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Coping Among Advocates with and without Lived Experience of Sexual Assault

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Running Head: COPING AMONG ADVOCATES

Coping Among Advocates with and without Lived Experience of Sexual Assault

A Master's Thesis

Presented in

Partial Fulfillment of the

Requirements for the Degree of

Doctor of Philosophy

By

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October 9, 2017

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Biography

The author was born in Prešov, Slovakia, on December 8, 1989. She immigrated to the United States in 1999, attending Taft High School in Chicago. She received her Bachelor of Science degree from DePaul University in 2012.

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Abstract

Volunteer sexual assault survivor advocates are vital to the provision of services by rape crisis centers. Volunteer advocates are exposed to trauma by witnessing the emotional and psychological impact of sexual assault on survivors. Trauma exposure places providers at risk for experiencing negative outcomes, such as vicarious trauma or secondary traumatic stress. Additionally, advocates who are survivors of sexual assault may be at higher risk for these negative outcomes. However, trauma exposure can also be a source of positive outcomes, such as posttraumatic growth. Focusing on advocate strengths, such as coping and self-care strategies that help advocates overcome distress during advocacy and their ability to navigate relational resources, whether at their organization or within their personal life, is important to preventing negative outcomes, promoting positive outcomes, and retaining volunteers in rape crisis centers long-term. Because some advocates may be survivors of sexual assault, understanding if and how experiences of advocates who are survivors compare to those who are not may further illuminate coping processes of advocates.

The current study sought to explore experiences of advocates through qualitative interviewing with eighteen advocates, eleven of whom identified as survivors of sexual assault. Participants were recruited from three rape crisis centers in a Midwestern region. Transcribed interviews were analyzed using thematic analysis under a constructivist paradigm and themes were identified inductively. Themes were identified relevant to (a) individual coping strategies: debriefing with family or friends, distraction, non-verbal emotional expression, focusing on positives, information gathering and problem-solving, mindfulness, preparing, relaxation, self-evaluation, setting limits, compartmentalizing, and lack of coping; (b) organization support of volunteers: building an advocacy community, debriefing with members of the organizations,

support around calls, and encouraging self-care; and (c) barriers and limitations to coping: barriers that are advocate specific, need for formal support services, limited options for social support, and role specific barriers. Differences between advocates who survived sexual assault and advocates who did not experience sexual assault were found primarily in the functions of coping strategies, such as selecting strategies to cope with triggers during calls, and unique organizational support needs for survivors. Findings may inform coping strategies and organizational support.

Introduction

Rape crisis centers provide various services catered to survivors of sexual violence, including advocacy within the emergency room (ER) for survivors who seek post assault care (ICASA, 2007). Most rape crisis centers rely on volunteers for advocacy outreach in ERs. The Illinois Coalition Against Sexual Assault (ICASA, 2013) describes the responsibilities of an advocate as providing information and supporting survivors through the process of receiving care from various systems, such as the medical and legal systems. Advocates may listen to the survivor's story, witness the survivor's reactions to rape, and provide support through the evidence collection process, which expose advocates to the physical and emotional consequences of rape (Ghahramanlou & Brodbeck, 2000). The role of a sexual assault survivor advocate involves exposure to trauma, which may have negative outcomes for advocate well-being and, in turn, high turn over rates. Therefore, understanding the experiences of advocates is essential for organizations in retaining volunteers (Hellman & House, 2006).

High attrition rates among volunteer advocates are commonplace in sexual assault and domestic violence organizations. One study reported that half of 20 interviewed sexual assault and domestic violence hotline volunteers dropped out immediately following their initial training (Yanay & Yanay, 2008). Of these women, only one woman who was a survivor dropped out; hence, in this particular sample, survivors of assault were more likely to remain in their role (Yanay & Yanay, 2008). The authors proposed that one reason for the high attrition rate might have been that women felt overwhelmed after the intense training period (Yanay & Yanay, 2008). Furthermore, volunteers may have, as a result of their commitment to the process of engaging in the intense training, felt that they have fulfilled their role as volunteers (Yanay & Yanay, 2008). If feelings of being overwhelmed are a cause of immediate dropout, feeling

overwhelmed may also be experienced by those who select to remain, but drop out later. Hotline volunteers who dropped out after a year or more reported a lack of clear delineation of boundaries with clients by the organization leading to “confusion, overload, and a growing feeling of vulnerability, which they called ‘secondary trauma’” (Yanay & Yanay, 2008, p. 73). In fact, using a grounded theory approach, a qualitative analysis found that staff burnout was identified as one of the barriers to providing services to survivors (Ullman & Townsend, 2007). Some advocates reported burnout as a cause of leaving advocacy work (Ullman & Townsend, 2007). While these reports were made by staff, similar experiences may be reported by volunteers as well. In light of feelings of burden and feeling overwhelmed as potential causes for attrition, supporting advocates in their role is essential to ensuring advocate well-being and addressing issues of attrition related to burden, and, ultimately, providing effective services to survivors being served by advocates.

Furthering the need to ensure advocates are supported in their work is the likelihood that some advocates are survivors themselves because a) the prevalence of rape is high and b) those with lived experience may be drawn to helping others who have experienced sexual trauma. In a national sample of the general population, 19.1% of women reported experiencing attempted or completed rape (Smith et al., 2017). While studies have rarely focused primarily on the unique experiences of advocates who are survivors, a number of qualitative studies reported in their demographics advocates who identified as survivors (Campbell, & Clark, 2002; Clemans, 2004; Rath, 2008; Wasco, Yanay & Yanay, 2008). For instance, Wasco and colleagues (2002) reported that four of eight advocates identified as survivors. Yanay and Yanay (2008) reported that nine of 20 volunteers identified as survivors of sexual or family violence. Clemans (2004) reported that 10 of 21 staff advocates identified as survivors of sexual or intimate partner violence.

Advocates who are survivors may have different experiences than advocates who have not experienced sexual assault, such as being triggered or reminded of their own trauma during their advocacy work. Therefore, it is essential to understand how advocates who are survivors uniquely experience their role, including coping strategies they may use and support needs advocates may have from the organization within which they provide services.

Outcomes Associated with Trauma Care

Directly experiencing traumatizing events, such as rape, can have a significant impact on an individual's beliefs, emotions, and behaviors. Trauma may also be experienced indirectly, such as by advocates who work with rape survivors. Indeed, the diagnostic criteria for trauma under Post-Traumatic Stress Disorder (PTSD) acknowledge the possibility of experiencing PTSD symptoms after witnessing, learning about, or having repeated exposure to the details of a traumatic event (APA, 2013). Examples provided by the DSM-5 include, "first responders collecting human remains; police officers repeatedly exposed to details of child abuse" (APA, 2013, p. 271). Rape survivor advocates are among first responders and are repeatedly exposed to details of sexual assault survivors' experiences, which may place them at risk for experiencing PTSD symptoms.

Burnout

Repeated indirect exposure to trauma among advocates may lead to burnout. While burnout is characterized by emotional exhaustion and cynicism, burnout is not specific to trauma care (Maslach, 1981). Counselors working with sexual assault survivors compared to counselors who do not work with sexual assault survivors have reported higher rates of burnout (Johnson & Hunter, 1997). Sexual assault and domestic violence workers and volunteers, including crisis workers, scored in the high range of one subscale of burnout (Baird & Jenkins, 2003). Further,

level of risk for burnout may be different for staff vs. volunteers. Sexual assault and domestic violence volunteers were found to be more likely to experience burnout when they saw fewer clients, but this relation was not found for staff (Baird & Jenkins, 2003). While work-related stress may lead to burnout (Figley, 1995), and burnout may be experienced by providers working with any population (Kadambi & Ennis, 2004), the concept of secondary traumatic stress (STS), also referred to as compassion fatigue, is specific to providers who work in trauma care (Figley, 1995).

Secondary Traumatic Stress/Compassion Fatigue

STS is a construct developed based in understanding that PTSD can occur indirectly; therefore, STS involves emotions and behaviors resulting from exposure to trauma as a provider that may mirror PTSD symptoms (Figley, 1995). As sexual assault survivor advocates provide services to individuals who have experienced trauma, STS is relevant to consider in understanding their experiences as advocates and the impact of trauma exposure on providers. Staff rape survivor advocates reported symptoms of STS in a qualitative study, including recurring dreams, hypervigilance, and anxiety (Clemans, 2004). Volunteer crisis workers are at likely similar or higher risk, given that they do not have regular interaction with colleagues through the structure of employment at crisis centers. It is also possible that due to volunteer advocates having less frequent interaction with survivors than staff advocates, they may not have the opportunity to develop sufficient coping strategies.

Vicarious Trauma

A construct related to STS is vicarious traumatization (VT). The concept of VT was originally conceptualized to explain therapists' responses to work with clients who have experienced trauma (McCann & Pearlman, 1990), and has since been explored in other types of

trauma care, such as social workers, interpreters, and rape crisis staff (Cohen & Collens, 2013). In contrast to the focus of STS on the emotional and behavioral response to trauma care (Figley, 1995), VT refers to a change in an individual's belief system as a result of providing care for individuals who have experienced trauma (McCann & Pearlman, 1990). For example, some providers may begin to believe the world is dangerous after listening to repeated stories of trauma among their clients. VT is conceptualized within a constructivist self-development theory framework, which postulates that individuals base their reality in schemas, including beliefs and assumptions, which are utilized to understand events (McCann & Pearlman, 1990). When new information is gained, the individual strives to incorporate the information into existing schemas; when incorporating new information is not possible, the individual alters their schemas. In essence, following the constructivist self-development theory, exposure to trauma disrupts the beliefs that a provider has in relation to trust, intimacy, self-esteem, power, and safety (McCann & Pearlman, 1990). With repeated exposure to traumatic materials, providers may incorporate the trauma into their schemas and alter their beliefs (McCann & Pearlman, 1990). This may result in experiences of PTSD symptoms (McCann & Pearlman, 1990). Individual differences in how providers are impacted by traumatic material may arise in which schemas are salient to providers; for example, a provider to whom safety is particularly salient might not select to work with survivors of rape (McCann & Pearlman, 1990). Counselors working with survivors of sexual assault have described belief changes related to their work, such as becoming more distrustful of men (Schauben & Frazier, 1995). Staff rape survivor advocates have reported belief-system change, particularly feeling more vulnerable and less safe, and having trouble being intimate (Clemans, 2004).

According to a metasynthesis of 20 qualitative studies conducted with various human service providers including advocates, social workers, and counselors working with trauma survivors such as survivors of sexual violence, several factors can increase or decrease one's vulnerability to the negative consequences of engaging in trauma work, such as self-care, spirituality, and remaining realistically optimistic (Cohen & Collens, 2013). In light of the impact of trauma care on providers, considering the impact on volunteer crisis workers, such as sexual assault survivor advocates, is essential. Additionally, some volunteers may deny experiencing VT, while still describing the negative impact of the work (Howlett & Collins, 2014). In other words, advocates may not recognize the impact of their work, but being exposed to trauma may still have negative outcomes.

Survivor Status and Vicarious Trauma and Secondary Traumatic Stress. Because some rape survivor advocates may be survivors of sexual assault themselves, considering the impact of their personal history of trauma is relevant to understanding their experience as advocates. Personal trauma history was found to predict STS among psychotherapists who work with individuals who have experienced trauma, primarily child survivors of sexual abuse (Killian, 2008). Additionally, research has found that survivors of sexual assault may experience changes in schematic beliefs (Littleton, 2007), and trauma-related schematic beliefs may be strengthened through subsequent indirect traumatization, or VT. Therefore, VT and STS may be particularly relevant to advocates who may also be survivors of sexual assault themselves.

The role of personal history of trauma in impacting the likelihood of trauma care providers developing VT and STS has been investigated, but findings have been inconsistent. Some studies have found a relationship between being a survivor and STS/VT (Dunkley & Whelan, 2006; Dworkin, Sorell, & Allen, 2014; Ghahramanlou & Brodbeck, 2000; Pearlman &

Mac Ian, 1995; Slattery & Goodman, 2009), while other studies have not found this relationship (Adam & Riggs, 2008; Kadambi & Truscott, 2004; Michalopoulos & Aparicio, 2012; Schauben & Frazier, 1995; Way et al., 2004). For instance, in critique, a comprehensive review of studies on VT argued that VT does not occur disproportionately among trauma care providers compared to providers working in other fields (Kadambi & Ennis, 2004). Based on their review, the authors suggested that providers' personal trauma history may be the primary factor that increases vulnerability to VT rather than exposure to others' trauma (as conceptualized by VT).

Regardless, negative responses resulting from trauma care are well documented across studies (Cohen & Collens, 2013). Additional research in this area is needed to flesh out the disagreement in regards to the utility of the construct of VT, especially how personal history of trauma should be conceptualized. Longitudinal studies, for example, are needed in light of the reliance on cross-sectional data analysis to track belief system change over time in providers with trauma history and to tease out the role of trauma history in VT. Additionally, whether experiences of VT/STS are associated with personal trauma history and/or exposure to trauma, learning about *how* advocates who are survivors experience advocacy can offer more information not only on how to best support advocates, but provide insight into the process of VT.

Regardless of the limitations of VT research, two studies that focused specifically on sexual assault survivor advocates, including staff and volunteers, found that advocates with personal trauma history were more likely to experience VT/STS (Dworkin, Sorell, & Allen, 2014; Ghahramanlou & Brodbeck, 2000). In one study, 164 staff rape survivor advocates completed a survey, including demographics questions, questions regarding supervision, client load, the Posttraumatic Checklist-Civilian Version (PCL-C) to assess STS, and the Sexual Experiences Survey (SES) to assess survivor history (Dworkin, Sorrell, & Allen, 2014). Findings

indicated that lower levels of STS were related to lack of survivor history, older age, more supervision for non-advocates (those not providing direct advocacy, such as educators). Agency-level indicators for lower STS were having a lower overall agency client load mean and high agency supervision mean, indicating that there might be importance to the overall agency factors and consideration of co-workers (Dworkin, Sorrell, & Allen, 2014). In a second study, 89 sexual assault trauma counselors completed the following surveys: the Impact of Events Scale after the most stressful call recalled, Modified Fear Survey III-Rape Related Fear Scale, Penn Inventory of PTSD (Penn), and the Symptom Checklist-90-Revised Global Severity Index (SCL-90-R GSI) (Ghahramanlou & Brodbeck, 2000). Findings indicated that personal trauma history and age predicted symptoms on the SCL-90-R GSI. Satisfaction level, personal trauma history, and age predicted severity on the Penn (Ghahramanlou & Brodbeck, 2000).

Further, differentiating among advocates (i.e., crisis workers/counselors) and clinicians (i.e., psychotherapists/counselors) is essential in parsing out impact on provider well-being. Orientation and training are additional agency-level factors that may not adequately protect against VT and STS among advocates. Because advocates have limited training—a 40-60 hour certification, advocates might not receive adequate training on VT compared to therapists specializing in trauma care (Ghahramanlou & Brodbeck, 2000). Additionally, advocates primarily provide crisis services, signifying that the nature of their work differs from the primary role of a clinician (Ghahramanlou & Brodbeck, 2000; Howlett & Collins, 2014). More specifically, volunteer advocates accompany survivors in emergency rooms; as such, advocates are witnessing survivors at a heightened, distressed state and do not have many opportunities to follow up with survivors beyond a few follow up calls within the crisis period (a day or two after the initial ER response). On the other hand, clinicians working with survivors have opportunities

to develop longer relationships and work with survivors beyond the immediate crisis, potentially witnessing posttraumatic growth. Further, clinicians may have more training on how to manage personal reactions related to their own histories of trauma compared to advocates. Compared to clinicians, advocates may have more difficulty processing their own past trauma within the context of their role due to the limited training and support structure offered at some agencies.

Alternative Frameworks for Understanding Outcomes of Trauma Care

Although negative outcomes associated with trauma work have been a focus in the literature, alternative frameworks for understanding the experiences of advocates acknowledge positive outcomes of trauma work. For example, vicarious posttraumatic growth (VPTG) posits that positive changes in one's belief system can occur as a result of working with populations that have experienced trauma (Cohen & Collens, 2013). Compassion satisfaction refers to positive emotions experienced as part of trauma care (Samios, Abel, & Rodzik, 2013). Further, negative emotional responses to trauma work have also been re-conceptualized in an adaptive framework. These alternative frameworks may promote a more holistic understanding of the experiences of rape survivor advocates in general and the subset of advocates who are survivors.

Vicarious Posttraumatic Growth

The concept of VPTG is considered to be a separate process from VT in which providers can simultaneously experience growth while experiencing distress (Cohen & Collens, 2013). The term is based in the construct of posttraumatic growth (PTG), which refers to positive changes occurring after experiencing trauma, such as increased appreciation and shifting priorities (Tedeschi & Calhoun, 2004). In VPTG, providers report positive changes in attitudes, beliefs, personal qualities, and daily activities. A metasynthesis of qualitative research by Cohen and Collens (2013) provided examples of positive changes among counselors working with

populations who have experienced trauma, including focusing on what is most important in life, and becoming more compassionate, accepting, and humble. However, these changes seem to be related to observing client growth and more research needs to be conducted to determine whether roles that do not allow time for this process to occur are related to experiences of VPTG (Cohen & Collens, 2013). Yet, the possibility exists that client growth may occur during a short time span as research has found that sexual assault survivors have reported positive changes even two weeks after assault (Frazier, Conlon, & Glaser, 2001).

