

**A Comparative Discursive Case Study of
Supports for Survivors of Sexual Violence**

by

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Abstract

The anti-violence movement developed a feminist discourse of sexual violence that offered alternative, contextualised understandings and practices. The movement was the catalyst for specialised centres that aimed to meet survivors' needs, recognising that traditional services were capable of further victimising women. This comparative case study examines four urban sexual violence support centres. Archival data and interviews with twelve rape workers from community- and hospital-based sites were collected and analysed using a historically informed, gender-based discourse analysis. The majority of participants had a feminist-informed understanding of sexual violence, which was associated with feminist practices and overlapped with descriptions of positive social reactions that enhance survivors' well being. In contrast, one site understood sexual violence from a mainstream and legal discourse, which de-contextualised understandings and practices. This thesis illustrates the relationship between understandings and practices, as well as the importance of a feminist discourse in working with survivors.

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List of Abbreviations**Sites Analysed**

OHCC	Ottawa Hospital – Civic Campus
ORCC	Ottawa Rape Crisis Centre
SASC	Sexual Assault Support Centre
WCH	Women’s College Hospital

General Terminology

DA	Discourse Analysis
RCC	Rape Crisis Centre
SANE	Sexual Assault Nurse Examiner
SATC	Sexual Assault Treatment Centre
SV	Sexual Violence

A Comparative Discursive Case Study of Supports for Survivors of Sexual Violence

Prevalence rates suggest that 30% to 50% of women experience sexual violence (SV)¹ (DeKeseredy & Kelley, 1993; Johnson & Dawson, 2011). Despite the common reality of SV in women's lives, prior to the 1970s, SV was not acknowledged or addressed by society. Beginning in that decade, the women's movement developed a language and recognition of SV against women. Legally, SV can be defined by the lack of consent and not the act itself. SV includes a spectrum of actions be they emotional, verbal or physical that are sexual in tone. Feminists have stressed a gendered understanding of SV that recognises such violence as an expression of male power and control (e.g., Brownmiller, 1975).

Acknowledging SV as a social issue led to the development of services and supports, such as rape crisis centres (RCCs) and hospital-based sexual assault treatment centres (SATCs). RCCs were pioneering and founded on feminist principles (e.g., believing and not blaming survivors²) that offered a much-needed alternative to stigmatising traditional services (Chesler, 1975/2005; Rebick, 2005). Traditional services have historically (and contemporaneously) endorsed rape myths and denied and/or silenced SV, which has exasperated negative psychological impacts of SV (Martin, 2005; Ullman, 2010).

¹ For the purpose of my research, I use the term SV because of its broad meaning. I will use the term *sexual assault* only when referring to legal discourse, as *sexual assault* is a legal term defined by the *Criminal Code* as any completed or attempted sexual contact or threat that is unwanted (Johnson & Dawson, 2011).

² I will use the term *survivor* rather than *victim* to recognise the agency of women victimised by SV.

Based on the distinctions between feminist and traditional services, many narratives of the history of SV services have framed these two communities as contentious and distinct (e.g., Martin, 2005). However, some RCCs facilitated training on the topic of SV with professionals in traditional services and played a role in changes in North American legal and medical institutions (Riger et al., 2002; Women Against Violence Against Women, 2008). Given that the scientific paradigm often obscures the impact of social and cultural influences on medical understandings and practices (Foucault, 1972), it is interesting to explore the relationships between hospital-based SATCs and community-based RCCs.

I hope to better understand the impact of the feminist community organising on SATCs in Ontario; that is, what are the understandings and practices of RCCs and have they influenced Ontarian SATCs? In regards to rape work,³ are feminist understandings and practices compatible and/or sustainable with dominant hospital frameworks (i.e., the medical model)? If feminism *can* be integrated into health care understandings and practices, what is the significance of this on the psychological health of survivors?

Post-Structural Theoretical Perspective

Beyond describing written or verbal communication, discourse can be defined as a “Set of meanings, metaphors, representations, images, stories statements and so on that...together produce a particular version of events” (Burr, 1995, p. 48). From a post-structural perspective, individuals subjectively interact with cultural signifiers of discourse (i.e., words, images, objects) and

³ Rape work is defined as, “Labour involved in doing something to, for, or with victims after they report being sexually assaulted” (Martin, 2005, p. 2).

interpret and understand the signifier in context-dependent ways. Rejecting dominant knowledge systems, post-structuralism argues that there are no universal truths and that "Meaning is constituted through language" (Gavey, 2005, p. 84). Despite the lack of a single truth, dominant discourse creates a fictional coherence of knowledge through power structures that define the widely received worldview of a particular society at a particular time (Foucault, 1980). This fictional coherence reflects the status quo and limits how individuals read and use information.

Binary oppositions represent one example of how meaning is linguistically constituted and are argued to communicate power relations (Gavey, 2005). Discourse disrupts the individual-social binary that regards the individual and the social as separate entities (Fairclough, 2001; Gavey, 2005). From a discursive perspective, the individual and the social are regarded as inseparable and interdependent. The social and the individual are argued to inform the understandings and actions of one another (Fairclough, 2001); that is, individuals shape social organisation and relations, and social organisation and relations concurrently shape the individual.

A goal of post-structuralism is to decentralise mainstream discourse by deconstructing binaries, truths and the sense of coherence that uphold dominant systems of meaning. Foucault (1980) argued that this decentralisation and deconstruction can be accomplished using a method of discourse analysis (DA) called *genealogies*. The method of genealogy replaced and is described as complementary to the archaeology of knowledge, Foucault's earlier form of

historical and epistemological inquiry (Macey, 2001). Archaeology aimed to highlight the relations between knowledge, language and action, while genealogy goes a step further and aims to unite scholarly knowledge with marginalised ways of knowing, integrating an understanding of the social, cultural and political factors that informed transformations of knowledge. A genealogy renders visible and relevant marginalised ways of knowing that are related to but have been silenced by the dominant worldview. Genealogies also illuminate the *process* by which minority ways of knowing are erased from dominant discourse. By establishing this process, Foucault believed that dominant thought could be criticised and re-imagined through the re-emergence of silenced knowledge systems. The concept of genealogy is significant to my research, as a gendered understanding of SV is generally absent in contemporary Canadian society with provincial and national policy emphasising a gendered neutral discourse of interpersonal violence (DeKeseredy & Dragiewics, 2009).

Power is productive, everywhere and capable of absorbing counter knowledges and practices into mainstream discourse (Foucault, 1980). Walker (1990) traced the process by which the discourse of Canadian anti-violence activists was absorbed into dominant institutional structures. Walker noted that the anti-violence movement has had to navigate the contradiction of only having the “oppressor’s language” available to them. Although language was used for a feminist, political agenda, it was “Controlled by those who have the power to define its content and meaning” (p. 95). This is important because Walker

describes language and the concepts related to violence as more than descriptive:

They organise the social construction of knowledge: ways of thinking about, defining, and giving abstract and generalised meaning to our particular experience. Knowledge, thus produced, provides for particular ways of taking action. Thus concepts can be seen to do more than name a phenomenon. They are part of a social relation...that brings into being and organises particular phenomenon in specific ways, providing for responses to what has been identified. (p. 101)

Foucault's post-structural concept of genealogies guided both the development and execution of this project. Given my own involvement in feminist anti-violence work, I was aware that some hospital settings are historically connected to local feminist activism. Given this, I was interested in constructing a partial genealogy that illuminated the influences of RCCs on understandings and practices relevant to supporting survivors. I was interested in whether a feminist understanding and practice has been buried or disqualified by mainstream medical discourse at the local level. By tracing the histories of sites included in my comparative case study, I hoped to understand the process by which feminist knowledge systems have been integrated into and/or erased from SATCs.

Historical Context of the Canadian Anti-Violence Movement

In the 1960s and 1970s, North America experienced what is now known as second-wave feminism. During this time, the ideological and material foundation of anti-violence feminist organising was developed (Adamson, Briskin & McPhail, 1988). Canadian women in the anti-war movement formed the peace

organisation Voice of Women, which lobbied the Canadian government to create a Royal Commission on the Status of Women (Rebick, 2005). Although the Royal Commission on the Status of Women did not initially mention violence as a women's issue, by 1973 it had become a defining topic for the Royal Commission on the Status of Women and the women's movement more broadly (Eliasson & Lundy, 1999).

The rape crisis centre movement. A rape crisis centre (RCC) movement emerged in light of the discovery that SV was common and that survivors were unsupported by society. The majority of RCCs built upon a feminist analysis that framed SV as a patriarchal expression of power and control (Brownmiller, 1975), situating themselves as a support service and a vehicle social change (Matthews, 1994; Rebick, 2005). In general, there were two types of RCCs: conventional social service agencies that were staffed by professional women and survivor-driven egalitarian collectives (Rodriguez, 1988). Martin (1990) described these differences as arising from divergent feminist ideologies, where liberal feminism framed conventional social service agencies and socialist, radical and lesbian feminisms framed grassroots collectives.

The first documented Canadian RCCs were independently organised in Vancouver (1973), Toronto (1974) and Ottawa (1974) (Eliuk, 1979; Heney, 1987; O'Conner, 2005; Rebick, 2005). Although RCCs were organised with little knowledge of each other, the movement was soon national. In 1975, the first national RCC conference took place, and in 1978 the Canadian Association of Sexual Assault Centres was formed (O'Conner, 2005). In general, little social

science literature has examined RCCs within the Canadian context (Beres, Crow & Gotell, 2009; Masson, 1999).

The RCC movement and institutions. By organising at the national and provincial level, RCCs had regular interactions with government and other dominant institutions. The first national RCC conference in 1975 put forth legal recommendations regarding sexual assault (Canadian Rape Crisis Centres, 1975). In response to RCC activism and the growing societal recognition of SV, the Ontario Secretariat for Justice consulted the Ontario Coalition of Rape Crisis Centres in 1977 to establish a subcommittee on rape (Ontario Coalition of Rape Crisis Centres [OCRCC], 2012). At this time Ontarian RCCs also took steps to advocate for changes to the health care system. In 1977, the Toronto Rape Crisis Centre tabled the *Hospital Project* during the Canadian Rape Crisis Centre's annual general meeting (Canadian Rape Crisis Centres, 1977). The *Hospital Project* stressed the intersections of medical and legal institutions in rape work and called for Toronto hospital staff to be trained and effective in conducting sexual assault care and forensic evidence collection. Although the goal of the *Hospital Project* was not met, specialised SATCs began to be established in Ontario in the 1980s (OCRCC, 2012).

Throughout the 1980s, there were changes to the Canadian *Criminal Code* that expanded the definition of sexual assault. Broadening this definition emphasised the need to improve forensic evidence collection and prosecution rates (Johnson and Dawson, 2011). Hospitals were recognised as obvious partners in forensic evidence collection and in 1980 health and legal

professionals in consultation with the Ontario Coalition of Rape Crisis Centres conceptualised and designed sexual assault forensic evidence kits (OCRCC, 2012). The “rape kit,” as it is commonly called, was available for use in Ontario in 1981 (OCRCC, 2012). Initially, emergency department staff worked without specialised training in the kit or sexual assault and as a result the collection of evidence and survivor’s care was inconsistent (Sheila, interview, February, 2012).

Critiques of the health care system’s treatment of survivors became high-profile media stories that resulted in public pressure. Newspaper articles and taskforce reports highlighted how survivors were re-victimised when they accessed emergency departments due to long wait times, triage routines and a lack of understanding of sexual assault (e.g., Maychak, 1982, 1983; Orwen, n.d.). These local media stories placed pressure on hospitals and the Ministry of Health and Long-Term Care to respond (Lipovenko, n.d.). Women’s College Hospital (WCH) created Ontario’s first SATC⁴ (press release, n.d.) and the Ministry of Health and Long-Term Care launched a strategy to roll out SATCs across Ontario throughout the late 1980s and 1990s (Sexual Assault Treatment Program, 1995; Sheila, interview, February, 2012). Many of these programs were created by medical professionals in conjunction with the knowledge, experience and support of RCCs (e.g., Sexual Assault Network [SAN], 1993; Women Against Violence Against Women, 2008). This is significant because it

⁴ In 1998, the provincial mandate of SATCs was expanded to include domestic violence and they were renamed Sexual Assault/Domestic Violence Treatment Centres (e.g., Women’s College Hospital, 1998). I will use the term SATC given my focus on SV.

illustrates how through a social issue like SV, various individuals, organisations/institutions and thus discourses come together for a common aim (i.e., supporting survivors).

Supports for Survivors

RCCs and SATCs were important social developments as traditional services (e.g., hospitals, counselling) were generally unresponsive and/or inadequate in supporting survivors of violence (Chesler, 2005; Rebick, 2005). The founding intentions of RCCs and SATCs included increasing the availability of effective, empathetic support for survivors (DuMont, Parnis & Ontario Network of Sexual Assault Care and Treatment Centres, 2002; Rebick, 2005; SAN, 1993).

Rape crisis centres. RCCs were the first organisations to offer support framed by a feminist understanding of SV. Since their inception the primary service has included 24-hour support hotlines for counselling, information and referrals. These organisations were (and typically remain) volunteer-driven. RCCs are also engaged in community activism, lobbying focused on policy and law reform, face-to-face counselling, as well as accompaniment⁵ and advocacy (Heney, 1987). Accompaniment and advocacy have generally focused on the navigation of legal and healthcare settings (Mathews, 1994). Survivors who access RCCs are more likely to access legal and medical services (Ullman, 2010).

⁵ Accompaniment is a service where RCCs accompany survivors to other institutions/agencies (e.g., hospital, police) as a support person.

Survivors are more likely to access freestanding⁶ RCCs than any other SV services (O'Sullivan & Carleton, 2001). Furthermore, RCCs are more accessible to women of colour and young women because they perceive the criminal definition of SV endorsed by traditional services as threatening (O'Sullivan & Carleton, 2001). Despite the high level of RCC use, RCCs may only work with 5% to 10% of the survivors in a given community (Ullman, 2010). Speaking to the extent of SV, although RCCs only support a small number of survivors who choose to disclose, RCCs continuously struggle with long wait lists for their support programs and a lack of resources (Beres et al., 2002;⁷ Kathy, interview, November, 2011; Susan, interview, March, 2012).

Sexual assault treatment centres. While situated within hospital emergency departments, SATCs are generally separate spaces that create a more relaxing environment for the survivor. When accessing a SATC within seventy-two hours of SV, survivors are connected to a Sexual Assault Nurse Examiner (SANE) for a forensic examination, preventative health care, the treatment of injuries and referrals. Some SATCs provide short-term individual counselling.

During the examination, forensic evidence may be collected using a rape kit. A rape kit includes a documentation of a woman's emotional status and the

⁶ Since the 1980s, a growing number of American RCCs have been housed within larger organisations (Matthews, 1994). This does not appear to be the case in Canada, where to the best of my knowledge the majority, if not all, RCCs are freestanding.

⁷ Although this citation is dated, my interviewees discussed struggling with waitlists and the precarious funding of RCCs, whose funding has not recovered from previous cuts or kept with the rate of inflation.

collection of possibly evidentiary skin, hair, saliva and semen samples from various locations on the woman's body (Du Mont & Parnis, 2001). Current SANE treatment guidelines discuss following up on immediate psychological needs and possibilities for short-term counselling (Du Mont & Parnis, 2001). In the United States, SANEs have had positive relationships with RCCs and have regarded RCC staff as a critical component of SV response teams (Ledray, 2001). In the contemporary Canadian context, the relationship is less clear and appears to vary from city to city, RCC to RCC and hospital to hospital.⁸

Hospitals and secondary victimisation. Due to factors at the individual, social, organisational and environmental levels, survivors have had (and continue to have) negative experiences when accessing hospitals (Ullman, 2010). Medical systems and the individuals that work within them can add to a survivor's psychological trauma by constructing and/or perpetuating negative experiences. These negative experiences include access barriers, unavailable services and/or resources, as well as negative reactions by service providers (Ullman, 2010). Negative reactions can include blaming, disbelief, endorsing rape myths and being unsupportive. Such reactions are not uncommon and can result in what has been coined as a "secondary injury" (Symonds, 1980), "second assault" (Martin & Powell, 1994), or "secondary victimisation" (Campbell and Raja, 1999; Williams, 1984) (cited in Ullman, 2010, p.4). For my thesis, I will use the term *secondary victimisation*. In part, SATCs were developed to address secondary

⁸ This comment is based on my experience working with RCCs in Vancouver, Toronto and Ottawa.

victimisation perpetrated by health care providers (Women's College Hospital, 1992).

Discourses of Sexual Violence

Given the impact of the reactions of others on survivors' psychological health, an examination of discourses is important. Each discourse of SV encompasses a particular belief system (Parker, 2004; Wood & Kroger, 2000) that has divergent outcomes in the actualisation of support for survivors. At the individual level, if a woman does not name or understand her experience of SV as violence, the violation may be normalised, lead to self-blame, negative psychological outcomes and the risk of future violence (Kilmartin & Allison, 2007). Such normalisation decreases her likelihood of disclosing the violence and seeking support. Interpersonally, when a woman discloses her experience of SV, the beliefs of other individuals impact upon her well being. For instance, friends, family and professionals who minimise, express disbelief or do not understand violence typically respond by blaming and/or inadequately supporting the survivor, which increases the survivor's expression of post-traumatic stress disorder symptoms (Ullman, 2004).

While SV against women is a "truth," there is no singular, absolute meaning or understanding of SV. Indeed, each woman will understand her own experience in a unique way, which may differ from the understandings of the individuals, organisations and institutions she comes in contact with. By looking at the assumptions embedded within how organisations and the individuals that work within them talk, write or otherwise represent meaning, we can learn a great

deal of information about SV within social environments. Below I will incorporate some literature on violence against women more generally as the majority of research on discourse, survivors and health professionals have focused on violence against women (i.e., Loseke & Cahill, 1984; Mildrof, 2005; Warshaw, 1989). Sexual, physical, verbal and emotional violence have similar impacts on survivors and are explained using similar feminist and mainstream discursive frameworks (Kilman & Aillison, 2007).

Mainstream discourse. In general, there is great misunderstanding among Canadians as to what constitutes SV (Johnson & MacKay, 2011).

According to Martin (2005):

Mainstream discourse represents rape as a more or less inevitable sex crime, as in “sex run amuck,” and as committed by “bad apples.” “Normal” men (or boys) do not rape, only disturbed people do. Society can reduce rape, although not eliminate it, if potential victims avoid risky behaviour and places and rapists are removed by means of stringent conviction and incarceration. (p. 122)

Mainstream discourse renders the gender of the rapist invisible and “abstracts the agents of rape from their social, political, and cultural contexts” (Martin, 2005, p. 125) by using gender-free language. From a feminist perspective, this is problematic as it does not recognise the gendered dynamics of SV or hold men and boys accountable for their perpetuation of violence.

Rape myths. One mechanism by which mainstream discourse is communicated is through rape myths. Despite four decades of feminist public education and significant changes in our legal institutions, rape myths prevail (for a review see Loway & Fitzgerald, 1994). Rape myths affect how survivors

understand their experience of SV and the response of others to disclosures of SV. Payne, Lonway and Fitzgerald (1999) categorised rape myths as: (a) women provoke rape (i.e., "she asked for it"), (b) rape as the result of a misunderstanding (i.e., "he didn't mean to"), (c) rape as "just sex" or trivial, (d) women lie about rape, (e) rape as an act committed by deviant men and (f) believing there is a distinction between what is and what is not a legitimate rape. These rape myths are stereotypes that inform mainstream discourse. Reviewing the literature on rape myths, Ullman (2010) asserted that:

Rape myth acceptance is related to negative evaluations of survivors of rape, greater blame of victims for rape, lower conviction rates for accused rapists, and shorter sentences for convicted rapists in mock jury trials.

