Narratives of Embedded Oppression and the Covid-19 Pandemic Response: Voices from Marginalised Sexual Violence Survivors in Aotearoa New Zealand

A thesis presented in partial fulfilment of the requirements for the degree of

Doctor of Clinical Psychology

at Massey University, Manawatū,
Aotearoa New Zealand

Caitlin Helme

2023

This thesis is dedicated to all victims/survivors of sexual violence, to disabled people who have long been left out of this conversation, and to those working tirelessly to end sexual violence. May your strength change the world.

Abstract

The prevalence of sexual violence in Aotearoa New Zealand was of epidemic proportions even before the arrival of Covid-19, with people experiencing social marginalisation harmed more frequently, in different ways, and with less appropriate support available to them than the hegemonic population. In trying to understand these issues through a lens of intersectionality, I broadly enquired into the importance, impact, and challenges of navigating sexual violence for disabled people who experience multiple layers of oppression. Respondents told stories within both the pre- and peri-Covid-19 landscape.

Seven respondents shared their stories during eight unstructured, teller-focussed interviews (Hydén, 2014). All seven respondents were service providers, with four respondents also being survivors of sexual violence themselves. Respondents had lived experience of marginalisation, with many inhabiting multiple marginalised social locations. All survivors identified as disabled, with further marginalised identities including being Indigenous, female, and/or queer, among others. A reflexive narrative analysis was conducted to make visible the expert stories as an ethical response to social justice.

The narrative analysis outlines how embedded social inequities and power structures, including ableism, racism, sexism, and cisgenderism, intersect oppressively for survivors and create barriers to accessing appropriate support. Inequities are longstanding and rooted within historical oppressions such as colonisation. Respondents spoke of the compounding of existing inequities following the arrival of Covid-19, making visible an already under-resourced sector bearing the brunt of an unprecedented influx of sexual violence and the detrimental effects on survivors and providers alike. Radical change is required to address social inequities in promoting an equal response to sexual violence.

Keywords: Sexual Violence, Inequity, Intersectionality, Disability, Marginalisation, Covid-19

Acknowledgements and Gratitude

To my respondents and community advisors…

I need to express my sincere thanks to everyone who shared their stories in this project, I hope I did them justice. Your passion and openness showed me exactly why we need to do this work. I am inspired by your bravery in talking about some of the worst experiences of your life, and how you are navigating a sector under such immense stress—I hope you know this project is much yours as it is mine.

Thank you to all the community insiders who made the time to help me expand my cultural humility: Dr Simon Bennett, Etta Bollinger, Irie Schimanski, old colleagues from the sexual violence sector, my respondents, and all those who spoke with me informally along the way. When centring lived experience was the foundation of my project, yours has been invaluable.

To my (incredible) supervisors…

Mandy and Leigh, I'm not sure thank you quite grasps how grateful I am for having had you guide me through this process. Thank you for your unwavering support, understanding, and our many thoughtful conversations.

I knew in taking on a project of this nature I would need supervisors who would not shy away from hard topics, while keeping people at the core of all things we do. Little did I know how important this would become with the arrival of Covid-19 and the myriad of issues it threw us—both personally and professionally. Thank you for your shared outrage, disbelief, and total bewilderment at some of what has arisen during these years. Never having to censor myself with you has helped me grow immensely, and your push to remain political and provocative has helped me in my development both as a researcher and a clinician. Thank you for seeing my disabilities as a strength, for always adapting to my needs, and for unapologetically looking after yours when it was needed. We need far more people like you in the world.

Thank you also to Geneva for coming in at the last minute to get me to the finish line. You are so appreciated!

To my fellow students and friends…

Thank you to my Massey cohort/s and the students both ahead of and behind us who offered me support. There is no other group I would rather share this rollercoaster with, you are going to make one badass group of psychologists. While special thanks must go to Irie, Emma, Dasha, and Kate who were my original support crew, to name every fellow student who has been important to me here would be a thesis in and of itself—you know who you are. I'm so immensely grateful.

Thank you to my Otago friends who all these years later are still rooting for me. Thank you especially to Sophie, Ashleigh, and Jane, who were always up for a proofread (and whose high standards always kept me accountable!). Your surprise presence at my nana's funeral really showed me how deeply you care. You're something special, you guys.

To my family…

I need to express my gratitude to Mum, Dad, and Jack, and to my second family—the Mathesons—, whose undying support got me through these nine long years. Thank you for reminding me to have a life outside of study. For the weekends away, for the various times feeding us, housing us, and consoling me when times were hard. Somehow, you always had faith in me even when I didn't.

I need to give special thanks to my Nana Janet, whose life inspired me, and whose death nearly totally derailed me. You were always my biggest cheerleader (and number one cheese-roll maker), I'm not sure whose heart broke more when I left Dunedin to start this programme. You taught me what kindness really means and I remain adamant I will never again meet someone as selfless as you. I wish you were here to see this all come to fruition–I miss you so much.

Finally, to Cam, who has been at my side since the very beginning of my study journey. To sum up everything you have done for me over this time would be impossible. You have been there during every moment of triumph, but also for every diagnosis, every hospitalisation, and every (sometimes long) period where I couldn't get out of bed. You were there when I was totally elated to get into this programme, but also for every moment of self-doubt that followed. Thank you for always reminding me I am valuable and loved no matter my ability; it has taken me many years to no longer equate my productivity with my self-worth and I owe a lot of that to you. I am so proud of the life we have built and the future that awaits us from here.

i stand
on the sacrifices
of a million women before me
thinking
what can i do
to make this mountain taller
so the women after me
can see farther

- Legacy

A poem from *The Sun and Her Flowers*
Rupi Kaur (2017, p. 202)[1]

---

[1] From very early on in my research journey a copy of this poem was mounted above my desk. It has always resonated with me, with the temporal framing reminding me of the rich history of activism that I am building upon. I am merely one voice in a long, convoluted story advocating for equity, and reflecting on the change-makers who came before me has given me strength when this project has all felt a bit too much. Here’s to you, my friends.

Table of Contents

Preface

The doctoral study roller coaster was a very familiar metaphor at the start of my research journey. I expected these years to be full of ups and downs, moments of excitement, and moments of triumph; even the odd loop-de-loop that would set me back considerably. However, I did not anticipate what felt like the complete de-railing of my cart one year into my research when Covid-19 reached Aotearoa New Zealand.

Back to the Beginning

When I began formulating this research project in late 2018, I knew a few things for sure. I wanted to champion the voices of people who are often silenced in academia; use my lived experience to reflect on the research project critically; and finally, research within an area important to me and where improved knowledge is also important to society. At the time, I worked as a sexual violence crisis worker in Te Whanganui-a-Tara[2] (Wellington), each shift seeing and hearing about the harm that sexual violence leaves with victims/survivors and their loved ones. I noticed that some people experience more barriers when they reach out for help: a woman whose back was broken by gang members in an assault at her home but was not eligible for emergency housing without a police report she was too afraid to make; a Deaf woman who completed an entire forensic medical exam without telling the doctor she was Deaf because she would have needed to explain that her hearing loss resulted from previous violence that she did not wish to speak of. These are merely two of the many stories from my work in the sector, highlighting inequity and complexity in the way we care for sexual violence survivors' needs.

I identify as physically disabled. I live with rheumatoid arthritis and Crohn's disease diagnosed as a teenager, myalgic encephalomyelitis, and elements of neurodiversity that have only become apparent to me in my adult life. My chronic fatigue can, at times, be

---

[2] As te reo Māori is an official language in Aotearoa New Zealand, any definitions will not be italicised but will remain included for clarity.

almost entirely debilitating, as well as the mental health challenges that can come from being disabled in an able-bodied world. My own experiences of access barriers and an ingrained passion for advocacy and social justice mean that I am passionate about disability rights and equity. Within a lens of post-positivism, this framework of meaning will undoubtedly entwine its way throughout this thesis, in my position as both an insider and researcher.

In summary—or indeed, as a starting, middle, and never-ending point that is undoubtedly influential—it is my own lived experiences that solidify to me why this project is so important. My initial literature review discovered a paucity of sexual violence literature focussed beyond the dominant narratives of the hegemonic population, appealing to my nature to tell the unheard stories. In collaborating with my research supervisors this project was born and has been my baby ever since, in a process of fluidity and movement that can only be conceptualised as a living journey that continues beyond the conclusion of this project.

Fast Forward: The Covid-19 Speedbump

In 2020, when Covid-19 arrived in Aotearoa New Zealand, my project was already well underway. With the aspirations of bringing voice to the lived-experience narratives of barriers in disability sexual violence care, I had received ethical approval to do face-to-face interviews with sexual violence service providers, as well as disabled sexual violence survivors who inhabit multiple marginalised social locations. However, we quickly realised that continuing the project as planned was not possible for several reasons.

Firstly, I was conducting interviews around a highly sensitive and emotive topic that would inevitably unearth the vulnerabilities of those willing to speak with me. Likewise, sexual violence service providers were essential services having to learn to work in new ways during a time of unprecedented demand. Through discussion and consideration to understand the needs of those working in the sector, we deemed that adding to their workload in a crisis would be unsafe and did not sit well within my priorities of community care and social justice ethics.