Research on the construct of VPTG among advocates is limited in the current literature. One qualitative study that used a strengths perspective with domestic violence advocates indicated that perceived success in coping and having good coping role models was found in those describing less stress (Bell, 2003). Additionally, many advocates described lived experience with domestic violence as a motivation and those who had felt they had processed their trauma described less stress (Bell, 2003). The occurrence of positive change has been found to be associated with experience in one's role, time, belief in overcoming emotional responses, and observing client growth (Cohen & Collens, 2013). Medical advocates who support sexual assault survivors within an ER serve a unique role in that, in most cases, they are present solely during the survivors' crises. As a result, they may not have an opportunity to experience survivors' growth if growth occurs for the survivors with whom advocates work.

On the other hand, if the advocate experienced PTG after her own assault, she might experience positive outcomes when working with others. Survivors of sexual assault have reported experiences of PTG even after only two weeks after experiencing assault (Frazier et al., 2001). Positive changes included increased empathy, positive changes to relationships, and improvement to spiritual well-being. Among these changes, the most prominent change reported

was an increased concern for others who have experienced a similar event (Frazier et al., 2001). An increased concern for other survivors may be related to motivation to volunteer as an advocate. Volunteer and staff domestic violence and sexual assault counselors and crisis workers who were motivated to volunteer by having experienced sexual assault were more likely to experience positive changes, report that advocacy work improved their own recovery than individuals with other motivations to volunteer, but were also more likely to report experiencing STS (Jenkins, Mitchell, Baird, Whitfield, & Meyer, 2010). Advocates who have experienced sexual assault and who have experienced PTG may continue to experience positive changes as part of their own PTG experience but also in the context of their advocacy experience in the form of VPTG. In other words, while advocates may not have the opportunity to observe client growth due to short-term service provision, advocates who are survivors may experience their own growth which might impact on the positive changes they experience as advocates. In fact, counselors working with survivors of sexual assault who are themselves survivors reported that counseling has aided them in their own recovery (Schauben & Frazier, 1995). Additionally, recent research has found that, among other factors, more severe trauma histories of sexual assault and domestic violence advocates were related with vicarious resilience, a construct composed of both vicarious posttraumatic growth and compassionate satisfaction measures (Frey, Beesly, Abbott, & Kendrick, 2017)

Compassion Satisfaction

Compassion satisfaction refers to positive emotions experienced as part of trauma work, such as feelings of fulfillment or pleasure from supporting others (Samios, et al., 2013). This has been conceptualized as unique to the experience of therapists (Samios et al., 2013); however, recent research has demonstrated the applicability to advocates (Frey et al., 2017). Compassion

satisfaction has been found to be predicted by a variety of work-related factors, such as higher social support and less work hours (Killian, 2008). In a unique study, compassion satisfaction was conceptualized within the broaden-and-build theory, which posits that positive emotions can help individuals broaden their mindset and build coping resources (Samios et al., 2013). In this sense, compassion satisfaction is one coping resource that counteracts the exposure to trauma (Samios et al., 2013). Indeed, compassion satisfaction was found to moderate the relationship between STS and anxiety among therapists, such that therapists who reported low compassion satisfaction reported higher levels of anxiety when they reported higher levels of STS, but levels of anxiety did not differ depending on STS levels for therapists reporting high compassion satisfaction (Samios et al., 2013). Further analysis into the mechanisms of compassion satisfaction found that positive reframing partially mediated the relationship between positive emotionality and compassion satisfaction; however, the results should be interpreted with caution as the mediation model was based on cross-sectional data (Samios et al., 2013). The authors concluded that therapists should not only be aware of possible negative outcomes of working with individuals who are survivors of trauma, but also positive aspects, such as compassion satisfaction, that may be beneficial (Samios et al., 2013). Additionally, positive outcomes may be related to personal histories of trauma (Frey et al., 2017).

Emotional Responses

While compassion satisfaction typically refers to positive emotions (Samios et al., 2013), emotions that are traditionally understood as negative responses may also serve positive functions for advocates (Wasco & Campbell, 2002). In this sense, emotional responses to trauma work can be understood as adaptive rather than within the VT framework (Wasco & Campbell, 2002). Advocates have reported that their emotions of anger and fear are adaptive (Wasco &

Campbell, 2002). For instance, anger can serve to motivate advocacy for change and remaining in direct service provider roles, and encourage empathy (Wasco & Campbell, 2002).

Understanding how advocates conceptualize their emotional reactions to their work is essential to supporting them, such that positive ways in which advocates channel their emotions may be discovered.

Based on the literature, it is apparent that advocates may experience positive and negative responses to their work. Another way to conceptualize provider responses is that providers experience a range of emotional and belief-related changes as a part of their role. While these responses are outcomes related to trauma care, understanding how advocates cope with trauma exposure during advocacy is important to learning more about differences in outcomes.

Additionally, as mentioned, having experienced trauma may impact advocate experiences. Because some advocates may be survivors (Rath, 2008; Wasco & Campbell, 2002a; Yanay & Yanay, 2008), it is important to understand if and how their survivor status impacts their responses to their advocate role. For example, VT has been conceptualized as being a concept specific to survivors (Kadambi & Ennis, 2004) and research specifically with providers who are sexual assault survivor advocates has found that advocates who are survivors may be more likely to experience STS (Dworkin, Sorell, & Allen, 2014; Ghahramanlou & Brodbeck, 2000). Perhaps being a survivor is related to belief system changes associated with VT and experiencing related STS symptoms.

Coping

Facilitating coping with stress and trauma exposure in rape crisis centers is essential to counteract negative outcomes and promote positive outcomes. Stress is defined as an experience based in the transaction between the individual and her environment that causes distress through

over or under arousal (Aldwin, 2007). Certain stressors, trauma in particular, are severe and appraised as exceeding an individual's resources for coping (Aldwin, 2007). Coping refers to a process of effortful cognitive and behavioral engagement in addressing or tolerating stress that is perceived to be burdensome "or exceeding the resources of the person" (Lazarus & Folkman, 1984, p. 141). Because coping is a process, coping changes depending on situational demands and appraisal. Further, coping is differentiated from automatic responses to stress. Lazarus and Folkman (1984) theorized that coping is situated within a transaction between the stressor, the individual's appraisal, and coping resources.

According to Lazarus and Folkman (1984), appraisal is an essential aspect of coping that is thought to account for individual differences in responding to stress. The concept of appraisal, based in phenomenological ideas of meaning making, brought a cognitive interpretation to the traditionally physiological understanding of stress and coping (Lazarus & Folkman, 1984). Appraisal is reflective of an interaction between the person and her environment. Lazarus and Folkman explain that "cognitive appraisal reflects the unique and changing relationship... between a person with certain distinctive characteristics (i.e. values, commitments, and styles of perceiving and thinking) and an environment whose characteristics must be predicted and interpreted" (Lazarus & Folkman, 1984, p. 24). Appraisal is composed of primary and secondary appraisal, two processes that do not necessarily indicate precedence of one (primary) over the other (secondary) or a temporal relationship (Lazarus & Folkman, 1984). Primary appraisal refers to a categorization process of experience in which an individual decides whether an experience is benign or positive, irrelevant, or stressful. Secondary appraisal refers to an evaluative process of coping options or resources available and possible outcomes based on an interaction with primary appraisal. Secondary appraisal can include perceived efficacy and

expectations of outcomes (Lazarus & Folkman, 1984). Appraisal is distinct from reactions to stress, such as emotional responses. However, there is an interaction between emotional reactions and appraisal, such that emotions can be a result of appraisal or a cause of appraisal (Lazarus & Folkman, 1984). It is important to note that appraisal is a transaction between the individual and the environment, as the environment can influence how an individual appraises the stressor (Aldwin, 2007). Reappraisal can also occur following initial appraisal of an inciting experience. When new information is gained from the environment or even the individual's own response, appraisal could re-occur (Lazarus & Folkman, 1984).

Further, advocacy may be conceptualized as a chronic stressor given that advocates respond to multiple shifts throughout the course of their volunteer work. However, the experience of chronic stress is, too, dependent on appraisal (Gottlieb, 1997). The present study focused on volunteers, who are exposed to crisis response less often than staff advocates. As mentioned previously, staff advocates may have developed different coping strategies in light of stressors staff face more regularly. Further, chronic stress may be a consequence of negative outcomes of trauma care, such as increased awareness of one's own vulnerability, as chronic stress has been conceptualized as spanning multiple role domains (Gottlieb, 1997). More specifically, limiting the definition of stress to experiences within advocacy may not fully capture the range of stressors with which advocates cope, as they may be coping with the chronic stress of negative consequences (e.g. a chronic STS symptom).

Coping Functions

Emotion-focused and problem-focused coping. According to Folkman and Lazarus (1980), coping serves two functions categorized within emotion-focused and problem-focused coping. Emotion-focused coping is an attempt to minimize emotional responses to stress, such as

by avoiding the cause of stress or finding positivity in a negative event. Problem-focused coping is an attempt to change the relation between the individual and her environment in which the stress originates.

Approach and avoidance coping. The model of approach and avoidance coping originated in Roth and Cohen's (1986) work in the 1980s. Roth and Cohen (1986) developed a model of coping in an attempt to integrate existing models of coping, such as in anticipatory-threat research and traumatic stress research. Approach and avoidance both indicate cognitive, emotional, and behavioral responses to stress; avoidance coping means activity away from threat, while approach coping means activity toward threat. An example of avoidance coping is distraction and denying threat, while an example of approach coping is being open to engaging with the threatening stimuli (Roth & Cohen, 1986). This distinction is similar to Lazarus and Folkman (1984) distinction between emotion-focused and problem-focused coping. However, Lazarus and Folkman's (1984) model includes finding positivity within emotion-focused coping, which is typically related to avoidance. Similar to Lazarus and Folkman's (1984) model, Roth and Cohen's (1986) model allows some flexibility as approach and avoidance can vary within and across individuals. For instance, some individuals may select certain strategies that are inconsistent with situational demands due to a personal coping style.

The approach and avoidance model of coping also provides a framework for understanding adaptive and maladaptive coping (Roth & Cohen, 1986). Avoidance is useful in reducing anxiety and worry, and may be adaptive when used in "doses" to avoid becoming overwhelmed with the trauma when one's coping resources are insufficient. In this way, avoidance can also be a path to approach coping, such that threat can be avoided until the individual is ready to utilize approach coping. Additionally, avoidance is useful to avoid

unnecessary worry when there is no control and no action to be taken. On the other hand, approach coping is useful when the situation is controllable or an action can be taken. Approach coping can also allow for emotional expression and the integration of the trauma to the individual's self. However, these coping styles are not without negative consequences.

Disadvantages of avoidance include numbness, lack of integration and emotional expression, and intrusions. For example, an individual who engages in avoidance may limit her activities to such extent in avoiding trauma that it can be maladaptive. Disadvantages for approach coping include more distress in addressing trauma and, when there is no option to take an action—in other words, a mismatch between style and situation—, it can cause distress. In summary, coping adaptiveness is dependent on situational factors such as whether there is some form of control. Adaptiveness of these coping strategies also depends on a number of factors, such as whether integration is even possible or the amount of available resources, such as support (Roth and Cohen, 1986).

Provider Coping. Counselors working with sexual assault survivors have endorsed “active” coping strategies that can be equated to approach coping, such as, “I make a plan of action,” as well as avoidance coping engagement related to denial and detachment (Schauben & Frazier, 1995). However, when compared to counselors who do not work in sexual assault, research has indicated that counselors working with survivors of sexual assault may have different coping patterns (Johnson & Hunter, 1977). Sexual assault counselors were more likely to report engaging in escape-avoidance coping as compared to counselors who do not work with sexual assault survivors, which emphasizes the importance of understanding the experiences of providers for sexual assault survivors (Johnson & Hunter, 1977).

Appraisal of emotional reactions is important to outcomes. For instance, some advocates may think of anger as being adaptive (Wasco & Campbell, 2002). Experiencing these responses to trauma care and the way in which advocates appraise them may impact the ways in which they cope with these responses. However, advocates may not be aware or focusing on their own reactions during a call. In a qualitative dissertation study, one advocate explained, “My feelings? I’m not aware of them really. I usually—after they’re gone—absorb everything...So I don’t really think about my own feelings” (Smith, 1998, p. 114). Therefore, coping for some advocates, may not occur until after the call has been completed. On the other hand, dissociating from the call while providing services may also be considered a form of coping for advocates (Smith, 1998). Additionally, re-appraisal may be important in understanding advocate experiences. It is possible that over time, advocates alter their appraisal of the severity of stress and their need for coping. For instance, first time advocates may appraise the experience as being highly traumatic, but, over time, advocates may appraise a visit to the ER as stressful, but not traumatic.

Coping with responses to trauma care may additionally involve coping with personal trauma. Although studies have not formally investigated rates of histories of sexual trauma in survivor-advocates, various studies have reported samples of advocates self-identifying as survivors as part of the demographics description (Rath, 2008; Wasco & Campbell, 2002; Yanay & Yanay, 2008). As a result of the possibility that some advocates may also identify as survivors, coping for advocates may include considerations of whether advocates have processed their own trauma or utilized avoidance in coping with their own trauma (Cohen & Collens, 2013). Advocates who are survivors may describe utilizing approach or avoidance coping in addressing potential issues of VT. Based on past research (Johnson & Hunter, 1997), it may be

that advocates may report more instances of engaging in avoidance coping during their advocacy work. On the other hand, they may report having utilized both approach and avoidance coping in addressing their own trauma (Campbell, Dworkin, & Cabral, 2009).

Additionally, survivors who become advocates may also have different appraisal experiences. Some survivors may appraise responding to a call as more traumatic, perhaps particularly so if the call is re-traumatizing or reminds them of their traumatic experiences. Other survivors may appraise responding to a call as less traumatic because of having survived a traumatic experience that have exceeded their coping resources; (this might particularly be the case if survivors find themselves to be successfully coping with their experience.)

Survivor Coping. The model of approach and avoidance coping (Roth & Cohen, 1986) has been applied to coping after sexual assault. Avoidance coping (e.g., avoiding triggers or painful emotional experiences) has been found to be associated with negative outcomes, such as length of recovery time (Campbell, Dworkin, & Cabral, 2009). In contrast, approach coping strategies such as social support seeking, have had mixed findings; some studies have found that social support seeking was related to distress (Campbell, Dworkin, & Cabral, 2009). The lack of consistent findings for approach coping has provided some support for the hypothesis that avoidance coping may be an adaptive response to stress (Campbell, Dworkin, & Cabral, 2009). Frazier and Burnett (1994) investigated coping strategies used immediately after sexual assault trauma by utilizing measures of symptoms and open-ended questions, which were coded for approach and avoidance, cognitive, behavioral, or emotional coping, and problem or emotion-focused coping. The coping strategies most likely to be used were checking the door before opening and keeping doors locked, while the least likely were not answering the phone or pretending not to be at home. Factor analysis defining 8 factors, which explained 57% of the

variance, confirmed that precaution was most common and withdrawal was least common for this group. Based on open-ended responses, the most common helpful coping strategies were talking, expressing emotion, and social support. Approach, behavioral, and emotion-focused coping strategies were most common. When comparing the relationship between coping and symptoms, remaining at home and withdrawal were related to higher symptom levels than suppressing thoughts and keeping busy. Since the latter group of coping strategies can be classified under avoidance, this study (Frazier & Burnett, 1994) provides evidence that avoidance may be useful immediately after trauma. In contrast, remaining at home and withdrawal, while still under the avoidance coping category, seem to be grouped together by emphasizing a lack of activity. Therefore, avoidance coping may be adaptive immediately post sexual assault (Frazier & Burnett, 1994), but that there exists more nuance in coping strategies than solely the division between avoidance and approach coping, some of which may be trauma-specific. Because rape is an uncontrollable event, most approaches may be emotion-focused and avoidant (Frazier & Burnett, 1994). However, avoidance coping may be most adaptive when used in conjunction with approach coping to facilitate integration of the trauma with the self.