(p. 20)

Consistently, survivors have rated physicians (along with police/legal personnel and clergy) as most unsupportive following the disclosure of SV (Ullman, 1999). Although several factors beyond occupation predict social reactions toward survivors, researchers have examined medical professionals' attitudes toward survivors. For instance, Best, Dansky and Kilpatrick (1992) had 215 medical students read scripts regarding a non-sexual assault patient, a stereotypical sexual assault patient or a non-stereotypical sexual assault patient. Following the reading of the script, students completed various scales, including a rape myth scale and questionnaire that measured attitudes toward rape. They found that medical students were likely to express negative attitudes toward non-stereotypical sexual assault survivors and endorse rape myths. In contrast, RCC counsellors have positive, supportive attitudes toward survivors and actively work

to debunk rape myths (Ullman, 2010). Through rape myths, mainstream discourse perpetuates, creates and maintains attitudes, values and belief systems that normalise SV and blame survivors (Martin, 2005). Because the stereotype of what is and what is not a legitimate rape or a “good” victim is narrow, the majority of survivors’ experiences are silenced and/or denied (Martin, 2005; Ullman, 2010).

Medical discourse. The dominant discourse of hospital practice is referred to as the medical model (Mildorf, 2007). The medical model separates mind and body, assigning roles to the health practitioner and patient. In line with the scientific tradition of modern medicine, the practitioner aims to be clinical, meaning that they are objective and separate from social and cultural influences (Mildorf, 2007). As a social issue without biological causes, SV challenges the medical framework. Because SV is not an illness, the health care system has generally resisted and struggled with medicine’s role and responsibility in addressing SV (e.g., Kurz, 1987).

Medical discourse has been argued to serve a social control function in that it defines what is genuine illness, the passive naive role of the patient and the active expert role of the doctor/nurse (Foucault, 1973). According to Williamson (2000), the medical model positions the compliant patient as responsible for assisting in recovery by following physician recommendations. Patients who understand their experiences differently from their doctor, or choose not to follow medical recommendations, may be stigmatised within the health care system for behaving inappropriately (Williamson, 2000). This

traditional doctor-patient dynamic has been critiqued for reproducing the power imbalances inherent in women's experiences of violence (Kurz, 1987; Warshaw, 1989).

Medical discourses have significant impacts on understanding violence against women and the survivor. In her discourse analysis of interviews with twenty British physicians, Mildorf (2007) demonstrated how dominant medical discourse framed survivors as incompetent and indirectly responsible for causing their own victimisation. In earlier research on battered women, Loeske and Cahill (1984) found that medical labels:

Constructed a situation where victims of wife assault may lose control over their self-definitions, interpretations of experiences and, in some cases, control over their private affairs. In a sense [women are]...victimised twice, first by their mate and then by the experts who claim to speak on their behalf. (p. 306)

Given the possibility of discursively perpetuating secondary victimisation, it is important to look at how SATCs understand and work with survivors.

Feminist discourse. Feminist understandings of SV offer a social-level explanation:

Feminist discourse says that rape stems from a system of gender inequality that devalues women, girls and the feminine, while valorising men boys and the masculine. It frames rape as an act of violence that men and boys pervasively commit against women and girls. (Martin, 2005, p. 123)

Second-wave feminism positioned SV as a social problem where the root cause was patriarchal inequality between men and women (Brownmiller, 1975; Ullman, 2010). Brownmiller, a pioneering figure in the anti-rape movement, critiqued

psychology along with other disciplines and social institutions for turning a blind eye to the realities of rape. She argued that by virtue of their penis, all men were potential rapists. Through men's realisation of this power, Brownmiller argued that men engaged in a process of intimidation designed "To keep all women in a state of fear" (p. 5). Male social dominance was argued to influence all aspects of daily life from the micro- (i.e., the family) to the macro-level (i.e., federal policy and governance). Gendered inequalities that produce and maintain VAW have since been recognised by some governmental reports (e.g., Harder, 1994).

Third-wave feminism developed in the late 1980s from feminist critiques of the racial bias embedded within the second-wave feminism. White feminist activism had universalised the concept of "woman" and had failed to incorporate other aspects of identity (e.g., race) into its analysis. Critics noted that Black women's experiences of rape were shaped by colonial, racist and capitalist power systems that second-wave theorising/organising failed to address (Collins, 2004). In response, third-wave feminism developed an intersectional anti-oppressive and anti-racist theory and practice through the 1980s and 1990s. Third-wave feminist discourse understood that each individual subjectively experiences context-dependent privilege and oppression based on multiple markers of their identity (e.g., ability, sexuality, social class, education, religion). From this perspective, intersecting power systems are an analytic tool to understand diverse experiences of SV.

Feminist discourse has been instrumental to the work of RCCs. Moreover, feminist discourses have been argued to lead to better support

services for survivors (Matthews, 1994; Riger et al., 2002). Compared to other social supports for survivors, RCCs are rated most positively by survivors (O'Sullivan & Carleton, 2001; Ullman & Townsend, 2007). Furthermore, women who use RCCs are more knowledgeable of other services (e.g., legal, medical, and mental health) and report lower levels of distress (Campbell, 2006). Given the practical implications of understanding SV from a feminist discourse, feminism has been integrated into many traditional interventions and therapeutic supports for both survivors and perpetrators (e.g., Waterhouse, 1993). However, some have argued that integrating feminism into dominant institutions will appropriate and depoliticise the feminist understandings and practices (Beres et al., 2002; Bonisteel & Green, 2005; Walker, 1990).

The (im)possibility of integrating feminist and medical discourse.

Although some hospital-based SATCs may have initially been informed by a feminist discourse, they may have been limited by dominant language. Feminist linguist Dale Spender (1980) has described this as a "language trap." The language trap is a paradox in which language can be redefined and reclaimed, yet it remains restricted by oppressive meaning systems of the dominant group. Feminist community members and health care professionals have re-imagined and re-defined SV and related concepts. To understand the opposing worldviews constructed by mainstream and feminist discourse, please see Appendix A. In this table I have reproduced Martin's (2005) idealised models of how each discourse understands and responds to sexual assault. This table illustrates the distinctions between feminist and mainstream discourses of SV. In

general, each discourse has a different way of conceptualising why SV occurs, who is responsible, whether it is preventable and if so, how. From an applied discursive perspective, each discourse would have implications in the provision of support. In Table 1 I have extended Martin's discursive oppositions and aimed to illustrate how feminist and mainstream discourse would divergently inform the support of survivors.

To illustrate the importance and difficulties of a shared language and understanding of SV within hospitals, consider the concept of *symptoms*. In a classic study, Kurz (1987) compared the views and behaviours of 104 staff members working at hospitals with and without specialised staff training on woman abuse. This study found that staff members of emergency departments without such training were less likely to acknowledge violence as relevant to health care and that most staff members did not respond, or responded negatively, to survivors. In fact, in these three hospitals, only 11% of the staff responded positively to the survivor on the condition that she fit the stereotype of the "good victim." The staff members of the emergency department that had received specialised training on violence against women were more likely to respond positively to survivors and see "evasive" women or women with certain attributes (e.g., they had consumed alcohol) as demonstrating "symptoms" of abuse rather than being responsible for their circumstances. In effect, then, staff understandings of the "symptoms" of violence and institutional values guided how staff responded to the survivor.

Table 1

Feminist and Mainstream Discourse

Question/Issue	Feminist discourse	Mainstream discourse
Do survivors require specialised care?	Yes, the traditional medical model may re-victimise survivors given the power dynamics. Woman-centred, trauma-informed care is important.	No, everyone should receive the same standard of care.
What is the purpose of SATCs?	To increase survivors' choices and access to medical and forensic services. To decrease system barriers and inadequate/inappropriate health care.	To ensure that hospital staff understand the legalities and are able to administer a rape kit.
Who is responsible for survivors' disclosures?	Health and social service staff should feel comfortable asking questions about violence and they should be able to spot the signs.	Survivors should feel comfortable telling people who can help them what is wrong.

While a common language such as “symptoms” was an important tool in challenging hospitals to consider violence against women as a relevant health issue, this tool is limited by dominant meanings. For example, from a feminist understanding of violence, a “symptom” is understood as a normal, understandable reaction to violence. In contrast a traditional medical model may

redefine symptoms in individualised, pathologising terms. While a feminist framework is possible within the health care system, some researchers have argued that hospitals medicalise concepts of violence and violence intervention through processes of individualisation and reductionism (Bonisteel & Green, 2005; Kurz, 1987).

Health professionals are defined as “experts” and survivors are further disempowered through their lack of control in decision-making (Bonisteel & Green, 2005). This is communicated in the literature by statements of what women “should” do following a sexual assault (e.g., Ledray, 2001) and judgments of what constitutes “successful coping” (e.g., Resnick et al., 2007). Additionally, treating symptoms runs the risk of ignoring the etiology of a woman’s effects, behaviours and/or cognitions, and as a result may fail to provide support directly related to violence. Although medical language can be an effective tool for communicating about health issues related to violence, using such language may inadvertently depoliticise violence by ignoring the context in which violence occurs and framing it in terms of individual pathology.

Discourse and Social Reactions

Discourse guides social reactions. Social reactions are of utmost significance given the potential for the secondary victimisation of survivors. Aiming to understand the positive and negative social reactions that survivors experience, Ullman (1996a, 1996b, 2004) developed the *Social Reactions Questionnaire*. This questionnaire categorises positive social reactions as providing survivors with: (a) emotional support, (b) tangible aid and (c)

information support. Negative social reactions are categorised as: (a) victim blaming, (b) egocentric responses, (c) stigmatising responses, (d) distraction and (e) controlling responses. Based on qualitative data from survivors, Ullman (2010) further defined positive social reactions as including: (a) belief/validation, (b) non-blaming, (c) listening, (d) reassurance and (e) sharing experiences. Additional negative social reactions included: (a) rape myths, (b) trust violation, (c) minimising response, (d) re-victimisation and (e) disbelief/denial. Social reactions may be further understood by contextualising them within the discourse they draw upon. For instance, mainstream discourse may be communicated through negative social reactions and feminist discourse may be communicated through positive social reactions.

The Present Study

In this survey of the literature I have examined the concept of SV, interventions designed to support survivors and the concept of discourse. This study was designed to explore how RCCs and SATCs understand SV and the relationship of their understandings to their support practices. The goals of this project are multiple. First, given the limited documentation of the Canadian anti-violence movement, my hope was that this research would help ensure that the history of Canadian sexual assault organisations is recognised. Second, I have aimed to illustrate possible relationships between hospital-based and community-based SV centres' understandings and practices. Third, in developing this account, I have explored whether a feminist discourse was compatible with the medical model. Finally, I have considered whether some understandings and

practices contribute to positive social reactions and thus decrease secondary victimisation. Overall, I hope to develop an understanding of anti-violence work in urban Ontario that will allow us to better understand rape work.

Method

Philosophical and Theoretical Framework

The specific theoretical, philosophical stance underpinning my research is a social constructionist paradigm with feminist axiology. Adopting a social constructionist feminist value-laden perspective resolves the difficulties of post-structuralist methodological ambiguity. Foucauldian post-structuralism has been described as difficult to apply given Foucault's lack of concise, coherent descriptions for the application of his theories as methodological tools (Graham, 2005). In contrast, social constructionism has been extensively written about from an applied psychological lens (e.g., Burr, 1995; Gergen & Gergen, 2009). Feminist philosophy is deeply entwined with social constructionism and feminist researchers have been instrumental in the social constructionism movement of modern psychology. Indeed, Gergen (1985) noted that feminists (including feminist psychologists):

Have been forerunners in employing interpretive research strategies, documenting the scientific construction of gender, demonstrating the pragmatic use of constructionist inquiry and exploring the foundations of constructionist metatheory. (p. 272)

Furthermore, feminist theory developed an intersectional, identity-based understanding of power that was absent in Foucault's work (Bordo, 1993).

Consistent with my research questions and design, social constructionism and

feminism underpin many modes of qualitative analysis, including discourse analyses (DA) (Clark & Braun, 2009; Parker, 1993) and case study (Lin, 2009).

Social constructionism. The philosophy of constructionism overlaps with and was inspired by post-structuralism (Burr, 1995; Gergen, 1985), further developing post-structural understandings of discourse. According to social constructionist theories, various social structures employ power to construct the individual and language is an important tool in regulating, maintaining and perpetuating structural power systems.

There are central assumptions that social constructionist stances are united by: (a) being critical of taken-for-granted knowledge, (b) regarding knowledge as historically and culturally located, (c) assuming that knowledge is constructed through social interactions and (d) that actions are inseparable from understandings (Burr, 1995; Gergen, 1985). From a social constructionist perspective, taken-for-granted knowledge is *productive*. Received truths are argued to organise social relations and interactions at individual, institutional and societal levels. For instance, dominant discourses that inform health care practitioners (i.e., doctors, nurses, psychologists) work to establish and maintain dominant ideas and values of their field. In turn, these dominant discourses inform societal structures (i.e., hospitals, organisations, who is a legitimate professional) and individuals over whom these discourses have power (i.e., survivors, patients, clients).

By referring to “taken-for-granted knowledge,” social constructionism invites the researcher to interrogate everything they do and do not know,

including themselves. The meaning of terms such as “rape,” “sexual violence (SV), “victim,” “survivor” and so forth are not stable and cannot be assumed. Indeed, these terms mean different things to different individuals within different contexts. The mere choice of words used to describe SV and survivors has the ability to shape related knowledges and practices.

Feminist philosophy. Feminist values are consistent with, complement and inform social constructionism. Feminist theorists were the first to demonstrate that categories of gender, and thus social roles and expectations, are socially constructed binaries (e.g., Unger, 1989). Throughout history, feminists have approached the topic of SV from diverse perspectives. Overall these approaches can be categorised as first-, second- and third-wave, although it is important to note that there is much variation within and continuity between each wave.

First-wave feminism and sexual violence. The first-wave feminists addressed the issue of male sexuality (i.e., sexual violence) as an argument for the temperance movement, given the impact of male sexuality on (white) women’s purity (Gordon, 1988).

Second-wave feminism and sexual violence. During the anti-violence movement, divides were established between types of feminism. The dominant feminist ideologies were liberal, radical and socialist.

Liberal feminism has been defined as an individual-level analysis that seeks to establish equality between men and women by integrating women and women’s issues into our existing social, legal and political structures. From this

perspective, increasing women's equality in the workplace, legal system and political system could prevent SV.

Radical feminism understands women's subordination as rooted within patriarchal power systems that organise all levels of society — from the home to the state. From this perspective, SV must be addressed by dismantling all oppressive, patriarchal power structures that assert male supremacy.

Socialist feminism argues that patriarchy is not the sole form of women's oppression and incorporates a Marxist critique of capitalism; that is, women's inequality is regarded as stemming from their economic reliance on male partners and low or no pay/recognition for their work. From this perspective, SV is understood as resulting from women's economic dependence on men who view her body as a commodity.

Third-wave feminism and sexual violence. The majority of contemporary feminism (which has been labelled as third-wave) has moved beyond a simple analysis of gender and aims to be intersectional. Intersectionality understands that "woman" is not a uniform identity or experience. Rather, multiple axes of one's social location (e.g., ability, sexuality, race, class, religion, geographical location) inform gender (Sheilds, 2008). Feminism aims to understand how these various factors interact to construct empowerment and disempowerment (Sheilds, 2008). Markers of identity are thought to operate through binaries (i.e., white/racialised, able-bodied/disabled, straight/queer) that organise social relations and uphold the power of the dominant group. From this perspective, marginalisation and identity-based

oppression (e.g., SV) can be understood as a means of expressing, regulating and maintaining power.

In my thesis, feminism will be open to self-definition by each participant/site to encompass the diversity of how participants and the site they are affiliated with may define feminism. As a feminist worldview shapes my day-to-day life, it is difficult to describe explicitly how a feminist perspective informed my analysis, although I did come of age in a third-wave, community-based feminism. I believe that gender and other markers of identity are analytical tools that enhance our understanding of social issues. As such, a feminist perspective guided my research design, analysis, interpretation and discussion.

Research Design

Case study is an exploratory qualitative method that allows researchers to understand complex social issues in context (Yin, 2009). Since the 1970s, case studies have been regarded as important methodological tools for social inquiry (Stake, 1995). Across the social sciences, researchers have used case studies to examine a small number of organisations, events or relationships in depth, drawing upon multiple sources of evidence (Yin, 2009). Case study utilises multiple forms of data, which may be qualitative or quantitative in nature. In my thesis, I utilised multiple sources of qualitative data. Given that I was interested in developing a contextualising interpretation of the understandings and practices between different sites that supported survivors, case study appeared to be an appropriate method with which to organise my research design.

Case study is critiqued for not being generalisable. However, Yin (2009) has argued that case studies illuminate the complexities of social issues, provide detailed accounts and consider multiple factors. For instance, from a case-study perspective, answering my research questions will be inseparable from accounting for political, social, historical and individual factors.

I used the case-study method in the design of my thesis. Specifically, my research was designed to examine four sites: two community-based Rape Crisis Centres (RCCs) and two hospital-based Sexual Assault Treatment Centres (SATCs). Each site was unique in its history, organisational philosophy, structure and approach to rape work. As an exploratory approach, my case study will examine the relationships and dynamics of the understandings and practices utilised to support survivors within the sites selected for analysis.

Researcher-as-Instrument Statement

I have been involved in the feminist, anti-violence movement for eleven years and am invested in a feminist understanding and practice. My feminist inclinations include being committed to understanding SV as a gendered, feminist issue and regarding some traditional practices as reductionistic, individualistic and detrimental to a survivor's well being. Primarily, my involvement in the anti-violence movement has been through RCCs, and over the course of this study I was employed by the Ottawa Rape Crisis Centre (ORCC) as a public education consultant/community-based researcher. Additionally, I have worked as a research student at Women's College Hospital (WCH), evaluating a trauma therapy program for survivors of child abuse. It was

working at WCH and at a RCC in Vancouver that inspired the present study. Specifically, I became aware that feminist consciousnesses, both inside and outside of medical institutions, had informed the development of the policies and procedures of hospital services. These experiences have given me the experience of working from multiple perspectives and with various organisations/institutions on the topic of SV. My experience in the anti-violence community enhanced access to and rapport with organisations and participants, which is important for research in community settings. In regard to research experience, this project was my second qualitative thesis and first time conducting a case study or DA. I have six years of experience volunteering on qualitative research projects in various settings and have completed a graduate-level course in qualitative methods.

During the interview process, my own biases and assumptions became clear. For example, I assumed that all community organisations privileged peer-support models and were non-hierarchical structures that were critical of traditional therapeutic practice. Because my experiences and politics informed such assumptions, I documented, interrogated and addressed my biases. As biases arose, I discussed them with colleagues to better understand and negotiate their influence on my research. I engaged in "memoing." Memos have been defined as, "A collection of hunches, interpretations, queries and notes made by the researcher" (Morrow, 2005, p. 256). As I became more immersed in the data, these memos allowed me to note similarities and differences within and between interviews. Over the course of this research, I believe I became more

aware of the binaries that exist in my own thinking. I also developed a broader understanding of the practice of feminism and how it can inform dominant structures.

Site and Participant Selection

I focused on RCCs and SATCs in Toronto and Ottawa because they were the first Ontarian cities to officially develop anti-violence organisations. I aimed to interview three individuals at each site. These interviews included: (a) an individual from the "early days" (i.e., someone who was involved in the first decade of the site's operation and preferably participated in its establishment), (b) a current leader (i.e., an individual who was currently employed in a leadership position) and (c) another individual currently involved (i.e., an individual who was currently involved with the case in a non-leadership capacity). Early day individuals were interviewed to develop a sense of the changes and continuities over time.

As individuals at different levels of a site have different perspectives, my intention was to explore the diversity of perspectives within a single site. While there were multiple discourses on SV, which may have resulted in inconsistent practices and understandings within a case, this goal proved too onerous. As each site represented a unique perspective, I decided to focus my analysis *between* rather than within *and* between sites; that is, my results will present a comparative case study rather than presenting each site individually, although when necessary I will go in depth into a single site to explain differences between sites.

Interviewing three individuals at each centre was not always possible given the time constraints of frontline workers, limited organisational resources and in one case, a policy not to participate in student projects. At some sites I conducted more than three interviews since multiple individuals were interested in participating. Anticipating that my research questions might change as my understanding of the project developed, I collected as much data as possible as recommended by qualitative researchers (Kidder and Fine, 1987; Wood & Kroger, 2000).

