my job.	☐	☐	☐	☐	☐	☐	☐
Helper B: Because I think your death would be a terrible waste, and it concerns me that things are so that you are considering suicide. You need help to get through this critical period	☐	☐	☐	☐	☐	☐	☐

Page #8

 Please rate each response in terms of how appropriate or inappropriate you feel the reply is to the caller's comment. Be sure to respond to each helper response, and try not to leave any blanks.

 17. Caller: I really hate my father! He's never shown any love for me, just complete disregard.

	-3 (Highly inappropriate response)	-2 (Inappropriate response)	-1 (Marginally inappropriate response)	0 (Neither appropriate nor inappropriate)	+1 (Marginally appropriate response)	+2 (Appropriate response)	+3 (Highly appropriate response)
Helper A: You must really be angry at him for not being there when you need him most.	☐	☐	☐	☐	☐	☐	☐
Helper B: You shouldn't feel that way. After all, he is your father, and he deserves some respect.	☐	☐	☐	☐	☐	☐	☐

 18. Caller: I don't think there's really anyone who cares whether I'm alive or dead.

	-3 (Highly inappropriate response)	-2 (Inappropriate response)	-1 (Marginally inappropriate response)	0 (Neither appropriate nor inappropriate)	+1 (Marginally appropriate response)	+2 (Appropriate response)	+3 (Highly appropriate response)
Helper A: It sounds like you're feeling pretty isolated.	☐	☐	☐	☐	☐	☐	☐
Helper B: Why do you think that no one cares about you anymore?	☐	☐	☐	☐	☐	☐	☐

 20. Caller: My psychiatrist tells me I have an anxiety disorder. Do you think that's what's wrong with me?

	-3 (Highly inappropriate)	-2 (Inappropriate)	-1 (Marginally inappropriate)	0 (Neither appropriate nor inappropriate)	+1 (Marginally appropriate)	+2 (Appropriate)	+3 (Highly appropriate)
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Helper A: I'd like to know what this means to you, in this present situation. How do you feel about your problem?

Helper B: I'm not sure I agree with that diagnosis. Maybe you should seek out some psychological testing, just to be certain.

 21. Caller: I can't talk to anybody about my situation. Everyone is against me.

	-3 (Highly inappropriate response)	-2 (Inappropriate response)	-1 (Marginally inappropriate response)	0 (Neither appropriate nor inappropriate)	+1 (Marginally appropriate response)	+2 (Appropriate response)	+3 (Highly appropriate response)
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Helper A: That isn't true. There are probably lots of people who care about you if you'd only give them a chance.

Helper B: It must be difficult to find help when it's so hard to trust people.

22. Caller: {Voice slurred, unclear over telephone}

	-3 (Highly inappropriate response)	-2 (Inappropriate response)	-1 (Marginally inappropriate response)	0 (Neither appropriate nor inappropriate)	+1 (Marginally appropriate response)	+2 (Appropriate response)	+3 (Highly appropriate response)
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Helper A: You sound so tired. Why don't you get some sleep and call back in the morning?

Helper B: Your voice sounds so sleepy. Have you taken anything?

Appendix H

The Short-Form Feminist Perspectives Scale (FPS)

Instructions: In these next set of items, you will be asked your opinion about a set of statements. You may find many statements in this section that you disagree with; or you may find many that you do agree with. Some of these items may seem unusual to you. Please don't worry about how many statements you agree or don't agree with, just answer as truthfully as possible. There are no right or wrong answers, just what you believe.

For each of the following statements, please indicate your disagreement or agreement. Please don't change a response after going on to other items. Don't look back to see how you answered a previous item. Be sure to respond to all items.

Instructions. In these next set of items, you will be asked your opinion about a set of statements. You may find many statements in this section that you disagree with; or you may find many that you do agree with. Some of these items may seem unusual to you. Please don't worry about how many statements you agree or don't agree with, just answer as truthfully as possible. There are no right or wrong answers, just what you believe.

For each of the following statements, please indicate your disagreement or agreement. Please don't change a response after going on to other items. Don't look back to see how you answered a previous item. Be sure to respond to all items.