In studies with rape survivors (Littleton, 2007; Littleton & Radecki Breitkopf, 2006), factors related to differences in coping strategies were investigated. Negative sequelae post trauma such as self-blame and level of force during victimization were related to avoidance coping (Littleton & Radecki Breitkopf, 2006). Additionally, outside of the victimization itself and related sequelae, social support has also been investigated as a factor contributing to approach coping. For example, others may encourage the expression of emotion. As a result social support may decrease negative outcomes post trauma. Littleton and Radecki Breitkopf found that self-blame and low self-worth were related to avoidance coping utilization,

demonstrating the importance of cognition in recovery from trauma (Littleton & Radecki Breitkopf, 2006). Avoidance coping was also found to be related to egocentric responses from others (e.g., “Expressed so much anger at the other person involved that you had to calm him/her down” [Littleton & Radecki Breitkopf, 2006, p. 109]). The relationship between egocentricism and avoidance could be due to the survivor not being able to provide support due to experiencing her own emotional response. In addition, egocentric responses would require survivors to provide support as opposed to focus energy on receiving support (Littleton & Radecki Breitkopf, 2006). Although survivors engaging in avoidance were not more likely to have less support, social support acted as a “buffer” for self-worth (but not self-blame) which was associated with level of avoidance coping. Overall, social support was not related to avoidance. Use of force was related to avoidance. It could be that experiencing use of force is evaluated as exceeding coping resources, thereby leading to the use of avoidance. Additionally, use of force was related to egocentric responses (Littleton & Radecki Breitkopf, 2006).

Beliefs. Furthermore, coping patterns have found to be associated to schematic beliefs, following the information processing model (Littleton, 2007). The information processing model posits that experiences of interpersonal violence may challenge existing schematic beliefs of survivors. Survivors may assimilate their experiences of violence by incorporating them into their belief system, change their beliefs to “accommodate”—or integrate— their experiences of violence, or “overaccommodate” experiences by making maladaptive changes in beliefs, such as by believing that the world is dangerous or that the survivor herself is worthless.

Overaccommodation has been suggested to occur when survivors do not have sufficient social support or when they have been revictimized. In a cluster-analysis of sexual assault survivors’ coping patterns, scores on the Coping Strategies Inventory were consistent across three groups:

those who were high utilizers of avoidance, those who used both avoidance and approach, and those who did not engage much in coping (Littleton, 2007). These groups were supported by differences in beliefs, distress, and labeling. For instance, survivors who utilized accommodation experienced less distress than survivors who overaccommodate, but more than survivors who assimilate their experiences of violence. The finding that survivors who accommodated experienced more distress than survivors who assimilated is inconsistent with the assumption that survivors who accommodated might experience best outcomes as they are “not minimizing the severity of the rape or dramatically altering schematic beliefs” (798). It may be the case that survivors who accommodated have not completely gone through the reintegration process; therefore, they are currently accommodating, not accommodated. Survivors who assimilated were found to be less distressed, which could be due to a lack of processing and the possibility that long-term consequences may surface later on. Survivors who assimilated were also less likely to consider their experience a victimization and less likely to use verbal and physical resistance, which could be because they might perceive that they did not resist enough and might be more likely to avoid labeling their experience as victimization. It may also be the case that since survivors who assimilated are less likely to think of their experience as victimizing, they will be less likely to remember engaging in resistance. However, based on these particular findings (Littleton, 2007), it is unclear whether coping causes distress or vice versa.

Rape acknowledgment. Rape acknowledgment is important to consider in the context of coping among providers who have experienced sexual assault. Acknowledgement of rape, or labeling one’s assault experience as rape, has also been found to be relevant to coping as most survivors do not acknowledge their experience as rape (Littleton, Axsom, & Radecki Breitkopf, 2006). Survivors who label their experience as rape reported more use of avoidance coping, (but

not approach coping), which could be due to a reliance on avoidance because they consider the assault to be beyond their coping resources. Survivors who label their experience as rape were more likely to disclose and disclosed to more people, and more likely to receive egocentric responses, yet maintained their just worldview. The ability to maintain a just worldview regardless of receiving egocentric responses could be because egocentric responses often mean anger at the perpetrator, which could reinforce beliefs in a just world. (Littleton et al., 2006). Findings indicated that acknowledgment does not necessarily mean positive outcomes for recovery as evidenced by the finding that acknowledgment was related to more likely use of maladaptive avoidance coping, for example. However, findings need to be replicated as the study did not have equivalent groups. (Although differences were controlled for, this does not completely account for differences as having equivalent groups initially would be ideal.)

Because rape acknowledgement often relates to coping, such as seeking social support, rape acknowledgement is relevant to advocate experiences for survivors. Advocates who are survivors may struggle with decisions of disclosure and most advocates explained that disclosure occurs on a case-by-case basis (Smith, 1998). One advocate explained,

“And there’s been one survivor in the hospital who did ask me if I had ever been raped. And I told her, and that seemed to really help her immediately. That, well, here’s somebody who’s gone through what I’ve gone through. And so—I didn’t go into details with her, obviously. We were told this in training, what if somebody asks you? And that’s your own decision. And I’d always thought, well, I’ll just use my own judgment at the time as to whether I think it’s going to help. But I was asked, point blank. I would never volunteer that information. I don’t think it’s appropriate. But in this case, I felt like she

would be helped by a direct answer. I didn't want to beat around the bush with her, and I think it was a good decision on my part" (Smith, 1998, p. 133).

As apparent, advocates who are survivors who do label their experience as sexual assault may encounter situations that may require them to decide whether to disclose their survivor status, which may, for some, be perceived as taxing and an experience that may result in engagement in coping.

Self-Care

Self-care is a method of promoting one's ability to cope with stress and involves regular engagement in wellness-oriented activities. Self-care refers to resources that individuals draw on to actively engage in coping (Lazarus & Folkman, 1984). Self-care is often thought of as a proactive, rather than reactive, strategy to address exposure to trauma. Personal self-care includes daily routines, such as exercise, meditation, engaging in leisurely activities, psychotherapy, as well as occasional activities, such as vacations (Cohen & Collens, 2013). Based on coping theory, self-care may involve drawing on various resources, such as the ability to recruit others in coping or having a generally positive outlook (Wasco et al., 2002). Self-care resources can be conceptualized as material, such as finances, or abstract, such as skills or attitudes (Lazarus & Folkman, 1984). Additionally, considering an individual's resources also involves their ability to find, access, and utilize resources (Lazarus & Folkman, 1984).

Lazarus and Folkman identified six resources, including social skills, social support, positive beliefs, problem-solving skills, health and energy, and material resources. However, Lazarus and Folkman acknowledged that categorization might not include all possible resources. Additionally, the way in which research on provider self-care has developed categories has differed. While some qualitative studies with trauma providers identify types of self-care

strategies based on findings arising from the data, (Killian, 2008) others code data using pre-existing models of self-care (Wasco et al., 2002). Across studies on provider self-care, the following self-care resources are often cited: social, cognitive, physical, and spiritual.

Lazarus and Folkman identified social skills and social support as two resources for self-care, which together can be categorized within a broader category of social resources. Social skills refer to having the ability to communicate and behave effectively to effectively draw on social support resources. In turn, social support refers to having others who can serve as resources themselves. (Lazarus & Folkman, 1984). Similarly, social resources focus on relationships (O'Halloran & Linton, 2000) and can sometimes be referred to as relational (Shannon, Simmelink-McCleary, Hyojin, Becher, & Crook-Lyon, 2014).

Positive beliefs and problem-solving skills may be categorized as cognitive self-care strategies. Positive beliefs as a resource refer to positivity, such as hope or an internal locus of control, as a self-care strategy (Lazarus & Folkman, 1984). Problem-solving skills refers to an ability to evaluate a decision-making situation, weigh various options, and make a decision to follow (Lazarus & Folkman, 1984). In essence, problem-solving skills involve action-orientation as a method of self-care.

Health and energy as a resource can also be conceptualized as a physical self-care strategy. Being healthier and having more energy are resources to coping under stress (Lazarus & Folkman, 1984). Finally, Lazarus and Folkman identify material resources, meaning having the monetary means as a resource for coping. Having finances may increase options for coping and provide access to additional resources.

Self-Care Among Providers. Specifically for providers working with individuals who have experienced trauma, self-care focuses on strategies in dealing with vicarious exposure to trauma (Wasco, Campbell, & Clark, 2002). Much like broad studies of coping, studies focusing on provider self-care have identified primarily four self-care strategies, including social, cognitive, physical, and spiritual. For example, specific strategies that have been categorized as social resources include spending time with others (Wasco et al., 2002) and debriefing (Killian, 2008; Shannon et al., 2014). One rape survivor advocate reported, “I surround myself with positive people that have positive interests” (Wasco et al., 2002, p. 742). A clinician treating clients who have experienced sexual abuse spoke regarding her social support, “You have to have people to process with, and have people to process with that get it,” (Killian, 2008, p.36). Additionally, types of self-care strategies were found to influence work-related stress, but not experiences of compassion fatigue and satisfaction, and burnout (Killian, 2008).

Cognitive resources can be conceptualized as internal and, in general, involve changing the way an individual perceives their experience (Wasco et al., 2002). These can involve having a positive attitude or positive beliefs (Lazarus & Folkman, 1984; Cohen & Collens, 2013). Cognitive strategies for providers can also involve avoidance of material related to trauma, distractions such as watching television (Killian, 2008), and self-talk (Wasco et al., 2002).

Physical resources are often conceptualized as health-related (Lazarus & Folkman, 1984), such as yoga for exercise (Killian, 2008). However, exercise may exclude other strategies, such as relaxation techniques, crafts (Shannon et al., 2014), and physical resources associated with other senses, such as music (Wasco et al., 2002); therefore, physical resources is a more encompassing category. One rape survivor advocate explained, “physical activity, exercise, I do

that. The really hard ones, I cry. And sometimes I drive around and cry” (Wasco et al., 2002, p. 742).

Spiritual resources can be based in religion or other value system, such as philosophical beliefs (Wasco et al., 2002). While Lazarus and Folkman did not mention spirituality as a resource, they did acknowledge that other resources beyond their list exist. Rape survivor advocates reported engaging in various faith-based practices, such as praying (Wasco et al., 2002). Clinicians reported engaging other practices, such as meditation as part of a daily ritual (Killian, 2008). As apparent, certain strategies, such as meditation, can be conceptualized within different categories of self-care resources. Engagement in spirituality has also been found a protective factor against negative effects of trauma care (Cohen & Collens, 2013).

While social, cognitive, physical, and spiritual resources were reported consistently across studies focused on providers of self-care (Killian, 2007; Shannon et al., 2014; Wasco et al., 2002), other categories are also possible. For instance, Wasco and colleagues (2002) identified verbal strategies, which included utilizing language as a resource. This can be internal, such as by keeping a diary, or external, such as by communicating with others (Wasco et al., 2002). Verbal resources may also be conceptualized within other categories. Diary keeping could be considered a physical strategy and sharing with others could be a social strategy.

While understanding types of strategies that advocates may draw on is important, considering the functions they serve provides a more nuanced understanding of how advocates may cope with the challenges in their roles. The functions served by self-care strategies were identified from the data rather than using an existing model (Wasco et al., 2002). Advocates were found to utilize self-care strategies in an effort to experience *catharsis*— to manage work related stress—, or to *integrate* their work experiences by integrating new skills or supports to address

stress (Wasco et al., 2002). Examples of proactive cathartic strategies included exercise, being selective about the types of movies watched, such as avoiding violent movies, or social support seeking, such as venting or debriefing (Wasco et al., 2002). Similarly to the cathartic method (Wasco et al., 2002), social work students describe cognitive strategies serving to avoid further exposure to trauma, such as by avoiding traumatic material outside of coursework (Shannon et al., 2014). Examples of integrative strategies included changing beliefs, such as realizing that the advocate does not have to fulfill all support roles for the survivor and proactively selecting the types of people an advocate is around (Wasco et al., 2002). Studies have also found that providers attempted to “tune out’ from thinking about work” by compartmentalizing their work and home lives (Cohen & Collens, 2013, p.574), which may be conceptualized as serving a third function of compartmentalization. Prior research has not specifically investigated whether self-care strategies and their functions differ for providers depending on they have a history of sexual assault.

Organizational Context

Organizational factors are relevant to provider outcomes, as they serve as the settings that can promote coping and self-care in providers. Among other factors, work drain and lack of work morale predicted burnout, while feeling powerless and work drain predicted compassion fatigue (Killian, 2008). As apparent, organizational factors, such as work drain, level of control at work, and lack of work morale are important to outcomes. Although self-care was unrelated to compassion fatigue and satisfaction, and burnout, self-care strategies were associated with work stress, such that avoidance was associated with higher levels of stress. Additionally, adaptive self-care was associated with lower work stress levels (Killian, 2008). A possibility is that self-care strategies associated with work stress are a function of whether the provider is experiencing

compassion fatigue and burnout. As a result, Killian (2008) underscores that organizational efforts to emphasize individual coping are not successful; efforts should be placed on organizations to facilitate self-care and address burnout and compassion fatigue, such as redistribution of workload.

Findings on the relationship between self-care and work-related outcomes show the importance of extra-individual factors, or perhaps the interaction between individual and microsystem in outcomes of compassion fatigue and satisfaction, and burnout (Killian, 2008). For providers of individuals who have experienced trauma, coping with trauma-related work involves organizational support and personal self-care (Cohen & Collens, 2013). The necessity for internal and external coping resources aligns with the ecological theory of self-care, which contextualizes self-care within an interaction between the individual and her environment, including extra-individual resources such as organizational support (Wasco et al., 2002). Organizational support can involve a range of methods implemented by an employer to reduce stress among staff, such as diversifying workloads and providing effective training and supervision (Cohen & Collens, 2013). Most clinicians who work with survivors of child sexual abuse explained that self-care was not addressed in their training (Killian, 2008), while advocate volunteers may have had training on self-care. Developing self-care strategies can occur in training (Shannon et al., 2014). One participant in a study of social work students describes the freedom of feeling emotions which she experienced, “Until taking this course, I would have likely been concerned or even ashamed by some of my emotional reactions to hearing or reading about another person’s traumatic experiences...I have learned that these are all ‘normal’ responses...it is imperative to be mindful of my emotional reactions, in order to process my feelings in a healthy and productive manner, so that I can provide effective services/treatment”

(Shannon et al., 2014, p. 447). Similarly, for rape crisis center volunteers, satisfaction was positively related to perceptions of the value of monthly meetings and training, and social support (Hellman & House, 2006). Further, value of monthly meetings was also found to be related to whether volunteers intended to remain (Hellman & House, 2006), providing further evidence of the importance of organizational factors in decreasing turnover. Burnout was reported as related to insufficient supervision as well as lack of funding by current and past rape crisis workers (Ullman & Townsend, 2007). Racism was also identified as a barrier in rape crisis center with clear implications for burnout, as advocates reported witnessing lack of resources in neighborhoods composed primarily of ethnic minorities and experiencing racism in their workplace (Ullman & Townsend, 2007). Among domestic violence and sexual assault advocates, higher scores on a measure of compassion satisfaction were related to higher rating on perceived organizational support (Frey et al., 2017).

Receiving organizational support in coping with the impact of trauma care is associated with positive outcomes for providers. In investigating the relationship between personal self-care and organizational support, findings indicated that when more organizational support was available, coping strategies were more likely to become integral to the advocate's life by becoming a skill, strength, or support incorporated into advocate's life (Wasco et al., 2002). Providers therefore may be more likely to engage in self-care if the organization emphasizes and provides resources for coping. Additionally, higher social support, lower work hours, and higher locus of control at work predicted compassion satisfaction (Killian, 2008), indicating the importance of organizational factors in provider outcomes.

While organizations may provide support to providers in dealing with negative aspects of their work, organizations can also emphasize possible positive outcomes. Because compassion

satisfaction serves as a buffer for the relationship between secondary traumatic stress and anxiety, authors concluded that compassion satisfaction, in addition to other constructs focused on positive aspects of trauma work, such as positive emotionality and reframing, may be explored between the therapist and her supervisor (Samios et al., 2013). In essence, organizations may help providers build on positive self-care strategies or coping methods.

Because some advocates may themselves be survivors, organizations may provide additional support for providers who are survivors. Since personal trauma history may manifest as post-traumatic stress disorder (PTSD) symptoms, the traumatic experience may continue to have a negative impact on therapist worldview (Killian, 2008). Killian (2008) suggests that organizations focus on providing support to providers who may have personal trauma history, such as by providing affordable access to employee assistance programs. Response to self-identified survivors in rape advocacy organizations depends on the individual's needs and motivations for seeking volunteerism. For instance, a rape crisis center offers support to those who seek volunteer activities as a way to cope with their trauma by providing counseling and inviting them to serve as advocates after they have begun to address issues related to their trauma history (Rath, 2008). Although personal trauma history was mentioned previous studies (Killian, 2008; Shannon et al., 2014; Wasco et al., 2002), the relationship between self-care and personal trauma history was not explored. One dissertation study, however, explored the process of survivors transitioning into advocacy roles (Smith, 1998). Advocates who are survivors provided suggestions for improvement in organizational support, such as receiving support from an experienced volunteer, more emphasis on what to expect, and receiving an exit interview (Smith, 1998). While these suggestions were provided by survivors, similar suggestions might be

expressed by non-survivors. Because experiences of survivors have not been formally compared to non-survivors in studies, how survivor status impacts organizational needs remains unclear.