Site characteristics. Three sites were located in Ottawa (i.e., ORCC [ORCC], Sexual Assault Support Centre [SASC] and Ottawa Hospital – Civic Campus [OHCC]). The fourth site was WCH in Toronto. One RCC was a hierarchical social service agency and the other was a non-hierarchical survivor-driven collective that offered peer support. The hospital sites were similar in their structural characteristics, although their size and guiding philosophies differed. Table 2 summarises the number of sites and participants. See Appendix C for a summary of site characteristics.

Participants. Following consent⁹ from Carleton University Psychology Research Ethics Board, the Research Ethics Board of WCH and the Ottawa Hospital Research Ethics Board, purposeful recruitment was conducted by sending a letter of invitation to the selected sites. When these efforts did not yield the required number of participants, I utilised a snowball-sampling technique by discussing my research with personal contacts in the community.

⁹ See Appendix B for documentation of ethics clearance.

Table 2

Sites and Number of Participants

Community-Based Sites		Hospital-Based Sites	
Ottawa Rape Crisis Centre (ORCC)	$n = 3$	Women's College Hospital (WCH)	$n = 3$
Sexual Assault Support Centre (SASC)	$n = 2$	Ottawa Hospital – Civic Campus (ORCC)	$n = 4$

This resulted in a sample of twelve participants.

All women who consented to participation completed a one-time interview. Table 3 summarises participant demographics. Participants were primarily white and ranged in age from 35 to 70 years with a mean of 49.11 (12.37). Three women identified as lesbian and nine as heterosexual. All but one of the women were mothers and eight women reported being partnered at the time of the study. All women had some university-level education and incomes above \$50,000. Women who worked in hospital settings were more likely to have a higher income and graduate degree. Three women were Francophone, one woman was Jewish and three women were Catholic.

Table 3

Participant Demographics

Name/ Pseudonym	Age	Race	Income	Highest Degree	Sexual Orientation	Relationship Status
Kathy	37	Black	n.r.	n.r.	Heterosexual	Partnered
Erin	35	White	50,001- 75,000	Bachelors	Heterosexual	Single
Wendy	51	White	Over 100,000	Bachelors	Lesbian	Partnered
Susan	n.r.	White	n.r.	n.r.	n.r.	n.r.
Jody	59	White	50,001- 75,000	Graduate	Lesbian	Partnered
Sheila	51	White	75,001- 100,000	Graduate	Heterosexual	Single
Deb	n.r.	White	n.r.	Graduate	Lesbian	Partnered
Mary	70	White	75,001- 100,00	Graduate	Heterosexual	Partnered
Carol	36	White	Over 100,000	Graduate	Heterosexual	Partnered
Mandy	n.r.	White	n.r.	n.r.	Heterosexual	Partnered
Halina	53	*	50,001- 75,000	Graduate	Heterosexual	Partnered
Pauline	50	White	50,001- 75,000	Graduate	Heterosexual	Partnered

Note. n.r. = no response; * = self-identified as Polish/Brazilian.

Sample size and rationale. Sample-size guidelines are not as explicitly defined in qualitative methods and vary with the analytical approach. Case studies focus on at least a single person, event or organisation, and in DA sample size is based on the rationale (Wood & Kroger, 2000). Potter and Wetherel (1987) noted that as the primary focus of DA is on the way language is used, rich data is often available with a small number of interviews. Parker (1992) has stated that a rigorous DA can be conducted with a *single* source of text. I found the amount of data I had initially collected and the number of comparisons overwhelming and selected twelve interviews for the final analysis, focusing my analysis on the data on contemporary understandings and practices ($n = 7$). The five early days interviews provided historical context that facilitated interpretation.

Sources of Data

The primary data was derived from face-to-face semi-structured interviews. I also located and utilised archival and other textual documents, as well as field notes and observations.

Semi-structured interviews. I conducted one-time, iterative, semi-structured face-to-face oral history interviews from fall 2011 to spring 2012. Interviews were arranged via e-mail or telephone and took place in a quiet location of the participant's choosing. This was typically her private home or workplace. After reading and signing an informed consent form (see Appendix D for consent and debriefing forms), participants completed a brief demographics questionnaire. Participants with limited time requested that the questionnaire be

e-mailed to them, with some choosing not to or forgetting to complete it. Women in a current leadership role were asked to provide some basic information regarding characteristics of their site (see Appendix E for all research materials).

I conducted the interviews and occasionally a volunteer research assistant attended to shadow. The interviews used for analysis ranged from 1 hr 5 min to 1 hr 49 min, with a mean time of 1 hr 20 min and a median time of 1 hr 20 min. In general, the interviews involved a discussion of how participants' defined SV, how they became involved with the site/rape work, the supports offered by their site, how the site changed during the tenure of their involvement and any relationship their site had to other supports for survivors. I closed the interview by asking participants where they would like to see anti-violence work move forward and if there was anything else they would like to speak about. A copy of the original interview protocol is located in Appendix F.

Interview questions. The interviews quickly changed, particularly as I learned more about a site through previous interviews and my historical research. Questions that were originally of interest to me (e.g., the topic of professionalisation) were not clear to participants, although some indirectly discussed the concept. Therefore, I omitted these questions and followed the individual participant with an aim to incorporate the topics that were of interest to my research. I began the interview by describing the goals of the project and followed her lead with what information she felt was important. I used questions from the original protocol as prompts when necessary. Using the feminist

interviewing technique of positioning the interviewee as expert (Hesse-Biber, 2006), I found participants freely addressed the topics I was interested in.

Interview transcription. All interviews were recorded and transcribed verbatim by an undergraduate volunteer or myself.¹⁰ Each transcript was edited two or three times to ensure accuracy and address inaudible sections. Transcripts were notated with symbols for non-verbal instances (i.e., a pause) and verbal utterances (i.e., a laugh, stutter or change in choice of words). I attempted to strike a balance with the level of notation and “readability” by limiting the number of notations used. The level of notation included in a transcript decreased as I developed a better understanding of what was significant to my analysis (Hunston & Oakey, 2010). As the particulars of talk is of great relevance for DA, I listened and re-listened to the audio recordings of the interviews to understand the talk in a manner that could not be captured by transcription.

The complete transcript was e-mailed to participants who indicated a desire to review it. This step was taken to verify the accuracy and representation of their account. Participants had the opportunity to elaborate upon, alter or omit any of their dialogue. Two participants offered minimal edits to their transcripts, generally pertaining to the spelling of names.

Archival documents. I contacted archivists and reviewed the fonds of the Canadian Women’s Movement Archive, WCH Archive, City of Toronto Archive, City of Ottawa Archive and Province of Ontario Archive. An archive for

¹⁰ Data did not leave the lab, and research assistants signed confidentiality agreements.

the Ottawa Hospital could not be located, although I was able to locate relevant documentation of the Ottawa SATC through the Sexual Assault Network. I reviewed the violence against women's finding aid of the Canadian Woman's Movement Archive and consulted any documents on the topic of SV from Toronto- or Ottawa-based organisations, as well as relevant documents from provincial and national organisations/conferences. I also reviewed the finding aid for the SATC of WCH at the WCH archive and consulted all available documents.

Organisational documents. I reviewed any relevant centre documents that existed at the time of the study (i.e., pamphlets, mandates, website content). In addition, I visited two community organisations (i.e., Sexual Assault Network and the Ottawa Coalition to End Violence Against Women) to review historical documents related to Ottawa's SATC that had not been officially archived. I consulted one document at the Ottawa Coalition to End Violence Against Women and a number of documents related to the development of Ottawa's SATC from the Sexual Assault Network. See Appendix G for a summary of archival and organisational documents. Archival and organisational documents are cited in both my literature review and results where I interpret discursive similarities and differences.

Field notes and observations. Following an interview, I recorded notes about my observations, thoughts and general experience. When a research assistant attended the interview, she also recorded detailed notes about her experience and impressions. These notes were essential for later interpretation

and analysis of the interview transcripts as they provide context and helped trigger memories. For a copy of the note-taking form, see Appendix E.

Data Analysis

I have infused several forms of analysis to conduct what I will refer to as a historically informed, gender-based DA. I analysed language because I was interested in the relationship between talk, understandings and practices. I have primarily been guided by a DA that is enmeshed with a historical land-gendered lens.

Historically Informed analysis. For my historical analysis, I have conducted an extensive search of the literature, consulted multiple archives and collected interview data. My literature search included academic databases, published and unpublished Canadian theses, reviewing the citations of relevant literature, reports and guidelines of professional bodies. My interviews included an oral history focus, particularly when I spoke to early day women. Because I have focused this thesis on understanding contemporary understandings and practices, interviews with early day members are not extensively quoted. However, I have incorporated the readings of these interviews into my analysis and cited interviews where appropriate.

I immersed myself in the historical data through reading and writing. I have included historical information in my Results rather than my Method section because they are interpretations rather than historical facts. Given the shortcomings of individual memory, the small number of interviews and the inadequacies of documentation, my historical interpretation is only partial and

does not preclude alternate explanations or versions of events. Nevertheless, the historical data I have collected helps contextualise my DA and I believe meets Parker's (1992) criteria of historically locating a discourse.

Gender-based analysis. A gender-based analysis (also referred to as a sex- and gender-based analysis) is an analytical tool described by Health Canada (2000) as emphasising diversity, equity and the intersecting social determinants of health. A gender-based analysis can be used as a tool for practice, policy, research and program development. Recently, the Ontario Women's Health Framework (2011) demonstrated how a gender-based analysis could enhance women's health by enhancing an appreciation of women's need for safety, respect and empowerment within healthcare systems. In regards to research, a gender-based analysis identifies how different groups of women have differential experiences of health due to biological and socio-cultural factors. Although a gendered analysis can highlight the inequitable experiences of individuals from any gender, I have focused my analysis on understanding the needs and experiences of women who are survivors of sexual violence and how multiple, intersecting factors construct their experience of health care and social services.

Discourse analysis. I primarily drew upon a discourse analysis (DA) of data. DA is not necessarily a method, but an approach and a perspective (Fairclough, 2001; Parker, 1992; Wood & Kroger, 2000). Wood and Kroger (2000) described DA as, "A perspective on the nature of language and its relationship to central issues in the social sciences" (p. 15).

I used two approaches to conduct my DA, one outlined by Parker (1992) and the other by Wood and Kroger (2000). Parker (1992) describes seven criteria for identifying and developing an analysis of a discourse that guided my analysis. These criteria involved several “steps” comprising a reflexive practice of critical reading. However, Parker cautioned against using these criteria as “steps.” Instead, Parker argued that his criteria should be used as an “approach” in no defined order where some readings may be of relevance to some research projects and not to others. In general, I continually read and re-read the text asking, “What was said? Why wasn’t this said? And what are the connotations of what was said?” (Parker, 2004, p. 252).

Conceptually, the researcher goes through the text at least seven times, each time with a different analytical focus. Each subsequent reading adds an additional layer of meaning. My early readings attempted to construct a thematic understanding of what united my sites, the diverse organisational characteristics and the history of RCCs and SATCs in Ontario. Following these initial readings, I proceeded with a focus on discourse. Parker’s criteria for constructing a discourse are summarised in Table 4.

Parker (1992) cautions that post-structuralism and social constructionism approaches can obscure the “real” that is embedded within discourse. This word of caution reflects a larger debate within the ethics of feminist oral history research (Sangster, 1994). For instance, as the construction and deconstruction of discourses become increasingly abstract, it is important to ground analysis in the fact that SV is a “real” lived phenomenon. Although a social constructionist

Table 4

Parker's (1992) Criteria for Discourse Analysis

Criteria	Focus of Reading	Analytical Questions
1. Realising a discourse	Identifying pieces of the larger discourse.	<ol style="list-style-type: none"> 1. Where are pieces of the object I'm studying? 2. What terms are used? 3. What are the connotations?
2. Objects of a discourse	Objectifying the text and treating it as if it were an object.	<ol style="list-style-type: none"> 1. What is the commonplace knowledge the text refers to? 2. What objects are located in the text? 3. How are they described? 4. How is my analysis a discourse?
3. Subjects of a discourse	Who is implicated in the text and what roles are ascribed to them.	<ol style="list-style-type: none"> 1. Who is present in the text? 2. Who is absent? 3. What is the reader's assumed stance? 4. What roles are assigned?
4. Coherence and meanings	The single-meaning system was employed so that meaning appears stable.	<ol style="list-style-type: none"> 1. What are the cultural understandings? 2. How would other perspectives read this? 3. How would the worldview of the discourse navigate criticisms?
5. Other discourses	Understanding how multiple discourses interact and are present.	<ol style="list-style-type: none"> 1. What metaphors and analogies are used? 2. What are the contradictions? 3. How would two discourses talk differently about the "same?"

6. Discourse reflecting itself	Understanding how the speaker navigates moments of incoherence.	<ol style="list-style-type: none"> 1. Where is an instance of contradiction and incoherence? 2. How does the speaker understand this "dilemma?" 3. Is this "dilemma" present in other texts? 4. What are the politics of the dilemma?
7. Historical location	Understanding how meanings change over time and space.	<ol style="list-style-type: none"> 1. What are historical understandings? 2. What are they today? 3. What has changed? 4. What has stayed the same?
8. Institutions	Identifying how institutions are maintained or subverted.	<ol style="list-style-type: none"> 1. What institutions are identified in the discourse? 2. What institutions are reinforced? 3. What institutions are attacked?
9. Power relations	Power relations among subjects identified.	<ol style="list-style-type: none"> 1. What groups gain? 2. What groups lose? 3. Who promotes this discourse? 4. Who demotes it?
10. Oppression	How oppression subjugates minority discourses.	<ol style="list-style-type: none"> 1. How do multiple discourses interact to construct oppression? 2. How does the dominant group talk about their history and present? 3. How are minority discourses discredited and buried?

framework informs me, I aim to be grounded by and honour the experiences of my participants and survivors. To achieve this, the analysis was conducted with careful consideration of the context and social patterns rather than individual narratives.

Parker's (1992) steps for tackling text were used in combination with Wood and Kroger's (2000) fifteen "analytical processes" (p. 91) for identifying assumptions and interpreting text. These analytic processes are reproduced in Table 5 and provide accessible suggestions to guide the researcher through the reading of a text. Analysis was conducted by constructing tables in Microsoft Word and note taking while re-reading and reflecting upon the data.

Quality and Evaluation

Qualitative research is a creative cyclical process of moving between the refinement of methods and theory generation. Rather than resolving competing ideas to arrive at *the* truth, social constructionist methods acknowledge and embrace multiplicity and seek to develop an account that includes "contradictory subjectivity" (Holloway, 1989, p. 572). Given the extensive differences between qualitative and quantitative methods, positivistic standards of quality (e.g., reliability) are not considered appropriate or useful in the evaluation of qualitative research (Tindall, 1994). Tindall regards validity as integral to qualitative research, as it demonstrates the extent to which a researcher adequately understands the subjective meanings of their participants. One measure of validity is the extent to which the researcher's own subjectivity is acknowledged. I have engaged in reflexivity through the process and have attempted to make

Table 5

Analytical Processes for Identifying Assumptions

Discursive Analytical Processes

-
- Pay attention to your emotional reactions to the text.
 - Do not ignore the obvious in the search for deeper meaning.
 - A focus on literal meaning is useful.
 - Consider what is *not* there in both content and form.
 - Consider whether the presence of something is critical.
 - Play with the text by re-reading and omitting or re-phrasing text.
 - Notice how the text is structured in terms of content and function.
 - Be open to a single discourse having multiple functions.
 - Occasionally pretend to forget that you are doing a DA and think about how you would then approach the text.
 - Be open to developing a new vocabulary to describe your understandings and processes.
 - Examine how participants construct categories.
 - Creatively focus on variation in the text and draw comparisons through dichotomies.
 - Pay attention to grammar.
 - Understand your own subjective position.
 - Allow yourself to interpret the text.
-

Note: This table summarises suggestions by Wood and Kroger (2000, p. 91).

my own subjectivities clear by describing how the research questions were developed and shifted. I have also briefly discussed my own history and politics in regards to rape work. These factors allow you as a reader to understand and consider how my subjectivities have informed my research.

Triangulation is an important concept that can be used to evaluate my research. As Tindall (1994) described, "Triangulation allows illumination for

multiple standpoints, reflecting a commitment to thoroughness, flexibility and differences of experience" (p. 145). As the use of any singular perspective or method is limited, I have aimed to include a combination of data and theories to facilitate a richer and more valid interpretation of my data. In regard to data triangulation, I have collected data from participants involved in different activities and at different times within a single site. I have also collected data from different comparable sites. In regard to investigator triangulation, I have had regular meetings with my volunteer research assistants where I described my process and thoughts and received their feedback. Additionally, I have invited colleagues to comment on and challenge my work. In regard to theoretical triangulation, I have utilised social constructionism, feminist theory, along with Foucault and discursive theory. My theoretical pluralism allowed my analysis to be informed by psychological, feminist, linguistic, sociological and organisational literature. Lastly, I have addressed Tindall's recommendation for levels of triangulation by interpreting data in regard to historical, individual, organisational and societal contexts.

Antaki, Billig, Edwards and Potter's (2003) description of six analytical shortcomings of DA are useful because they provide social psychologists with a lens to evaluate the quality of DA. The six shortcomings are as follows:

- Under-analysis through summary (i.e., presenting a summary of their data without illustrative quotations and without any interpretation, explanation or evidence of analysis).

- Under-analysis through taking sides (i.e., a presentation of the data where the only description beyond the text is the author's political, moral or personal stance).
- Under-analysis through over-quotation of through isolated quotation (i.e., the presentation of the raw data organised according to themes, without a commentary that extensively goes beyond the data).
- The circular identification of discourses and mental constructs (i.e., allowing the data to speak for itself and suggesting the presence of a discourse without substantial evidence for the claim beyond explaining the text with the text itself).
- False survey (i.e., the generalisation of findings to the world at large).
- Analysis that consists in spotting features (i.e., focus on particular details [e.g., specific notation] of the text without consideration of the larger context of the data).

I feel that I have avoided these analytic shortcomings and have met standards of quality used to evaluate qualitative psychological research; that is, I feel that my research has satisfied the relevant tenets of trustworthiness (i.e., credibility, dependability). Through triangulation, frequent discussions with colleagues and my thesis supervisor, "thick descriptions" of my data (Morrow, 2005) and the congruency of my findings within the published literature, I believe that my research is credible. With DA, transferability is not a criterion for trustworthiness, as such attempts would be considered a "false survey" (as

described above). Rather than being transferable, the aim of a DA is to generate theory and future research rather than transferable findings.

Given my transparency and descriptions of my research process, I believe I have positioned this thesis as dependable. Through reflexivity and the presentation of the data, I feel that my interpretation of the data meets the criteria for confirmability from a DA perspective and that my findings were not the result of an “anything goes” approach to analysis.

Results

This study was designed to explore how Rape Crisis Centres (RCCs) and Sexual Assault Treatment Centres (SATCs) understand sexual violence (SV) and the relationship of their understandings to the support they offer survivors. I found that each of the RCCs and SATCs represented a unique “community of practice.”¹¹ I came to appreciate that my initial intention to contrast community-based RCCs and hospital-based SATCs represented simplistic thinking that was accompanied by various binary assumptions (i.e., paraprofessional/professional, social change/social service, feminist/medical, collective/hierarchical). These erroneous assumptions rendered invisible the variations within RCCs and SATCs. Thus, rather than comparing RCCs to SATCs, I considered each site a unique case.

The results are organised into two sections that reflect my research questions. In the first section, I explore how sites understood SV, and in the

¹¹ A community of practice is, “an aggregate of people who come together around mutual engagement in an endeavour. Ways of doing things, ways of talking, beliefs, values, power relations — in short, practice — emerge in the course of this mutual endeavour” (Eckert & McConell-Ginet, 1992, p. 464).

second section I examine how sites framed supporting survivors. I conclude each of these sections with a cross-case interpretation of the similarities and differences.