1. A man's first responsibility is to obtain economic success, while his wife should care for the family's needs.

1. Strongly disagree	2. Moderate ly disagree	3. Somewha t disagree	4. Undecide d	5. Somewha t agree	6. Moderate ly agree	7. Strongly agree
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2. Women of color have less legal and social service protection from being battered than white women have.

1. Strongly disagree	2. Moderate ly disagree	3. Somewha t disagree	4. Undecide d	5. Somewha t agree	6. Moderate ly agree	7. Strongly agree
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3. People should define their marriage and family roles in ways that make them feel most comfortable.

1. Strongly disagree	2. Moderate ly disagree	3. Somewha t disagree	4. Undecide d	5. Somewha t agree	6. Moderate ly agree	7. Strongly agree
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4. The government is responsible for making sure that all women receive an equal chance at education and employment.

1. Strongly disagree	2. Moderate ly disagree	3. Somewha t disagree	4. Undecide d	5. Somewha t agree	6. Moderate ly agree	7. Strongly agree
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5. By not using sexist and violent language, we can encourage peaceful social change.

1. Strongly disagree	2. Moderate ly disagree	3. Somewha t disagree	4. Undecide d	5. Somewha t agree	6. Moderate ly agree	7. Strongly agree
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6. Homosexuals need to be rehabilitated into becoming normal members of society.

1. Strongly disagree	2. Moderate ly	3. Somewha t disagree	4. Undecide d	5. Somewha t agree	6. Moderate ly agree	7. Strongly agree
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disagree

7. The workplace is organized around men's physical, economic, and sexual repression of women.

1. Strongly disagree	2. Moderate ly disagree	3. Somewha t disagree	4. Undecide d	5. Somewha t agree	6. Moderate ly agree	7. Strongly agree
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8. Rape is best stopped by replacing the current male oriented culture of violence with an alternative culture based on more gentle, womanly qualities.

1. Strongly disagree	2. Moderate ly disagree	3. Somewha t disagree	4. Undecide d	5. Somewha t agree	6. Moderate ly agree	7. Strongly agree
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9. Men's control over women forces them to be the primary caretakers of children.

1. Strongly disagree	2. Moderate ly disagree	3. Somewha t disagree	4. Undecide d	5. Somewha t agree	6. Moderate ly agree	7. Strongly agree
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10. Making women economically dependent on men is capitalism's subtle way of encouraging heterosexual relationships.

1. Strongly disagree	2. Moderate ly disagree	3. Somewha t disagree	4. Undecide d	5. Somewha t agree	6. Moderate ly agree	7. Strongly agree
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11. Men need to be liberated from oppressive sex role stereotypes as much as women do.

1. Strongly disagree	2. Moderate ly disagree	3. Somewha t disagree	4. Undecide d	5. Somewha t agree	6. Moderate ly agree	7. Strongly agree
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12. Putting women in positions of political power would bring about new systems of government that promote peace.

1.	2.	3.	4.	5.	6.	7.
Strongly disagree	Moderately disagree	Somewhat disagree	Undecided	Somewhat agree	Moderately agree	Strongly agree

13. Men use abortion laws and reproductive technology to control women's lives.

1.	2.	3.	4.	5.	6.	7.
Strongly disagree	Moderately disagree	Somewhat disagree	Undecided	Somewhat agree	Moderately agree	Strongly agree

14. Romantic love supports capitalism by influencing women to place men's emotional and economic needs first.

1.	2.	3.	4.	5.	6.	7.
Strongly disagree	Moderately disagree	Somewhat disagree	Undecided	Somewhat agree	Moderately agree	Strongly agree

15. Racism and sexism make double the oppression for women of color in the work environment.

1.	2.	3.	4.	5.	6.	7.
Strongly disagree	Moderately disagree	Somewhat disagree	Undecided	Somewhat agree	Moderately agree	Strongly agree

16. Beauty is feeling one's womanhood through peace, caring, and non-violence.

1.	2.	3.	4.	5.	6.	7.
Strongly disagree	Moderately disagree	Somewhat disagree	Undecided	Somewhat agree	Moderately agree	Strongly agree

17. Using "he" for "he and she" is convenient and harmless to men and women.

1. Strongly disagree	2. Moderate ly disagree	3. Somewha t disagree	4. Undecide d	5. Somewha t agree	6. Moderate ly agree	7. Strongly agree
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18. It is a man's right and duty to maintain order in his family by whatever means necessary.