Theoretical Framework

Lazarus and Folkman's (1984) theory of stress, appraisal, and coping was used as a guiding theoretical framework for the study. The stress response process includes the following components: (a) a threat, (b) appraisal composed of the individual and her environment (c) emotional reactions, (d) coping (Lazarus & Folkman, 1984). Additionally, self-care is conceptualized in the current theoretical framework as an aspect of coping. Participants were asked about all three components (i.e., threat, appraisal, and coping) to generate data pertinent to coping.

More specifically, threat in the context of the present study was conceptualized as stressors encountered during advocacy. Because coping processes can be indicative of patterns, but are also situationally dependent, meaning that they may change based on the demands of the environment, different ER calls may yield different coping strategies. Aspects of individual calls were conceptualized as the stressors within the coping model. Personal history of trauma was identified as another potential stressor impacting experiences of survivors as they cope within an advocacy role.

Regarding appraisal, incorporating perceptions of the environment in understanding coping is essential because coping is dependent upon environmental demands. In the current study, advocates were asked about specific calls they have responded to in an ER. To incorporate aspects of the environment within the interview, advocates were asked about what they found challenging during the call and what they felt good about.

Regarding coping, participants were asked about what they do in response to reactions, which are, in essence, reactions to their own appraisals of stressors experiences during advocacy.

The utility of using a transactional model of coping that includes, within appraisal, a transaction between the person and her environment, is that this model lends itself to conceptualizing coping as not only individually based, but externally based. Considering external aspects of coping is particularly important in light of research indicating that organizational-level factors promote positive outcomes (Cohen & Collens, 2013; Killian, 2008; Samios et al., 2003; Shannon et al., 2014; Wasco et al., 2002). Ecological models of coping are often based in Bronfenbrenner's ecological model. By nesting the transactional theory of coping within an ecological framework, Wang and Heppner (2011) conceptualized coping as a transaction between the immediate environment and the individuals—survivors of childhood sexual abuse (CSA)—influenced by systems at different levels i.e., the individual, the relational, and the sociocultural context. The current study focused on the individual and relational contexts in understanding coping processes (see Figure 1).

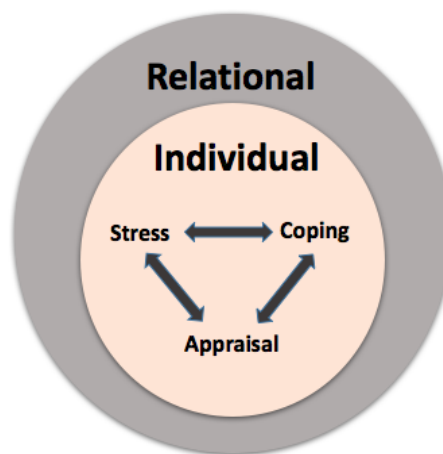


Figure 1. Guiding theoretical model.

Within the present study, the environment was conceptualized as the relational level of the coping model. According to an integrative model of coping and ecology, the environment is composed of both the physical and social environment (Holahan & Spearly, 1980). The environment described by advocates as being particularly challenging, might be interactions with medical or legal staff. Survivors who have experienced negative interactions with police officers, for instance, might perceive interactions with police as an advocate to be particularly demanding. As a result, the relational level of the proposed guiding model may include organizational factors, such as supervision interactions, support groups, or other forms of social support within the organizational context.

Each level of the proposed guiding model is inclusive of the transactional model between stress, appraisal, and coping. At the individual level, the immediate experience of providing ER services may be the stressor, while appraisal may be based on various factors including survivor status, which may, in turn, impact coping. Coping, in turn, may impact further appraisal as well as how the stressor is experienced. At the relational level, the stressor may be lack of organizational support, such as effective supervision or interactions with survivors in the ER. Likewise, coping may depend on relational factors, such as whether support groups and additional training is provided when needed. As such, discussing aspects of stress and appraisal in interviews facilitated discussing coping.

Rationale

Many rape crisis centers are able to provide services primarily due to a large pool of volunteers providing services in ER settings. Rape survivor advocates have a significant amount of responsibility, in that they serve as first responders to survivors. As such, advocates are exposed to trauma within the context of their role, which may lead to experiences of PTSD-like

symptoms conceptualized as STS and belief system changes conceptualized as VT. Working with survivors of sexual assault has been found to be related to higher rates of burnout than counselors working with other populations (Johnson & Hunter, 1997) and experiencing burden may be related to attrition among sexual assault and domestic violence advocate volunteers (Yanay & Yanay, 2008). To retain volunteers and ensure their well-being in a role that exposes advocates to trauma, providing adequate support is a key component of preventing possible negative outcomes, such as VT and STS, and facilitating positive outcomes, such as compassion satisfaction (Samios et al., 2013) or re-appraisal of emotional responses such as anger and fear as motivating and adaptive (Wasco & Campbell, 2002). In essence, rape crisis centers have the responsibility to adequately prepare volunteers and provide ongoing supervision; in turn, advocates as individuals are responsible to identify and utilize resources helpful to them and seek support when needed.

The present study aimed to explore how advocates cope within their roles. Further, advocates who are themselves survivors may experience outcomes differently, as they may be at higher risk for STS (Dworkin, Sorell, & Allen, 2014; Ghahramanlou & Brodbeck, 2000). Prior research has not investigated how providers with lived experience in the same trauma as the population they work with might cope differently than providers who have not experienced that trauma. In light of higher rates of STS in providers with history of trauma, understanding how advocates who are themselves survivors of sexual assault conceptualize their trauma history as part (or not) of their role is important to providing support to advocates who are survivors. As such, the present study also sought to explore the impact sexual assault history might have in shaping advocate experiences of coping. In order to explore the unique contribution of survivor status to coping, experiences of advocates who are survivors were compared to advocates who

did not experience sexual assault. It is possible that survivors who become advocates have non-avoidant coping strategies that contribute to their choice to volunteer, for instance. This might also provide insight into how advocates who are survivors take care of themselves after potentially triggering ER calls. Comparing coping experiences of survivors to women who do not label as having experienced sexual assault may also demonstrate that survivors cope similarly, or perhaps that differences in coping across survivor status are dependent on where survivors are in their coping process with their own personal trauma. Findings from the present study inform organizational support for advocates and advocate personal self-care.

The present study focused specifically on women. Women report experiencing rape more often than men (Smith et al., 2017). However, men who are survivors often under-report experiences of rape and may have different experiences than women who are survivors, such as ways in which victim blaming occurs (Davies and Rogers, 2006). Men are blamed when they did not physically fight back, while women are blamed for aspects of their character (Davies & Rogers, 2006). Male survivors who select to be advocates may therefore have different experiences, challenges, and coping mechanisms than women survivors. Further, prior research with advocates has focused primarily or all on women likely due to higher rates of women providers in rape crisis centers (e.g., Clemans, 2004; Houston-Kolnik et al., 2017; Rath, 2008). Given differences in experiences of survivors based on gender and existing research on advocates who are women, the present study focused solely on women to obtain a more homogenous sample and be situated within the literature.

Given the exploratory nature of the study, a qualitative methodology was used. Rather than focusing solely on differences in the types of coping strategies used among advocates with and without lived experience of sexual assault, one of the goals of the present study was to

clarify how the *functions* of various coping strategies may differ for survivors. For instance, while both advocates with and without lived experience might use avoidance strategies, survivors might use avoidance to serve a different purpose than women who did not experience sexual assault. As such, qualitative methodology promoted the exploration of the function of strategies.

Lazarus and Folkman's (1984) theory of stress, appraisal, and coping served as the guiding theoretical framework for the proposed study. More specifically, the theoretical framework guided the research questions for the proposed qualitative study in order to generate responses regarding coping practices; however, themes related to coping strategies were identified inductively. Under Lazarus and Folkman's (1984) transactional model, advocates were asked about their stressors, appraisal, and coping, and the transactions between them. The purpose of this strategy is that participants may have trouble identifying coping strategies without first discussing stressors and how they appraised the stressors. This may particularly be the case for avoidance coping strategies; for instance, individuals may not realize they are using alcohol as an avoidance strategy to cope with a stressor that they appraise as not having sufficient resources to manage. More specifically, participants were asked about what is particularly challenging as a way to naturally lead to their perceptions of what coping strategies they use in response to stressors.

Outside of an explicit focus on the theoretical model, the interview guide was also developed based on existing key factors that may impact stressors, appraisal, and coping. Advocates were asked about changes they have seen in themselves since beginning advocacy work as a way to prime advocates to discuss outcomes, such as VT and STS, that may lead advocates in identifying ways they cope. Additionally, the study sought to learn about the

motivations that survivors have for selecting to provide advocacy services. Motivations have been found to be relevant to outcomes for advocates. Advocates motivated by their own experience of assault reported more positive changes, but were also more likely to experience STS (Jenkins et al., 2010). Further, motivations could be reflective of advocate coping with their own trauma, which may impact their experiences of PTG and subsequent coping. In other words, being motivated by having experienced assault may impact engagement in coping; as such, asking participants about motivations was used as another angle through which to generate participant identification of their coping mechanisms.

To distinguish between immediate reactions to providing advocacy services and coping, advocates were asked about automatic emotions and cognitions they experience during service provision that are distinct from coping (Lazarus & Folkman, 1984) as well as coping strategies. Regarding reactions, advocates were asked about thoughts and feelings in response to ER calls. In terms of coping engagement, advocates were asked what they do in response to reactions to gauge how they might engage in conscious or unconscious coping. While the language was vague, if participants did not speak to coping, the interviewer probed using the word “cope” and “self-care.” Additionally, participants who are survivors of sexual assault were asked explicitly about how they cope as advocates who are survivors. Coping was also conceptualized at the organizational level, such that advocates were asked about ways in which organizations where they volunteer support them. Further, participants were also asked about unmet needs. To generate ideas specific to survivors, participants were asked about whether there are unmet needs at their organization specific to survivors.

Research Questions

Research Question I: What coping strategies do rape survivor advocates use to cope with exposure to indirect trauma within their role as advocates?

Research Question II: How do the coping practices compare among advocates with and without lived experience of sexual assault?

Research Question III: How do organizations support advocate coping?

Research Question IV: How could coping with advocacy be improved?

Method

The present study utilized a qualitative design to investigate experiences of women who volunteer as sexual assault survivor advocates. Interview questions focused primarily on coping of two groups of advocates: women who identified as survivors of sexual assault and women who did not experience sexual assault. The study was conducted in collaboration with three Midwestern organizations that provide rape crisis services, including medical and legal advocacy in hospital emergency rooms. Moving forward, subsequent mentions of “ER calls” refer to emergency room response.

Participants

Eighteen rape survivor advocates who served as emergency room advocates were recruited from rape crisis centers in a large metropolitan area. Two groups of advocates were recruited: advocates who identified as survivors of sexual assault (n=11) and advocates who did not identify as having experienced sexual assault (n=7). The inclusion criteria included: being a woman, a current volunteer advocate who has responded to at least two calls within an ER, and at least 18-years-old, not having experienced trauma within the last six months, and either (a) someone who has not experienced sexual assault or (b) someone who has experienced sexual

assault and was comfortable talking about their experience with a trained interviewer.

Individuals were excluded if they have experienced a traumatic event within the last 6 months, if they were a staff member, an advocate who identifies as a man, an advocate who has responded to less than 2 ER calls, or advocates who serve only on hotlines.

Materials

The interview protocol used in the study can be found in Appendix A. The protocol was developed by the researcher based on previous literature, primarily the coping model underlying the conceptualization of the study (Lazarus & Folkman, 1984). Advocates who are survivors were asked how their survivor status has impacted their coping, but were not asked to describe their traumatic experience in detail. If the participant became distressed, such as becoming tearful, the interviewer paused the interview to provide crisis counseling and reminded participants of their option to continue. The interviewer was prepared to conduct risk assessments if necessary; however, this was not needed with the present sample of participants. Regarding training, the interviewer has completed a 60-hour training for rape victim advocacy and is receiving clinical training as part of her ongoing graduate studies. The interviewer has also studied and practiced qualitative interviewing skills, including probing, re-directing, and avoiding leading questions (Patton, 2002; Seidman, 1998). In a qualitative study, survivors have emphasized that interviewers acknowledge how their understanding of rape might be limited (Campbell, Adams, Wasco, Ahrens, & Sefl, 2009). As a result, the interviewer avoided phrases such as “I understand” (Campbell et al., 2009) regardless of survivor status and relied on neutral phrases such as “I hear you” and reflection by using participant language. Additionally, survivors explained that interviews can create a safe environment and establish trust by allowing “women to talk at their pace and give them control over what they choose to discuss” (p. 606). The

interviewer was supervised by a licensed psychologist, who provided oversight, feedback on implementation of qualitative interviewing skills, and debriefing regarding emotional responses to conducting interviews.

Following the interview, participants were provided with a paper and pencil survey. The survey asked questions related to demographics and advocacy experiences, such as number of ER calls advocates have responded to. The full survey may be found in Appendix B.

Procedures

The investigator contacted local organizations that provide sexual assault medical advocacy in emergency rooms. Participants were recruited via emails and in-person recruitment with consent from organizations. Flyers were distributed to volunteer advocates via email by staff, primarily volunteer coordinators. The recruitment email contained a link to an online screening survey (Appendix C). At the end of the survey, advocates were asked to provide their contact information. The recruitment materials also included the research lab phone number and the investigator's university email to allow potential participants the choice to call or email about their participation. Individuals who selected to call about the study were screened using an eligibility screening script similar to the online screening survey. Individuals who contacted the investigator via email were provided the link to the online screening survey. Advocates were also recruited in-person at an organizational event. The investigator recruited participants using a verbal script and provided flyers.

Individuals who were eligible to participate were asked about their interest in participating. Advocates who chose to participate were scheduled for an interview with the researcher. Interview schedules were tracked via a password-protected file. Interested participants had the choice of meeting at DePaul, a private meeting room in a neighborhood

public library, or in their home. At the scheduled interview time, the principal investigator met the participant at their desired location and obtained informed consent. Participants received \$20 cash compensation for their time immediately following informed consent to emphasize that receiving the incentive was not dependent on completing the full interview. However, all participants selected to stay for the entire study participation. The interview was conducted using open-ended questions and audio-recorded with the participant's consent. Interviews occurred between October 2015 and March 2017, and lasted on average 1 hour and 16 minutes.

Audio-recorded interviews were transcribed verbatim in separate Microsoft Word documents using Express Scribe and transferred into NVivo 11 for analysis. During the transcription phase, participant interviews were de-identified. To ensure accuracy, the transcribed data were examined against the recordings multiple times (Braun & Clarke, 2006).

Organizations. The three organizations that agreed to participate are located in a large metropolitan area and suburban areas in the United States. All organizations provide various sexual assault services, including mental health counseling, crisis ER advocacy, and long-term medical and legal advocacy. One organization is a small center with approximately twenty-five active volunteers. The second and third organizations have multiple locations and advocates dually serve as hotline and ER volunteers. Seventy-eight percent ($n = 14$) of all participants reported serving as hotline responders at their organization beyond ER response. In all centers, volunteers were provided training that is grounded in ICASA's standards with additional specialized training focused on specific needs of the community served, such as cultural sensitivity, providing bilingual Spanish and English services, and work with law enforcement. While most volunteers complete year-long contracts, a small number of volunteers continue to provide services long-term.

Data Analysis

Data were analyzed using thematic analysis; common ideas present across participants were grouped together in themes identified by the coder (Braun & Clarke, 2006). A theme was defined as a common, reoccurring idea that is important to the research questions. While a theoretical framework guided the research questions, themes were identified inductively –from within the data— as opposed to deductively or data that is organized by pre-existing themes based on theory (Braun & Clarke, 2006). Use of an inductive approach allowed themes to be more representative to the data as opposed to tied to preconceived theories, which was essential to the exploratory nature of this study in understanding the experiences of first responder providers with and without lived experience of sexual trauma. As such, a constructivist paradigm guided the analyses. Constructivism postulates that reality is constructed by individuals, thereby there does not exist one reality that can be understood through research as under positivism (Creswell, 2013.) In essence, constructivism posits that research findings are co-constructed between the researcher and participants (Guba & Lincoln, 1994), emphasizing the agency of participants in understanding their own experience and, therefore, a shared power between researchers and participants in the creation of knowledge. In practice, constructivism is apparent through research methods that rely on data collected through interactions between researchers and participants (Guba & Lincoln, 1994). Constructivism lends itself to an interviewing style heavily based in probing techniques to clarify the interviewer’s working hypotheses as well as explore new ideas and interpretations relevant to the research questions that arise within the interview.

According to Braun and Clarke (2008), the process of thematic analysis is flexible and iterative in that it requires constant engagement with the specific case being analyzed, the larger

data set, and the written piece. The primary components, as a result, did not necessarily occur consecutively, but recursively. The primary components of thematic analysis include: becoming familiar with the data, creating initial codes, identifying themes from codes or data, reviewing the themes by ensuring that the coded portions match the themes, naming and defining the themes (Braun & Clarke, 2006).