Section One: Cross-Case Comparisons of Understandings of Sexual Violence

Participants drew primarily upon feminist, legal and mainstream discourses to understand SV. A feminist discourse united the Ottawa Rape Crisis Centre (ORCC), the Sexual Assault Support Centre (SASC) and Women's College Hospital (WCH). These sites will be contrasted to the Ottawa Hospital – Civic Campus (OHCC), which was the only site that solely drew upon mainstream and legal discourses. In general, a feminist discourse regarded SV as stemming from systemic gender inequalities. Legal discourse exemplified the *Criminal Code* definition of sexual assault, and mainstream discourse endorsed rape myths and cultural silences.

Feminist discourse and feminist sites. Members of ORCC, SASC and WCH drew upon a feminist discourse of SV. This discourse regarded SV as (a) gendered, (b) a form power and control, and (c) systemic. In addition, survivors' reactions to SV were framed as normal reactions and/or ways of coping.

Sexual violence as gendered. Using gendered terminology to refer to survivors (e.g., she, her, women, woman) the ORCC, SASC and WCH positioned SV as a gendered issue. As such, women are disproportionately the survivors and men disproportionately the perpetrators of SV. For example, Kathy, a current leader of ORCC, said:

One out of every three women gets sexually assaulted...I think ninety-seven percent of victims and survivors are women and ninety, maybe a hundred percent are, well, that's not quite [right]. Maybe ninety-nine percent of the perpetrators are men.

Similarly, Susan, a current SASC collective member, explained:

SASC recognises that people of either sex can be abused by perpetrators of either sex. However we work from the perspective that the majority of abusers of violence are male and the majority of survivors are women.

Sheila, leader of WCH, used comparable language:

I think it's important for us doing the work that we understand the context of violence in women's lives. That we come at it with the understanding that it [sexual violence] is a gendered-based crime.

Like Sheila of WCH, Susan of SASC regarded a gendered understanding as critical to "doing the work." Discussing the de-gendered perspective of an organisation she previously worked for, Susan commented:

Until we start looking at that [the gender of the victim and perpetrator], we're never gonna eradicate it [violence]. 'Cause we're not looking at preventing it. We're looking at managing it...instead of looking at the root causes. For the SASC collective, doing rape work was inseparable from working to eradicate VAW and oppression more broadly.

Unlike the feminist sites, the OHCC strove to be gender-neutral in their approach to rape work. Carol, a current leader of OHCC, commented:

We wanted to make it [the program] just more of a person-, patient-centred thing. Which is more of a philosophy of the hospital...And so we're on that side of things more than being particularly woman-based. That being said the majority of our clients are women — both of partner [abuse] and sexual assault. And we do have links with a lot of

the women's groups and things like that, so we do take um women's philosophies and women's rights into the whole process of it. But we are more medically based and gender-neutral by choice.

Adopting a gender-neutral approach was described as increasing (primarily gay) men's accessibility to their services and as being consistent with the institutional philosophy. It was unclear how the OHCC integrated "women's philosophies and women's rights" into their philosophy and practice beyond providing survivors with occasional referrals to local women's organisations.

While a gendered perspective was critical to feminist site's understandings of SV, the meaning of gender was not singularly defined. The RCCs (i.e., ORCC and SASC) drew upon an anti-oppressive, anti-racist feminist understanding that women's lives are not simply gendered. This is illustrated by SASC's (2011) website definition of SV:

It is impossible to isolate VAW from other oppressions, because women do not exist separate from other identities, such as those based on race, class, sexual preference, ability, etc. Therefore, a commitment to ending VAW also involves a commitment to end all other forms of oppression.

Understanding violence from an anti-oppressive framework recognised that survivors' experiences of SV intersected with other privileges and oppressions that accompany various markers of identity.

Sexual violence as male power and control. ORCC, SASC and WCH understood SV as a socialised expression of power and control that was rooted in male privilege and dominance. Mainstream discourses were critiqued as victim blaming by misconstruing SV as a random act resulting from women's provocation:

People really don't understand that SV is about power and control. People think it's about the woman doing things and provoking. That it's provocation. (Kathy, ORCC)

[People say] that men need to be "educated" because they don't know what they are doing, so we have to tell them. We have to tell them they are doing bad stuff and then they'll stop. Really?! Really? I think you have to be a fucking idiot to not know that VAW is an issue and if you haven't figured out that what you are doing is violence then you are just an asshole. Education is not going to help that...Like it is easier for us to think it [SV] is a misunderstanding or a loss of control and that they [men] need to be educated than to actually have an analysis of how it is deliberate and systemic. (Deb, WCH)

Understanding SV as rooted in male power and control recognised the historical, economic, social and cultural subordination of women. As a result, women's equality was regarded as a means to prevent SV. Speaking to the structural devaluation of women, participants from each site¹² believed that how SV is understood and responded to by society would look different if men were disproportionately the survivors.

Sexual violence as systemic. Gender inequity was regarded as systemically embedded in social organisations and relations. As a systemic issue, SV was interconnected to other aspects of women's inequality (e.g., poverty) that created, perpetuated and maintained violence. Thus, SV did not simply involve the power of individual men over women, but oppressive power systems:

¹² For OHCC, the participants who expressed this perspective were early members.

We recognise, it's not just the individual male power but also the system and the barriers that condone violence in the system. And [we recognise that because of systemic issues] why it's so difficult for people to come forward and you know, have it [SV] acknowledged for what it is.. (Sheila, WCH)

I have women who say that they were absolutely devastated and that we made a huge difference. Now they will get a huge difference if they go to us, but they still have to deal with first responders — who make a huge difference in what they say and what they do. We are here because emergency departments treat people like crap. And if they didn't then we wouldn't be here. [For example,] they say [to survivors], "oh why would you do that" and "what were you thinking?" (Deb, WCH)

As a society we are looking at managing violence in women's lives. We aren't looking at the root causes. That if women did not live in poverty or were not treated unequally we would not experience the same things. We are not acknowledging the violence that is in all of our lives, the wars we are waging and the entertainment that perpetuates a very violent society. (Susan, SASC)

In the above quote, Sheila of WCH recognised systemic violence as preventing survivors from accessing services due to structural barriers. Deb of WCH recognised that systemic violence is the reason SATCs exist, as they help minimise the violence survivor's experience within the health care system. Susan of SASC extended the concept of systemic violence by describing violence as invisibly embedded within all of our lives.

Sheila of WCH further illustrated systemic violence by describing the legal system as a "male-dominant, military-type structure" that can re-victimise

survivors. The ORCC, SASC and WCH all had regular interactions with the legal system and recognised that, given its de-contextualised understanding of SV, survivors can be re-victimised by the legal system, which generally fails to meet their needs:

We had one police officer come to volunteer training that said that only one in nine women reporting rape are credible. Credible was the word he used. I will never forget that, you know. And now they are very open about the fact that they don't pursue most cases...it is just how the justice system is set up. (Erin, ORCC)

Echoing Sheila and Deb's comments above, participants from all sites¹³ recognised that the traditional medical model could also perpetuate systemic violence:

We talk about traditional approaches, like the medical model, as just bad. The professional is the expert on what the client would need to do to get better. It is very prescriptive. It is not collaborative. (Erin, OCC)

Discussing the intersections of the legal and medical system, Deb of WCH believed that rape kits caused more harm than benefit and that they should be discontinued:

What is important in nursing and medicine is "evidence-based practice." And if you think about the sexual assault evidence kit and how it is actually used, if we actually had evidence-based practice, we wouldn't use it. I mean if less than 1% are convicted and it's only used in stranger cases. And of course, [according to the defense] we all want it rough. I mean kits don't make a difference in conviction rates.

¹³ Includes the current staff of the OHCC that was peripherally involved.

Furthermore, Deb noted that twenty self-defence courses could be funded by the cost of one kit.

Normalising survivors' reactions. Participants from ORCC, SASC and WCH stressed regarding survivors reactions to sexual violence as normal.

According to the participants, one example of how healthcare professionals can perpetuate systemic violence is by pathologising women's reactions:

There are those women [we work with] who are actually seeing a psychologist or psychiatrist. Because that language is what they're using and when they come to us. We're always deconstructing that language and making it normal. Normalising what reactions they're having and demonstrating... "you're not alone." So many other women are having the same reaction that you are and we don't need to put a label on your experience. (Kathy, ORCC)

There is a big trend right now in mental health. They're seeing women's ways of coping with SV as mental health issues. They don't want to stigmatise women but they are still seeing it as a disorder, as something that is wrong. A pathology of some kind. And that is extremely worrisome. They're trying to fit all these symptoms into the medical model. They are not medical, they are coping mechanisms...And that is why we listen to survivors and have a space for them to talk. Which is really unusual these days. Even psychiatrists don't talk, they just prescribe. (Susan, SASC)

We spend a lot of time and energy educating internally and to the police...to try to get them and understand why she is responding the way she is. Why not crying is normal...I know that when I see them [survivors] that it has taken them back to whatever happened before...I need to let them know that they're not crazy. (Sheila, WCH)

Feminist sites emphasised the importance of normalising women's reactions. For example, several participants framed the use of drugs and/or alcohol as methods of coping rather than disordered behaviours.

Legal discourse and the non-feminist site. Legal discourse defined SV according to the *Criminal Code* definition and regarded SV as a crime. While all cases agreed that SV included a spectrum of unwanted actions (as defined by the *Criminal Code*), only the OHCC failed to describe SV extensively beyond this definition. Specifically, on the OHCC website, sexual assault is described as "Any unwanted, non-consensual or forced sexual activity." During our interview, Carol of the OHCC echoed the legal definition by stating, "Sexual assault for us is defined as any unwanted sexual contact so um- that can include kissing, touching, all the way up to what you see in the movies." Carol's definition was concise in that it was straightforward and closely mirrored the official program definition. As a leader of a program embedded within a large institution, it is likely important that understandings expressed in her interview are in line with the philosophies and understandings of the hospital she works in.

From the perspective of Carol, the SATC and hospital-based rape work were regarded as important because her team took responsibility for working with legal systems, an intersection of medicine and law where other health practitioners feel uncomfortable:

Everybody [hospital staff] fears going to court. They would rather have us deal with it [violence] because we have the expertise and can weed it out of their hands. So whether it is sexual or whatever else they can put it in our hands. We know the safety implications, the resources and contacts,

the forensic stuff...our little group of people know and do it enough so that they feel comfortable and competent. "What can you say to police?" "What can't you say to police?" And what if you get a subpoena or a warrant or whatever. There's always those small details that people are not sure about and are really worried about. (Carol, OHCC)

Participants from all sites agreed that SV was a crime and that perpetrators should be held legally accountable. However, they did not uniformly agree that SV should always be prosecuted. Feminist sites believed that given the shortcomings of our legal system, survivors should make informed decisions as to whether or not she wanted to report SV. From a feminist perspective, the legal system was seen as having the potential to re-victimise survivors. Thus, feminist sites were supportive of survivors who chose not to report the SV, despite their belief that SV is a crime:

When women say, "I just don't know if I can come forward and report it." and that's like, "I understand." "It's okay." Right? You have to do what's best for you. Sometimes the police will come in and say, "You know, you have a judicial obligation to others." And it's like no, no, no, no [she doesn't]...I think how we understand violence [includes understanding] what prevents women from coming forward and the realities of our legal system...I think there is also the understanding that for our clients, whatever the decision she made at the time, whatever decision she made after, is the best decision for her. (Sheila, WCH)

As women are often sexually assaulted by men known to them, including men they love, participants at RCCs commented that it may not make sense for women to report SV, especially in racialised communities where men are disproportionately criminalised and reporting may reinforce negative stereotypes.

Mainstream discourse and the non-feminist site. A mainstream discourse constructed SV through absences, silences or indirect references that could be argued to reflect rape myths. In regard to silences, on two occasions, Carol described sexual assault indirectly using references to “the movies” (recall Carol’s definition of sexual assault above). The indirect descriptions and absences within Carol’s discussion of SV are worthy of further exploration as they reflect cultural silences and obscure SV by framing it as abject and incomprehensible. For instance, “What you see in the movies” was an unnamed imaginary that was contrasted with kissing and touching, which are perhaps more acceptable or innocent violations. In the second instance Carol described:

When I was first getting involved in this work in the early 2000s, rape was what you saw in movies — in horrible movies with awful events where your clothes were ripped off and now there’s all kind of stuff. So now there is a more subtle definition and people are trying to understand that as well.

In this example, she illustrated rape through the insertion of expressive words. These expressive words (i.e., “horrible,” “awful”) indicate the presence of a mainstream discourse by perpetuating the myth of the “real rape”; that is, rape as physically violent and forceful. This example frames rape as violent through the indirect movie reference, suggesting that SV is that which is too horrible to name. Physical violence is more clearly described by the description of ripped clothes. She contrasted this violent image with “Now there’s all kind of stuff,” suggesting a spectrum of SV and that rape is not necessarily physically violent. However, stating “Now there’s all kind of *stuff*” does not provide a clear description of SV. “Stuff” can be left up to the imagination and may not be as “horrible.” Although

she uses global language, Carol may be speaking to how her own understandings of violence changed as a result of working with survivors. These indirect descriptions of SV may also reflect physicians' discomfort working with survivors.

By critiquing mainstream discourse for framing SV as abject, I am not suggesting that feminist sites did not regard SV in negative terms. However, limiting the discussion to indirect descriptions and emotionally laden terminology limits understandings of SV. When SV is framed as a horribly violent act, it reflects the myth that SV is a sick and disturbed act committed by sick and disturbed people. Such rape myths perpetuate silence by obscuring the realities of rape and evoking discomfort so that individuals avoid confronting and/or acknowledging SV. It also perpetuates the myth of the "real rape."

Kathy of ORCC had a cognitive explanation for why SV is "so misunderstood" by dominant society. She suggested that people do not want to understand the prevalence or realities of SV because it is difficult to hold and bear witness to. As she put it, SV becomes silenced because it is "Too hard to talk about" and "People don't want to deal with it." This understanding reinforced ORCC's dedication to public education and breaking the silence.

Interpreting cross-case similarities and differences. The development of knowledge of SV has not been a linear, stable process for sites in my research. Factors that affected understandings of SV were numerous and exerted influence from multiple directions (i.e., bottom-up, top-down, internal, external). Not surprisingly, shared meanings facilitated collaboration within and

between sites, whereas divergent meanings and practices facilitated discord (this will be illustrated by a historical discussion of ORCC and SASC in Section Two).

Similarities and intertextuality. Understanding why some sites shared a feminist discourse is significant because it can illustrate a shared history and is referred to as intertextuality. Intertextuality is a concept that can help us understand how meanings are constructed and sustained over time (Fairclough, 2001). Fairclough describes shared discourses as providing an interpretive context where participants have interpreted the same or similar texts.

Specifically:

The concept of intertextual context requires us to view the texts from a historical perspective, in contrast with the more usual position, which would regard a text as analysable without reference to other texts, in abstraction from its historical context. (Fairclough, 2001, p.129)

Consistent with this, participants and sites from ORCC, SASC and WCH, that drew upon a feminist discourse, shared experiences and background knowledge.

Although there were differences in what feminism meant to participants affiliated with ORCC, SASC and WCH, they drew upon common factors in understanding SV. Contrary to the dominant narrative of the anti-violence movement and rape work arising from consciousness-raising groups,¹⁴ there were other important factors in developing an understanding and practice of SV that were elicited by my interviews. Participants drew from bottom-up (e.g., personal experiences of violence) and top-down (e.g., medical and psychological praxis) influences. The most salient influence in developing an understanding of

¹⁴ It is important to recognise that women who participated in consciousness-raising groups did not come to these groups as blank slates.

SV was “doing the work” and *listening* to survivors. Other factors that informed shared understandings included: (a) American research and writing (e.g., rape trauma syndrome [Burgess & Holmstrom, 1974], *Against our will: Men, women and rape* [Brownmiller, 1975], *Women and madness* [Chesler, 1975]), (b) the Vancouver anti-violence movement, (c) local feminist women (e.g., Halina Siedlinowski, Deb Parent, Joan Gullen, Lee Lakeman, Deborah Sinclair), (d) shared educational resources (e.g., pamphlets, booklets) and (e) critiques of traditional practices and understandings. Additionally, there were shared workers between sites. Specifically, several nurses had volunteer experience in RCCs and former ORCC volunteers established SASC due to ideological differences.

Differences that may explain the non-feminist site. The clearest difference between sites was that a feminist understanding of SV was absent within the OHCC. Why the OHCC drew upon legal and mainstream discourse, rather than feminist discourse, can partially be explained by considering the site’s history.

The OHCC’s current understanding of SV is distinct from the meanings and intentions that informed the SATC’s development. Founded in 1994, the SAPACP¹⁵ was created by the Sexual Assault Network in partnership with the Riverside Hospital and the Children’s Hospital of Eastern Ontario (Gullen, n.d.; Sexual Assault Network, 1993; LeBlanc & Siedlikowski, 1997). The Sexual Assault Network was (and is) an anti-violence community network guided by

¹⁵ Originally entitled the Regional Sexual Assault Treatment Program.

feminist principles. From 1994 to 2005, Ottawa's SATC operated according to a feminist framework and was a joint community-hospital program. The founding framework of Ottawa's SATC acknowledged women's historical disempowerment and worked from a woman-centred, feminist-based approach (see Ottawa-Carleton Sexual Assault Protocol, 1999, for a description of the survivor-centred framework).

Several factors contributed to changes in the program and the erasure of its original feminist understanding of SV. First, its funding status changed with shifts in provincial government, and by 2005 SATC funding was no longer considered a priority.¹⁶ As a result, the hospital had greater control over the program's budget. This led to the hospital gaining control over the program budget and thus its services were restructured:

Overall, I think that the institutionalisation of these programs has been a great thing for women. I think it's been great to have that. I think it's unfortunate that the funding has stopped being protected, because any time you provide services for a small population, the actual amount of money per person is greater because the population is small. And so, you know, the government are viewing these programs as not cost-effective or something like that. That's always been the battle with these programs.

(Halina, interview, November, 2011)

Additionally, the Ministry of Health and Long-Term Care no longer mandated SATCs to have community advisory councils (Halina, interview, November, 2011). As a result, Ottawa's SATC's community advisory council disbanded in

¹⁶ As priority funding, SATC budgets were provided by the Ministry of Health and Long-Term Care and could not be decreased or reorganised by hospital administrations.

2005, decreasing the level of community involvement and ownership. As Halina explained:

It wasn't necessarily to the hospital's advantage to have a community advisory committee. So they weren't necessarily promoting the committee structure.

From an institutional perspective, community involvement may have been viewed as slowing down administrative processes and challenging institutional norms.

While the Ottawa anti-violence community originally had equal ownership of the program at the time of my study, community members were concerned that they "Did not know what is going on" and, therefore, were unable to support the OHCC. Many of the individuals I interviewed from Ottawa expressed concern that without a community connection the OHCC was no longer able to meet the community's needs. Many individuals were concerned that a feminist understanding of SV may have been lost and that the power dynamics embedded within the medical model could re-victimise survivors.

Another factor that transformed Ottawa's SATC was a merger of Ottawa hospitals. In 1999, the SATC moved from the Riverside Hospital to the OHCC (Halina, interview, November, 2011). The Riverside Hospital was a community-based hospital and a local leader in women's health care, whereas the OHCC was a general hospital. Speaking to the impact of the merger, Halina stated:

The transfer of the program from the community hospital to a large hospital had an impact. I believe it had a negative impact because when we were in the small hospital, if you needed anything, I knew everyone who could make an immediate change. But once you go into a hospital that has layers and layers of administration and departments, and

sometimes the department you're looking for is not on your campus but on another campus, you stop being able to be responsible to your population. Perhaps most damaging to the community-hospital relationship, and thus a collaborative relations and shared understanding of SV, was an incident that occurred in July of 2010. The Ottawa police took a young woman to the OHCC on a Sunday morning after she had possibly been drugged and gang raped (*Ottawa Sun*, July 5, 2010). There were no nurses available to conduct a rape kit and the woman was given two options: wait until Monday morning (although if she bathed, changed or used the bathroom she could lose evidence) or she could commute to the Cornwall or Renfrew hospital to receive a rape kit (*Ottawa Sun*, July 5, 2010). The local RCCs and police publicly commented on the unacceptability of the situation and how it violated the city's Sexual Assault Protocol (*Ottawa Sun*, July 5, 2010), of which the Ottawa Hospital was and remains a partner. Several organisational factors may have contributed to this unfortunate situation, including a shortage of nurses, a low on-call nursing wage (i.e., \$3.20/hour), no coordinators staying more than two years following Halina's resignation in 2005, hiring younger nurses¹⁷ and high turnover (with nurses rarely staying beyond six months). Several participants spoke highly of Halina as a feminist leader and commended her for protecting Ottawa's SATC from de-politicised hospital administrations, balancing conflicting demands and cultivating strong community relationships.