1. Strongly disagree	2. Moderate ly disagree	3. Somewha t disagree	4. Undecide d	5. Somewha t agree	6. Moderate ly agree	7. Strongly agree
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19. Being put on a pedestal, which white women have protested, is a luxury women of color have not had.

1. Strongly disagree	2. Moderate ly disagree	3. Somewha t disagree	4. Undecide d	5. Somewha t agree	6. Moderate ly agree	7. Strongly agree
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20. Social change for sexual equality will best come by acting through federal, state, and local government.

1. Strongly disagree	2. Moderate ly disagree	3. Somewha t disagree	4. Undecide d	5. Somewha t agree	6. Moderate ly agree	7. Strongly agree
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21. Romantic love brainwashes women and forms the basis for their subordinations.

1. Strongly disagree	2. Moderate ly disagree	3. Somewha t disagree	4. Undecide d	5. Somewha t agree	6. Moderate ly agree	7. Strongly agree
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22. Women's experience in life's realities of cleaning, feeding people, caring for babies, etc. makes their vision of reality clearer than men's.

1. Strongly	2. Moderate	3. Somewha	4. Undecide	5. Somewha	6. Moderate	7. Strongly
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disagree ly t disagree d t agree ly agree agree

disagree ly disagree

23. In rape programs and workshops, not enough attention has been given to the special needs of women of colour.

1. Strongly disagree	2. Moderate ly disagree	3. Somewha t disagree	4. Undecide d	5. Somewha t agree	6. Moderate ly agree	7. Strongly agree
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24. It is the capitalism system that forces women to be responsible for child care.

1. Strongly disagree	2. Moderate ly disagree	3. Somewha t disagree	4. Undecide d	5. Somewha t agree	6. Moderate ly agree	7. Strongly agree
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25. Women should not be assertive like men because men are the natural leaders of earth.

1. Strongly disagree	2. Moderate ly disagree	3. Somewha t disagree	4. Undecide d	5. Somewha t agree	6. Moderate ly agree	7. Strongly agree
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26. Marriage is a perfect example of men's physical, economic, and sexual oppression of women.

1. Strongly disagree	2. Moderate ly disagree	3. Somewha t disagree	4. Undecide d	5. Somewha t agree	6. Moderate ly agree	7. Strongly agree
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27. All religion is like a drug to people, and is used to pacify women and other oppressed groups.

1. Strongly disagree	2. Moderate ly disagree	3. Somewha t disagree	4. Undecide d	5. Somewha t agree	6. Moderate ly agree	7. Strongly agree
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28. Bringing more women into male-dominated professions would make the professions less cut-throat and competitive.

1.	2.	3.	4.	5.	6.	7.
Strongly disagree	Moderately disagree	Somewhat disagree	Undecided	Somewhat agree	Moderately agree	Strongly agree

29. Capitalism forces most women to wear feminine clothes to keep a job.

1.	2.	3.	4.	5.	6.	7.
Strongly disagree	Moderately disagree	Somewhat disagree	Undecided	Somewhat agree	Moderately agree	Strongly agree

30. Discrimination in the workplace is worse for women of color than for all men and white women.

1.	2.	3.	4.	5.	6.	7.
Strongly disagree	Moderately disagree	Somewhat disagree	Undecided	Somewhat agree	Moderately agree	Strongly agree

Appendix I

Demographic Questions – ORCC CL Training Program Survey

Please complete the demographic questions below.

1. What is your date of birth?

(day/month/year)

2. Where were you born?

(country/province or territory/city or town)

3. What is your marital status?

• married • living common-law • divorced • separated • single, never married

4. What is the highest level of education have you have attained?

• some high school • some community college • some undergraduate university • some graduate university

5. In the past 12 months, how many hours a week did you usually work at all paid jobs?

6. How many children do you have?

• 0 • 1 • 2 • 3 • 4 or more

7. Please describe your ethno-cultural background.

8. What is your current profession or occupation?

(e.g., office clerk, forestry technician, full time student).