To this day, the very nature of the virus is changing our lives in unmeasurable ways, even more so for essential workers and people who were experiencing discrimination in their everyday pre-Covid-19 lives. As the safety of research respondents is always a top priority, new methods of gathering their voices had to be considered. It quickly became apparent that Covid-19 would inevitably change the narratives most pertinent to respondents, thus the research needed to shift into “real-time” focusing on how the sexual violence field was impacted by Covid-19 and what this means for survivors already experiencing inequity. Rather than viewing this change as a negative, we were offered an unprecedented opportunity to conduct sexual violence research during a crisis response—research that could never be planned in advance.

The nature of shifting to real-time research means this thesis structure may not be what you expect, it is not what I was expecting either. In this thesis, the analysis must be considered through critical reflection rather than a succinctly documented history. A crisis such as Covid-19—causing such marked disruption to everyday life globally—is novel to modern society; thus, the previous literature can only go so far in guiding a response to these unfolding events. In this situation, the voices of the community on the ground are paramount as they share their developing understandings of Covid-19 and its impacts. In turn, the analysis of narratives in this project are presented as an unfolding story. That being, they are told as multiple integrated, large collective narratives interpreted and explained by me as the researcher—the person living the unfolding crisis alongside respondents in real-time. This will be explained further in later sections of this thesis.

An Explanation of Thesis Structure

In a somewhat untraditional manner, my methodology and method are presented early in this thesis, following this preface and a prologue which explain my positioning as a researcher, and outline some important terminology. I chose to present my writing in this way, as grasping the theoretical basis that underpins this thesis, as well as my own social and theoretical positioning, is paramount to understanding where I was situated when I completed this project. Presenting introductory literature without an understanding of how I was reading and interpreting this information would have undermined my position, whereby researchers cannot be considered impartial parties in the research process. It was important to me that my voice, and my active interpretation of information, was clear from the very beginning.

In reflecting the unfolding nature of the crisis, and in a way working to "live" narrative methodology and present this thesis as an unfolding story in itself, my literature reviews and analysis chapters are then presented in a chronological order that reflects before and after the arrival of Covid-19. That being, my first literature review chapter—an introduction to the sexual violence landscape in Aotearoa New Zealand before the arrival of Covid-19—is presented first, to assist with contextualising sexual violence in a pre-Covid-19 world. Following this literature review I then present chapter one of my analysis. This chapter presents narratives centred pre-Covid-19, highlighting the inequity in the sector that was present even before the pandemic.

In continuing to reflect the real-time nature of this project, as Covid-19 had since arrived in Aotearoa New Zealand, I then present a chapter reviewing Covid-19 related literature and how the sexual violence sector has changed; vital information for understanding the circumstances that surround the narratives to follow. Subsequently, my second analysis chapter—which encapsulatesperi-Covid-19 narratives—is presented. Finally, a reflective conclusion sums up my findings and journey.

Prologue

Talking Equity: Terminology and Language Use

There is a vast history of people in power determining the language (and languages) that the non-hegemonic group may use. For example, throughout the 1800s, acts were passed that forbade the use of te reo Māori (Māori language), with this push towards monolingualism negatively impacting te reo Māori and te ao Māori (Māori worldview*)* in ways that continue to permeate today (Cotter, 2007). The Deaf community experienced similar abolition of their language, following the Milan ruling in 1880, which effectively banned the use of all sign language worldwide, and the subsequent closing of Deaf schools (Cotter, 2007; Sins Invalid, 2017). Similarly, when deafness was categorically labelled as a disability as an imposed medical term—i.e., one given by those in power to address *their* needs, rather than one selected by the Deaf community to represent themselves—for the first time, Deaf people were placed within an administrative category with all other forms of disability (Sins Invalid, 2017). Thus, when laws insisted that all disabled children receive mainstream education, many more Deaf schools were closed. Despite the re-emergence of sign language and recognition of Aotearoa New Zealand Sign Language (NZSL) as a national language, audism[3] and audiocentricity[4] continue to oppress the Deaf community significantly.

In addition to the majority group determining which language may be used, the use of exclusive or oppressive language—whether intentionally or ignorantly—also acts to discriminate against people who inhabit marginalised social locations. As language, thought,

---

[3] Audism: "Oppression based on the assumption that all people should navigate the world as hearing people do" (Sins Invalid, 2017, p. 145).

[4] Audiocentric: "Believing that people who can hear (or behave in the manner of those who can hear) are superior to those who can't or don't" (Sins Invalid, 2017, p. 145).

and action intertwine, exclusive language may inform negative beliefs and reinforce discriminatory actions, which then inform further exclusive language as an oppressive cycle (Cotter, 2007). In turn, wide-ranging harms come from using exclusive language. As one recent example, Dolan et al. (2020) demonstrate how the misgendering or mislabelling of transgender people increases their mental health needs while also reducing the likelihood of them engaging with health services, possibly with dire consequences.

When considering the terminology surrounding sexual violence, care must be taken to prevent any further harm to survivors. Harmful language can further stigmatise survivors through victim-blaming, reinforcing stereotypical attitudes and rape myths, and protecting the people who cause harm (Femifesto, 2015; Greijer & Doek, 2016; Sutherland et al., 2016).

The media hold a powerful position in disseminating information throughout society. However, through their language use and choice of stories for reporting, the media frames some forms of violence—as well as some survivors—as more or less legitimate than others (Femifesto, 2015). For example, the Canadian media gives three-and-a-half times less coverage to missing/murdered Indigenous women than white women in the same province, with reports also of shorter length and less detail (Gilchrist, 2010). While this reporting does not explicitly say that Indigenous women are ‘less important’ victims, the silencing of their stories implicitly reinforces such beliefs by mediating our knowledge. We learn as a result of what is around us, only being privy to stories of women who fit the dominant ‘perfect victim’[5] storyline strengthens these (often fundamentally flawed) narratives, not allowing counter-narratives space to permeate popular media to challenge the status quo.

Recently, media language-use guidelines were produced advocating for appropriate communication about sexual violence (Sutherland et al., 2016). These reinforce that terms such as rape and sexual assault be used to adequately highlight the violent and non-consensual nature of such acts, rather than addressing the topic using less succinct language (Sutherland et al., 2016). Likewise, when discussing people who cause harm,

---

[5] A concept that will be discussed in a later section

dismissing their violence or reinforcing their community status—i.e., describing their positioning as fathers, people in jobs of high power, or those who may otherwise be positively involved in their communities—deflects blame. At the other end of the spectrum, using narratives of perpetrators as “monsters” or “beasts” (Sutherland et al., 2016, p. 9) suggests a deviation from normality, when actually most perpetrators are everyday people known to the person they harmed.

Like all forms of language, the language used to describe sexual violence continues to develop to align with social movements, more recently moving to reflect accountability of those who cause harm. Previously the use of terms such as child prostitution/prostitute was common, yet they are now recognised as harmful, acknowledging a child can never consent to be involved in transactional sex, or sex whatsoever (Greijer & Doek, 2016). In line with this, suggesting that there is a “customer/client” (Greijer & Doek, 2016, p. 90), paying for these illegal acts fails to recognise criminality and thus omits blame and accountability. There are many similar examples where the preferred language has changed, and the categorisation of behaviours have shifted to be more survivor-focussed. In turn, people must be open to shifting with developing preferences and being corrected when wrong, acknowledging that understandings and terminology will never remain static.

In light of increased media coverage surrounding cases such as Harvey Weinstein and Jeffrey Epstein, some journalists are becoming more aware of appropriate reporting and holding others to account. For example, Jane Gilmour, a feminist journalist who writes for the Guardian in Australia, has started the Twitter hashtag #FixedIt. She edits the titles of published news articles that use inappropriate or harmful language to describe sexual and domestic violence (Gilmour, 2019). One example of this is her editing of an article title from ‘*Role model dad sentenced for attacking partner*’ to ‘*Violent man sentenced for attacking partner*’ (Gilmour, 2021). While progress is slow, this increased awareness of accountability makes me hopeful that we will see better reporting practices in the near future. Personally, I see accountability as paramount in shifting the blame away from survivors, who are never at fault for the harm against them.

While acknowledging differing preferences and that language continues to shift, in the present research, all terminology will be considered for how it reflects the autonomy of people who experience social marginalisation and refusing to minimise actions of those who cause harm. I want to acknowledge the possibility that in the future my choices of language will no longer reflect preferred terminology, yet I hope they will never be deemed harmful. If that is the case, I hope you may take solace in knowing that I carefully considered how to align this thesis with current preferred language, and that—because I will always take guidance from those with lived experience—my use of language will have likely developed with time, too.

What follows in this section is the description of some terminology that is frequently used in this project, where I believe the voice of the community must be paramount in ascribing meaning.

“I” and “Me”

The American Psychological Association and wider academia oppose using first-person language in research literature (i.e., the terms “I” and “me”). However, aligning with post-positivism, I believe this neglects to acknowledge the beliefs, perspectives, and experiences researchers bring with them into the research process. This is more pronounced when conducting research with respondents who share personal accounts of their lives and when using methodologies where the co-construction of narratives occurs between the respondents and the researcher.