¹⁷ One participant expressed that many nurses drawn to SATCs are survivors. She was concerned that a trend of hiring younger women may increase the chance of burnout, as younger nurses may not have engaged in their own healing.

It appears that Ottawa's SATC did not choose its trajectory, but responded to multiple structural factors that compromised the ability of the SATC to actualise and maintain its feminist values. The lack of a stable internal culture may have decreased commitment to the program on an individual level, thereby decreasing program/staff cohesiveness and increasing stress, all of which could have compromised collective understandings of SV. By not having consistent leadership or staff, individuals would likely struggle to learn the work and would cope with the day-to-day stressors of working within a SATC. As a result they may not have the time or energy to reflect upon their work or work to shift and/or maintain ideological underpinnings of the SATC.

In response to the high-profile media incident, many community members commented that OHCC had since “retreated back into its medical model” (participant interview) and now emphasises response times (e.g., Sexual Assault Partner Abuse Care Program Wait Times, 2012) rather than strengthening community relations and the overall care of survivors. Given the loss of the community advisory council, a community partnership and a feminist leader, there was likely no strong internal influence or understandings of how a feminist understanding of SV could beneficially inform a hospital-based program and the care of survivors.

Summary. In Section One, I have described how participants understood SV. I have categorised these understandings according to the discourses they represented (i.e., feminist, legal and/or mainstream). Interpreting the similarities and differences between sites, I highlighted multiple context-dependent factors

that informed site understandings. The OHCC provides an example of the instability of institutional meanings and how meanings can be redefined, erasing previous knowledges that are incongruent with the current dominant meaning system. I will now examine how participants from each site framed supporting survivors, and how these practices were related to the discourse they drew upon.

Section Two: Cross-Case Comparisons of Practices to Support Survivors

The discourse that framed how sites understood SV informed their support of survivors. Generally speaking, feminist understandings challenged power dynamics of traditional practitioner-client support models and emphasised context. In this section, I focus on philosophies of support work and how these philosophies were actualised. Although the RCCs shared a feminist understanding of SV, they varied in their approach, which may reflect distinct feminist standpoints. In regard to the SATCs, while WCH incorporated a feminist understanding into their "emotionally supportive continuum of care," (Sheila, WCH) and OHCC framed their work according to a gender-neutral, patient-centred philosophy. Differences between SATCs may reflect the divergent underlying ideological commitments of the institutions they are embedded within. I do not only aim to highlight how language, understanding and practice are interrelated and construct one another; rather my overarching goal is to consider how the talk that informs support is significant in that it affects survivors.

Philosophies of practice. As described in Section One, ORCC, SASC and WCH understood SV according to a feminist discourse. This understanding translated into their practice by providing values and a rationale for their work. In

contrast, OHCC drew upon a medical philosophy and framed their support as gender-neutral medical care that focused on procedures and processes rather than highlighting the differential care needs relevant to supporting survivors.

Feminist sites and a feminist philosophy of practice. A feminist philosophy framed a survivor as the experts of her own experiences and needs. Thus, it was important for sites to work with survivors from a non-judgmental, non-directive perspective that provided survivors with options. A feminist philosophy of practice was described as providing survivors with: (a) choice, (b) control and (c) empowerment.

Choice. Choices were described as providing survivors with information about their options and respecting/supporting their individual choices regardless of their decision.

For our centre, [working with survivors] is about understanding that for our clients, whatever decision she made at the time or after, whatever that decision is, it is the best decision for her...We just provide information for her to make her own choices. There is a reason for her to do what she does and it is not our job to tell her what she should do or judge. (Sheila, WCH)

For us [at the ORCC] the biggest aspect for providing support [from a feminist framework] is letting women know their options and empowering them to make their own choices. (Erin, ORCC)

Many participants emphasised wanting to provide women with choices, stating that the more choices in services women have, the better.

Survivors were supported to make choices regarding her options both inside (e.g., what services they would like access to) and outside of the site (e.g.,

report to police, visit a hospital). Given their mandate, smaller size and greater flexibility, RCCs were better able to offer choices in healing beyond individual talk therapy (i.e., art, dance, activism, groups) and were able to respond quickly to the women's particular needs. The ORCC stressed their ongoing goal to be culturally competent by providing culturally appropriate choices for women from diverse backgrounds. Aiming to provide women with more choices, each case was reflexive in that they listened to what survivors were asking for and sought to identify survivors who were not using their services (e.g., women with disabilities) and sought to take action to meet the needs of underrepresented communities.

Emphasising the importance of choice situated WCH outside of traditional medical frameworks (e.g., active practitioner/passive patient). Sheila of WCH described this as follows:

In the healthcare system there is this sense that our job is to fix it, to tell people what to do. But we don't do that. Sometimes we run into difficulty with our own system because we sort of work a little against other healthcare professionals with this value of choice.

Although WCH is embedded within a women's hospital that is active in improving the care of survivors, the value of choice conflicted with the dominant institutional discourse. Furthermore, Deb felt that "choice" could be a complicated value in practice. While she recognised the importance of giving survivors choices, she also recognised that women are socialised to make decisions according to relational expectations:

Women make decisions in the context of relationships, "My parents or boyfriend want me to call the police so I call the police." You have to be careful with that, because they are also asking you to tell them what to do.

Deb found supporting survivors required a careful balancing act to inform them of their choices without guiding them, as many survivors want to be told by the “experts” (i.e., nurses) what they should do.

Control. The guiding principle behind choice was giving survivors back their sense of control.

When SV happens control is taken away from the client, the woman.

Then our job was to give her back her control. And that was really critical to how we operated. (Mary, WCH)

By understanding that control was taken away from a survivor in the act of SV, supporting a survivor necessarily involved helping her reinstate her sense of control by providing her with options. The ORCC, SASC and WCH described supporting survivors’ choices unconditionally and accepted that there was no one right decision. For SASC, women’s choices shaped their group support:

Our groups have ... always been a sort of open-ended type groups, where women direct the process. They have control. They decide on the agenda, they decide on the topics, the focus. The facilitators, we’re there to help create safety and help guide discussions, but a perfect groups is when the women do it themselves...We’re not the ones who are helping and supporting. It means more for the women when they hear it [supportive comments] from other women and have a sense of control. (Susan, SASC)

We let our client control the pace of things. “What’s gonna happen next?” I mean we explain what we need to do, how it happens and when. But if she wants to go out for smoke, she wants to call a family member, she wants to take a break, she wants to advise us on what we can and can’t do and how, we listen. What we typically do is not like “it’s 12 o’clock and we must do these things to you.” (Deb, WCH)

Participants described giving survivors control over all aspects of the support services, such as setting the pace and agenda in counselling or rape kit examinations rather than following standardised routines.

Empowerment. Providing survivors with choices, thereby increasing their sense of control, was inseparable from the goal of empowerment. Empowerment is defined as giving someone the power or authority to act and, more specifically, helping someone become stronger and more confident in their life, especially in regard to claiming and asserting their rights (Empowerment, 2012). The ORCC, SASC and WCH described the value of empowerment as a desire for survivors to leave their space/supports feeling stronger and with a better sense of belonging in the world.

We work from a strength-based perspective that it is about empowering women. Like, you know what, the world is made up of all kinds of people and every person brings their own strength and we need all those people to have a well functioning society. I think it can be very empowering for women to hear that and know that it is not them. That there is oppression in the world. (Erin, ORCC)

To try and have people leave here a little bit empowered is one of our goals. That even though, you know, they weren't able to stop [the SV] no matter what they did, they can still be in control of themselves. I think that's really probably one of the most important things because we all want to control our own destiny. (Sheila, WCH)

Kathy of ORCC described empowerment as "An old thing from way back. I don't think that'll ever change." By recognising empowerment as a historical value of RCCs, Kathy was able to situate ORCC's work within a continuity of

feminist values. The ORCC, SASC and WCH aimed to empower survivors by increasing survivors' awareness of oppression and rape myths. In this fashion, sites aimed to "change" or "transform" lives beyond simply healing from the SV. Each feminist site regarded debunking rape myths as one of the most significant aspect of the job. For example, the majority of current and early day participants described the message "it is not your fault" as foundational to rape work.

Non-feminist Site and a Patient-Centred, Gender-Neutral Philosophy.

At the time of the study, the OHCC's philosophy of practice did not overlap with the other sites. The OHCC appeared to be a routine medical service without a trauma-informed lens of care, focusing on the perspective of service providers rather than survivors. Instead of regarding survivors as experts of their own experiences and needs, the OHCC's team was described as being comprised of "experts" and survivors were described as patients. This differs from early staff of the Regional Sexual Assault Treatment Program (the predecessor to the OHCC) and WCH's staff who rejected the term "patient," given its passive and pathological connotations. Instead the terms "client," "survivors" or "woman" were preferred.

Rather than describing particular characteristics and values of working with survivors (e.g., non-judgmental, non-directive, choice, control, empowerment, context) as significant, the OHCC focused on clinical descriptions of the procedures provided. When asked directly "Do you have any sort of guiding philosophies?" Carol responded:

I think originally it was a little bit more a women — we always had a medical philosophy, just because we have been a hospital-based

program. And unlike some of the community resources and some other programs, we do all the medical care stuff. So we do HIV testing and it doesn't matter what gender you are, there's not really anyway to get away from all that unfortunately. It doesn't matter what gender you are, you still have to go through the same process of HIV post-exposure prophylactics...So that's a big component of it. We've try to become more gender-neutral because we have, not necessarily significant, but a portion of our patients are male...so we wanted to make it just more of a person-, patient-centred thing, which is more of a philosophy of the hospital.

Although there was some recognition that there may have originally been a "woman-centred" philosophy for Ottawa's SATC, this was subjugated by stating that "We always had a medical philosophy." The statement rendered invisible the history of the program's community partnership and feminist framework. Drawing upon assumed common-sense understandings of healthcare, the medical philosophy was rationalised because the program was hospital-based and provides medical care. While this "makes sense," WCH has shown us that this is not the only way to interpret the medical model.

Commonplace understandings of the medical model position hospital and health providers as experts who diagnose and treat using allegedly objective medical technologies and procedures. While it is true that, regardless of gender, survivors would have many of the same service options available, it was unclear whether the choice was that of the survivor or the practitioner. The above quotation positioned HIV testing and prevention as a routine procedure where gender, and therefore context, risk, choice and control are irrelevant. According to the concept of cultural competency, context and the individual identities of health care clients (including gender) is significant. By treating all clients the

same, health care systems and providers fail to address differences that are related to health disparities among various disenfranchised groups. According to a gender-neutral, patient-centred philosophy, support may be offered as a standardised routine without reflection on how such de-contextualised routines may cause secondary trauma or access barriers.

Past nurses of Ottawa's SATC spoke of the important integration of a feminist understanding of SV, choice, control and empowerment in their work. However, it was unclear whether such perspectives operated within the program today. Indeed, past employees and community members were concerned that a framework that understands the particular needs of survivors may have been lost as feminist practice interferes with institutional norms of the OHCC.

These anonymous quotes represent the perspectives of various community members and former employees of Ottawa's SATC:

I think being gender-neutral is not being realistic because I think it's a bit a utopian view...I think gender-neutral is kind of minimising the issue because I think that because all the stats clearly say the preponderance of [survivors are] women...and issues of power and who has the power in our society is still, I mean you see it all the time. So I think that [gender-neutral] minimises the situation [of SV].

[Ottawa's SATC] is back to delivering, EXACTLY delivering, a service. I find that to be completely depressing and not productive. It has been reduced to a service, like a client using a product. It does not address the root of people's experiences. It is a Band-Aid approach that is contradictory to everything we believed the service could have been.

I don't believe that the OHCC is really invested in making the SATC work. It's just not high on their agenda. It's not that they don't value it as a program. I don't think the institution feels that it's worth a lot of energy and effort right? And so I don't think it's high on their agenda. So I think that is the reason they've always had a staffing problem...the feedback that I'm getting informally is that they're so focused on PR and not being exposed to the media. And [because of] this logistic model that they're working on-clients are falling through the cracks.

If you don't know what the intention of the community was for the creation of this program, then you can't meet the needs of that community properly. Or you run the risk of not meeting the needs of that community. Because you end up — your contact ends up only being only with survivors of a trauma.

The concerns, such as those quoted above, informed (and thus biased) my analysis of the OHCC. It is important to note that I was unable to interview any active staff beyond a leader. This is a shortcoming as individual staff may work from a philosophy that differs from that of an individual in a leadership role. Although I had an interview scheduled with one nurse, she resigned before our interview, perhaps speaking to the instability of the internal culture. Furthermore, given Carol's leadership role, she may have less direct work with survivors. Although Carol may have also discussed the program in a manner that is consistent with official institutional meanings, there may be a difference between what is on paper and what is done in practice.

Counselling or the lack thereof. The philosophies of practice were consistent with the discourses/understandings discussed in Section One. I will now provide examples of how these philosophies of practice may be actualised

and impact the support of survivors by examining the concept of counselling. The feminist sites (i.e., ORCC, SASC and WCH) all offered short- or long-term mental health counselling. In contrast, the OHCC had dismantled their in-house mental health counselling and framed counselling as medical (i.e., test results) or crisis intervention.

Feminist discourse and structured counselling. In my study, ORCC and WCH offered support services that were described using traditional language, such as “client” and “services.” These sites were also structurally organised in a manner that reflected traditional, hierarchical health and social service organisations. For example, counselling sessions were structured with time limits and facilitated by a staff counsellor. I will briefly describe each site individually.

ORCC. Feminist counselling was defined as recognising clients as experts of their lives, acknowledging power imbalances, bringing in an anti-oppressive analysis and working to empower women by providing them with information to make their own choices. A “therapy and counselling model” (Kathy, interview, November, 2011) was described as being better able than peer-support models to “Offer women a variety of mediums for their healing” (Kathy, interview, November, 2011) and as being more accountable to funders in regard to liability concerns.¹⁸ The ORCC’s counselling program provided six crisis sessions for survivors who had experienced a recent assault, and survivors interested in short-term counselling were able to access up to forty-two sessions

¹⁸ As defined by the Ministry of the Attorney General (which funds RCCs), the ORCC works with vulnerable persons.

within a year. Group counselling utilised a closed format that met for a specific amount of time with set start and end dates. Counsellors facilitated individual and group counselling sessions, although there was flexibility that allowed survivors to direct the process. At the time of the study, counselling was provided in person or via telephone by staff counsellors and volunteer counsellors answered the hotline after business hours.

Although they worked from a therapy and counselling model, staff counsellors were not required to have a relevant degree (although most did). Instead, ORCC considered education, volunteer and work experience equitably — believing that “Academic credentials do not translate into being an excellent counsellor.” Working from a therapeutic counselling model, ORCC integrated aspects of professionalism, which they defined as “building your skills.” Namely, staff counsellors were expected to keep abreast with the field of counselling, understand various counselling techniques, participate in continuing education and be knowledgeable of current community issues. The ORCC hosted internal trainings for their counsellors that included counselling issues (e.g., bereavement, suicide, mental health and feminist counselling) and political topics (e.g., anti-racism and anti-oppression).

WCH. According to Sheila of WCH, providing emotional support was the primary aspect of their work. Emotional support was described as being a part of their “continuum of care” (Sheila, interview, February, 2012) and was integrated into all of their care services (e.g., rape kits). Given the importance placed on psychological health, WCH also offered short-term counselling to survivors and

their support persons (e.g., family). Like ORCC, their counselling services were structured with a set number of sessions (i.e., fifteen to twenty sessions), although there was some flexibility if an individual woman needed more time. Counselling was offered on an individual basis by hospital staff with professional training, including nurses, social workers and mental health therapists. Counsellors provided individual talk and art therapy that was informed by in-depth, non-pathologising understanding of the impact of violence on survivors' lives. Counselling was also described as holistic, as there was an understanding of the interconnections between current and historical experiences of abuse, as well as other issues (e.g., addiction). In this regard, Deb described herself as working with "the whole woman" rather than problematically separating issues into those that are and are not relevant or helpful for a survivor to work through, which is required in some other social service agencies.

Feminist discourse and peer-support counselling. Although SASC shared a feminist discourse with ORCC and WCH, it was also significantly different. Social change was their primary focus and this was incorporated into every aspect of their organisation, including supports for survivors. As such, they rejected terms such as "client" and "counsellor," instead referring to themselves as support workers and to survivors as women. Aiming to address the root causes of SV, SASC constructed supports that were designed to minimise oppressive power relations, such as hierarchical structures. Unlike other sites, SASC offered unstructured counselling, meaning there were no time limitations on counselling. As women were regarded as the experts of their own

experiences, SASC collective members believed that the survivor would know when she was ready to end her counselling. Individual and group counselling were non-directive in that the survivors guided the process (recall the quote earlier in Section Two).

According to SASC's peer-support framework, survivors were viewed as more knowledgeable than professionals on the topic of SV given their lived experiences. Furthermore, support was thought to have more impact if it came from another survivor. The SASC support workers described themselves as learning from each woman they worked with and did not feel the need to draw upon academic or professional expertise. Instead of drawing upon counselling techniques, the foundation of support was *listening* to women, providing them with information and supporting them in making their own decision and in their healing. Rather than asking, "How can we help?" (a question that guided early ORCC members), SASC asked, "How can we support you through your process?" which was conceptualised as granting the survivor greater agency (Jody, interview, March, 2011).

As a non-hierarchical collective, staff and volunteer members of SASC participated in support work regardless of their work or education background.

Susan noted,:

I don't have any degrees, I'm self-taught. All of the academic knowledge, all of the stuff, we learned to do it, we learned it ourselves. And we're almost doing the opposite. If someone has degrees in the staff, it's almost like "Oh my goodness, we have to un-train them." Right? Those who have lived experience get it. We know what it's like to feel powerless, 'cause that's what it's all about, it's about power.

Critical of traditional models of trauma counselling, much of which they believe has been appropriated from feminist organisations, SASC does not engage in internal trainings on counselling topics. Instead, internal training covers political issues such as the psychiatrisation¹⁹ of women or current anti-oppressive issues.

Medical discourse and medical counselling. In the past, the OHCC offered short-term counselling provided by a staff social worker or provided funding for survivors to receive short-term counselling in the community. This internal counselling was more structured than that provided by the WCH. On paper, counsellors were directed only to address a survivor's most recent assault. Referrals to the community were only provided for practitioners who had been screened as having a feminist or somewhat feminist understanding of SV (Interview Format for Counselling Services, Regional Sexual Assault Treatment Program, n.d.; Pauline, interview, February, 2012).

At the time of my study, psychological counselling services had been eliminated from the OHCC. Reasons given for the elimination of internal counselling included: (a) the lack of funding (Pauline, interview, February, 2012; Mandy, interview, April 2012), (b) "dysfunctional services" that required an internal investigation (Carol, interview, April, 2012) and (c) survivors not wanting to return to the "scene of the crime" (Carol, interview, April, 2012). It is also possible that the dominant discourse of the OHCC does not regard short-term psychotherapeutic counselling as a relevant or appropriate service for an

¹⁹ Psychiatrisation is a term used by mad activists to describe the process or act of being constructed as psychiatric, such as through diagnosis and treatment.

emergency department program. Additionally, emphasising response times, forensic evidence collection and the legal obligations of SV may negate the inclusion of short-term care. The OHCC staff received ongoing internal training that addressed clinical counselling issues (e.g., test results) and crisis intervention techniques.