Familiarization with the data included several interactions with the transcripts through listening, note-taking, and open coding. Open coding facilitated familiarization of the data; further, open coding was done concurrently with re-listening to the audio recordings to ensure that meanings found in intonation were captured in open coding. An individual code is the smallest component of the data that can be meaningfully identified as a coherent piece of information (Braun & Clarke, 2006). Open coding refers to labeling and categorizing of data (Strauss & Corbin, 1990). Any mention of coping was open coded during this process. Coping was differentiated from automatic reactions and automatic reactions were not coded. One complication is that cognitions could be reflective of both reactions to a stressors and coping efforts. This required active distinguishing of coping and reactions. For instance, if a participant mentioned thinking positively about the client-survivor, but did not state that still was in an effort to manage their reaction to the call, the mention was not coded. On the other hand, if a participant mentioned thinking positively about the client-survivor as positive reframing technique, for instance, this was coded. Open coding included annotating a selected portion of transcribed interview text in Microsoft Word. Larger portions of the text were highlighted to include the surrounding context for later reference. Additionally, due to the potential of overlap in themes, the same pieces of text may be coded for different codes. When inconsistencies were

noted within the data, such that inconsistent themes are found, the inconsistencies were to be retained to preserve a full understanding of the data (Braun & Clarke, 2006).

Transcripts of interviews with survivors ($n = 11$) were open coded first by two coders. Initially, to achieve consensus on open-coding, 3 transcripts were coded by both coders. Because open codes across these 3 transcripts were highly similar in nature, all subsequent transcripts were open-coded separately by the investigator and the secondary coder. Within the first group of transcripts of interviews with survivors, 5 were coded independently by the investigator and 3 by the secondary coder. If a coder did not code a particular transcript, their task was to listen to the audio recording. Once a few transcripts were open coded, the open codes were compiled and transferred into a single Word document. Consensus agreement was used in transferring open codes to the compilation document. As additional interviews were open coded, the open codes were added to the document that compiled all open codes. Similar open codes were placed closer together in the compilation document to begin identifying common patterns. In essence, this began the process of theme identification, which requires an analysis of existing open codes across participants. Themes are broader than codes and are composed of claims that get at the research questions and are based in interpretation of the transcript. Patton (2002) suggests focusing on “internal homogeneity and external heterogeneity” (p. 465). In other words, data that is coded at one theme should be similar to one another, but meaningfully different from data coded at a different theme. Themes were determined at the semantic as opposed to latent level, such that descriptive and meaning-making themes were identified along with implications and relation to the literature. However, themes were not identified at the latent level, which requires moving beyond interpretative comments and exploring larger assumptions, ideas, or ideologies that underlie those descriptions and their meanings (Braun & Clarke, 2006).

A systematic coding framework, or codebook, was developed as a way to organize themes based on the compilation document. While the use of a codebook deviates from Braun and Clarke's (2006) description of thematic analysis, using a codebook created a more systematic methodology and improves translation of findings during the writing stage. Additionally, the development of a codebook has been argued to be an essential step of identifying data saturation (Ando, Cousins, & Young, 2014). Saturation refers to a point in the coding process at which no additional unique codes are identified (Walker, 2012). The codebook consisted of each theme, its definition, and an example from the text (DeCuir-Gunby, Marshall, & McCulloch, 2011). As additional interviews were open coded, the working codebook was revised. At times, this required broadening themes to be more inclusive, combining themes, adding themes, or revising the thematic hierarchy.

Next, interviews for advocates who did not identify as having experienced sexual assault ($n = 7$) were open-coded, of which 5 were coded by the investigator and 2 were coded by the secondary coder. Open codes were compared against the themes within the working codebook. Given that open codes for this second group of interviews (i.e., women who did not identify as survivors) were highly similar to the codebook themes (i.e., based on interviews with survivors), one codebook was utilized. The process of comparing open codes against the codebook resulted in either (a) determining that open codes were already captured within the codebook themes or (b) making slight alterations to the codebook to ensure all open codes are captured.

The resulting codebook contained a broad array of themes, some of which were irrelevant to answering the specific research questions of the present study. As such, themes relevant to the research questions were selected to conduct the codebook coding process. For instance, themes surrounding participants coping with sexual assault, rather than advocacy, were not used for the

purpose of this study. Once all themes relevant to the research questions were selected into a unique codebook for the present study, all transcripts were reviewed and re-coded in NVivo 11 using this framework. Data surrounding hotline calls or training, for example, were not coded as the present study focuses on ER calls. However, training is included as organizational support when it is focused on coping with ER response. Additionally, survivor status was coded for each participant for later analysis comparing experiences of survivors to women who did not experience sexual assault. Once all transcripts were re-coded in NVivo 11 using the codebook, the coded portions of the transcript were reviewed to ensure that they meaningfully compose each theme. Final revisions to the codes were made via consensus with the supervisor. The final themes were fully defined and their associated coded data reviewed to develop a clear understanding of the meaning and utility of each theme. Themes were defined as individual entities but also in relation to the larger context of the data set and the thematic framework. Sub-themes were also clearly delineated at this stage (Braun & Clarke, 2006). Additionally, the prevalence of themes was identified to shed light on the keyness of each theme, referring to, for the purpose of the present study, how many participants mentioned that theme (Braun & Clarke, 2006).

The final analysis involved retrieving all data coded under each relevant theme, re-reading the coded data, and drafting summaries. Exerpts belonging to survivors were compared to those belonging to individuals who did not experience assault, and these differences (if present) were highlighted in the summaries. Representative quotes were selected and added to the summaries.

Trustworthiness

Trustworthiness of data is demonstrated through existing concepts evaluating quality of data analysis, similar to establishing reliability and validity in quantitative research.

Trustworthiness refers to goodness criteria, including credibility, transferability, dependability, and confirmability (Guba & Lincoln, 1994). One way to demonstrate credibility, which mirrors internal validity (Guba & Lincoln, 1994), is through the fairness criterion (Morrow, 2005). The fairness criterion refers to respecting diverse perspectives (Morrow, 2005). In practice, this meant noting differences mentioned by single participants in the present study. Unlike quantitative aims for objectivity, the aim of including diverse voices as a key component of the fairness criterion is inclusion and thus avoiding marginalization (Lincoln & Guba, 2000). Furthermore, diverse experiences in the way that themes function for individuals are respected in the present study by noting differences mentioned by single participants.

Transferability, mirroring external validity, is demonstrated through triangulation. The triangulation criterion (Morrow, 2005) is demonstrated through the triangulation of interpretations by multiple individuals involved in data analysis. Two coders were involved in open coding and codebook development and audit was provided by the investigator's advisor. As such, generalizability was demonstrated through agreement on a shared understanding of the data based on involvement of multiple individuals with varying backgrounds and value systems. Transferability was promoted through thick description of the organizational context as well as the data analytic method to allow readers to determine generalizability to other contexts.

Dependability, mirroring reliability, was promoted by audit. The investigator's advisor audited the codebook coding process, by reviewing transcripts and open codes, as well as working with the investigator to arrive at agreement regarding the codebook hierarchy and

codebook coding of specific transcripts that were difficult to place initially. As mentioned previously, coding with a secondary coder was based on consensus agreement to promote dependability.

Confirmability, similar to objectivity, was established through the investigator's reflexivity during debriefing sessions with the investigator's advisor. The investigator considered how her personal experiences may impact her interpretations of the data.

Results

Table 1

Demographic Characteristics

Characteristic	Total	Survivors	Non-Survivors ^a
	<i>N</i> = 18	<i>n</i> = 11	<i>n</i> = 7
Age <i>M</i> (<i>SD</i>)	32.8 (8.68)	33.36 (10.24)	30.57 (5.74)
Women <i>n</i> (%)	18 (100%)	11 (100%)	7 (100%)
Race/Ethnicity <i>n</i> (%)			
Asian	2 (11%)	1 (1%)	1 (14.29%)
Black/African American	2 (11%)	2 (18%)	0 (0%)
Latina/Hispanic	3 (17%)	2 (18%)	1 (14.29%)
White/Caucasian	11 (61%)	6 (54.5%)	5 (71.43%)
Months Volunteering <i>M</i>	22.44 (18.75)	20.82 (16.34)	25.00 (23.22)
(<i>SD</i>)			
Number of Times			
Dispatched to Emergency			
Room ^b			
<i>M</i> (<i>SD</i>)	8.33 (9.02)	9.81 (11.27)	6.00 (2.93)
<i>Mdn</i>	5	5	5

Note. ^aOne woman did not identify as a survivor during recruitment (and is therefore counted in this sum), but during the interview described surviving an incident of sexual abuse and attempted sexual assault.

^bSome participants reported a range, in which case the average was taken. For example, “4-5” was counted as “4.5.” When participants reported an average, such as “about 5,” that digit was used (e.g., “5.”)

Overview

Participants were recruited from all three agencies as follows: 3 (17%) from agency A, 7 (39%) from agency B, and 8 (44%) agency C. Table 1 provides the sample demographics. While the interviewer did not ask participants who identified as survivors of sexual assault about the circumstances and characteristics of their experience of sexual assault, survivors reported experiencing childhood sexual abuse, sexual assault as teenagers or adults, kidnapping, assault by multiple perpetrators, domestic violence, and sex trafficking. Most women mentioned knowing the perpetrator. One participant reported experiencing sexual assault after beginning her work as an advocate. Participants across the sample also reported experiencing a range of other traumas including loss, having family or friends who survived sexual assault, and experiencing mental health issues such as surviving a suicide attempt. Participants reported coping at the individual-level and organizational-level support for coping and, as such, findings are reported to (a) describe individual coping strategies, (b) organizational support offered by agencies and whether participants engaged in these services, and (c) any barriers and limitations to coping identified by participants. Each section (i.e., a, b, and c) includes multiple subthemes. Differences between the way themes are experienced or described by survivors and women who did not identify as survivors are noted where relevant. As noted in Table 1, one woman did not identify as a survivor of sexual assault, but during the interview described an experience of sexual abuse and attempted sexual assault. To respect her identification and given that she would not have been recruited to the study if the study only sought survivors of sexual assault, she was placed with the group of women who did not experience sexual assault. This did not impact the findings or, more specifically, differences seen across groups. Table 2 provides a list of themes and associated prevalence, and unique aspects of themes for survivors. Theme prevalence is

provided as a descriptive measure of the data. However, theme prevalence within each groups is not reported to avoid misleading readers because (a) prevalence does not necessarily equate theme importance and (b) differences across groups were not identified based on theme prevalence.

Table 2

List of Themes, Theme Prevalence, and Qualitative Differences Among Groups

Themes and Subthemes	Number endorsed (% of total)	Unique Aspects among Survivors
Individual Coping Strategies		
Debriefing with family or friends	8 (44.44%)	Survivors consider who might be safe to disclose reactions to triggers to.
Distraction	7 (38.89%)	Survivors might distract from reminders of their own experiences.
Non-verbal Emotional Expression	3 (16.67%)	No unique aspects among survivors found.
Focusing on Positives	10 (55.56%)	Survivors uniquely reported utilizing gratitude journals and using positivity to maintain a balanced outlook.
Information Gathering and Problem-solving	3 (16.67%)	No unique aspects among survivors found.
Mindfulness	15 (83.33%)	Survivors reported mindfully choosing to focus on the client-survivors rather than their own experience during ER calls. Survivors noted developing this strategy during recovery.
Preparing	9 (50.00%)	No unique aspects among survivors found.

Relaxation	13 (72.22%)	One survivor described using relaxation in response to triggers.
Self-evaluation	13 (72.22%)	One participant who identified as a survivor described coping by knowing that she is helping others as a survivor.
Setting limits	11 (61.11%)	Two survivors described taking breaks from advocacy. Non-survivors said no to calls.
Compartmentalizing	17 (94.44%)	Survivors suppressed triggers during calls and separated their identity and trauma from the client-survivors.
Lack of Coping	4 (22.22%)	No unique aspects among survivors found.
Organizational Support		
Advocacy Community	13 (72.22%)	One survivor reported enjoying connecting with another survivor who is an advocate.
Debriefing	16 (88.89%)	One survivor described being supported by the volunteer coordinator as a survivor in recovery and another debriefing about triggers of sexual assault.
Encouraging Self-care	10 (55.56%)	No unique aspects among survivors

		found.
Support Around Calls	11 (61.11%)	One survivor reported being trained on how to respond to being asked personal questions about trauma by client-survivors and how to use mindfulness when triggered.
Barriers and Limitations to Coping		
Need for formal Support Services	4 (22.22%)	Survivors reported a need for access to psychotherapy for advocates who are survivors.
Limited Options for Social Support	17 (94.44%)	One survivor reported wanting meetings for survivors who are advocates specifically and another survivor reported not feeling connected with other members of the organization.
Role Specific	9 (50.00%)	Survivors reported the need for training on triggers and option to decline calls.
Advocate Specific	5 (27.78%)	No unique aspects among survivors found.

Individual Coping Strategies

Twelve themes emerged relating to coping strategies identified by participants, including: debriefing with family or friends, distraction, non-verbal emotional expression, focusing on positives, information gathering and problem-solving, mindfulness, preparing, relaxation, self-evaluation, setting limits, compartmentalizing, and lack of coping.

Debriefing with family or friends. Participants in both groups sought social support from individuals outside of the organization (e.g., friends, family, significant others, therapists, or members of their professional network) to debrief. Debriefing included sharing, processing and understanding reactions and triggers, being listened to, receiving validation, feedback, or coping ideas, sharing the weight of the call, or discussing ideas for conducting prevention work.

One participant described the utility and process of debriefing:

especially with this kinda work, um if you kind of keep it all bottled in, um, I think that it just- it's hard and m- ya know. So I think it's important to be able to connect with people for me, um and just feel listened to, feel validated, um, yeah and to let them know how I'm doing (11).

As such, debriefing created a space for participants to express their reactions, for some even receiving feedback, such as an interpretation of their own emotional response. Some participants talked about the impact of debriefing in terms of better understanding their reactions, identifying additional self-care strategies if needed, or, as mentioned briefly above, sharing the weight with others so that advocates are not coping alone.

Some participants described how they chose certain individuals as sources of support for advocacy work. Two participants described having friends who are advocates, which is advantageous in that they are familiar with the role. One individual described seeking support

from her partner who is her main source of support in other life domains. Similarly, another participant who identified as a survivor discussed the importance of a father figure “who knows everything about me, um, who I’ve been open to, helps with coping” (14); this individual has been a source of support for the participant during her recovery.

While some participants from both groups mentioned how they selected individuals for social support, one survivor spoke specifically to the need for identifying “safe people” with whom to debrief such as people in the mental health field who are good listeners and will not be too severely impacted by debriefing or someone the participant is comfortable disclosing her history of sexual assault to, which might be necessary when seeking to debrief regarding triggers. She elaborated:

close female friends, um, maybe not ones who had been survivors themselves cause if they don’t have the tools to deal with it themselves I don’t want to bring up stories from my, or just, like, my experiences and my job if they don’t feel comfortable with, like, rape crisis centers in their own life (10).

This indicates that debriefing involved various considerations in selecting the appropriate individual, including considering to whom a survivor feels comfortable disclosing experiences of triggers and, as such, their personal history of trauma.

Distraction. Both survivors and advocates without sexual assault histories utilized distraction as a way to avoid thinking about reactions related to advocacy, often co-occurring with other coping strategies. Strategies include any activities that help distract the individual, such as spending time with family and friends. One participant explains: “trying to get involved in more activities outside and meet people, something-another thing on my list. Trying to get out. So I, my mind's focused on other things besides work and over thinking this stuff” (12). As

apparent, distraction may aid in compartmentalizing as a way to transition from the advocacy role to home life. Beyond avoiding rumination, some participants also described the function of distraction as aiding in compartmentalizing, or in moving on from the advocacy role to home life. Distraction, for survivors, may be used to distract from personal experiences of their own trauma. One participant noted:

leaving a lot of these calls, I, goes back to, to my experiences and so, um... just getting that help from [individual providing social support] to, to think of ways that ...how I can help other people from becoming victims... I, distract myself with other things, like talk about prevention (14).

Non-verbal Emotional Expression. Participants described non-verbally expressing emotions as a coping strategy, such as by screaming or engaging activities to facilitate emotional expression. One participant discussed martial arts as a way to vent anger: “It’s all just shadow boxing and kicking the air, but th-it’s possible that that’s actually helping me vent some of that frustration and kind of helpless rage against these, you know, nameless perpetrators” (4).

Emotional expression can also occur within the context of other coping strategies, such as mindfully allowing oneself to experience reactions. One participant described allowing herself to experience irritation as a form of coping:

I was just kinda like irritated, but then I went home, and it was done... I think sometimes you just have to let things be like it’s okay to feel irritated it’s okay to feel frustrated, like, you just kinda like tolerate that distress and then you go on about your day, you can’t like hold on to things (17).