I am a woman, I am disabled, I am an advocate, and I have been impacted by sexual violence in my family and wider relationships. My experiences shape my passion for social justice and who I am as a researcher; without them, I could never have undertaken such a sensitive project. Therefore, I approach this research with the ability to reflect on my own interlocking identities and passions and to challenge them with literature and the experiences shared by respondents. I will be using first-person language throughout, in respect to who I am, in respect to the brave respondents who deserve the best of me and my knowledge, and in respect to this project as a whole.

“Survivor” and “Victim”

“Whether I call myself a survivor or victim is a relatively simple question—I’m a grown woman who can call herself whatever she wants”

(Harding, 2020, p. 98).

The terms victim and survivor are both used frequently, often interchangeably, within the academic literature, support services, criminal justice spaces, and by victims/survivors of sexual violence themselves (Campbell et al., 2009a; Harding, 2020; Jordan, 2013; Sexual Assault Kit Initiative, 2020). Within each of these spaces, some victims/survivors hold strong preferences while others do not (Harding, 2020). Alongside this, many victims/survivors will fluctuate in their individual choice between these terms, while others may identify with both or neither label at any given time (Harding, 2020; Jordan, 2013; Sexual Assault Kit Initiative, 2020). However, it is generally accepted that when someone’s preference is not stated, victim and survivor can be used interchangeably if done so in a respectful manner (Harding, 2020; Sexual Assault Kit Initiative, 2020).

Before delving deeper into the nuance of such terms, it is essential to reiterate the fluidity of the journey that follows being sexually harmed. For some, the journey following sexual violence is conceptualised as a transition from victimhood to survivorship, while other journeys are a complex, non-linear experience (Jordan, 2013). It is important to note that the nature of being a victim and/or survivor is also not exclusively determined by the sexually violent event/s itself. For those who pursue charges post-assault, women describe having to survive the often disbelieving, humiliating, and revictimising criminal justice processes, as well as negative experiences when seeking help from loved ones or support services (Harding, 2020; Jordan, 2013). For others, feeling unable to share their story safely with anyone at all acts to perpetuate feelings of shame and guilt (Rousseau et al., 2020). In summary, it would be unwise to consider sexually violent experiences as a one-off experience with a start and an endpoint, when all experiences of violence are embedded within a societal structure that continues to victimise women following sexual violence.

The way we label and understand sexual violence and its associated outcomes is embedded in culture and differ based on social location. As Rousseau et al. (2020) explain, for women, this is within a patriarchal system designed to discredit their experience, allowing the proliferation of rape myths that can cast doubt and blame into the mind of those harmed. These scripts, or dominant narratives of what constitutes sexual violence and victimhood, inform how women label unwanted sexual experiences, with themes of normalisation, minimisation, self-blame, and rationalisation commonly described (Rousseau et al., 2020). These scripts also underpin what has been called “unacknowledged sexual violence” (Rousseau et al., 2020, p. 1), where people do not consider themselves to have been sexually harmed, owing to the dominant narratives that determine who is a ‘true victim’ of ‘real’ sexual violence and is thus ‘deserving’ of such titles. Harding (2020), a victim/survivor, advocate, and author, describes how victim terminology and the meaning behind the harmful event was somewhat bestowed upon her by others, rather than an independent realisation: “I don’t recall who first told me that I wasn’t a victim, but it happened soon after someone told me I was raped” (p. 90). What is important in these findings is that terminology—and the meaning behind that terminology—is as much socially mediated as it is an individual positioning.

Coming from an understanding of sexual violence being fundamentally an abuse of power, with the very threat of it a tool of women’s systemic oppression, considering oneself a victim of this convoluted patriarchal system feels appropriate for many (Harding, 2020). For others who do not think their life was at risk during the harmful event, the term survivor may not feel like theirs to hold (Harding, 2020). The feminist movement of the late 1980s ascribed further meaning to these terms, categorising victimhood as emphasising passivity, vulnerability, and helplessness, while survivorship emphasises agency and resilience (Harding, 2020; Jordan, 2013). Alternatively, avid supporters of the term victim argue that the term survivor fails to emphasise the violent and devastating sense of having one’s autonomy removed through violence, thus it is a term that should be reclaimed to reflect the true harm caused (Harding, 2020).

I see the separatist categorisation of victims and survivors as both helpful and harmful; it comes from a place of women's empowerment in an attempt to let people determine what terminology best fits their experience, yet comes with an inflexibility that separates victims/survivors into categories when they may feel both or neither fit with them. I further question the accuracy of the sentiment behind such categories, with the myriad of protective actions that people demonstrate during an assault showing that one can be both resilient and strong even while being victimised (Jordan, 2013). In a lived experience of resistance towards existing within a single, rigid category, a victim/survivor describes that for them, "survivor is a term that empowers me and allows me to communicate that I have been through an ordeal, but I have come out the other end. … I use the term victim to express that this crime is horrific, life-changing, affects everyone that is near and dear to me" (Sexual Assault Kit Initiative, 2020, p. 2). In summary, people who have been harmed suggest that one is never solely a survivor nor victim, that the categories overlap and may exist in parallel, with it erroneous to suggest that one's journey is linear in nature (Harding, 2020; Jordan, 2013; Sexual Assault Kit Initiative, 2020).

The reality is that no matter one's preferred term, it would be ideal not to need to use either. Harding (2020), who has grappled over time with this terminology, explains that "There's no option for 'Would prefer not to confront adversity as a rule, but it's not always up to me'" (Harding, 2020, p. 100). I fluctuate in my personal preference for these terms, but I also think it is important to note that given the violent nature of sexual violence, unfortunately, people will sometimes lose their lives; thus, will never even have the option of identifying as a survivor. Having an immediate family member lose their partner following a sexually violent attack—in turn growing up with an acute awareness of the harm sexual violence can cause—the term victim holds particular meaning for my family. While she will never personally stand as a survivor, I believe her loved ones are now both victims and survivors in their own right; they will be forever impacted by the widespread web of harm that sexual violence and murder weaves across society.

Given the lack of consensus and ongoing debate about these terms, alongside my priority of valuing lived experience, I have chosen to use these terms interchangeably throughout this project. If respondents express a preference for the term victim or survivor, their preference will be used. If a particular term is used in previous literature I am reviewing, I will reflect this preference, assuming that the researchers respect respondents' preferred language use in a similar way to me. Sometimes both terms will be used—i.e., victim/survivor—if it feels right or important to do so. Either way, I hope those reading this who have been harmed by sexual violence feel included, no matter how you identify with your experience/s.

"Disabled People" and the "Disability Community"

Wide-ranging terminology is used to categorise members of the disability community and is often entrenched in debate. Language is frequently imposed upon the disability community with no consultation, reflecting stereotypical and oppressive views and/or over-medicalised descriptions of identity. These practices fail to reflect the inclusion and empowerment of people whose bodyminds[6] differ from dominant norms (Sins Invalid, 2017), further solidifying the status of the (non-disabled) group as superior to the 'other' (Cotter, 2007).

Historically, a medicalised model of disability assumed that people are disabled by their limitations, unable to meet society's expectations of what a bodymind should be able to do (Hughes, 2010; Sins Invalid, 2017). More recently, there has been the proliferation of the social model of disability, a model that acknowledges that diversity within the human experience is entirely normal, and it is the bounds of society's expectations that act to

---

[6] "Bodymind" refers to the integration of body and mind, both which may differ from dominant, able-bodied norms, and which are inseparable, co-existing parts of oneself (Sins Invalid, 2017).

disable people with non-normative lives (Hughes, 2010). In turn, the word “disabled” is being reframed to reflect how the community wishes to be seen. Sins Invalid (2017), a disability justice organisation led by disabled people of colour, describe disability as:

> a word that links people of common overlapping related experiences of oppression based in navigating a world designed and defined by non-disabled people. This term has been reclaimed by people whose bodyminds have been medicalised and pathologised, working from an empowered perspective (p. 153).

This reclamation acts as a voice of resistance to those who previously stripped disabled people of their right to choose how to define themselves. The ability to self-categorise as disabled, and this term encompassing all forms of disability and/or illness, feels meaningful to me as someone passionate about equity.

Despite accepting the use of the terms disability and disabled, debate continues to exist around how these terms should be framed in the context of identity, i.e., the use of identity-first or person-first language (Sins Invalid, 2017). Specifically, this refers to saying “disabled person/people” (identity-first language) versus “person/people with a disability” (person-first language). This debate centres around the idea that identity-first language sees someone’s disability before seeing them as a whole person; however, proponents of identity-first language believe that not using disabled as an explicit descriptive continues to frame disability as a negative (Dalziel, 2001; Robson, 2016; Sins Invalid, 2017). At the same time as the American Psychological Association advocates for the use of person-first language, the trend for disabled people in Aotearoa New Zealand is to use identity-first language, aligning with the reclaiming of the word disabled and thus themes of disability pride, identity, and the social model of disability (Dalziel, 2001; Hughes, 2010). With aspirations of living in an equitable world where diversity is celebrated, not criticised, this also reflects my preference. In my use of identity-first language, this choice is an intentional resistance to the oppression of non-normative bodies; I refuse to see my disabilities as something to be ashamed of and will continue to model this until society is forced to agree.