A cross-case comparison of the hospital-based sites. Although WCH integrates a feminist discourse into its practice, feminist understandings have been subjugated at the OHCC. I will now compare WCH and OHCC to examine how discursive differences divergently informed the descriptions of mental health referrals, disclosure of SV to triage nurses and framing of the forensic evidence examination.

Mental health referrals. Current Sexual Assault Nurse Examiner (SANE) guidelines recommend attending to survivors' psychological health (DuMont & Parnis, 2003). Both WCH and OHCC provided mental health referrals. WCH attempted to connect survivors with individual practitioners that were experienced in the area of SV and matched a survivor's individual needs. In contrast, the OHCC referred to agencies that met the cultural needs of a survivor.

WCH offered referrals to survivors who were not interested in on-site counselling or if the team believed they were not the best service for the survivor. Providing referrals and connecting women with appropriate practitioners were described as an important aspect of providing a "continuum of care." In describing their referrals, Deb stated:

We have counsellors that have been here for quite a while. They have developed their networks in the community so they have a pretty good

sense of who meets what needs. Who would be best for what issues and experiences? That's just our experiences. I mean there are agencies that we can refer people so that they [survivors] can choose on their own, obviously. But yeah, I think our counsellors work pretty hard to try and connect people to the best individual practitioner based on what the client is saying that they want, rather than a general agency.

While WCH could and does provide referrals to social service agencies, they preferred to connect women to specific counsellors in the community who had experience and a good reputation for working with SV. Survivors were referred to practitioners in the community based on their particular experiences, identity, wants and needs.

As the OHCC did not offer on-site counselling, all survivors who were interested in mental health counselling received a referral. It is unclear if survivors routinely received this information. When asked about referrals and whether they referred to practitioners who specialised in SV, Carol responded:

People [staff] just kind of know [where to refer to] because people don't usually advertise that apart of it [specialising in SV] ... Like they don't tend to have that listed as their qualifications... but through community agencies we give them [survivors] the idea that there are people out there who tend to do this more often than others, and so we tend to tunnel people, right? But, it's hard because it, it's like any other relationship. You have to see whether it works. Basically we try to present people with a number of options. So, you know, there is somebody who is Jewish. There is a couple of Jewish Family Services. And then, then if you're a student there is campus counselling.

Referrals seemed to be based on informal "word-of-mouth" resources that hospital staff were familiar with. Survivors were referred to community agencies

that reflected their individual background (e.g., student, Jewish). This differs from early procedures of Ottawa's SATC that emphasised competency with trauma in addition to cultural competency. Specifically, in the site's early days they maintained a list of screened referrals that included experienced individual practitioners in private practice that shared or "somewhat shared" feminist understandings and practices (Halina, interview, November, 2011; Pauline, interview, February, 2012; Interview Format, n.d.).

It is possible that referral practices at the OHCC have shifted because fewer Ottawa practitioners specialise in SV. However, the ORCC was knowledgeable of psychologists, psychiatrists and other mental health practitioners in the community who shared their values and, therefore, could refer to. While it is important to refer survivors to agencies that meet their identity-based needs, it is also important to ensure that survivors are linked to resources that have an understanding of violence to prevent secondary victimisation and promote healing. In speaking to the shortcoming of care for survivors of SV in traditional health care and social service settings, Gondolf noted:

Mental health clinicians may not identify and address the violence, or they may misdiagnose and mistreat a woman because they do not fully grasp the nature of the abuse. Part of the difficulty lies in applying the conventional perspective and practices of clinical psychology to what battered women's advocates have long argued is a deep seated social problem. (1998, ix)

Triage referrals. One way a survivor accesses a SATC is by being referred by a triage nurse from the emergency department. Participants at WCH and OHRCC described triage referral differently. Specifically, WCH placed responsibility on hospital staff to screen for violence and OHCC placed

responsibility on survivors to disclose:

There's a lot of effort for emergency departments to screen for violence. It has been a slowly uptake. I would say [staff are] reluctant to ask the questions. I think perhaps there's a little bit of fear either of, "What do I do if they answer yes?"...So [we're] trying to encourage screening wherever people are working and then having us as a referral. So that's worked. I mean it — it gets tried. If it doesn't seem to work, try again. It's hard [for hospital staff] to get that. People are too afraid to ask even though the evidence is showing that women don't mind being asked. But I think there's a concern around people feeling singled out. (Sheila, WCH)

Sometimes people come in and they're umm timid. They don't want to say why they're here. It's, you know, something that's embarrassing to them. They say they're here for abdominal pain or headache or you know whatever else that seems is more acceptable. And then when they are seen by umm the emerge staff they're, "Oh by the way, I have headache because I've been assaulted with my head bumping and so on." And then we get called from there. (Carol, OHCC)

In the WCH example, responsibility was placed on hospital staff to ask about sexual (and domestic violence) and refer to the SATC if need be. This expectation may have been emphasised given the site's understanding that violence is also systemic, with one access barrier to receiving support being health practitioners' discomfort with violence.

In contrast, the OHCC example framed the disclosure of violence as the survivor's responsibility. Describing survivors as "timid" or reluctant to disclose because they are "embarrassed" individualises disclosure. I believe that this perspective frames an individual survivor as responsible for overcoming her own self-consciousness, shame and awkwardness rather than positioning hospital

staff as responsible to routinely screen for SV. This understanding fails to consider the possibility that a survivor may not disclose for fear of negative social reactions, such as not being believed or being blamed by health professionals. Furthermore, by placing responsibility on survivors to disclose, OHCC may not consider structural factors (e.g., screening, positive social reactions) that could increase disclosure rates and thus timely referrals to the SATC.

Forensic evidence examination. The leaders of WCH and OHCC differed in their descriptions of the forensic evidence examination. The leader from the OHCC framed the procedure from the perspective of staff, whereas the leader of WCH framed the procedure from the perspective of the survivor.

Carol described the rape kit as difficult rape work because of legal and emotional factors:

Nobody [hospital staff] wants to do the kit. Nobody wants to be subpoenaed to court. Nobody is interested in doing that just because it's a very daunting kind of thing to do. I have gone to court a couple of times and it's not a whole lot of fun. They are not there to make you feel comfortable or make you feel at ease...you know a lot of people outside of us are quite afraid to this stuff so that's a part of why we exist, we're the experts ... I'm speaking to their residents and teaching them how to do the kit ... It's actually not very hard. A very step, step, step, thing. But I think it's a mental block, the thought that in two years from now you're sitting giving testimony. You're very afraid at that point. Plus the patient themselves is not in the best state. It's not the easiest of patient encounters. The emotional part on top of the legal part. So, it becomes a really tough thing for people.

In this description, the process of collecting forensic evidence is labelled in negative terms (e.g., "daunting," "afraid," "tough"). The fear of the legal system

creates stress for health practitioners and “mental blocks,” particularly because giving court testimony is “not fun.” The patient can exacerbate these challenges given that they are “not in the best state.” Although it is safe to assume that most emergency department patients could be in states of distress, non-SV patients may be more compatible with the medical model and not complicate care by introducing legal issues. Despite these difficulties, the kit itself was described as “not very hard,” in that you follow routine steps to administer it; that is, the kit in and of itself is an objective step-wise medical technology.

In contrast, Sheila of WCH also described the forensic evidence collection process as difficult, but from the perspective of the survivors:

The process of collecting evidence...it's an invasive — the very last thing anybody would ever want done. A necessary evil so to speak in terms of collecting DNA. That [the kit] might be important to document the injuries. It's not what she [the survivor] wants to have done. So we try and make it as tolerable. I mean that's never gonna be easy so we can only try and make it as tolerable and give her that control of the information so that she feels a bit empowered in the process. I guess that is what we want. And with that, she could do nail clippings. I don't actually ever do the nail clipping. So as much as I can I will explain this is what we need, you know, what we're gonna do next. This is why we're gonna do it and then I let her clip her own nails or whatever.

Sheila went on to describe how she aimed to empower women in the evidence-collection process while still maintaining “continuity of the evidence,” describing herself as an advocate for survivors from evidence collection to the courtroom. Although the kit was also described in negative terms (e.g., “necessary evil,” “invasive,” “never easy”), these terms recognised the impact of the process on

survivors and did not frame the health practitioner as struggling with their own emotions. This differs from the previous example where the voice of the survivor was absent. Furthermore, instead of describing the kit as a step-by-step routine, it was framed as an individualised process where survivors made choices and controlled the pace in an effort to make the kit more “tolerable.”

Interpreting differences between sites. There were both subtle and significant differences in how each of the sites worked with survivors. Sites that offered psychotherapeutic counselling were informed by a feminist discourse. However, the actualisation of feminism varied, where ORCC and WCH worked from a normative social service model and SASC worked from a non-hierarchical peer-support model. Because of various possible factors, the OHCC no longer offered mental health counselling. I further examined differences in practice by contrasting how WCH and OHCC divergently framed mental health referrals, triage disclosure and the forensic evidence examination. I will now explore several explanations that may contextualise why discursive differences between sites exist.

Historical context. Several participants commented that each site had “different starting points” or arose “from different roots.” Challenging my initial assumption that community-based RCCs and hospital-based SATCs were two separate, homogeneous support services, each RCC and SATC had a unique starting point. The origins of a site and its subsequent trajectory had an impact on internal understandings and practices.

RCCs. Since the early days, ORCC was a more “practically focused” hierarchical²⁰ social service organisation that was founded and staffed by professional women who collaborated with dominant institutions, such as the Ottawa General Hospital (Jody, interview, March, 2012; Wendy, interview, February, 2012; Ottawa Rape Crisis Centre, 1976). At the time of SASC’s establishment, the founders (many of whom were former ORCC volunteers) critiqued ORCCs “bourgeois feminism,” its affiliation with dominant institutions and the medical model influence (Jody, interview, March, 2012). Specifically, SASC members believed that the ORCC pathologised and othered survivors in general, and incest survivors in particular (Jody, interview, March, 2012). Furthermore, SASC women felt that social change rather than social service should be the primary focus of a RCC (Jody, interview, March, 2012). SASC founders’ discomfort with the ORCC provided building blocks for establishing SASC as a collective, non-hierarchical, survivor-driven, peer-support RCC. Whether professional or activist women founded a RCC shaped the women who were later drawn to working within the organisation, organisations’ understandings of violence, as well as organisational philosophies, structures and practices.

SATCs. Similarly, the hospital sites began at different places. WCH was conceptualised and driven by an interdisciplinary group of professionals who

²⁰ Although the archival documents I consulted and some of the interviews I conducted suggested that the ORCC originated in a somewhat hierarchical framework, another informant commented that in the early days the ORCC had steering committees that operated via consensus and required the approval of the general membership in decision-making.

worked within the hospital. From its origins, WCH integrated a woman-centred framework in which the traditional medical model was reframed by feminist principles (Mary, interview, February, 2012). In Ottawa, the Sexual Assault Network developed a successful project proposal in partnership with local hospitals and established Ottawa's SATC (Sexual Assault Network, Children's Hospital of Eastern Ontario and the Riverside Hospital of Ottawa, 1993). The founding proposal for the SATC integrated a feminist understanding of violence and a survivor/woman-centred framework of practice. As previously described, OHCC has since lost both its community partnership and feminist philosophy. Although both hospitals originally integrated feminism, at WCH the feminist philosophy was driven internally. As a result, feminist meanings of SV appear to be more stable, legitimate and valued as an aspect of care. In Ottawa, once the priority funding, community partnership and the program's feminist leader were lost, there seemed to be little institutional dedication to maintaining understandings and values that conflicted with the dominant institutional discourse.

Individual context. The individuals within an organisation had the ability to inform the understandings and practices of a site. I will briefly describe several individual factors that may explain differences in practice. Early members of RCCs and nurses with volunteer backgrounds in RCCs communicated a strong dedication, passion and commitment to working with and for survivors. These qualities may sustain involvement, as it is not *just* a job. Workers' emotions may also impact their practice. As previously noted, a past nurse with the OHCC was

concerned that many of the younger nurses who were being hired were survivors who may not have done their own healing, leading to occupational stress and subsequent burnout.

The educational background of workers and volunteers also informed understandings and practice. For instance, ORCC attracted a greater number of volunteers and staff with backgrounds in the helping professions (e.g., social work or psychology) (Erin, interview, December, 2011). SASC collective members were more likely to identify as activists, some of whom had university education in disciplines such as political science and women's studies (Jody, interview, March, 2012; Susan, interview, March, 2012).

Site leadership also had a significant influence on understandings and practices. For example, although the current executive director of ORCC is dedicated to anti-oppressive, anti-racist politics and framed the ORCC's work as inseparable from social change, one of the past executive directors was described as running the ORCC as a depoliticised social service agency. Many past employees of Ottawa's SATC regarded Halina's strong feminist leadership as protecting the SATC from the hospital's institutional norms, maintaining a strong community connection and feminist framework.

Finally, the identity of individual women (e.g., working class, white, able-bodied, university educated, lesbian, etc.) working within a site also informed their worldview and thus their understandings and practices. Participants who identified as lesbian and/or working class seemed to be more radical in their understandings of SV (e.g., Deb from WCH) and RCC affiliation (e.g., non-

hierarchical collectives [i.e., SASC]). Examining the diverse identities of workers and rape work could be a fruitful area for future research.

Organisational and institutional context. Not only were understandings and practices related to the individuals involved, they were also related to the structure of an organisation (for a summary of site characteristics please recall Appendix C). A RCC's leadership and decision-making structure was connected to its understandings of SV, philosophies and enactment of support. Additionally, the particulars of the hospital the SATC was embedded within (e.g., size, mandate) likely influenced understandings and practices.

The SASC, which was founded by activist women, operated as an egalitarian collectivist organisation. It appeared to be influenced by a radical feminist standpoint that aimed to address the root causes of SV by dismantling unequal systems of power — including those within their own organisation. In part their goal of dismantling oppressive power was accomplished by resisting traditional models of counselling that privilege counsellor understandings over the lived experiences and knowledge of women. In contrast, ORCC appeared to draw upon a liberal feminist standpoint. Rather than aiming to dismantle existing institutions, ORCC integrated anti-oppressive values and practices within them. For instance, they collaborated with traditional organisations and professionals, including a recent group trauma therapy program in partnership with the Royal Ottawa Hospital (Kathy, interview, November, 2011). Thus, the political standpoint of a RCC informed the site's understandings, structure and support.

In line with the hierarchical structure of hospitals, both SATCs were traditional, hierarchical, social service programs. WCH is embedded within a *women's* hospital and affiliated with the Women's College Research Institute. This is significant as both WCH and the Women's College Research Institute are dedicated to bettering the health care of survivors, with a staff that includes feminist researcher scientists whose careers have aimed to improve SATCs (e.g., Janice DuMont, Lana Stermac). The women-centred organisational context of WCH likely provides support and validation for their feminist-informed/women-centred understandings and practices. In contrast, OHCC's centre was embedded within a large multi-campus general hospital that emphasised gender-neutral, patient-centred care. A feminist value of care would conflict with OHCC's dominant framework.

Finally, stable organisational cultures contributed to stable, continuous understandings and practices. Consistent with this, ORCC and the OHCC were described as having higher turnover rates than the other sites. Structural factors ranging from the individual to the organisational level inform practice. Although I have not discussed them, social, cultural, economic and political factors at the local, provincial and national level also inform the understandings and practices of RCCs and SATCs.

Summary. Each site worked from a different framework. This had practical implications in regard to the philosophy and values that informed their practice, such as counselling. By contrasting similar topics discussed by each hospital-based SATC, I was able to examine how different discourses divergently

frame mental health referrals, triage disclosure/referrals and the forensic evidence kit. Together, I believe these findings illustrate that each kit is informed by a particular way of understanding SV and that these understandings have an impact on practice. Although I have focused on the hospital-based sites and the possibility of a feminist-informed medical model, I believe I have also illustrated diversity between RCCs and how community-based understandings of SV are connected to the understandings and practices of SATCs.

Discussion

The communities of practice in my research drew upon feminist, legal, medical and mainstream discourses. The Ottawa Rape Crisis Centre (ORCC), Sexual Assault Support Centre (SASC) and Women's College Hospital (WCH) framed their understandings and practices within a feminist discourse that was critical of dominant legal, medical and mainstream discourses. However, this feminist discourse was not homogenous and was interpreted and actualised in diverse ways. Illustrating the constructive relationship between understandings and practices, my research highlights that language is not a neutral form of communication. Rather, language is shaped by ideologies that produce, maintain and/or resist social processes and relations. In contrast to some feminists, theorising my research indicates that feminism is not necessarily incompatible with the medical model and dominant institutions. Rather, there are multiple ways of integrating understandings of sexual violence (SV) and supporting survivors.

Cross-Case Feminisms

Aside from Carol of the OHCC, all participants self-identified as feminist. What feminism meant to each participant was subjective, but was united by several factors: an analysis of women's oppression, an acknowledgment of inequitable social structures, framing SV as a feminist issue and framing one's work according to feminist values (e.g., choice) and goals (e.g., empowerment, social change). The RCCs openly identified as feminist organisations on their public materials (e.g., websites), but WCH did not. However, WCH did include links to resources for understanding SV that could be interpreted as feminist (e.g., the power and control wheel, a factsheet published by a feminist organisation). WCH may have abstained from publicly identifying as feminist to remain as inclusive as possible. For example, although Interval House Ottawa developed a staff definition of feminism, they do not publicly endorse feminism so that they remain inclusive to women who are critical of feminism and/or define feminism differently than staff members.

In her case study of feminist organisations, Goldman (2008) argued that feminist organisations have traditionally been radical or socialist in their ideological underpinnings, although liberal feminism dominated during the 1980s. In my research, I did not find clean examples of feminist sub-types. For example, although the early days of ORCC appear to have been more strongly aligned with a liberal feminism, they did include collectivist structural elements, which are more strongly aligned with a radical or socialist feminism. The development of SASC is a useful illustration of the polarisation of feminism during the earlier

years of the movement. SASC's critique of ORCC and their efforts to develop an alternative RCC were clearly informed by lesbian, socialist and radical feminisms. Today, both ORCC and SASC have been impacted by third-wave feminist organising and have integrated an anti-racist, anti-oppressive perspective into their organisations. However, how anti-oppression was articulated and actualised varied and was consistent with the historical and ideological underpinnings of each organisation.

The Interrelations of Understandings and Practice

A feminist discourse informed the understandings and practices of the ORCC, SASC, WCH and the early days of the Ottawa Hospital – Civic Campus (OHCC). In regard to Rape Crisis Centres (RCCs), this supported my assumption that community-based SV organisations are feminist organisations,²¹ although my assumptions of how feminism is organisationally integrated (e.g., RCCs as collectives, feminist counselling as peer support) was challenged. Furthermore, WCH and the history of Ottawa's SATC challenged my expectation of feminism being incompatible with hospitals and health care.

I categorised and conceptualised participant understandings as feminist discourse because themes represented feminist values and understandings of SV. This included understanding SV as gendered and as characterised by multi-level power systems. Additionally, feminists have strongly advocated that

²¹ Finding that RCCs were feminist challenged a small body of American literature that suggests that anti-violence workers and RCCs have worked from a depoliticised social services perspective that does not integrate a feminist understanding of VAW (e.g., Andersen & Rensettu, 1980; Lehrner & Allen, 2009; Mailer, 2008; Martin, DiNitto, Byington, & Maxwell, 1992). This also highlights the need for Canadians to document the Canadian anti-violence movement.

survivors' reactions to SV should be regarded as normal. These understandings mirrored feminist discussions of SV in the literature (see Brownmiller, 1975; Burstow, 1992; Matthews, 1994; Martin, 2005; Ullman, 2010). Understanding women's psychological reactions to SV as normal has been a significant critique of traditional psychological theories and therapeutic interventions (e.g., Chesler, 2005) that led to the development of non-pathologising supports for survivors, such as feminist therapy²² (e.g., Burstow, 1992; Waterhouse, 1993).