Focusing on positives. Participants described coping with advocacy by maintaining a positive outlook and shifting their perspective to positivity as needed. For instance, some

participants described utilizing self-talk as a way to remind themselves that the client-survivors who they supported would be okay. Participant 17 described believing in the client-survivor's resiliency and trusting that others within system will provide other services:

people are very resilient... I know this person's probably gonna be okay in their own way. Like it might take them awhile, or it might take 'em a process, or they might need to do A, B, and C before they're okay, but I just kinda believe people will be okay, in some way. Like they'll kinda just keep pushing forward, and again, I did my part. I did like my limited role, like I provided that service and then, it's up to other people to fill in those other, kinda gaps. You can't kinda think like oh I wanna do it all, right, or I wanna like make sure this person's okay like it's someone else's responsibility after it leaves me.

To avoid feeling helpless regarding advocacy, another participant described focusing on how her role was supporting the larger system. Participants also described sending positive thoughts to client-survivors or "include them in my prayers... having faith that there's-there's a higher power that will-that will take of them" (16). As apparent, focusing on positives served the purpose, for some, to avoid feeling helpless. For others, focusing on positives qualmed worries about the client-survivors. Similar to believing in people's resiliency, having faith allowed participant 16 to pass on responsibility rather than continue to worry about outcomes for client-survivors. Another participant described using self-talk to feel comfortable leaving a client-survivor at the end of the shift when they are being supported by significant others.

During calls, another participant also described finding positivity in stressors she encountered during advocacy, such as when witnessing lack of support of survivors by law enforcement; she described shifting her perspective by reminding herself of what their role and goal is: to find the perpetrator.

Participants who identified as survivors described focusing on other positive life domains as a way to maintain a balanced outlook on life including “have things to look forward to” (13).

Two participants who identified as survivors described currently or in the past keeping a gratitude journal, serving the function of balance or serving as a reminder to engage in activities.

One participant explained:

Writing down things that, um, were significant, uh, each day or that brought me joy...doing things that, um, that could produce those, kind of, good intentional, like, okay I-I took a walk and then I saw this today, um, or I was in [neighborhood name] and then I, ya know, spent some time on a bench and, like, read, like, a chapter of a book, or I did some-I’m religious so, like, did some prayer” (10).

Information Gathering and Problem-solving. Three participants mentioned action-oriented strategies to address stressors of helplessness or not knowing what happens to survivors, such as engaging in prevention work or educating people. One participant discussed information gathering in terms of seeking out opportunities to be involved in prevention work, while another participant described searching for information about a client-survivor on social media in response to feeling concern. In terms of problem-solving in response to reactions to an ER call, one participant described educating medical providers in the ER as a way to contribute to larger system change:

I like to tell the nurses kind of um, ya know, some of the things that I said to provide support... Being able to tell the nurse, ya know, I let her know that regardless of the fact that there was drinking going on- a lot of teenagers drink and that doesn’t mean um it doesn’t mean that she deserved this. And that there was nothing that she did to bring this

on herself that it was a decision that was made by the person who decided to do this very terrible- this very bad thing (16).

Mindfulness. Participants described coping with advocacy using mindfulness or choosing to pay attention to one thing at a time in the present moment. Distinguished from compartmentalizing, mindfulness was described as deliberately attending to the present moment rather than actively suppressing reactions. One participant describes this difference:

I feel like It's like an hour, you know, it, it, I have the time that I'm driving home and then it, it kinda just starts ta... to fade I guess, to where it needs to go, umm, in that hour. So I just, I guess I give myself the time, umm and don't try to do anything, I don't try to jump from one thing to the next, that's, I'm not running to a soccer game afterwards, you know, umm. So give it the respect that it deserves and then move into the next role (7).

Within emergency rooms, mindfulness means being present in the moment and focusing on the advocacy role i.e., supporting the survivor:

Whatever I have going on with myself I'll deal with it later, after I'm done. For now it's the survivor, so like I acknowledge it, I'm like, 'Yeah, I am upset' and rightfully so because there's this person who is, like, suffering or is in pain umm, so I put that to the side and be, like, yes I am sad, but let's focus on the, on the survivor (1).

After calls, participants describing utilizing mindfulness techniques as a way to process or a way to focus presently on other activities. Some participants described mindfulness as a form of a self-check: "like am I okay, like... how am I doing? You know, how um, where am I at right now, what do I need" (11). Another participant described mindfully attending to family members who are toddlers as a way to distract herself.

Mindfulness can be facilitated by or facilitate other coping strategies or various activities, including exercise such as yoga. One participant described utilizing relaxation strategies such as deep breathing to aid her in being mindful to the present moment when balancing support of the client-survivor and their significant others. Being mindful can also facilitate compartmentalizing or moving on from the advocacy role, in that once reactions are experienced and acknowledged, the participant can move on.

For survivors, being mindful during calls may mean acknowledging reminders of their own experience and deciding to focus on the survivor rather their own trauma

it is not about me. I am not there to resolve my own shit...I am, I am there to assist somebody. I am there to just be a hand holder, I'm there to be supportive, and to let you know you're not alone. So, I guess, one way of coping is knowing that. Knowing that, owning that, believing in that (7).

Participants differed in the way they developed mindfulness as a coping strategy. Some participants described learning mindfulness strategies through the organization or in classes outside of the organization, indicating that organizational support contributed to the development of this coping strategy for some participants. Additionally, some participants described developing mindfulness following surviving sexual assault, emphasizing the importance of existing coping strategies that individuals may have, particularly in coping with experiencing or witnessing trauma.

Preparing. Participants described preparing for calls such as by reviewing materials to feel more relaxed about being called, prayer to do well, or bringing physical materials to the call such as stress balls or snacks for client-survivor. Participant 16 describes the utility of preparedness in addressing pre-call stress:

I just bring all my resources with me no matter where I go. I have literally every single step of the rape kit ... if I didn't have my resources I would just be like a basket case because I wouldn't be able to provide them with the information that they need and that would cause me a lot of stress cause' that's what I'm there for.

One participant described how prayer helps her feel more confident and addresses her anxiety prior to calls:

I just say, like, a- a prayer to, like, um, to God that I say the right things, you know, um, to the person and, you know, um, things like that my words, like, help this person, like, to be there for them (5).

Participants described feeling prepared for the advocacy role more broadly by having received training in psychology or through the training provided by their agency, including roleplays. During calls, coping by preparing manifested as thinking through tasks or actively recalling what the participant learned during training. After responding to calls, preparing could mean completing paperwork for hand-off or preparing to conduct follow up phone calls to client-survivors. These strategies helped participants feel more prepared and ultimately more calm and relaxed during ER calls.

Relaxation strategies. Participants mentioned using various strategies as a way to relax. Prior to or during calls, participants described using relaxation strategies such as deep breathing to calm reactions. This was particularly true for one survivor who described being triggered when anticipating ER calls. As such, she utilized relaxation strategies to calm a sense of panic she felt prior to arriving to the hospital. Another participant described the utility of relaxing while on call, or waiting to be called,

not trying to like, multitask in terms of like run errands and get a bunch of things done and maybe that's also gonna happen...Eat healthy that day, meditate. Read, relax...having more calm mind and feeling surrounding me then helps me walk in and be calm (18).

One participant described the utility of monthly massages as a way to relax:

I thought that was really helpful because not only is that considered just, like, self-pampering thing, it's also this very healthy, wholesome form of human touch and as I was telling you earlier, like, this- doing this kind of work can really exacerbate trust issues and it's really all about invasive touch and violations and so, trusting someone while they're touching you and knowing that they're only try- you know, helping you and that it's very consensual situation and they're, um- it's just a situation of wellness (4).

Self-evaluation. Participants described using self-evaluation as a coping strategy involving processing the call and understanding that there is a limit to the role of an advocate. Regarding processing, participants discussed reflecting on their performance, what they believed they did well and ways they could improve. One participant described this process:

after any call I usually give myself some time to ...kind of go over the whole scenario if I could've um said something better – just to think— make sure I didn't miss anything. And to just give myself a moment to process it...because I have a habit of ...ruminating too much, and so I give, I intentionally give myself like 10 minutes, 5 or 10 minutes (2).

Three participants described reflecting on their performance with members of their organization, which will be discussed in the organizational support section. Regarding coping by knowing there is a limit to their role, participants described acknowledging that they did the best they could, being comfortable with not knowing everything, and knowing that since they have

fulfilled their responsibilities, the responsibility is passed on to others. One participant who identified as a survivor described coping by knowing that she is helping others as a survivor.

Setting limits. Participants discussed setting limits to their involvement in advocacy, including taking time off or not doing this work daily, taking breaks during a call, deciding not to work with sexual assault survivors as a career, changing shift times, or asking not to respond to a call. Setting limits during calls could be helpful to manage reactions or triggers: “she was really badly bruised ... seeing those, that kinda attack on someone br-, it brought me back and... I had to give myself some space cause I... really felt like I, I was shaking, I, I went, I was on the verge of crying” (14). One participant described taking a year off from advocacy after working a long shift at her primary employment and subsequently responding to two emergency room calls:

I just felt, like, overwhelmed and I had I take- I had to take time off, yeah.... ‘Cause, like, when I signed up, it was just, like, when I know I’m on call I feel this overwhelming feeling, like- I’m on call next week, I’m already feeling like, ‘Oh my god, I’m on call, I’m gonna get a call.’ I’m already feeling that right now (5).

This participant demonstrates having an awareness of her limits in that she sensed a negative reaction to thinking about signing up for a call and decided to take time off.

Participants who identified as survivors of sexual assault described taking breaks from advocacy, one who was overwhelmed due to advocacy work (described above) and another participant who was overwhelmed with having too many ongoing engagements, including applying for graduate school. Participants who did not identify as survivors, unlike survivors, described saying no to taking calls, whether saying no to responding to a second call or saying no to responding to a call when overwhelmed by the work at her primary employment. However, these differences are unlikely related to survivor status, and more likely to be related to other

domains in the participants' lives (e.g., graduate school, day job) as well as general burnout or fatigue due to advocacy response.

Compartmentalizing. Compartmentalizing emerged as a theme across both groups of advocates and manifested in two ways for participants: compartmentalizing cognitive and emotional reactions and switching to another life domain to facilitate a separation between home life and advocacy work. Compartmentalizing reactions involved participants avoiding having emotional or cognitive reactions during calls such as by thought stopping—actively pushing thoughts aside—or self-talk to avoid having an emotional reaction. After calls, this form of compartmentalizing could manifest in participants by increasing the number of activities in their day to avoid thinking about a call. Regarding the second form of compartmentalizing, participants discussed moving on past their advocacy role, such as by engaging in planned tasks, to separate their personal life from their advocacy role. Some participants discussed managing both forms of compartmentalizing:

On the calls themselves, I'm great. I am very much able to compartmentalize things and so, you know, just put everything to the side and focus on, 'I am going to be here for this person, um, I have to remember to do- you know, say these following things,' and just definitely put myself in the role that I need to be at that time. Um, it's then- yeah, coming off the call where you're- you're kinda shifting back into your life and, you know, you possibly missed a night of sleep at this point and you just kinda have to...process the heaviness of, you know, the trauma you've just witnessed while shifting back into regular mode (4).

More specifically, compartmentalizing during calls can be accomplished by orientation to tasks, much like the participant above mentions when she explains that she focuses on the client-survivor. Another participant explained,

I just tuck it away inside of me, like I don't really express that or let them know that...I just don't think about it; I just kind of think about it later, you know, do my job now, and then think about it later (15).

One way to achieve task orientation is to avoid dwelling on the trauma experienced by the client-survivor. One participant described her strategy:

I try to focus on what I'm doing, and not on like what happened to the person, so kinda not like focusing on sort of the reason I'm there, like, you know this person was sexually assaulted, like I don't, I try not to think about I- I think like, I'm here to provide support (17).

Compartmentalizing in the moment to focus on advocacy in emergency rooms thereby may facilitate distancing oneself from the trauma experienced by the client-survivors.

While rapport building is useful in advocacy, connecting with survivors may lead to more difficulty in coping. As such, conceptualizing oneself as distanced from the client may aid compartmentalizing. One participant explained: "You kinda have to...disconnect yourself from them a little bit. Um...and not be too involved in their lives like that, but it's hard, um, you really care for these individuals and you wanna know they're doing fine" (14). Another described needing to have an emotional distance from survivors discussed in the media. More specifically, while participants discussed compartmentalizing advocacy work during or after calls, compartmentalizing may also involve triggers to advocacy work occurring outside of the role. To maintain her mental health, one participant explained that she must not dwell on survivors she

hears about in the media and cannot help beyond signing petitions. As such, compartmentalizing may be a result of realizing that dwelling on things an individual cannot control is not useful.

Compartmentalization can co-occur, be facilitated by, or facilitate other coping strategies. Mindfully processing reactions to advocacy may also lead to the outcome of compartmentalizing. One participant explained that, “because I’m very in the moment, I can leave things in the moments that have passed” (7). One way to separate advocacy work from home life is to distract oneself by engaging in other activities such as spending time with friends. Further, suppressing negative reactions to advocacy work can leave room for focusing on the positive with a function to have a more balanced viewpoint rather than focusing solely “on the ugly of the world” (7).

Debriefing may facilitate compartmentalizing, in that reaching out to a supervisor, for example, may facilitate compartmentalizing. One participant explained, “And then you’re not taking it home cause you talked about it in the car and it’s gone” (8). Adding to the utility of debriefing with supervisors for compartmentalization, one participant described how confidentiality restrictions may aid compartmentalizing, in that since cases may only be discussed or processed in detail with appropriate third parties (i.e., advocacy staff), advocates move on from the call once they have tapped into their debriefing resources.

Separating advocacy work from other areas of living may be facilitated by work practices participants have developed. One participant discussed immersing herself in her day job as a way to cope, in essence spending more time and energy in another life domain. Another participant discussed habits she developed as a human services provider aware of negative outcomes such as burnout.

Compartmentalizing was primarily viewed as a useful strategy by participants. One participant explained that compartmentalization aids in avoiding rumination: “I just do things that are not gonna make me dwell on whatever just happened, you know? Because you, you went there and you did what you needed to do and now st- to move on” (8). While compartmentalizing may have benefits, one participant discussed its disadvantages in that while compartmentalizing helps her attend to the crisis, “I seem to forget to get around to the point of having my reaction” (4). In essence, if compartmentalizing is not paired with other approach coping methods, individuals may miss opportunities to process their emotional reactions.

For survivors, compartmentalizing may have the added meaning of keeping their survivor identity separate from their role as an advocate as well as suppressing reactions due to their own experiences of assault being triggered.

I think I’m able to, um, not think about it- like, I try not to think about it, like- there maybe, like, sometimes, like, um- something may... make me remember, but right at that moment, you know, I’m- I’m not, but later I may come up like, ‘Oh, what I went through,’ but at that moment it’s just, like, about that, um, person or whatever, but, um, so, I think just being there for someone, like, that helps me cope, that I know that I help someone else, but being a, um, a survivor (5).

Additionally, maintaining emotional distance from survivors may be differently experienced by some advocates who are survivors of sexual assault. One participant explained compartmentalizing by having an awareness that trauma experienced by client-survivors is not her own: “We’re two separate people... This is a trauma that you are having. I am just joining you in it, but I have a wall that separates me from you” (9).

Lack of coping. A few participants explicitly mentioned not needing to cope with advocacy overall or with a particular call. This included not having a particular coping ritual related to advocacy due to not experiencing advocacy as stressful or not as stressful as other life experiences. No differences were apparent between survivors and women who did not identify as having experienced sexual assault. Notably, all of these women mentioned coping strategies in other sections of the transcript. Not needing to cope with a particular call could be due to the participant experiencing the call as being resolved and witnessing resiliency in the client-survivor or because calls have not been particularly distressing. One participant explained that she feels she has responded to a limited number of calls and, as such, has not needed to cope. Later in the transcript, she also described considering engaging in coping by reaching out to the organization, but did not do so and was unable to identify the reason. Two of the participants in this group also described use of habitual self-care strategies that they did not connect to advocacy work in particular. As such, having the experience of not needing to cope could be due to participants already having established solid self-care practices in their lives. One participant explained:

I don't ha-I might use any of the coping ski-you know, again, even at a bad day at work... Yeah, I I-I-I don't think I would do anything different than any of those I would normally use because it was a call (9).

Organizational Support

Participants discussed various ways in which the organizations where they volunteer provide support, which culminated in the following three themes: building an advocacy community, offering debriefing with members of the organizations and support around calls, and encouraging self-care. These themes outlined organizational support that was offered rather than

solely activities in which participants engaged. There was at least one participant from each organization who endorsed each of these themes.

Advocacy community. Participants discussed ways that the organization helps build a community, which was facilitated through a supportive environment, social functions such as movie nights or appreciation events, email chains, or talking to others during debriefing meetings. Participants who were engaged in these activities felt a sense of connectedness or comradery in an otherwise isolated advocacy role. Demonstrating the interrelatedness of themes, one participant described the utility of email chains in forming a community that encourages self-care: “we’re all in an email chain, the volunteers and like I know I have sent out resources before of like, uh- ya know, here’s some quick videos for like breathing or like mindfulness, like self-care videos” (11). Some participants spoke to the importance of knowing other advocates on an individual level, which increased, for one participant, comfort in reaching out and asking others to cover shifts. Other participants spoke to forming friendships or bonds with other advocates, which led to opportunities for social support when needed. One participant who is a survivor discussed the value of connecting with another advocate who is a survivor and experiencing a sense of comradery in that “knowing that people are at that-that level with you. Like,... people that have never been through it, ta-talk differently about the subject than people that have been through it ...we share something we don’t have to talk about” (12).