Despite the preferences of the majority, it must be acknowledged that not all people who live with non-normative bodyminds will identify with this terminology. For example, people may identify with the mental health rather than disability community. The Deaf community often understands themselves as a unique community with their own language and cultural norms (Robson, 2016; Sins Invalid, 2017). Of further note, the use of a capital ‘D’ on the word Deaf reflects community pride and will thus be used throughout this project, whereas a lowercase ‘d’ on the word deaf reflects the medical understanding of deafness as impaired hearing (Sins Invalid, 2017).

I unapologetically identify as disabled and refuse to neglect the positioning it brings into this project. Not using identity-first language, as I do in my everyday life, would go against the social-justice principles that matter to me and that formed the foundations of this project. Following discussion with disability advocates and alignment with recommendations from the Aotearoa New Zealand Disability Strategy Revision Reference Group (Dalziel, 2001), I decided to use identity-first language in this study, despite this being opposed by the American Psychological Association. However, suppose any respondents prefer person-first language or have other preferred terminology for making sense of their identity, any information in the study that refers to them will align with their preferred choice of language.

“Marginalisation”

In a literal sense, marginalisation can be understood as someone being pushed to the edges of society. Cook (2008) describes a social understanding of marginalisation, whereby marginalised people are “those excluded from mainstream social, economic, cultural, or political life ... by no means limited to, groups excluded due to race, religion, political or cultural group” (p. 495). Marginalisation is sometimes referred to plainly as social exclusion, reflecting the particular disadvantage in a social sense (Appleton-Dyer & Field, 2014).

While many minority groups experience marginalisation, the term minority is not interchangeable with marginalised. Disabled people living in Aotearoa New Zealand make up 30% of our population and are thus far from a minority, and similarly, Māori are Aotearoa

New Zealand’s Indigenous people and were marginalised long before they could ever be deemed a minority (Statistics New Zealand, 2013). However, inequity does facilitate further mistreatment in a vicious circularity, meaning that minority groups are also often those marginalised and vice versa—with Māori having poorer health outcomes and higher rates of disability than Pākehā people living in Aotearoa New Zealand (Statistics New Zealand, 2013). Many people live in multiple marginalised social locations, the mistreatment of which compounds to increase their unique experiences of discrimination, being more likely to live with material deprivation, and having less normative integration and social participation (Appleton-Dyer & Field, 2014). Intersectionality will be explored further in a later section of this thesis.

The availability of resources and conditions of everyday life is determined by one’s social location and the resultant social structures that marginalise certain people and their communities (Allen, 1996; Mullaly, 2007). People are not inherently of lower social standing due to their identification within the social categorisations of race, culture, gender, sexuality, or ability; instead, dominant social views discriminate against identities that do not conform to hegemonic[7] norms (National Academies of Sciences & Medicine, 2018). In this way, a social hierarchy stems from historical oppressions that continue a cycle of discrimination through current policy and dominant societal views (National Academies of Sciences & Medicine, 2018). Such discrimination happens both at an individual level—such as a support service being unable to meet the accessibility needs of a disabled survivor—and societal levels, such as perceptions that devalue disabled people as sexual beings and thus prevent improvements being made to support services to better accommodate all abilities (Appleton-

---

[7] In this research, the term “hegemonic” is referring to the dominant group who use their social advantage to set and maintain social norms. These identities become the ‘reference’ for which others in society are compared, leading to categorisation and marginalisation of those who do not fit the hegemonic groups ideals—be it due to race, age, class, gender, ability and/or more.

Dyer & Field, 2014). These perceptions not only enable exclusion but facilitate widespread harms, including alienation and poor health outcomes (Appleton-Dyer & Field, 2014).

The voices of people who experience marginalisation can be some of the most well informed and important voices to hear. This is because, when living on the metaphorical lower rung of the social ladder, one has not only the knowledge that comes from experiencing discrimination but also the knowledge of the dominant ways of being that act to marginalise them and perpetuate inequity (Allen, 1996). That being, people with marginalised identities may live within a subjugated position within society, but in experiencing these wide-ranging and multi-faceted forms of discrimination, they also view the world from an outsider-within standpoint (Allen, 1996).

In this project’s use of the word marginalisation, I acknowledge the widespread harm that comes from society’s unjust mistreatment of people with non-hegemonic identities. While describing marginalised groups by saying something such as *‘people who experience unique and wide-ranging forms of discrimination because of how society unjustly categorises and locates certain people as better or worse than others, as a result of their sameness or difference from the hegemonic norm’* would be preferable, the term marginalised will be used for conciseness and clarity. In using this term, I stress that no community is at fault for their mistreatment by broader society, and I wish a better term were available that could reflect the multidimensional levels of harm you experience.

Methodology

A Methodological Journey

Owing in part to the many unexpected changes that came with Covid-19, but also my own personal development in growth and understanding that took place throughout this project, my methodology is best conceptualised as an unfolding journey with many twists and turns along the way.

My starting place, at the very beginning of this project, was an interest in disability and a desire to gather the unheard lived experiences related to the sexual violence sector. In looking at ways to do this, I was drawn to thematic narrative analysis as outlined by Riessman (2008). I connected with this method because of the way it could tell stories that keep the person at the core, and that the topics that were most important to respondents would remain at the forefront of the project. I read about the way that humanist principles were central to the conception of narrative methods, pushing us to connect with individual stories and hold people as experts in themselves, which I felt fit with my aspirations of the project. I also identified with the way that social constructionism allows multiple "truths" and "realities", meaning that marginalised voices can be privileged alongside the majority, when often they are not.

At the same time as this line of thinking was developing, so was my interest and understanding of intersectionality. This started to challenge how I was thinking about privileging the voice of the individual, and how not considering the structures that we live in was only telling part of the story. I realised that humanism and social constructionism do not naturally align with intersectionality, and I needed to explore a new balance whereby I could reflect the shared experience of the group while still acknowledging diversity in experience. That being, I had to draw upon, and build from, elements of each methodological concept, and work to flexibly integrate these into a method that gave appropriate voice to my respondents. I came to realise that just presenting the "what" of one's experience was not going to account for the "why" or "how" of those experiences—what is traditionally presented in a thematic narrative analysis (Riessman, 2008)—, and in turn miss crucial elements of context and understanding. Rather, I needed to take this analysis a step further, to a place of interpretation and integration, to understand both the presented narratives but also the world of context that surround these.

In summary, this project draws upon components of intersectionality, social constructionism, and thematic narrative analysis to develop a highly reflexive, interpretive analysis of narrative. The section that follows outlines each of these methodological components and the elements that I was drawn to, which acted as foundational stepping stones for my analysis to follow.

Introducing Intersectionality

Intersectionality weaves through this project at every level. In that way, it is much more than a theory—it is my fundamental ideology, method, ethics, and praxis. Intersectionality's roots in critical race theory and radical, political activism provide a framework to unpack the *unique* experiences of *all* people who experience discrimination due to their social position, aligning with the social justice principles that underpin the entirety of this research. As outlined in my prologue, I felt it pertinent to present this theory before almost anything else, as without understanding intersectionality the following discussions would have no foundation upon which to sit.

To adopt an intersectional lens is to understand that every person has a unique experience of discrimination or privilege because of how they are socially categorised by others, with interlocking systems of power acting to advantage or disadvantage someone based on this social location (Collins, 2015; Crenshaw, 1989; Salem, 2016). While embodying any socially-subjugated identity means someone is exposed to multi-level harms, multiply-marginalised people experience discrimination—e.g., ableism, sexism, racism, heterosexism and so on, the combination of which Collins (1990) termed the "matrix of domination" (p. 18)—in both categorically different and quantifiably intensified ways (Grabe, 2020). That is to say, those positioned further from the cultural hegemony are even more socially subjugated, disrespected, and/or ignored, with inequality not being a single force but rather operating as a “system of oppression” (Grabe, 2020, p. 6) operating at individual, interpersonal, and institutional levels (Grabe, 2020). In turn, this leaves people existing at marginalised social locations left out of conversations and underserved in policies, perpetuating social disadvantage and further reinforcing divisions from the hegemonic group (Collins, 2015; Crenshaw, 1989; Grabe, 2020; Salem, 2016).

In understanding the ways that intersectionality can be conceptualised, we face the dilemma of balancing narrow understandings that constrict its applicability with broader understandings that could cause the concept to lose saliency (Collins, 2015; Salem, 2016). Intersectionality has been described with terminology related to both research and praxis, from a paradigm, data, or measurable variable, to a perspective, concept, or theory (Collins, 2015; Crenshaw, 1989; Salem, 2016). While often framed as feminist in origin, intersectionality is also informed by critical race theory, queer[8] theory, and postcolonialism (Salem, 2016). While the discussions continue, Collins (2015) describes a current consensus among all interpretations of intersectionality that its “contours” (p. 2) reflect “the critical insight that race, class, gender, sexuality, ethnicity, nation, ability, and age operate not as unitary, mutually exclusive entities, but as reciprocally constructing phenomena that in turn shape complex social inequalities” (p. 2). In turn, an intersectional approach to this research reflects that experiences of multi-categorical oppression cannot be ameliorated by mono-categorical solutions, with intersectionality informing a way of thinking and being as equally as it informs method.