I defined a legal discourse as understandings of SV that reflected the *Criminal Code* definition. Martin (2005) defined a legal discourse as embedded within mainstream discourse because mainstream understandings assume that society can reduce rape through the conviction and incarceration of rapists. Interestingly, only Carol of the OHCC understood SV from a legal perspective and excluded a feminist understanding. This may reflect Martin's conceptualisation of legal and mainstream discourse as inseparable, as Carol was also the only participant who drew upon mainstream discourse.

Mainstream discourse was communicated through absences, silences and indirect references that evoked suggestions of rape as physically violent. These obscure references are significant because they represent what Ullman (2010) has described as a social denial and silencing of rape. Ullman describes silencing as reinforcing the myth of "real" or "legitimate" rape, where deviant individuals randomly commit rape. The silencing of rape is significant not only

²² Early members of the Toronto Rape Crisis Centre emphasised that feminist therapy was developed by anti-violence organisations and existed before it was named and defined by academics.

because it reinforces rape myths, but because it decreases the likelihood of survivors disclosing their experiences. For those who do disclose social denial and silencing may increase the negative social reactions (i.e., secondary victimisation), which can exacerbate negative mental health outcomes.

Neither WCH or OHCC employed a medical discourse in understanding SV. For WCH, resisting medical discourses of SV may have been rooted in the belief that the medical model leads to problematic responses to survivors — a common concern among feminist-informed frontline violence against women workers (National Resource Centre on Domestic Violence, 1994, as cited in Gondolf, 1998). Indeed, WCH staff refused to use the term “patient” because of passive and pathological connotations associated with this term.

Although a general medical discourse framed OHCC's practices, a medical discourse did not define their understandings of SV. This absence may have stemmed from medicine's struggle with how to include gendered violence within the practice of healthcare (Martin, 2005; Mildorf, 2007). As a social issue without a physiological etiology, SV challenges medical model biological understandings of health, as well as the role and responsibilities of health practitioners.

In an early discursive exploration of emergency departments' care of battered women, Warshaw (1989) found that physicians and nurses were uncomfortable addressing violence against women. Their talk was obscured through ahistorical, de-contextualised technical terminology that focused on

injury and symptoms and excluded the etiology of the health concern, which would have involved naming violence. Warshaw suggested that one reason violence against women might be challenging for hospital staff is because of the unpleasant emotions that accompany empathic care. Such empathic care challenges medical training that teaches practitioners how to be emotionally removed from patients to ensure objectivity.

The emotional aspects of rape work may be difficult for OHCC staff. Recall that Carol discussed rape work in negative emotional terms (e.g., “no fun,” “tough”). In contrast, Sheila of WCH explicitly believed that emotions were the “biggest component” of their work and did not regard it as a difficult component for staff. The WCH team emphasised, acknowledged, addressed and included emotions in their SATC. The WCH also had documents (e.g., Provider Support, n.d.) that discussed the emotional impact and possible triggers of working with survivors, along with the importance of staff self-care. Because of an organisational culture that acknowledges the presence of difficult emotions, WCH may be less likely to describe their work in negative terms because they may not feel as burdened or overwhelmed by their subjective discomfort. Acknowledging and including emotions within rape work may decrease occupational stress and enhance a stable organisational culture.

Understanding, Practice and Secondary Victimization

When a survivor discloses her assault she risks secondary victimisation. Secondary victimisation may occur because of the negative reactions of health and social service providers. Fortunately, there are also positive social reactions

that decrease distress and promote well being. In her research on society's responses to survivors, Ullman (1996a, 1996b) categorised positive reactions as providing: emotional support, tangible aid and information. These categories were later expanded to include: belief/validation, non-blaming, listening, reassurance and sharing (Ullman, 2010). The feminist understandings and practice I constructed with my data represent these positive social reactions.

The ORCC, SASC and WCH were driven by a feminist understanding and described offering survivors unconditional, non-judgmental emotional support in each of their programs (e.g., accompaniment, counselling, rape kit). Tangible aid is defined as direct actions that support a survivor, such as accompanying her to police or medical providers. The feminist sites in my study offered such tangible aid. RCCs' tangible aid involved counselling, accompaniment and advocacy. For Sexual Assault Treatment Centres (SATCs), this included physically providing wanted health and forensic services (e.g., emergency contraception, testing for sexually transmitted infections/diseases, evidence collection). Additionally, ORCC, SASC and WCH emphasised providing information so that survivors could make their own choices. Staff of the ORCC, SASC and WCH seemed to react positively to survivors by emphasising believing survivors, not blaming them, listening and de-bunking the internalised myth that "it's my fault." Finally, as a survivor-driven, peer-support organisation, SASC facilitated sharing between survivors to help them connect with others and know they are not alone. Given the association of feminist understandings and practices with positive social reactions to survivors, it would be useful to further evaluate whether or not

the organisational integration of a feminist discourse can prevent secondary victimisation and promote well being.

I do not feel that I have sufficient data to make claims as to whether or not the OHCC's understandings and practices could be associated with negative social reactions. However, there are aspects of the patient-centred, gender-neutral philosophy (and the medical model more generally) that merit critical examination. Overall, the OHCC's talk was degendered and medicalised, in that they focused on medical care and specific technologies and procedures, with staff instead of survivors positioned as experts. In describing the philosophy of the centre, the OHCC was separated from the community, feminist values and rationalised their rape work as informed by the dominant hospital framework because they "do all the medical stuff." This example illustrates how dominant mainstream discourses can rationalise understandings and practices as common sense or natural. As the medical model is a widely received worldview, it constructs what Foucault (1980) described as a fictional coherence and does not need to address or acknowledge counter-discourses that may inform rape work (i.e., trauma informed care). Without examining taken-for-granted assumptions embedded within the medical model, understandings and practices may unintentionally re-victimise survivors.

Research has found that power imbalances of the passive patient/active doctor binary may cause secondary victimisation by reproducing dynamics of the abuse (see Loeske & Cahill, 1984; Mildorf, 2007; Warshaw, 1989). As demonstrated by the comparative examples contrasting WCH and OHCC,

discourse may have an impact from internal triage referrals to external mental health referrals. Without a feminist discourse, SATCs may work without critical self-reflection that acknowledges how health care systems and providers may systemically or interpersonally cause secondary victimisation. Factors that may cause secondary victimisation include referring survivors to inappropriate or incompetent mental health services, providing the rape kit without sensitivity to the survivor's needs, not recognising the signs of SV or failing to screen for violence.

In an analysis of hospital records of women at risk of violence, Warshaw (1989) found that medical staff were primarily concerned with satisfying their minimum obligations (e.g., reporting to police, prescribing medication). In this process, the survivor and her subjective experiences were reduced to de-contextualised medical categories and processes that meet the needs of medical staff rather than the survivor. The survivor can become invisible and silenced by such routines. If forensic evidence examinations are conducted as a routine process to meet legal obligations, the survivor may be re-victimised by being positioned as a passive and (un)compliant body, a dynamic that mirrors abusive power relations.

Compatibility of Feminism and the Medical Model

Feminist theory has been instrumental in developing a critique of the medical model and influencing a women's health movement (Thomas, 2000). Despite the desire to dismantle binary thinking, this scholarship has generally regarded feminism as incompatible with the medical model and hierarchical

structures (see Bonisteel & Green, 2005; Gondolf, 1998; Walker, 1990, for a discussion of such critiques). I argue, and believe, that WCH has illustrated that a feminist discourse is not incompatible with the medical model or dominant institutions. I do not believe that a radical feminism (which aims to dismantle hierarchical and patriarchal structures) or the eradication of oppression within our health care system is possible in today's neo-liberal context. However, I do believe it is possible to construct understandings and practices within a medical context that are informed by feminist discourse. Power imbalances within the medical model are not inherent; rather, they are *constructed* and thus can be reconstructed and remodelled for feminist aims.

It has been theorised that while feminists may use language for liberatory means, such as including gendered violence as a health issue, these efforts are limited by the oppressor's language (Walker, 1990). From this perspective, feminist language reclamation and, therefore, counter-meanings of violence become medicalised by dominant institutions and mainstream discourse, which frames violence in de-contextualised, individualised, pathologising terms that place survivors at greater risk of victimisation (Gondolf, 1998; Kurz, 1989). The process of medicalisation and the controlling power of the medical model on women's bodies have been documented (Findlay & Miller, 1994) and is of growing concern given the neo-liberal context of globalisation and entanglement of the pharmaceutical industry in our academic and medical institutions (Teifer, 2010). In her research and activism on the medicalisation of women's sexuality, Teifer (2010) argued that just as:

Women's sexual entitlements are beginning to be acknowledged, the primary factors needing to be addressed – social, political, relational—are downplayed by the biomedical emphasis. (p. 198)

The same could be argued for SV. While there has been a growing acknowledgment of the roles and responsibilities of health care systems and practitioners (e.g., the development of guidelines and recommendations), a contextualised understanding and practice has been downplayed by a neo-liberal, medical emphasis (Beres et al., 2002; Bonisteel & Green, 2005).

Women's organisations have been impacted by cuts in funding, an emphasis on privatisation, as well as de-gendered and depoliticised policies of violence against women (Bonisteel & Green, 2005). Janine Brodie (2007) argued that under neo-liberalism, Canada's Ministries are not responsible for the reduction of inequality; rather, responsibility for supporting survivors has been individualised and privatised. Survivors of "random violence" are responsible for engaging in self-help, which situates professionals as experts who facilitate individualised, incident-based, symptom-focused interventions. Women's organisations that receive government funding have been forced into adopting corporate language and models that seek to maximise efficiency and profit, which often conflicts with their core values (Bonisteel & Green, 2005). This would be consistent with the current finding that various structural processes erased the feminist discourse of Ottawa's SATC; that is, earlier contextualised understandings and practices have been individualised and reduced.

Despite the failure to sustain a feminist framework at the OHCC, it is possible to conceptualise of health and the expected role of practitioners and

survivors from a feminist framework. The early days of OHCC and the ongoing work of WCH demonstrated that a feminist discourse can be successfully integrated into hospital-based SV programs.

Feminist Medical Models

In a literature review that examined the medical model discursive practices in relation to the care of survivors, Lavis, Horrocks, Kelly and Barker (2005) recommended changes to better meet survivors' needs. Specifically, Lavis et al. (2005) recommended: (a) challenging practices that position "Health professionals as powerful experts" (p. 453), (b) increasing training on violence against women, (c) "Adopting a non-directive stance" (p. 454), (d) working with survivors in partnership, (e) being open to feeling uncomfortable emotions, (f) developing relationships with external agencies, (g) deconstructing power dynamics between patient-practitioner and (i) positioning survivors as strong women who are "Actively coping and competent in making [their own] choices" (p. 454). Lavis et al. (2005) noted that such changes would be accompanied by their own dilemmas and challenges, and that such change is not possible without attending to hierarchical structural factors.

Significantly, WCH met each of Lavis et al.'s (2005) recommendations. WCH positioned women as experts of their own bodies and as partners in care. By supporting women in making choices and being unconditionally accepting of these choices, WCH has redefined the traditional medical model and challenged power dynamics of the practitioner-patient relationship. Furthermore, staff were extensively trained in violence against women, regarded emotions as an aspect

of their work and viewed survivors in active, competent terms by rejecting labels such as "patient."

Literature has shown that feminism and the medical model are certainly compatible. Indeed the values of some contemporary health care (e.g., client-centred, empowerment) are rooted in the women's health movement (Thomas, 2000). The Vancouver/Richmond Health Board (2001) has detailed how and why a traditional medical model should be re-conceptualised from a women-centred perspective to increase women's safety, empowerment and reduce health inequities. Finally, Dankoski, Pais, Soppi and Kramer (2003) have argued for a paradigm shift that incorporates feminism into family therapy provided by general practitioners. The above examples demonstrate how feminism could and has successfully inform(ed) health care understandings and practices. It would be of interest to examine feminist-informed sites of medical practice to understand their successes, failures, strategies, challenges and dilemmas.

Though language is an important tool in maintaining and subverting power, the maintenance or erasure of a feminist discourse within a medical context is not purely linguistic. In my research, the feminist discourse of Ottawa's SATC was not solely erased by language systems that uphold power. Processes that had the power to redefine rape work understandings and practices were also informed by political (e.g., goals of the Ministry of Health and Long-Term Care), economic (e.g., budgetary decisions), individual (e.g., characteristics of staff) and organisational factors (e.g., leadership, turnover, staffing shortages) at multiple levels of the institutions (e.g., institutional philosophy, size, administration's

attitude toward program). However, in a sense each of these factors is also discursive.

Foucault, Discursive Analytics and Supports for Survivors

This discourse analysis (DA) has accomplished Foucauldian genealogical goals. Contrasting WCH and OHCC is of particular interest because it allowed me to explore how a feminist discourse is successfully integrated into one institution, but restricted and dismantled in another. My analysis illustrated the intertextuality that connects the feminist discourse of ORCC, SASC, WCH and the early days of Ottawa's SATC. I also illustrated how the community and feminist origins of the OHCC have been and currently are being erased.

Although medical science portrays an image of evolution and continuity (Foucault, 1972), the history of OHCC highlighted radical ideological shifts. It was first established as a joint community-hospital program that worked from a feminist framework and was transformed for multiple reasons. At the time of the study, it was a de-gendered centre where ownership was fully positioned within the hospital. At the local level, this analysis has put forth several structural explanations for how and why the SATC was modified in a manner that bears little resemblance to its founding intentions. Further consideration of Ottawa's SATC may illuminate the chronology of these events, macro-level influences, orders of discursive power and how specific factors may have amplified the effects of others.

Consistent with Foucault's (1972) conceptualisation of theory, I have not tried to develop a generalisable theory. Instead, I have examined the particulars

of localised mechanisms of power. I have examined factors that sustain and/or subjugate feminist knowledge in RCCs and SATC. The relationship between community- and hospital-based sites provides preliminary insight into the continuities and discontinuities of feminist knowledge. My findings may inform strategic knowledge to reinstate or successfully integrate feminist discourse into dominant health institutions.

Practical Implications

My thesis provided an example of how discourses that frame SV were related to the values that informed support. Other research has illustrated that supports that integrate feminist values decrease negative health outcomes and future victimisation, whereas traditional social service practices may unintentionally cause secondary victimisation (see Ullman, 2010 for a review). In order to minimise the likelihood of secondary victimisation, it is important for health and social service organisations and practitioners to examine the discourses they participate in critically and the associated values and assumptions. Discourses are communicated through dominant philosophies/structures, textual documents (e.g., mandates, policies, constitutions, procedures), leadership, talk, practices and so on. While a feminist discourse may conflict with and challenge organisational norms, it can partially be integrated by developing contextualised understandings and practices that aim to increase positive outcomes for survivors.

Methodological Limitations

Like all research, this study has its strengths and limitations. I only conducted a small number of interviews at each site and was unable to observe practices directly that challenged the credibility of my findings. As each individual may understand SV and support survivors differently, I do not have a broad understanding of the complex multiple meanings that constructed a site. Incorporating observational data or a review of case records would have facilitated greater insight into each site's applied understandings and practices. However, the focus of this research was on talk of understandings and practice, rather than observed understandings and practice, and I do not aim to generalise my findings. These findings provide theoretical inspiration for further research, theory generation and applied studies that more directly examine supports for survivors.

This project is also limited by its significant scope, which detracted from deeper levels of analysis. For this project, I collected data from twenty-four participants involved in multiple organisations and cities at diverse time points. I rationalised the interviews I intended to include in analysis as providing insight into the conflicting discourses within a site and how internal understandings and practices may have shifted historically. As this was my first DA, I felt overwhelmed by the multiple conflicting accounts. While it is important to understand and examine multiple understandings and practices within a site, this is a difficult intellectual task when one is also comparing understandings *between* sites. In hindsight, I believe a deeper level of analysis would have occurred

through a more in-depth study of a fewer number of sites (e.g., two RCCs or one RCC and one SATC).

While I have conducted an analysis to the best of my abilities, I feel in some regards that my data is under theorised by taking sides, as was cautioned against by Antaki et al., (2003). However, Antaki et al. also recognise that many critical researchers regard it as a moral duty to “take sides,” particularly when researching victims of SV. Indeed, developing understandings that privilege the meanings of the disenfranchised has been considered an important quality of feminist research (Fine, 1992). However, I do not feel that I have sufficiently interrogated the talk of feminist sites or fully empathised with the factors that construct normative discourses. I plan to engage in a secondary analysis of the data that critically examines feminist meanings.

Another limitation of my research was the minimal diversity of participants and the focus on two major urban Ontarian centres. The majority of my participants were white, heterosexual, skewed toward a higher income bracket and had some level of post-secondary education. Because what we know depends on who we are, it is unfortunate that the voices and experiences of diverse women who do rape work were not included. As a result, a number of perspectives and issues related to rape work have been absent. Furthermore, Ottawa and Toronto are two major Ontarian cities with particular resources and cultures. The experiences and issues impacting rural and northern Ontarian communities likely differ. However, consistent with DA this study does not aim to present generalisable findings.

Finally, as I collected, managed, analysed and interpreted all of the data in my study, my personal perspectives have clearly informed every aspect of this project. I have attempted to balance this through critical self-reflection, conversing with colleagues and taking time and space to revisit the project with fresh eyes. These steps have allowed me to interrogate my own assumptions and develop more nuanced understandings.

Future Research

Many avenues for future research arose during the course of this study that I believe would be important directions for future research. First, Canadian literature is lacking in regard to a documentation of the anti-violence movement and sexual assault services. It is important for Canadian researchers and activists to speak of our own history and document our existing institutions and organisations. Second, although I have no significant training in organisational psychology, I became fascinated with understanding each site as a fluid, living entity where power operated in multiple directions and various influences informed understandings and practices. It would be of interest to further explore the dynamics of organisations and the women that work within them. Finally, it would be of utmost importance to examine supports for survivors from the perspective of survivors. While each site has its own understanding of its work and practices, these might differ from those women who have utilised them. It is also important to develop a better understanding of Canadian health care and social service providers' reactions to survivors, how these reactions are or are not related to secondary victimisation, and strategies for restructuring our health

and social systems so that survivors are not re-victimised. It is clear that a large segment of the population consists of survivors of violence against women and children. These individuals come into contact with our health care system for multiple reasons beyond SV. Thus, a feminist discourse could benefit not only the understandings and practices of SATCs, but the care of all individuals.

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Appendix A

Feminist and Mainstream Discourse about Rape

Questions about rape	Feminist Discourse	Mainstream Discourse
Is rape theorised as a gender issue?	Yes. Rape is a consequence of women's subordinate status in society. Rape is a violence form of domination and degradation of women by men in a system of gender inequality.	No. Rape is a crime of sexuality where men's natural sexual urges get out of control or go too far.
Why does rape occur?	Rape is a predictable consequence of a system of gender inequality that allows men to dominate and control women.	Rape is a result of men's animalistic (natural, essential) traits and impulses.
Who rapes?	Normal boys and men rape given the right conditions. Men we know (e.g., boyfriends, husbands, friends, fathers) are the usual rapists.	Sicko or disturbed people rape. Normal people do not rape. [No mention of men or boys.] Most rapists are strangers.
Can rape be eliminated?	Yes. If women's status in society was improved.	No. Because we will always have sick individual in society.

Can rape be prevented?	Yes. If we refused to tolerate men and boys engaging in rape.	Yes. If women and girls were more careful and rapists were convicted.
Can a person cause herself to be raped?	No. Nothing a woman or girl does can cause her to be rape.	Yes. Women and girls who show poor judgment or are not careful can precipitate rape.
How much responsibility do rapists vs. victims have as precipitators of rape?	Responsibility should totally be on the men and boys who perpetrate rape.	Women and girls should make better choices and stop using poor judgment.
Are those who use this discourse to inform outsiders about rape trying to change society?	Yes. By making society more aware about the reality of rape and gender inequality.	No. Except to encourage more victims to report and women to be more careful.

Note. This table has reproduced Martin's (2005, p. 123-124) construction of idealised mainstream and feminist discourses.