Debriefing with members of the organization. Participants explained that their organization offers processing or debriefing individually with supervisors or other advocates, or in group meetings to (a) share reactions, receive validation, be listened to, and share the weight of the call; (b) ask questions and ask about ways to improve; or (c) discuss ways to enact change. Not everyone engaged in debriefing with the organization, but for those who did, they spoke to

the helpfulness of debriefing within the limits of confidentiality. Two participants also discussed ways that the volunteer coordinators at their respective organizations were supportive of not only them as advocates, but as a survivor or in professional roles outside of advocacy. Participants often debriefed to facilitate self-evaluation and address stressors of second guessing, in that they wanted to check in with supervisors to reflect with them on their performance. For instance, one advocate described the utility of reaching out to her supervisor:

if it's something like super involved, I think I'd call my supervisor, because I mean she's much more experienced in all this and she knows a lot more, especially if I had questions about if I did something the right way or the wrong way, there's sometimes you know um, I'll leave and I'll be like man should I have said this instead of this, or should I have done this instead of that, and I was like for next time, like, how should I handle the situation cause I wasn't sure, if I said the right thing to this person, or if I said the right thing to the nurse, or if I said the right things, so in those situations where it's more complex, I'll call my supervisor, who's, not just the fact that she'll hear me out just to, like, decompress, she'll also kind of help me guide ... how I should handle situations (15).

One survivor described the utility of debriefing with the volunteer coordinator regarding triggers:

she [volunteer coordinator] called me and she was worried and ...she really had to pull it out of me... where, okay, it felt like I was in the room with me, who had just been raped, and then, I was there as an advocate but I also felt like she was me in the bed, ya know, like, with her mom who seemed like my mom... (I: What part of that was the coping part?...) lessening my boundaries and allowing myself to talk with someone when I was so, like, not indignant but I think ...when you feel like you're too strong to, like, talk to

someone when you probably should talk to someone I think that there is something actually pretty weak about that. And so, um, I did have to really lo-had to, like, let down my gates, uh, to be able to, like, let that out. And, okay, processing, like, in a more fluid, everyday sense (10).

Debriefing about triggers was described by a participant who did not identify as a survivor, demonstrating the utility of debriefing with organizational members around triggers other than re-activations of sexual assault histories.

I'll- I'll be in my car and... that's when I'll call them to say, "Okay, I'm leaving ... and this is how it went and, um, I need you to call them tomorrow because they do want a police advocate" ... that's also where- when I'm able to vent about anything that might have, like, triggered me in any way. Even if it's, like, uh, "yeah, the mother was being so racist!" (4).

Encouragement of self-care. Participants mentioned ways in which the organization encourages self-care with the aim of preventing burnout, including asking about what advocates do for self-care as a form of accountability, having advocates develop a self-care plan, offering resources and training on self-care, burnout, and VT, and encouraging advocates to take breaks and have choice in responding to calls. Some participants discussed ways that the organization facilitates setting limits, in that staff encourage advocates to take breaks for example. "they want you to not be forced to volunteer, like, it should definitely-if we're all about consent... So, like, if I needed to take a break that would be totally good, like, totally acceptable" (10). While most participants did not discuss taking breaks, they expressed comfort in knowing that they could take time off. Others talked about the importance of check-ins: "them being supportive and

checking in with us and um whether like I say whether it'd be like texts before and after the hospital call" (18).

Support around calls. Participants reported that the organization provides support around calls, which decreases stress about the role. Staff prepare advocates for the advocacy role, such as by providing updates on law changes or offering for advocates to attend training days, are available while advocates are on-call to answer any questions or serve as a backup if needed, and receive feedback from advocates regarding other service providers. For instance, one participant described asking a staff member to respond to a second call as the participant was overwhelmed due to witnessing the physical and emotional impact on the client-survivor with whom she worked:

I was there for like two and a half to three hours and then right after there was another call for a hospital. But I was already so overwhelmed, umm so I actually asked one of the staffs to take over for me (6).

Participants who did not rely on the organization for support around calls, described experiencing comfort in knowing that staff were available should the need arise. Participants also described their organizations as receptive to and seeking feedback regarding other service providers, which offered a way for participants to address reactions: "there's times that I leave frustrated, and you know will share that in my report, that says you know what, we need to do some more training at this hospital, or, with this police department" (13).

A participant who is a survivor described being prepared for the role by staff addressing how to respond to client-survivors asking personal questions, including questions regarding survivorship:

sometimes they'll ask questions and, kind of we're always prepped on... that you do really wanna make it about just, like, providing the services and not being too, like, loosey-goosey about, like, what you say, and that stuff is always hard, or it has been for me (10).

The same participant also discussed how the organization prepares advocates for their role by providing suggestions on how to manage their reactions using mindfulness, such as “pinch the skin in between, like, your thumb and then your pointer finger, like, pinch it and then kind of, just, feel that sensation and, um, focus on it” (10) rather than expressing their reactions in front of client-survivors.

Support around calls was also provided by other advocates. One participant mentioned going on calls with another advocate and another mentioned asking the back-up advocate to bring extra packets to the hospital when she received a second call but ran out of pockets.

Barriers and Limitations to Coping

Participants reported barriers and limitations to their coping with advocacy work. Four themes were identified, including barriers that are advocate specific, need for formal support services, limited options for social support, and role specific barriers. For all but the theme of “need for formal support services,” there was at least one participant from each organization who endorsed each of these themes. Participants from two of three organizations mentioned a need for formal support services.

Advocate specific. Less than half of the participants mentioned barriers to coping that were specific to themselves or within the advocate's control rather than related to external limitations to coping. This theme included advocates not reaching out to the organization or others for support, such as due to not wanting to burden others or feeling too different to connect.

One participant described how avoiding burdening others prevented her from engaging her social support:

I just feel guilty sharing the stress that I been through to others. And you know, they didn't... I feel like they didn't choose to- they're not choosing to hear it like, rape cases or potential sexual assault cases, you know... so I don't try to put that in on others... If I'm stressed out don't I usually don't share why (1).

Within this theme, one participant also uniquely described how her coping strategy of compartmentalizing was preventing her from processing her reactions to calls; therefore, she spoke to wanting to be more proactive about processing calls.

Need for formal support services. A few participants mentioned the need for formal support services. One participant reported wanting to engage in other services outside of the organization such as massage or psychotherapy. Another made the suggestion that organizations show appreciation in forms of discounts to formal services by forming partnerships with local spas for instance. For advocates who are survivors, two participants suggested advocates who are recent survivors receiving access to psychotherapy provided by the organization or counseling to ensure readiness for advocacy. One participant explained how organizations could be more direct about helping advocates determine readiness:

maybe if they're gonna sit and say, "yes, I'm a survivor," to maybe have them do a counseling session with somebody and just see where they're at with that and make sure they're all good with that before you're actually really sending them to hospitals... or saying, "Did you have counseling for that? ... how do you see the-that affecting ... you going to a hospital or not?" (9)

Limited options for social support. Almost all of the participants mentioned limited options for social support both within their personal life and at the organization. Reasons for limited social support included that processing would mean disclosing experiencing sexual assault, interpersonal issues with supervisors, confidentiality preventing debriefing with individuals outside of the organization, staff and volunteer support not being prioritized due to lack of funding, scheduling conflicts with group meetings, or lack of a sense of community, check ins, or group meetings. One survivor described feeling different from other members of the organization which led her to feel disconnected. Because of insufficient check ins, one participant suggested the organization check in when noticing that advocates do not answer calls or when they respond to multiple calls: “And I think, like, when you know- when you know that, that’d probably be a good idea to reach out to someone. To say, ‘Hey, I see you took, you had so many calls. How are you doin?’” (5) Another participant suggested implementing a buddy system for debriefing. In essence, participants need check-ins that are focused on debriefing rather than logistics.

Some participants discussed wanting to have regular debriefing meetings at their organization or meeting more often, while another participant discussed wanting the focus at group meetings to be on debriefing rather than solely logistics. Another participant mentioned wanting meetings for advocates who are survivors. She described their function:

you’re hearing other people’s stories, and you know, just how their hospital experiences going on to hospital call. How this is affecting them. If it’s creatin’ triggers with them, just being able to talk about it amongst each other and share, you know, experiences to see like where you’re at in maybe this healing process... unresolved issues that you may

not know that. This is probably why you lose some volunteers. They probably don't even know cause they're not getting what they need (5).

Role specific. Participants made suggestions for improvement of the advocacy role such as advocates having choice in responding to calls, being able to follow up with survivors, or staff preparing advocates better for the role. One participant who identified as a survivor described wishing she had another advocate responding on a challenging call with her, so that they could work together to support both the client-survivor and the significant other. Another participant suggested that volunteers make a call after a few days or a month has passed rather than the typical 24-48 hours following the call. As a survivor and based on her own experience, this participant spoke to how client-survivors may “get lost in the system” (3) and not receive services, so following up after a more substantial amount of time has passed from the immediate crisis may facilitate engagement in services. She explained:

I would prefer to be able to like...we get to make a 24-48... hour follow up call. I would prefer for the process to give me the option to maybe make ah a seven day call, maybe make a 30 day call. You know, because I don't believe that many survivors are walking out of there and calling and this-and they don't get services. Unless they make the phone call...after that advocacy, we're not soliciting you to get help ... and I just don't believe that they call and it's like a-after that advo-that medical advocacy they can get lost in the system. ... if medical advocate was encouraged to stay connected, they might actually make that call. I just don't want- I would like to believe that no one would do what I did. (3).

One participant talked about wanting to be more prepared for the role, such as by being allowed to shadow; however another participant spoke to not finding shadowing useful as she

felt that nothing prepares an advocate for the role except being an advocate. Outside of shadowing, another participant recommend a “buddy system” (11) in which an experienced advocate could be paired with a new advocate as a form of support regarding the role. Further regarding being prepared for the role, another participant wanted to have more information regarding the role:

maybe a little more, I mean, about what calls are typically like. Cause I can remember too, when, ya know, I started myself and that classmate really saying, ‘So what’s it like?’” And they’d say, ‘well no two calls are alike.’... But, they coulda, maybe told us [Laughs.] say ya know... Yeah, do you really go in blind? (9)

Due to the possibility that some advocates may not receive calls for a while, continuing education was suggested as well.

Specific to survivor-related concerns, one participant explained the importance of being able to decline responding to a call:

I would definitely say being able to say no or, you know, if they don’t feel comfortable doing a call because they- it reminds them about what happened to them, to be able to say like, ‘You know what I don’t want to do this right now.’ And hopefully the supervisor would be like, ‘Totally understandable, of course we’ll take of it’ instead of guilting you into it (1).

Another participant suggested that organizations prepare advocates better for the role by training them on how advocates themselves could be triggered:

maybe more focused on what we may experience, or pot- or potentially be triggered by? ... because other than self-care they didn’t really focus on umm, feelings that we may have or umm, you know, how we might go into crisis our self with certain situations. So

maybe if they had just a brief training period where it was just focused on survivor advocates... I know some of the other volunteers who haven't disclosed to, like, the mass group, but have disclosed to me that, you know, that they're survivors as well. With it something that they don't want to necessarily talk about with other advocates who aren't survivors just cause that could maybe give them an identity that they don't want or be associated with. And I kind of understand where they're coming from- I think I kinda feel that way too (2).

Discussion

This qualitative study of rape survivor advocates with and without lived experience of sexual assault identified several themes related to individual coping and organizational support for coping, and barriers and limitations to coping. Twelve coping strategies were identified at the individual level and multiple coping strategies were often used simultaneously or as a process (i.e., one coping strategy facilitating another). Eight of the 12 coping strategies were utilized with a unique nuance among advocates who were survivors. Four themes emerged related to organizational support, and four themes emerged related to barriers and limitations to coping.

Coping Strategies

Findings were largely consistent with existing literature on coping strategies utilized by direct service providers. For instance, the individual coping strategy reported by most participants was compartmentalizing. Compartmentalization, also referred to as "segmentation," has a two-fold definition in the literature: more broadly separating different domains of living such as family and employment, and active work-related thought suppression to manage work-related stress at home (Edwards & Rothbard, 2000), similar to findings in the present study. During work, compartmentalization may manifest as not expressing reactions to upsetting

experiences as a way to maintain professional identities and promote task role-related accomplishment (Gerow et al., 2010). Counselors identified exercise, movies, and reading as ways to set boundaries between work and home life (Iliffe & Steed, 200; Hunter & Schofield, 2006). Remaining calm may facilitate compartmentalizing reactions from role-related tasks (Onslott et al., 1998), demonstrating the interrelatedness of coping strategies such that relaxation (calming oneself) may promote compartmentalizing (focusing on work tasks rather than reactions to work). Such overlap of utilizing multiple coping strategies was similarly found in the present study and may actually be indicative of processes involved in achieving coping goals. Continuing with the example of compartmentalizing with the goal of avoiding having cognitive or emotional reactions during advocacy, participants reported utilizing mindfulness to be present and focus on advocacy tasks.

While previous research with advocates has not explicitly identified compartmentalizing, advocates have reported functions of “catharsis,” or debriefing, and “integration,” or incorporating a new “skill, strength, or support” into an advocate’s life to address cognitive or emotional reactions to advocacy work (Wasco, Campbell, & Clark, 2002, p. 740). Both functions of catharsis and integration align with various coping strategies reported here; for instance, debriefing was identified as a strategy both within the participants’ personal circles and within the organizational context. Preparing, information gathering and problem-solving, and focusing on positives may be attempts at integration.

Further, coping strategies were largely consistent with theoretical conceptualizations of coping functions. For instance, debriefing and non-verbal emotional expression are forms of emotion-focused coping, while information gathering and problem-solving are forms of problem-focused coping (Folkman & Lazarus, 1980). Participants also described experiencing

support around their calls by being able to provide feedback about issues and challenges with other providers, such as hospitals, which is another form of problem-focused coping. In other conceptualizations of coping, compartmentalization and distraction align with avoidance coping, while debriefing, non-verbal emotional expression, and preparing fall under approach coping, for instance (Roth & Cohen, 1980). Similarly, the coping strategies identified can be categorized under existing self-care resources: cognitive, physical, spiritual, and social (Killian, 2007; Shannon et al., 2014; Wasco et al., 2002). For example, focusing on positivity can be considered a cognitive strategy. Further, findings were consistent with conceptualizations of coping responses to chronic stress. One example is the fluctuation between vigilance and respite, which may occur have been described as responses to chronic stress (Gottlieb, 1997). Vigilance, occurs when individuals have more awareness of their vulnerability but cannot predict when they may be threatened (Gottlieb, 1997). Advocates are often on call without knowing when they might be dispatched; as such some described the utility of preparing as a way to relax and feel ready, for instance. Respite is akin to gaining relief from hyperarousal due to vigilance (Gottlieb, 1997), similar to relaxation strategies identified in the present study. Setting limits, too, may facilitate respite as advocates are, in essence, in control of their vulnerability to stress when they set limits.

Differences Among Advocates with and Without Lived Experience of Sexual Assault

Survivors either explicitly spoke to how their experience of sexual assault impacted their coping or differences were identified based on patterns across the two groups. Indeed, various coping strategies may be experienced differently by survivors. Survivors described using compartmentalizing to maintain an emotional distance from the client-survivors, such as by cognitively having an awareness that the client-survivor's trauma is separate from their own trauma. As such, one reason for differences in the way coping strategies function may be due to

the difference in stressors. For survivors, compartmentalizing may require suppressing reactions to triggers of their own experience, mindfulness may mean choosing to focus on the client-survivor rather than their own experience, and relaxation may be used to calm oneself after being experiencing triggers. Consistent with research on survivor coping (Campbell et al., 2009, Frazier & Burnett, 1994), participants in the present study appeared to be engaging in a variety of coping strategies, both to avoid and approach triggers of their own experience. Further, selecting among coping resources may entail different considerations for survivors. More specifically, survivors may need to decide who is an appropriate person with whom to debrief depending on whether survivors feel comfortable disclosing their experience of sexual assault to, as survivors may want to debrief regarding triggers, for instance. Given that others' reactions to disclosures may impact survivor coping (Littleton & Radecki Breitkopf, 2006), selecting a source of social support that the advocate identified as "safe" is essential.

While other differences were reported across groups, some differences may be due to other factors outside of survivor status. For example, strategies may be consistent depending on whether participants were from the same organization. Differences in advocates who are survivors reporting setting limits by taking time off from advocacy are likely due to other domains in life in addition to survivor status.