---

[8] “Queer” is an umbrella term which encompasses sexualities and gender identities which differ from heterosexuality and cisgenderism. While historically used as a derogatory term, it has been deliberately reclaimed by the queer community and is now widely used and accepted (Zosky & Alberts, 2016). While the term “rainbow” is also commonly used, “queer” will be used throughout this project for consistency.

Intersectional Beginnings

Having travelled and developed considerably over time, maintaining the radical, activist roots that ground intersectionality in the examination of power relations is pertinent, rejecting liberal feminist and neoliberal interpretations that have reconceptualised intersectionality on a more individual level (Salem, 2016). Nineteenth-century first-wave feminism was predominantly focussed on gaining equality between men and women within a political frame (Armstrong et al., 2018). However, this depicted women as a homogenous group who have the same experience of life as female, and subsequently, who live the same experience and understanding of female oppression. With roots in Black feminism, intersectionality was brought to the forefront by activists who challenged first wave feminism as neglectful of women's experiences who do not fit the hegemonic white, middle-to-upper class mould (Crenshaw, 1989). That being, intersectional feminists championed the reality that Black, disabled, and poor women live heterogeneous experiences of oppression, with neither race nor gender the single determinant of a woman's social position and subsequent treatment (Collins, 2015; Crenshaw, 1989).

While mostly agreed that the foundational roots exist within Black feminist activism, there exists debate about the exact inception of intersectionality (Collins, 2015; Salem, 2016). It is not uncommon for contemporary telling's to attribute the birth of intersectionality to the point it emerged within academia, notably in the work of Professor Kimberlé Williams Crenshaw (1989). Specifically, she described how the experience of Black women is both similar and different to the experience of white women and Black men, with the experience not a sum of racism and sexism but a unique experience stemming from the combination of the two. In this way, Crenshaw (1989) was the first to use intersectionality to formally explain how people experience not just a combination of oppressions, but unique amalgamated oppressions specific to their intersecting social locations. However, while her paper is undoubtedly seminal to the theory, I believe suggesting that intersectionality was illegitimate before its coining in academic literature would disregard the plight of those living at the forefront of this movement and further reinforce the neoliberalist power of the academy. In light of this, I see Crenshaw's (1989) work best conceptualised as being monumental in advancing race, class, and gender studies in academia, more so than being the documented 'beginning' of intersectionality. This 'beginning' must rightfully sit with those who 'lived' intersectionality as a social movement long before it ever reached mainstream understandings—a sentiment to which I like to think Professor Crenshaw would herself agree.

Intersectionality Within Sexual Violence

There may be few other support services where both service users and service providers alike experience such injustice as sexual violence services. Sexual violence is often seen as a personal rather than a social issue, with culturally ingrained discrimination ignored in the conversation.

Sexual violence—both currently and historically—creates, perpetuates, and solidifies power imbalances between those who are vulnerable and those who maintain power through perpetration (Armstrong et al., 2018). In turn, exploring sexual violence within an intersectional lens is vital to understanding how and why it is so widespread, with sexual violence needing to be understood as a societal problem, not solely an individual one. For example, rape has long been used as a weapon during wartime and colonisation, but often without appropriate recognition of its use to intentionally dominate and the widespread harm it causes within communities (United Nations, 1998). Despite the United Nations recognising wartime rape as "systematic, deliberate, widespread, and planned" (Armstrong et al., 2018, p. 101), survivors/victims are not recorded among casualties or combatants of war. This therefore suggests that sexual violence is the perpetrators individual choice, ignoring the surrounding context of war whereby violence is encouraged as a means to gain power. This framing produces the systematic erasure of sexual violence as motivated by structural and political powers, deeming sexual violence to be purely an *individual* act of deviancy (Armstrong et al., 2018). This neglects the bigger picture and prevents change from happening, failing to acknowledge that individual-level solutions will not fix societal-level problems.

As explained by Collins and Bilge (2016), using intersectionality to examine social issues such as violence “reveals not only how violence is understood and practiced within a discrete system of power but also how it constitutes a common thread that connects racism, colonialism, patriarchy, and nationalism” (p. 47). As a similar example, the interlocking structures of a dominant race, class, and ability act to underpin an assumption of a ‘perfect’ or ‘ideal’ victim (Christie, 1986), determining who can be afforded victim status following sexual violence. Historically, Black men were framed as perpetrators, and Black women were not recognised as victims. Crenshaw (1989) explains that “when Black women were raped by white males, they were being raped not as women generally, but as Black women specifically: their femaleness made them sexually vulnerable to racist domination, while their Blackness effectively denied them any protection” (pp. 158-159). When exploring this with an intersectional understanding, the *combination* of racism and sexism underpinned the acts which removed not only their bodily autonomy, but arguably robbed Black women of any sense of individual personhood—working differently to how racism and sexism function as individual mechanisms.

An intersectional approach to this research is imperative. Using an intersectional framework to examine power and control that has socially categorised and marginalised people historically can help us understand how interlocking class structures cause and perpetuate inequity and oppression, leading to sexual violence and changing the outcomes for survivors. By looking at the intersectional nature of respondents’ social locations, and their lived experiences of seeking support within multiply oppressive systems, we can better explore the organisational and social structures that continue to work against survivors.

“Doing” Intersectionality: The Present Research

Since the 2000s, there has been an exponential increase in intersectionality’s acceptance as a research field (Collins, 2015; Sandoval, 2013). Disciplines with an emphasis on narrative telling’s can significantly benefit from taking an intersectional approach; however, Collins (2015) suggests that poorly considered intersectional research can “unwittingly uphold the same complex social inequalities that it aims to understand” (p.

14). In combatting this, a combination of guiding assumptions can improve intersectionality's analytical sensibility. In reflecting that each project prioritises different assumptions, I felt that one of Collins' (2015) assumptions held most true to this project and my priorities: "Intersecting systems of power catalyse social formations of complex social inequalities that are organised via unequal material realities and distinctive social experiences for people who live within them" (p. 14). The reason this holds meaning for me is threefold: it recognises that marginalisation stems from systems of power outside of one's individual control; that the world in which we live remains unjust as a result; and that this lived experience is distinct from the dominant population. Overall, Collins' reasoning emphasises the need to give voice to the people who experience interlocking oppression as an act of resistance against the powers that continue to categorise and marginalise.

The current research presents an intersectional approach to researching sexual violence. Research that emphasises intersecting identities in relation to broader social inequalities and unique experiences of discrimination continues to be in the minority of intersectional research topics (Collins, 2015). Likewise, intersectional research that emphasises complex social inequalities and social justice is less common than research that emphasises different guiding principles (Collins, 2015). In acknowledging that methodology cannot be entirely politically impartial—especially in topics as contentious as sexual violence—Sandoval (2013) goes so far as to call intersectional research a *Methodology of the Oppressed.* In hearing the experiences of people who live with intersecting social conditions that are more difficult than others, I aspire to shine a light on issues too often hidden in the shadows

Social Constructionist Epistemology

As described in the section outlining my methodological journey, this project was also guided by elements of a social constructionist epistemology; especially early on in my conceptualisations of this project. Here, I will describe the ways in which I was drawn to social constructionism, alongside background information to assist with understanding this epistemological approach

Underpinning several radical and critical approaches to modern psychology, social constructionism has been cited within the field since the 1980s (Burr, 2015; Gergen, 1985). A multidisciplinary theoretical orientation, social constructionism has roots within philosophy, linguistics, and sociology (Gergen, 1985). In line with post-modernism, researchers guided by this orientation understand there is no one governing system of knowledge; rather, there are multiple, co-existing ways of life which are constantly changing (Burr, 2015; Gergen, 1985; Muehlenhard & Kimes, 1999). In turn, to understand social life, we must look beyond individualism and interpret knowledge within the cultural, political, and economic landscapes that exist at any given time (Burr, 2015; Gergen, 1985). In understanding knowledge from a social constructionist perspective, three key questions warrant reflection: what can we know, where does knowledge come from, and who creates knowledge?

What Can We Know?

We live within a storied world (Burr, 2015; Riessman, 2008). There is no single universal truth, right or wrong, nor good or bad; there exists only the stories people share about their lives that give context or assign meaning to such concepts (Burr, 2015). At its most radical interpretation, everything in life can be considered socially-constructed—including social constructionism itself—with objective impartiality a complete impossibility (Burr, 2015; Gergen, 1985). As a more moderate interpretation, this framework reminds us to remain critical and think beyond a single reality we observe on a surface level, considering how knowledge came to be and what alternatives co-exist (Gergen, 1985).

Where Does Knowledge Come From?

Knowledge is constructed within the bounds of the culture and environment in which one lives (Burr, 2015; Gergen, 1985). Guided by language use and principles, knowledge is co-constructed through the sharing of experience between individuals and the specific stories in which they choose to share (Gergen, 1985; Riessman, 2008). Much like within a narrative framework, as discussed in further sections, this “performance” of chosen stories dictates the truth of a person’s reality and experiences, which changes depending on the telling to various audiences (Burr, 2015; Riessman, 2008). In turn, the audience assists the teller in meaning-making from the stories heard, creating a circularity of co-construction and shared knowledge (Burr, 2015).