Appendix B

Ethics Clearance



Ottawa Hospital Research Ethics Boards / Conseils d'éthique en recherches

725 Parkdale Avenue, Suite 411, Ottawa, Ontario K1V 4E9 613-798-8655 ext. 14962 Fax: 613-761-8311
 Web: www.ohri.ca/ethics

December 23, 2011

Dr. Karl Sampse
 The Ottawa Hospital - Civic Campus
 Department of Emergency Medicine
 1053 Carling Ave., Room M-206, Box 227
 Ottawa, ON K1H 4F9

Dear Dr. Sampse:

Re: Protocol # 2011779-01H Discourses of Violence Against Women in Canada

Protocol approval valid until - December 22, 2012

Thank you for the letter from Angela Marcantonio dated December 20, 2011. I am pleased to inform you that this protocol underwent delegated review by the Ottawa Hospital Research Ethics Board (OHREB) and is approved to recruit English-speaking participants. No changes, amendments or addenda may be made to the protocol or the consent form without the OHREB's review and approval.

Ethical approval is for the following:

- OHREB Application
- Revised Protocol, dated November 14, 2011
- English Information Sheet and Consent Form, dated December 16, 2011
- English Email to Director of SP/PA Program at Civic, dated December 16, 2011

The validation date should be indicated on the bottom of all consent forms and information sheets (see copy attached). If the study is to continue beyond the expiry date noted above, a Renewal Form should be submitted to the OHREB approximately six weeks prior to the current expiry date. If the study has been completed by this date, a Termination Report should be submitted.

The Ottawa Hospital Research Ethics Board is constituted in accordance with, and operates in compliance with the requirements of the Tri-Council Policy Statement: Ethical Conduct for Research Involving Humans; Health Canada Good Clinical Practice; Consolidated Guidelines, Part C Division 5 of the Food and Drug Regulations of Health Canada; and the provisions of the Ontario Health Information Protection Act 2004 and its applicable Regulations.

Yours sincerely,

Raphaël Saginor, M.D.
 Chairman
 Ottawa Hospital Research Ethics Board

End.

RS6



WOMEN'S COLLEGE
RESEARCH INSTITUTE

Health care for women: REVOLUTIONIZED

Women's College Hospital
Research Ethics Board
790 Bay St., 7th Floor Rm. 750
Toronto, ON M5G 1N8
Tel: 416.351.2535

Notification of REB Initial Approval

Date: 17 October, 2011
 To: Dr. Valerie Taylor
 Re: 2011-0035-E
 Discourses of Violence Against Women in Canada

REB Review Type: Expedited
 REB Approval Date: 12 October, 2011
 REB Expiry Date: 12 October, 2012

Documents Approved: TAMSN Application Form - Initial REB Application Form ver: 08/15/2011
 Fact Sheet - Fact Sheet: Discourses of Violence Against Women in Canada ver: 08/11/2011
 Letter - Email to director, nurse affiliated, and founding member of SANE/DV Program at WCH ver: 08/11/2011
 Consent Form - Research Informed Consent: Founding member ver: 08/11/2011
 Consent Form - Research Informed Consent: Program Director ver: 08/11/2011
 Consent Form - Research Informed Consent: Current Volunteers and Employees ver: 08/11/2011
 Letter - Debriefing Letter ver: 08/11/2011
 Letter - Letter of Support from Dr. Connie Kristiansen ver: 08/09/2011
 REB Letter Other Site - REB Comments from Carlton University ver: 07/12/2011
 Protocol - Study Protocol *Tracked Changes and Clean ver: 2 09/26/2011

Documents Acknowledged: TCPS Certificate of Completion - TCPS Certificate for Valerie Taylor ver: 02/25/2009

The above named study has been reviewed and approved by the Women's College Hospital (WCH) Research Ethics Board. WCH retains the authority to deny the implementation of REB-approved research protocols for reasons other than research ethics: such reasons may be administrative, programmatic, or resource-based in nature. Any additional approvals must be coordinated through the VP, Research Office prior to initiating research.

The quorum for approval did not involve any member associated with this project. If, during the course of the research, there are any serious adverse events, confidentiality concerns, changes in the approved project, or any new information that must be considered with respect to the project, these should be brought to the immediate attention of the WCH Research Ethics Board. In the event of a privacy breach, you are responsible for reporting the breach to the WCH Research Ethics Board and the WCH Corporate Privacy Officer (in accordance with Ontario health privacy legislation - Personal Health Information Protection Act, 2004). Additionally, the WCH Research Ethics Board requires reports of inappropriate/unauthorized use of the information.

If the study is expected to continue beyond the expiry date, you are responsible for ensuring the study receives re-approval. The WCH Research Ethics Board must be notified of the completion or termination of this study and a final report provided. As the Principal Investigator, you are responsible for the ethical conduct of this study.

The WCH Research Ethics Board operates in compliance with the Tri-Council Policy Statement, ICH/GCP Guidelines and Part C, Division 5 of the Food and Drug Regulations of Health Canada, Part 4 of the Natural Health Products Regulations, and the Medical Devices Regulations.

Approval of this study by the WCH Research Ethics Board entails that this study complies with current legislation as outlined in the Ontario Personal Health Information Protection Act (PHIPA) and all policies and guidelines established by Women's College Hospital.

Sincerely,

Dr. Miriam Shuchman, Chair, Women's College Hospital Research Ethics Board

Carleton University
Psychology Research Ethics Board
Certificate of Ethics Clearance

Principal Investigator

Department

Study Number

[Redacted]

[Redacted]

[Redacted]

Institution(s) where research will be conducted:

[Redacted]

Co-Investigators and other Researchers:

Researcher	Study Role	Position
Carol [Redacted]	Faculty Advisor	Faculty

Study Title: **Stigmatization of Victims Against Work in Canada**

Approval Date:

[Redacted]

Validity Term:

[Redacted]

Approval Type:

[Redacted]

Revised Protocol	Revised Approval	Approval Date

Comments:

Approval is conditional on your obtaining clearance from each centre. Once you obtain permission from a centre, please label the approval letter as an addendum to your protocol. No data collection in a specific centre can commence until final approval is received.

Certification

This document attesting the above-stated information was approved by Carleton University Psychology Research Ethics Board and the research procedures were found to be acceptable on ethical grounds for research involving human participants.

Chair, Ethics Committee for Psychology Research

This Certificate of Clearance is valid for the above-stated period and is no longer in effect if the research procedures:

[Redacted]

[Redacted]

Appendix C

Site Characteristics

Characteristics	<u>Community</u>		<u>Hospital</u>	
	ORCC	SASC	WCH	Civic
Year Founded	1974	1983	1985	1995
Founded by	Professionals/ Activists	Activists/ Survivors	Internal team	Community
Organizational focus	Social Service	Social Change	Medical/ Forensic Service	Medical/ Forensic Service
Structure	Hierarchal	Non-Hierarchical	Hierarchical	Hierarchical
Leadership	Executive Director	Collective	Coordinator, Hospital Administrators	Director, Hospital Administrators
Workers	Paid and Volunteer	Paid and Volunteer	Paid	Paid
Salaries	Varied	Equal	Varied	Varied
Union	No	No	Yes	Yes
Primary Funder	Ministry of the Attorney General	Ministry of the Attorney General	Ministry of Health and Long Term Care	Ministry of Health and Long Term Care

Decision Making	Top-down, voting, discussion	Consensus	Top-Down	Top-Down
Mission	"We counsel and support women, educate for change and work to create a safe and equitable community"	"Overall objective is the eradication of male violence towards women... providing support to women and children who have been victims of violence"	Medical and psychological care, forensic evidence collection.	Medical and forensic evidence collection.
Corporate-legal status	Free standing charity	Free standing charity	Not-for-profit women's hospital	Not-for-profit general hospital
Scale	Small (# employees, # volunteers), high turnover	Small (# employees, # volunteers)	Small program, (# employees), embedded within institution, small hospital	Small program, (# employees), embedded within institution, large multi-campus hospital, high turnover

Work Activities	Individual and group counseling, 24 hour hotline, referrals, volunteer training, public education, advocacy.	Individual and group counseling, 24 hour hotline, referrals, volunteer training, public education, advocacy, political action	STI/HIV prevention and treatment, pregnancy prevention and treatment, research, treatment of physical injuries, information and education, outreach, medication, forensic evidence collection, counseling	STI/HIV prevention and treatment, pregnancy prevention and treatment, treatment of physical injuries, referrals, outreach, medication, forensic evidence collection.
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Appendix D**Example Consent and Debriefing Form²³****Informed Consent: Current Volunteers and Employees**

This study has been reviewed and approved by the Carleton University Psychology Research Ethics Board (11-108)

Informed Consent Form: Discourses of Violence Against Women in Canada

Research Team: Jenna MacKay, MA (cand.), Dr. Connie Kristiansen

The purpose of this consent form is to ensure that you understand the goal of this study and the nature of your involvement. This information is provided so that you can make an informed decision about whether or not you want to participate. Please ask the researcher to clarify any questions you may have.

This study is being conducted by Jenna MacKay as part of the requirements for the Master of Arts degree, and is being supervised by Dr. Connie Kristiansen, both affiliated with the Department of Psychology at Carleton University in Ottawa. The purpose of this research is to gain an understanding how both community-based anti-violence organisations (i.e., Rape Crisis Centre's, Women's Shelters) and hospital-based programs (i.e., Sexual Assault Nurse Examiner/Domestic Violence Programs) understand violence against women. Specifically, I am interested in how understandings and language inform practice and the historical and current relationships between community and hospital-based organisations/programs.

In this study you will be asked to take part in a one to two hour interview about a) your understandings of violence against women, b) how your organisation/program supports survivors c) the relationship between your organisation/program and the other

²³ There were six versions of the consent form, as they were tailored to a participant's position (i.e., early member, current leader, current volunteer and employee) and each research ethics board required slightly modified forms.

types of organisations/programs included in the study, and d) any outside pressures that may affect your organisation`s/program`s work (i.e., professionalisation, community-lobbying). The interview questions asked of you today will not differ from the interview questions you received in advance. Interviews will be audio recorded and transcribed. You will also be asked to complete a questionnaire asking about your demographic characteristics (e.g., age, race/ethnicity, education, employment, income). These questionnaires will be used to place the interviews in context during analysis. Answering the questions in the questionnaire and in the interview is voluntary and you can skip any questions you like. Finally, after your interview is typed up, you may be asked to review the transcript for accuracy or answer follow-up clarifying questions.

All of the information you provide will be entirely anonymous in order to protect your working relationships at the organisation you are involved with. In addition, the director of the organisation/program you are affiliated with will not be aware of your participation and in any reports or presentations of the findings you will be identified by a pseudonym of your choice.

Due to the sensitive nature of the topic, some questions may be emotionally challenging for some individuals. It is therefore important that you understand that your participation is entirely voluntary. You are welcome not to answer any question for any reason without explanation and you are free to refuse or discontinue the interview at any time. If you wish to withdraw from the study, all recorded information will be destroyed and any information you provided will not be used for any current or future purpose.

Should you require any further information regarding the study, please feel free to contact Jenna MacKay at jmackay1@connect.carleton.ca, or Dr. Connie Kristiansen at (613) 520-2600 ext. 2675 or ckristia@connect.carleton.ca. If you have any ethical concerns regarding the study, you can contact Dr. Monique Sènèchal (Ethics Chair, Carleton University Research Ethics Committee for Psychological Research) at (613)

520-2600 ext. 1155 or monique_sénéchal@carleton.ca. If you have any questions or comments about any other aspect of the study, you are welcome to contact Dr. Anne Bowker (Chair, Dept. of Psychology, Carleton University) at 613-520-2600 ext. 4173 or anne_bowker@carleton.ca.

Consent to Participate

I have read the above information and understand the conditions of my participation. My signature indicates that I freely consent to participate in this study.

_____	_____	_____
Participant's Name	Participant's Signature	Date
_____	_____	_____
Researcher's Name	Researcher's Signature	Date

Consent to Audiotape

I hereby consent to the audio recording of this interview. I understand that it is being audiotaped for accuracy purposes only and that the tape will be destroyed at the end of the study.

_____	_____	_____
Participant's Name	Participant's Signature	Date
_____	_____	_____
Researcher's Name	Researcher's Signature	Date

Consent to Follow-up Contact

I hereby consent to the researcher contacting me in approximately one week following the interview to ask if there is anything I wish to add or delete from the interview and to clarify any ambiguities.

_____	_____	_____
Participant's Name	Participant's Signature	Date
_____	_____	_____
Researcher's Name	Researcher's Signature	Date

Debriefing: Discourses of Violence Against Women in Canada

This study is designed to explore the way in which the language and understandings of violence against women informs the work we do by comparing the language, understandings and services at community-based and hospital-based cases. Specifically, in this project I am interested in understanding the current and historical relationships between Rape Crisis Centre's, Battered Women's Shelters and hospital-based programs in Vancouver, Ottawa and Toronto. Hopefully the results of this study will provide further insight into anti-violence interventions, how language shapes policy and practice, and the relationship between grassroots organisations and professional knowledge and practice. As this research project is exploratory there no specific predictions regarding the findings of the study.

Just to remind you, if you agreed, you will be contacted in approximately one week to see if there is anything you would like to add or remove from your interview and to clarify any ambiguities. If you would like any additional information regarding the study, please feel free to contact Jenna MacKay at jmackay1@connect.carleton.ca. She would love to talk to you further about the project! You can also contact Dr. Connie Kristiansen at (613) 520-2600 ext. 2675 or ckristia@connect.carleton.ca.

If you have any ethical concerns regarding the study, you can contact Dr. Monique Sènèchal (Ethics Chair, Carleton University Research Ethics Committee for Psychological Research) at (613) 520-2600 ext. 1155 or monique_sénèchal@carleton.ca. Regarding any questions or comments about other aspects of the study, you are welcome to contact Dr. Anne Bowker (Chair, Dept. of Psychology, Carleton University) at 613-520-2600 ext. 4173 or anne_bowker@carleton.ca.

Talking about violence against women can be distressing. If you found this interview emotionally upsetting and would like to talk to someone, please feel welcome to contact your local Distress Centre for support or referrals (Distress Centre of Ottawa and Region: 613-238-3311; Distress Centre of Vancouver: 604-872-3311; Distress Centre of Toronto: 416-408-4357).

Thank you so much for your involvement in this project! Your help is sincerely appreciated!

Appendix E

Research Materials

Face Sheet: Discourses of Violence Against Women in Canada

Participant pseudonym or name:

Date and location of interview:

Length of Interview:

Follow up call permission: Yes / No

If yes, contact info: _____ **Date call made:** _____

Wants to review transcript? Yes/No

If yes: Contact info:

Wants final results? Yes / No

If yes: Contact info:

Other:

Demographic Questionnaire (all participants)

Answering these questions is entirely voluntary. If you would prefer not to answer a question, just leave it blank. This information will be used to provide contextual information that may help me better understand your interview.

Your age: _____ years old

Your gender: _____

Your race/ethnicity: _____

Your religion: _____ **Are you practicing?** Yes / No

Income (tick one):

_____ \$25, 000 or less

_____ \$25,001 – \$50, 000

_____ \$50,001 – \$75-000

_____ \$75,001 – \$100,000

_____ Over \$100,001

Education (tick one):

_____ Less than high school

_____ Some high school

_____ Graduated high school

_____ Some university or college

_____ Bachelors Degree

_____ Community College degree

_____ Graduate Degree (i.e., Masters or doctoral degree)

_____ Other: Please explain: _____

Employment status: Work status (circle one): Part-time / Full-time / Not working

Student status (circle one): Part-time / Full-time / Not a student

Citizenship (tick one): _____ Canadian _____ Other. Please explain: _____

Sexual Orientation: _____

Relationship status: _____

Do you have any children? Yes / No If so, how many? _____

Please add anything else you think is important (feel free to write on the back of this

page):

Program Characteristics (Executive Directors only)

Type of organisation: _____

Year established: _____

Number of employees: _____

Number of volunteers: _____

Organisational structure (circle one: hierarchical / collective / other

Decision-making (circle one): top-down / collective / other

Institutional affiliation: _____

Funding source (circle all that apply):

Governmental

Corporate

Fundraising

Private donations

Larger non-governmental organisation

Other: _____

Approximate annual funding: \$ _____

Do staff, placement students and volunteers participate in any ongoing training? If so, please describe the topics addressed by such training.

Post Interview Comment Sheet (for interviewer to fill out):
Discourses of Violence Against Women in Canada

Mood of the Interview

Emotional reaction of participant throughout interview

My emotional reactions to the Participant

My reactions to what the participant said

Strengths of the Interview

Weaknesses of the Interview

Additional comments

Appendix F

Original Interview Protocol

Discourses of Violence Against Women in Canada

Locating the Participant

- Can you tell me about how you became involved in the work you do/use to be involved with?
- Do/did you consider yourself part of the anti-violence movement? If yes, how so?
- Do/did you identify as feminist? What does that mean to you?
 - How does being feminist inform how you think about violence? How you talk about it? How does being a feminist affect your experiences with your organisation/program?

Violence Against Women (note: term may change depending on participant's language)

- When you hear the term “violence against women” what comes to mind?
 - What is violence against women? How do you define it?
- Has the way you understand such violence changed over the years? If so, how?
- Do you think that people you work with think or talk about violence differently than you do? What are those differences?

Practice

- Can you describe for me the work your agency/program does/did when you were involved?
- What issues do/did the services of your agency/program respond to? How?
- How do you see the role of your agency/program in regard to preventing violence against women and providing supports/interventions?

- What is/was the rationale for your services?
- What are/were the goals?
- How have you seen the work your agency/program does change over the years?

Comparing cases of practice: For participants from *community-based organisations*.

- What is/was your relationship with hospital-based services?
- How do/did you feel when providing accompaniment to hospitals in regards to interacting with hospital staff?
 - How do/did you act or talk about violence in a hospital context?
- How do hospitals understand violence? Is it different from your understanding?
- How do you understand the services hospitals provide?
- What are the positive aspects/advantages of hospital-based services for survivors of violence?
 - How do/did they relate to the work you/your agency does?
- Have you or your agency felt pressure to professionalise?
- What do you think about mental health professionals and their approach to violence against women?
- Does/did your agency have a relationship with hospital-programs or mental health professionals?
- How do you understand the relationship between hospital programs and mental health professionals and their approach to and understanding of violence against women

Comparing cases of practice: For participants from *hospital-based programs*.

- What relationship do/did you have with RCCs/BWS?
- How do RCCs/BWSs understand violence? Is it different from your understanding?

- How do you understand the services community organisations provide? How are they different from the services provided by the hospital?
- Do you see any limitations of community services?
- How do/did community agencies relate to the work you/your program does?
- Have you or your program ever felt pressure from community groups?
- What do you see as the relationship between mental health and violence against women?
- Does/did your agency have a relationship with mental health professionals?

Closing Questions

- Is there anything else that is important in understanding violence against women?
- Is there anything else I haven't asked you that you think is important to talk about?

Appendix G

Textual Documents Consulted

Type of Data	Contact with Archive/Organisation	Included in Thesis
Canadian Women's Movements Archive	Examined violence against women (VAW) finding aid and consulted all documents related to VAW within the context of Toronto, Ottawa, Ontario or Canada.	✓
City of Ottawa	Contacted the archivist and consulted a city report on a VAW task force.	x
City of Toronto	Contacted the archivist. Did not consult any documents.	x
Province of Ontario	Contacted the archivist and reviewed the online fonds. Was directed to the Ontario Women's Directorate.	x
Women's College Hospital	Contacted the archivist and consulted all documents related to the hospital's sexual assault treatment centre.	✓

Type of Data	Contact with Archive/Organisation	Included in Thesis
Archival documents		
Ontario Women's Directorate	Contacted the Ontario Women's Directorate via e-mail. They were unaware of documentation relating to the funding/development of sexual assault treatment centres.	x
Ottawa Rape Crisis Centre	Consulted a current pamphlet, website data and public education materials.	✓
Ottawa Hospital – Civic Campus	Consulted website data.	✓
Ottawa Coalition to End Violence Against Women	Consulted a document that was the guiding framework of Ottawa's hospital-based sexual assault treatment centre.	✓
Sexual Assault Survivors Support Line	Consulted website data.	✓
Sexual Assault Network	Reviewed the on-site archive and consulted all documents related to the development and execution of Ottawa's sexual assault treatment centre.	✓