Organizational Support of Advocate Coping

Participants identified four categories of themes outlining ways in which their organizations supported them, including facilitating a sense of community among advocates, offering debriefing, encouraging self-care, and providing support around calls. While not all of the advocates utilized these supports, most spoke to experiencing a sense of comfort in knowing that supports are available should the need arise for them. Further, thinking about organizational

support more broadly, adequacy of support may impact advocate coping, such as incorporation of new coping skills (Wasco et al., 2002). Participants emphasized the utility in having opportunities to debrief with members of the organization given limitations to social support in their personal lives and confidentiality boundaries. Monthly meetings have been found to be important for intent to remain for volunteers (Hellman & House, 2006). Previous literature has identified the importance of self-care training (Shannon et al., 2014), consistent with the theme of encouragement of self-care, which highlighted training as an important setting to implement encouragement. Further, support around calls, such as in the moment availability for supervision may quell anxieties particularly in an isolative role like rape crisis advocacy. Given that burnout was reported to be related to insufficient supervision (Ullman & Townsend, 2007), adequate and substantive supervision is needed for advocates, primarily volunteers who may not readily be able to access colleagues.

Survivors may be connected with other survivors who advocate when organizations create community building environments. Recent research has similarly found that a survivor identified the importance of knowing and debriefing with another survivor (Houston-Kolnik, Odahl-Ruan, & Greeson, 2017). Survivors may be supported through debriefing, or being prepared for their role in terms of how to respond when client-survivors ask about their trauma history or in managing reactions.

Enhancing Organizational Support for Advocate Coping

Barriers and limitations to coping included advocate specific barriers including fear of burdening others similarly found in the literature (Houston-Kolnik et al., 2017), limited options for social support, and role specific barriers, and need for formal support services. Previous research has identified the limitations of organizational social support, including scheduling

concerns and lack of inclusivity of individuals with diverse backgrounds (Houston-Kolnik et al., 2017); the present study also noted scheduling concerns. The present study also noted the quality of debriefing, such that some meetings tended to focus more on logistics; this is likely reflective of the idea that the *value* of meetings matters (Hellman & House, 2006). Role specific needs such as receiving a better understanding of the role and working with more experienced volunteers is consistent with previous research (Smith, 1998).

Uniquely, survivors spoke to a need for access to psychotherapy services for survivors, group meetings for survivors, and more choice in responding to calls. Consistent with the present study's findings indicating the potential need of survivors to access formal supports, Killian (2008) suggested that agencies offer affordable EAPs, particularly to those with personal trauma histories. However, funding is an issue for rape crisis centers and most providers are volunteers. As such, centers may consider partnering with other providers to offer discounted rates to volunteers or generate lists of mental health resources, and have honest, normalizing discussions about use of formal supports as well as supporting survivors in gauging readiness for advocacy (Rath, 2008).

Implications

Findings have clear implications for advocates individually, but perhaps more importantly, for organizational support of advocates. Self-care training is identified as a required component of the 40-hour rape crisis counseling certification process to ensure consistency across organizations, which includes discussing "vicarious trauma, boundaries, recognizing and minimizing burnout, roles and responsibilities of rape crisis workers" (e.g., ICASA, n.d., p.5). Based on findings from the present study, specifically providing examples of ways in which staff themselves cope could be useful in addition to having advocates develop an individualized self-

care plan. Further, organizations can provide training on coping strategy domains, much like those identified in the present study, which could aid advocates in developing their own plan based on a menu of options. Plans should be developed in the context of the individual as advocates differ in the challenges they may experience and may have different competing responsibilities. For instance, advocates who are survivors may need to be guided on how to cope with triggers. Training on vicarious trauma should include possible compounding effects of advocates' personal histories of sexual assault or other traumatic experiences. Further, advocates may differ in the types of coping strategies they have developed as individuals through various experiences, whether work-related, or as survivors in recovery.

Additionally, participants discussed utilizing various coping strategies depending on whether they were coping with stressors prior to, during, or after calls. As such, training may discuss how coping may manifest differently based on time. For instance, one participant mentioned avoiding multi-tasking and excessive productivity while on-call to facilitate task switching to advocacy if she were to be dispatched.

While training on self-care is essential and required, promotion of self-care may also occur as advocates continue to respond to ER calls. Given the compounding effects of chronic stress, advocates may need to be encouraged and provided accountability to engage in proactive self-care and coping practices. This may occur via the suggested increase in check-ins that provide accountability for self-care or focus on debriefing rather than logistics in meetings. Given that organizational support is associated with positive outcomes for providers (Killian, 2008; Wasco et al., 2002), organizations should conceptualize coping and self-care as part of the role of an advocate. Redistribution of workload is identified as a key form of organizational support (Killian, 2008); as such, organizations may consider what this may mean for volunteer

crisis workers as workload is often unpredictable. Participants in the present study spoke to the importance of staff advocates as back-ups, such as the participant who mentioned asking staff to respond to a second call she received immediately after responding to a call. Having the option to decline a call due to being overwhelmed or triggered is key, as reactions to calls may be unpredictable. While financial resources for crisis centers are limited, most centers have a system of scheduling multiple responders to ensure coverage, allowing some flexibility in redistributing workload. Diversifying workload is another important aspect of organizational support identified in the literature (Cohen & Collens, 2013). Thus, organizations may consider creating structures for advocates to be involved in prevention work, which is often a voluntary role. This may be particularly important given that engagement in system-level change work has been reported by participants in a qualitative study as a buffer against feelings of helplessness (Ilfie & Steed, 2000).

Ultimately, the goal is that burnout and unnecessary turnover in rape crisis centers are prevented and that quality services are provided to clients. Given this, recognizing the possibility of personal histories of trauma falls under the provision of trauma-informed care service philosophies (Wolf, Green, Nochajski, Mendel, & Kusmaul, 2014). Previous research on trauma-informed care in community services including crisis has found that much attention has not been paid to how trauma-informed care applies to staff (Wolf et al., 2014); as such, rape crisis centers may acknowledge the possibility of all traumatic experiences, including sexual assault, in their volunteers and staff when implementing training and continuing support structures. This does not mean turning away providers with lived experience from service provision, but ensuring they have adequate resources. For some, this may mean being able to connect with other advocates who are survivors. Crisis center may create spaces for this type of community building. Because

survivors may be at different stages of recovery and labeling of their experience, support groups aimed at survivors may be presented as groups focused on coping with triggers, for instance, to increase comfort in participating and avoid alienating survivors who may not identify or be ready to speak openly about trauma histories. While this specific study was focused on volunteers, findings have implications for staff coping, self-care, and support. Funding constraints may limit resources for staff and place additional burden in a role in which they may be balancing not only their own coping, but, for those who supervise volunteers, the coping of others. As such, similar principles of diversifying workloads, checking in, and others may be applied with staff.

Limitations

The present study has limitations given the small sample size and unequal group sizes. Given that the present study is comparative (i.e., composed of two groups), a greater number of participants and more equal group sizes may allow for more accurate comparison. Of note, saturation was reached, such that with the addition of the last few interviews, substantive changes to the coding were not noted. However, a larger sample size may have led to more mentions of themes or ideas within themes that have been reported by one or two participants. In essence, keyness of themes is likely related to sample size. A study of sample size in qualitative research reported that saturation was reached within 12 interviews (Guest, Bunce, and Johnson, 2006). The present study has 18 interviews; however the present study is composed of two groups, and currently there are no guidelines known to the author on adequate sample size for qualitative studies comparing multiple groups. Guest and colleagues (2006) did report that key themes were identified within 6 interviews, providing some evidence that 7 interviews for the non-survivor group are likely adequate. Future research may focus on larger samples using quantitative methodology to better understand predictors of positive outcomes and coping with

advocacy. The study only addresses the experiences of advocates from three rape crisis centers and may not fully represent the broader array of centers. Further, this study lacked a member check process, which would enhance credibility. Finally, participants self-selected into the two groups: survivors or sexual assault and women who did not experience sexual assault. While self-selection based on personal identification was a strength of the study to protect participants around a sensitive topic, differences identified may be more attributable to whether women identified as survivors rather than whether they are survivors. More specifically, some survivors do not label their experience as sexual assault and one participant in this study described a sexual abuse and attempt sexual assault incident, but did not identify as a survivor.

Directions for Future Research

A benefit of the study is the representation of community-based rape crisis centers in both suburban and urban areas; however, future studies may include tribal and rural contexts, as well as military or university campus centers. Future studies should include a greater number of centers with samples of greater diversity of participants for a more comprehensive assessment of coping among advocates. A member check process would also enhance credibility.

Future qualitative studies may explore what coping well means to advocates. While many studies identify functions of coping strategies, clarification is needed regarding how advocates know when they are coping well. This may be tied to existing constructs, such as vicarious resilience, as recent research has indicated that more severe trauma history and positive peer relationships predict vicarious resilience (Frey et al., 2017).

Additionally, the present study focuses on coping with sexual assault response rather than with training. Future research may benefit from focusing on stressors and associated coping experienced during training. Given that some survivors do not conceptualize their experience as

sexual assault, women may begin to explore labels during training, which was reported by some participants. Because the present study focused solely on coping in the context of emergency room response, coping with hotline work may be compared to build the literature on various types of roles. Additionally, future research may consider exploring the relation between coping in various domains of living, and how they impact one another. Individuals may identify strategies they use to cope with their primary employment or other volunteer roles, as part of various identities (as survivors or parents), or speak to coping more generally without tying their strategies to a particular stressor; as such, viewing individuals more holistically may better aid our understanding of coping, and its functions and facilitators. Finally, future work may consider extending these research questions to other human service fields.

Conclusion

This study of rape survivor advocates with and without lived experiences of sexual assault identified a wide array of coping strategies, organizational support, and barriers and limitations to coping. Advocates who are survivors appear to use similar coping strategies and have similar needs to advocates who have not experienced assault; however, the reasons or ways in which they engage in those coping strategies may differ. As such, differences across the types of stressors or appraisal of stressors across advocates with and without lived experience may be more pronounced compared to specific coping strategies used. Regarding organizational support, survivors may have specific needs that organizations may consider when creating structures for support.

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Appendix A: Interview Protocol

Introduction

This conversation will be recorded for research purposes. Please let me know now if you do not agree to being recorded. You can request that the recording stop at any time. Now, I'll give you a quick overview of the interview. Generally, I'll ask you a few questions about your experience being an advocate, the impact that has had on you, and how you cope.

For survivors: Then, I'll specifically ask a few questions about what it has been like for you to provide advocacy services as a survivor, and end with a few closing questions. While I won't ask you to describe your assault to me, you are welcome to share as much or as little as you'd like. Does this sound ok?

For non-survivors: Then, I'll end with a few closing questions. Does this sound ok?

For everyone:

- Can you tell me a little about why you decided to participate in this study?
- How did you become involved in this work? What motivated you?
- Can you tell me about what impact this work has on you?
 - Have you seen any changes in yourself since beginning this work? If so, what changes/can you elaborate?
 - Can you tell me about what has been particularly difficult in doing this work?
 - What has been particularly rewarding?

Based on survivor status, the interview will move to one of two sections below: “Survivor Only Questions” or “Non-Survivor Only Questions”

Survivor Only Questions

- How has your identity as a survivor influenced your work? In answering this question, you can share as much or as little as you want about your experience of sexual assault.
 - How do you cope in your role as an advocate who is a survivor?
 - I imagine that some advocates who are survivors might be triggered when working with other survivors in the ER. Is this something that is true for you? If so, would you like to share how?
 - Are you comfortable sharing with me how long ago this happened to you?
- Are there other experiences that you might have had in your life that may have impacted your advocacy work either positively or negatively?
 - [If applicable, how has that influenced your work?]
 - [If applicable, how do you cope in your role as an advocate who has experienced _____.]
 - Are you comfortable sharing with me how long ago this happened to you?
- Have you disclosed your experience within or outside of your role since beginning your work as an advocate? If not, have you considered it? If so, what has your experience been like?

Non-Survivor Only Questions

- How do you cope in your role as an advocate?
- Are there experiences that you might have had in your life that may have impacted your advocacy work either positively or negatively?
 - [If applicable, how that experience influenced your work?]
 - [If applicable, how do you cope in your role as an advocate who has experienced _____.]
 - Are you comfortable sharing with me how long ago this happened to you?
- Have you disclosed your experience within or outside of your role since beginning your work as an advocate? If not, have you considered it? If so, what has your experience been like?

Coping

- Now I'll ask you about specific calls you have taken: think about a particularly challenging call that you've had. *I'd like to remind you that I'm not asking you to share confidential information about the survivor. So, in answering these questions, focus on your experiences and reactions rather than confidential information about the survivor.*
 - What felt challenging about it?
 - How did you react? What went through your mind? How did you feel? How do you think these emotions or thoughts impact you?
 - What did you do in response to these emotions/thoughts during the call? After the call?
 - [If needed, probe:] How did you cope during and after the call?
 - [If needed, probe:] How do you take care of yourself?
 - Why do you think you responded this way?
- Think about a call you felt good about.
 - What felt good about it?
 - How did you react? What went through your mind? How did you feel? How do you think these emotions or thoughts impact you?
 - What did you do in response to these emotions/thoughts during the call? After the call?
 - [If needed, probe:] How did you cope during and after the call?
 - [If needed, probe:] How do you take care of yourself?
 - Why do you think you responded this way?
- Of the coping strategies you've described for these calls and maybe others you may have, what coping strategies work for you?
- Is there anything you'd like to change about how you've been coping?

Organizational Support

- What role has your organization played in your self-care?
 - What changes do you think could be made at your organization to improve your self-care for survivors?
 - Who do you go to to cope in the context of your role?

Closing

- What advice do you have for other advocates who are survivors? [OR what advice do you have for other advocates?]
- Is there anything you would like to add that I haven't asked you about?

[Thank you for sharing with me today. I really appreciate you taking the time out to talk with me.

Do you have any questions for me at this time? (Pause.) If you do have questions later, you can contact myself or my advisor. You can find our contact information on the consent form we went over.]

Appendix B: Paper Survey

Please fill out the survey below. You can choose not to answer any items. Please feel free to ask the researcher if you have any questions or concerns. Thank you for your time!

Demographic Questions

1. Age: _____

2. Ethnicity: _____

Advocacy Questions

3. How many calls have you responded to in an emergency room? _____

4. How long have you served in the advocacy role? _____

5. Which organization are you currently volunteering with to provide advocacy services?

6. What services do you provide to survivors through your organization (circle all that apply)?

a. Advocacy in the emergency room

b. Follow up calls after providing advocacy in the emergency room

i. If yes, how many times after the call do you usually follow up with the survivor? _____

c. Answering a hotline

d. Crisis support at events

e. Tabling events

f. Other: _____

Follow Up

Would you be interested in providing feedback on findings? If you agree, after a summary of findings is created, the researcher will contact you using the contact information you provided for the study. You may also provide the researcher with updated contact information.

Yes

No

Appendix C: Online Screening Survey

INTRO:

Thank you for your interest in our study. The goal of our study is to learn about the experiences of rape survivor advocates to better understand coping and trauma exposure. Our hope is that findings will inform improved support systems for advocates. The questions below will help us determine your eligibility for the research. If you are eligible and interested in participating or would like to hear more, you can leave your contact information below and we will get in touch with you. If you prefer to speak with us over the phone, you may call us at XXX. You may exit the survey at any time if you prefer not to answer any questions.

ELIGIBILITY SCREEN:

To be eligible, you must be able to answer “yes” to the four criteria in Section A and answer “no” to the criteria in Section B.

Section A:

1. Are you at least 18 years old?
2. Do you identify as a woman?
3. Are you a current rape survivor advocate?
4. Have you responded to at least 2 calls in the emergency room?

Section B:

For the purposes of this study, we are recruiting women who have NOT experienced a recent traumatic event within the last 6 months. The reason for that decision is that we want to protect the safety of our participants. Let me explain what I mean by trauma. Trauma means directly experiencing serious injury, being threatened with serious injury or death. I'm asking about trauma that you have personally experienced as opposed to witnessed or known about someone else. Have you experienced a trauma within the last 6 months?

Please select whether you are eligible for the study based on the criteria above.

- I am eligible for the study.
- I am NOT eligible for the study.

IF “NOT ELIGIBLE” is selected, the following script appears on the screen:

Thank you for your interest in our study. If you are a survivor of recent trauma and would like a list of mental health resources, please click the arrow. Otherwise, you may exit the survey. If you have any questions or concerns, please contact us at XXX.

IF “ELIGIBLE” is selected:

For the purposes of this study, we are recruiting both survivors and women who have not personally experienced sexual assault because we find it important to get perspectives from both groups. In order to correctly place you, this survey will ask if you identify as a survivor or if you do not. If you are not comfortable disclosing that information online, you may select “Prefer to share over the phone.” Do you identify as a survivor of sexual assault?

- Yes
- No
- Prefer to share over the phone

CONTACT INFORMATION

Please fill out the section below so that we may reach you about the study.

1. Please enter the phone number where we can reach you: _____
2. What is the best time to reach you? _____
3. Can we leave a voice mail? Yes No
4. Please enter your first name so that we can contact you: _____ (We will not use your name in the study.)

Thank you for your time. We will contact you soon. If you have any questions or concerns, feel free to contact us at XXX in the meanwhile.