Who Creates Knowledge?

Representations of knowledge and reality are only ever partial (Burr, 2015; Gergen, 1985). There will always co-exist other sets of knowledge, constructed within different cultural frameworks, systems of power, and across various points of history (Burr, 2015; Gergen, 1985). In turn, the interests of some individuals—usually the dominant cultural group—will always be privileged over others, with “greater power leading to greater influence over defining and framing social issues” (Muehlenhard & Kimes, 2000, p. 235). While the dominant cultural beliefs may overshadow less-accepted social norms, social constructionism acknowledges that non-dominant systems of belief are equally valuable and real for the communities in which they thrive (Burr, 2015). This, in turn, rejects the often imperialist and individualistic attitudes of some branches of psychology that impose Western ways of thinking onto Indigenous systems of belief (Burr, 2015).

A Social Constructionist Understanding of Sexual Violence

What is thought of as sexual violence has evolved over time (Muehlenhard & Kimes, 1999). Terms such as date rape, and the introduction of technology-facilitated sexual abuse, reflect that what constitutes violence is constantly changing. Likewise, forms of violence that may have previously been seen as permissible, e.g., domestic battery, are now widely socially and legally unacceptable (Muehlenhard & Kimes, 1999). However, progress on many of these issues has been slow and marred with controversy.

From a social constructionist perspective of sexual violence, a universal definition that reflects all versions of lived experience cannot exist (Muehlenhard & Kimes, 1999). Thus, any legal definitions created by those in power are made with their own interests in mind, often failing to reflect the lived experiences of people who inhabit marginalised social locations (Muehlenhard & Kimes, 1999). In protecting one’s own image, people benefit from rejecting descriptions of violence that may reflect actions they already perform—that being, actions which would label them as rapists if they were acknowledged as being harmful (Burr, 2015; Muehlenhard & Kimes, 1999). For example, in the 1900s, men who deemed the rape of their wives as acceptable were highly opposed to defining marital rape as a crime, with such a classification thus labelling them as rapists (Muehlenhard & Kimes, 1999). More recently, post the #MeToo movement, men are citing fear of being falsely accused of sexual harassment in the workplace (Soklaridis et al., 2018), without considering that if their actions could be construed this way then the behaviour is likely already unacceptable.

The use of social constructionism in informing this project promotes the understanding that all forms of lived experience and knowledge are as true, real, and important as the dominant stories heard. As described within an intersectional framework, combined forms of oppression create *unique* experiences of discrimination rather than a summation of their parts. For this reason, it is vital to give voice to *all* lived experiences, not just a majority narrative. Informing this project from these two frameworks means that all stories told are equally valid and important. No experience is rejected just because it was not 'corroborated' by others—others will never have walked in those exact shoes anyway.

Narrative Analysis

"Narrative is present in every age, in every place, in every society; it begins with the very history of mankind and there nowhere is nor has been a people without narrative … it is simply there, like life itself"

(Barthes, 1982, as cited in Riessman, 2008, p. 4).

There is significant cross-disciplinary interest in the concept of narrative, with equally diverse understandings and interpretations (Riessman, 2008). Narrative enquiry itself is a vast field often praised for its utility but equally, it is heavily contested. It is ontologically and epistemologically diverse, even at times considered an ontology and epistemology of its own merit, and without consensus on a particular method of analysis (Murray, 2015; Riessman, 2008). While a single definition of narrative cannot exist, an overview of how this concept is understood is important. In understanding how narrative works as a meaning-making tool for lived experience and identity—especially when informed by intersectional theory and social constructionist epistemology—its benefit as a methodology in the current research should become clear.

In acknowledging the diversity of the concept, Schiff (2012) describes that “pinning down” (p. 33) a single understanding of narrative is difficult and that as a discipline, psychology “appears to be content with an imprecise metaphor” (p. 33). In attempting to sum up narrative, he describes the concept as a placeholder for metaphorical understanding, often about life itself, but also as a window through which researchers can see into a person’s process of finding meaning from life’s events (Schiff, 2012). With a somewhat more concrete definition, Riessman (2008) describes narrative as “a universal way of knowing and articulating” (p. 6). However, while such a definition seems absolute, she does not suggest that each person shares a single universal view—something we know to be an impossibility via a lens of social constructionism. Instead, I believe she suggests that narrative, as a concept, is a universally applicable medium for understanding life and its heterogeneous intricacies. In this way, I must agree.

Interestingly, Riessman (2008) also uses the term narrative interchangeably with storytelling. However, I see narrative as going beyond arranging a mere sequence of events into a convincing story. Rather, the sharing of narrative can be conceived as a sense-making process that integrates the tales of one’s life into meaningful plotlines, painting a bigger picture of one’s identity and experience (Murray, 2015; Riessman, 2008).

As much as narrative is a meaning-making process for an individual, the shared story and its purpose change depending on the teller, the listener, and in the case of research, the reader. An individual’s experiences occur, are understood, and are re-told within sociocultural norms and expectations, each influencing the telling and understanding of narrative (Riessman, 2008). In turn, the stories told are a performance to the specific audience privileged to them and can be understood within, or equally be challenged by, the listener’s own worldview.

Of similar influence, the construction of narrative is heavily impacted by culture and mediated by vocabulary, with stories arranged in different forms. Riessman (2008) explains that the hegemonic Western norms of storytelling privilege the "I" rather than "we", reflecting the individualistic nature of Western society. Furthermore, unspoken Western rules dictate that a good story should be temporally ordered, it should be interesting, it must be topically organised rather than spatially or temporally, and it must provide "what, where, when, and how" which precludes general or habitual assumptions (Riessman, 2008). However, what is seemingly agreed cross-culturally, is that narrative shows contingency through pattern-making; the aligning of experiences or ideas add meaning to one's life story. Therefore, while narrative may be differently organised depending on one's heritage and norms within their culture, meaning-making through narrative is a concept that is understood cross-culturally (Riessman, 2008).

Dominant and Counter-Narratives

Societal "rules" place expectations on one's identity, such as what is normal, abnormal, and who it is okay to be (Bamberg & Andrews, 2004). In this way, the identity itself is a narrative (Bamberg & Andrews, 2004; Riessman, 2008). Like all forms of narrative, identity is fluid; it is formed and reformed with each telling. It is constructed through the stories one tells others—and, in turn, does not tell others—about themselves and the groups in which they live. Subsequently, these stories can either fit within and reinforce a dominant narrative; or push back against a narrative that does not fit with one's non-hegemonic experience and identity (Andrews, 2004; Bamberg & Andrews, 2004).

When one's narrative, be it identity and/or experience, opposes dominant socio-cultural norms, this is considered a counter-narrative (Bamberg & Andrews, 2004). The sharing of counter-narratives offers a form of resistance against dominant narratives—sometimes referred to as master narratives—whether such resistance is intentional or not (Andrews, 2004). While it seems logical that a counter-narrative can only exist in direct opposition to a dominant narrative, the two are not dichotomous entities. Instead, counter-narratives can live in opposition to a dominant narrative, but equally, can function alongside them (Andrews, 2004; Bamberg & Andrews, 2004).

There is comfort in fitting within a dominant narrative, as being part of a majority acts to normalise experience (Bamberg & Andrews, 2004; Riessman, 2008). However, internalising a dominant narrative also serves as the means for counter-narratives to emerge. Dominant storylines can be considered as a “blueprint” (Andrews, 2004, p. 1) for experience, against which individuals can compare their narrative for similarities and differences. In this way, these dominant storylines become the “vehicle” (Andrews, 2004, p. 1) for more comprehensive understandings; people must consider who they are in relation to the majority view and what deviates from it. Whether or not a person’s experience fits within this dominant narrative, the internalisation of these societal views reinforces the master narrative’s existence. This is because, whether implicitly or explicitly, one’s understanding of their own experience will exist within, or outside of, the dominant narrative (Andrews, 2004).

However, this is not to say there is no solidarity and validation from identifying with a counter-narrative. As a person lives an experience different from the dominant narrative, they are faced with the challenge of making sense of themselves and the world using an unfamiliar script (Andrews, 2004). However, this does not mean that these scripts do not yet exist. In reality, counter-narratives, like master narratives, can be understood individually but nonetheless share commonalities with others’ experiences outside of the norm. Such “deviant” (Andrews, 2004, p. 1) counter-narratives flourish within marginalised groups, where experiences of being an outsider are not unique. Even the most unique and individualised communities will share common scripts, making the sharing of counter-narratives a validating experience while being an act of resistance against the norm (Andrews, 2004).

Dominant Narratives and Sexual Violence

Given that sexual violence is a common occurrence and a highly politicised issue, narratives which privilege the majority dominate cultural understandings. These inform how and what people think about sexual violence—whether factual or not—and the internalisation of these dominant narratives can challenge one’s understanding of their experience, of who they are as a survivor, and in turn, who they are as a person (Bamberg &

Andrews, 2004). This is especially troubling in an area such as sexual violence, where many of the dominant narratives do not reflect survivors' experiences.

One example of these dominant narratives is the expectation of an ideal victim, first coined in the seminal work of Christie (1986). Rather than society simply allowing someone to self-identify as a victim if that fits their narrative, Christie (1986) describes the ideal victim as "a person or category of individuals who—when hit by a crime—most readily are given the complete and legitimate status of being a victim" (p. 18). The dominant narrative conceptualises ideal victims as a young, white, middle-to-upper class, and non-disabled woman; who did not know her male attacker; who fought back before giving in; and reported the crime immediately. Ultimately, that is someone legitimate and blameless who put effort into not becoming a victim (Bosma et al., 2018; Christie, 1986). Such a stereotype fails to address that most sexual violence survivors do not fit this narrative, most survivors know their attacker, and non-white, disabled, and queer people are disproportionately impacted by such attacks (Anderson & Overby, 2021; Jordan, 2008). The concept of being able to fight back is inherently ableist, neglecting to acknowledge both the physical and psychological power differentials between oneself and one's attacker. Likewise, being able to report the crime requires the physical and communicative ability to tell someone, assumes that someone has access to communication devices, assumes one understood a crime was committed against them, assumes one will be believed, assumes that appropriate support and safety will be available, and assumes that one has the internal strength and power to report the person whose very act stripped them of their autonomy (Robson, 2016).

When someone's reality reflects these counter-narratives—whether via identity, experience, or both—they can face widespread disbelief and stigmatisation following sexual violence. In turn, if they report the harm done to them, they receive poorer support services and are less likely to have their perpetrator convicted than a survivor who is seen as a perfect victim (Jordan, 2008). Others who share similar experiences then become less likely to report their experience, and the dominant narrative continues to proliferate societal views.

However, like all sociocultural understandings, dominant narratives change over time. This research will explore the perspectives of the dominant narratives as explained by respondents who experience marginalisation themselves, and likewise, may have been negatively affected by these dominant sexual violence narratives. At the same time, I hope to explore the counter-narratives, as acts of resistance, to consider how living on intersectional margins changes a person's experience of support.

Humanism and Narrative Methodology

When exploring the historical context of narrative methods, humanist approaches are considered a core component of its early inception (Josselson & Lieblich, 2001). An "interpretative movement" (Brown, 2017, p. 217), humanist narrative methods were born from the rejection of logical-positivist approaches which arguably fragmented human experience and removed the individual from the context which surrounds them (Josselson & Lieblich, 2001). In turn, this movement aspired to study and understand the individual as a whole person, and to "regard the person as complex, unified, and existing in context" (Josselson & Lieblich, 2001, p. 321).

In current understandings of the links between humanism and narrative methods, two elements most closely align with my aspirations for this research. Firstly, this approach aspires to keep the person—here, my respondents—and their story as the central point of interest, and holds them as the expert in themselves. In turn, narrative as informed by humanism understands that researchers must come as listeners without preconceived ideas about people or their experiences, and be open to surprises and alterative views that were not anticipated in the research process (Josselson & Lieblich, 2001). I see this as an important step in appropriately valuing the lived experience of respondents, as an ethical response to gathering stories of discrimination and marginalisation.

Secondly, Andrews et al. (2008) explain how "humanist and the poststructuralist traditions of narrative research are often brought together by their shared tendency to treat narratives as modes of resistance to existing structures of power" (p. 4). In this way, a narrative approach with humanist and post-structuralist underpinnings is particularly appropriate for people who experience wide-ranging forms of discrimination (Andrews et al., 2008). As this project is focussing on experiences of sexual violence, an area where people impacted are frequently harmed by dominant narratives which aim to discredit their lived experiences, conceptualising the sharing of narratives as a mode of resistance is highly appropriate.

A Rationale for Narrative Inquiry

To summarise, narrative methodology is particularly suitable for the present research,, as it allows a comprehensive examination of social issues underpinning sexual violence for people who experience multiple marginalisation, using processes that empower respondents and promote autonomy.

Narrative research is frequently described as a meaning-making process (Murray, 2015; Riessman, 2008). As our lives are intrinsically storied, traumatic events can disrupt expectations one has about the continuity of their life course. In turn, such events can impart a sense of chaos and an overflow of emotion that disrupt not only the narrative of that event but also one’s wider narrative of identity (Murray, 2000). In the context of this research, it may be that people must position themselves within a new narrative of being a sexual violence survivor. Thus, how does this new sense of identity change the narrative of already living with a marginalised identity? Riessman (2008) suggests that through the telling of stories, one can re-order the chaos and contain difficult emotions, searching for the meaning behind what happened, who the teller is now, and where to from here. In turn, using a narrative methodology should empower research respondents in the sexual violence context, helping them find meaning from chaotic experiences.

Riessman (2008) explains that “narratives, as sense-making tools, inevitably do things – for people, for social institutions, for culture, and more” (p. 8). In this way, narrative research is a political call to action; when we consider that society has dominant narratives, sharing stories that oppose these narratives can be conceptualised as an act of resistance (Andrews, 2004). In turn, championing the voices that reflect counter-narratives can also mobilise others to stand for social change and political action. When reflecting on the birth of some of the largest political movements of the twentieth century, sharing lived experiences of discrimination was an integral part of their groundwork (Riessman, 2008). Narrative sharing forms connections and these connections produce shared voices for justice. The exploration of power structures in this research, such as racism, ableism, and sexism, are, at their core, political social-justice issues.

Ethical Considerations

Social Justice Ethics: An Introduction

The ethical considerations at the forefront of my mind while conducting this research are those grounded in social justice. A key aspiration of this project was hearing the voices of people who are frequently excluded from academic research.

This project received ethical approval from the Massey University Human Ethics Committee (application 19/40), in a process which included thoughtful reflection on how I include and keep safe respondents who are less-often included in research settings. With the arrival of Covid-19, emendations were also made to allow for the use of Zoom for interviews, and approved by the committee. While this application process is foundational as part of ethical safety in research, such an approval is only the beginning of what I would consider good practice when working with people who have experienced wide-ranging discrimination. Therefore, I wish to expand on the ethical framework that guided this project.

The Code of Ethics for Psychologists Working in Aotearoa New Zealand (New Zealand Psychologists Board, 2002) outlines “Social Justice and Responsibility to Society” (p. 25) as one of four defining principles, designed to present values and practices to which psychologists should aspire. However, the recommendations remain ambiguous regarding what extent psychologists must engage in social justice work (Hailes et al., 2020). Furthermore, much of the discussion centres around ethical decision making in a therapeutic setting, which I believe neglects the scientist-practitioner identity that a good psychologist should embody. From where I sit, ethical, social justice work is of equal importance in both the therapeutic and research spheres.

In light of these limitations, Hailes et al. (2020) recently produced the *Ethical Guidelines for Social Justice in Psychology.* They believe that “it is insufficient for psychologists to engage only in microsystem work, such as psychotherapy, without also working to change oppressive policies and institutions that contribute to suffering and distress” (p. 2). In turn, they propose that three domains of justice can inform ethical practice within a framework of social justice—namely interactional justice, distributive justice, and procedural justice. While only recently defined, these guidelines have helped me find the terminology for concepts that have been foundational for my work throughout this project. Below, I will discuss how I have reflectively engaged with these principles throughout my research and flexibly integrated them into my practice.

Interactional Justice

Interactional justice, the first of the three overarching ethical principles, is bound in relational dynamics. It outlines three key concepts: *reflecting critically on relational power dynamics, mitigating relational power dynamics,* and *focusing on empowering and strengths based approaches* (Hailes et al., 2020). These concepts centre consideration of power structures, promoting fairness among all people during interactional exchanges. In turn, interactional justice is primarily considered as working on an individual or “micro” level, i.e., how an individual is impacted by the way in which they are treated. However, it would be antithetical to assume that solely working at a micro/individual level does not inflict changes across the higher levels of a system, with a multitude of small changes able to inflict larger change (Hailes et al., 2020). Ultimately, interactional justice reinforces the importance of speaking to individual survivors and those working on the ground, who best understand their *individual* treatment as part of the *larger* collective.

From a personal standpoint, Hailes et al. (2020) emphasise that psychologists need to be aware of their own status in the world and consider how privilege, power, and oppression operates within their lives. By doing so, psychologists—and in turn, researchers—are less likely to naively reinforce oppressive systems that have already harmed the people with whom they are working. Given the removal of autonomy that occurs for people impacted by sexual violence and the frustration that service providers experience in being unable to invoke high-level political change, this is a particularly pertinent consideration in the current project.

Positioning

As part of reflecting upon my own positioning and in line with social constructionism, I acknowledge that my complete objectivity and impartiality is impossible within the research process. In listening to the narratives of storytellers, I hear these from my position in the world; as a disabled, cisgender female, heterosexual, white, educated, researcher and practitioner. While I have experienced marginalisation at the intersection of some of these identities, I also stand privileged with my European background and access to higher education. In turn, while I share an insider status with respondents in some regards, I will always remain an outsider in others. Deeply considering my positionality throughout this project has kept Hailes et al. (2020) interactional justice principles at the forefront of my mind, prompting reflection of how my insider status, position of power, and lived experiences shape each element of the research process.

Being on the Inside

Having an insider status in research can improve rapport, trustworthiness, and access to respondents who may otherwise be hesitant to engage in research (Bhopal, 2010). However, others argue that such an insider status may lead researchers to take it for granted that they understand what the respondent is conveying (McCracken, 1988). McCracken (1988) puts this delicately, describing that “intimate acquaintance with one’s own culture can create as much blindness as insight” (p. 12). For these reasons, as much as I may have felt I understood respondents' experiences, I engaged in “manufacturing distance” (McCracken, 1988, p. 22) in the research process. This distance assists respondents to elaborate on their experience without assuming I hold extensive prior knowledge. Manufacturing distance became a balance of our shared knowledge and empathy and the sense of naivety I maintained about their stories. Despite my concern that such naivety may frustrate providers who expect me to have a good understanding of the sector, all respondents engaged well in this process and were more than willing to expand their explanations if prompted.

To Have Power?

It was important to me that my interview style promoted respondent autonomy as much as possible. Mishler (1991) explains that in a narrative interview, the researcher aims to ask questions that give way to detailed accounts of experiences or ideas. This interview style promotes respondent-guided storytelling, aiming to shift the power imbalance by having the researcher as largely a listener, rather than a questioner (Hydén, 2014). However, it must be acknowledged that a researcher does hold an intrinsic level of power in the research relationship, as hard as we may try to remove it (Hailes et al., 2020; McCracken, 1988).

For example, despite the interviews being an open style and teller led, any follow-up questions I asked were guided by my assumptions of the world and aspirations for the research. One of the benefits of the narrative approach is that respondent stories are kept in a fuller form, privileging their voices over mine (Riessman, 2008). However, despite this, the stories produced will have always been co-constructed with me, through the questions I ask, who I am, the understanding I have of their stories, and the research process I have chosen to undertake.

Unexpectedly, in some ways, the status I held as a trainee clinical psychologist was beneficial to the research process. In my experience of the sexual violence sector in Aotearoa New Zealand, clinical psychologists are overwhelmed, under-resourced, yet often an important part of survivors' recovery journeys. This meant that I was frequently met with enthusiasm when I approached key informants, who were excited by the prospect of me pursuing such work. Likewise, some respondents seemed to embrace the opportunity to tell me how their own experiences seeing a psychologist were poor, framing their sharing of narrative as an educational opportunity for someone else in this profession who may work with survivors in the future. This was an interesting balance to navigate—being cognisant of wanting to be seen on an equal level, but realising that my title, unexpectedly, added a positive layer of meaning for the respondents who spoke with me.

Self-Disclosure

As someone who has both worked in the sexual violence sector and been impacted by sexual violence in my family and wider relationships, the level of self-disclosure I shared with respondents required a lot of reflection. On one hand, I believe that sharing my experiences demonstrates to respondents that I come with some level of prior understanding and genuinely care about their experiences. However, on the other hand, I firmly believe that self-disclosure needs to have a benefit to those it is being shared with in every instance, with the experiences of the respondent remaining central to the conversation.

There were certain parts of my identity that I always saw as beneficial to disclose, such as my identity as a disabled woman. The disability mantra of “nothing about us without us”, means that having shared experience holds a lot of weight when conducting disability research. With many disabled people excluded from higher education, it can be uncommon for disabled people to be interviewed by disabled academics (Kosanic et al., 2018), making this process more unique than others. Comparably, I shared my work in the sexual violence sector as part of whakawhanaungatanga (process of establishing relationships), introducing my history briefly before moving on to only discussing theirs. While I wanted to focus primarily on hearing respondents’ stories, at times I felt that a deeper demonstration of empathy was required in the interview. In these situations, I sometimes shared some of my own lived experience with the purpose of showing them that—to the limited extent that another person could—I could relate to their experience, and to allow them to feel more at ease in sharing uncomfortable stories. On reflection, I often found that some of the toughest conversations had with respondents were the most enlightening—we gained a profound sense of connection after our shared disclosures. This only further highlighted to me the benefits of collaborative person-centred research, and the importance of acknowledging the active role a researcher takes in this process.

Distributive Justice

The second of the overarching principles outlined by Hailes et al. (2020) is distributive justice. This concept is concerned with the equity of outcomes, especially for people who experience social marginalisation where outcomes are more likely to be inequitable. This work is considered at a structural or societal level; however, as mentioned above, can operate across all levels. The two branches of distributive justice outlined by Hailes et al. (2020) are *focusing energy on marginalised communities* and *contributing time, funding, and effort to preventative work*. Given that marginalised communities are disproportionately impacted by sexual violence yet historically excluded from research, both of these concepts deserved thoughtful reflection.

Re-enfranchisement

Distributive justice, while perhaps a poorly considered factor in some research, is something that took particularly careful consideration in this work. Community humility and researcher trustworthiness are imperative when working with people who may have previously experienced disenfranchisement in similar processes (Hailes et al., 2020). Voices of disabled, queer, Māori, female, and other marginalised peoples have often been excluded by traditional research approaches, which makes their inclusion even more pertinent (Hailes et al., 2020). However, even now, researchers who choose to work with marginalised respondents—rather than the readily available university student cohorts often used—face additional barriers in the research process (Hailes et al., 2020). For the current study I wanted all respondents, as people who experience multiple marginalisation, to feel not only included but also welcomed which meant undertaking careful consideration of all possible access barriers to participation.

Accessibility

Accessibility is vital to ensure equitable participation of all people in society. In considering accessibility in this study, I reflected upon my own access needs as a disabled woman, I consulted with a disability advocate, and I spoke with an occupational therapist.

Together, we outlined possible access barriers in the research environment, while maintaining a flexibility to work with any new barriers that could come up for respondents.

Examples of accessibility in this research included all documents for respondents being produced in Easy-Read format, all interview locations being selected by respondents to meet their needs, all travel being reimbursed, and informed consent procedures being carefully considered so that they were robust and understandable for all who may wish to speak with me. It was important to me that respondents with learning disabilities had the opportunity to engage with the project, as they are often over-represented in sexual violence statistics, even within the disability community (United Nations, 2017). My own familiarity with staff in the sector, as well as using trusted intermediaries for respondent recruitment, were both beneficial in increasing my perceived trustworthiness throughout the project, which I hope helped respondents feel at ease throughout their involvement.

Safe Participation

In working alongside survivors of sexual violence in the research process, there can be unique safety considerations (Robson, 2016). It was determined that anyone with recent experiences of sexual harm, or still in close contact with someone who had harmed them, would not be included in the study. No advertising took place, with all respondents being recruited via myself or a trusted intermediary who works in the health sector. Likewise, I was wary of the safety of marginalised people, especially those of which I share no insider status. Community consultation—as will be outlined further below—helped me to consider ways I could keep respondents safe, such as the valuing and incorporation of tikanga, appropriate language use for the queer community, and the welcoming of support people into interviews where desired.

As someone training as a clinical psychologist, I am acutely aware that safety extends beyond physical harm to also include emotional harm. Provisions were in place to follow up with respondents in the days following the interview, and respondents would be referred to community support services if required. I checked in on respondents' wellbeing throughout the interviews, especially when distress became apparent. However, no respondents chose to pause or end the interview due to their distress.

Covid-19

Distributive justice took an unanticipated turn during the research process due to Covid-19. Respondents who already live within unjust systems were faced with new vulnerabilities to harm and it was important for me to consider how I engaged with people over this time. Firstly, the sexual violence sector as a whole was overrun. In consultation with my supervisors, we decided it was unethical to engage essential services in research at that time. Likewise, people who experience marginalisation faced additional stress during the Covid-19 response; thus, engaging survivors in research at this time could have added significantly to their burden. Making these ethical decisions meant my research was delayed and all interviewing was stopped indefinitely at that time. While this was not an ideal situation, as I have previously stated, the wellbeing of all people involved was paramount above and beyond all else.

Procedural Justice

As the final overarching principle, procedural justice emphasises the processes in which decisions come to be made, that may lead to the inequitable outcomes as discussed above. Likewise, this work is primarily considered as operating on a structural or societal level. The two key concepts within procedural justice include *engaging with social systems* and *raising awareness about system impacts on individual and community wellbeing* (Hailes et al., 2020). It is in this area that collaborative research processes shine, giving voice and autonomy to communities who have long been silenced in academia. Likewise, this concept emphasises not only that I can use my privilege to champion the voices of marginalised peoples, but that it would be unethical not to do so.

Community Consultation

A range of community consultations took place within the project to prioritise the needs of respondents. This included queer and disability advocates, a Māori clinical psychologist, a Māori research respondent who wished to be further involved in the study, a member of parliament, and local sexual violence services. These discussions began from the very initial stages of the research process, helping to inform both the focus of my research and the way it was conducted.

As part of ongoing consultation processes, respondents maintained an active role in how their stories were communicated beyond just the initial interview. They were invited to review and edit their transcripts as desired, meaning respondents who were stronger in written rather than verbal communication had an opportunity to clarify and/or edit anything they had said in person. Likewise, having respondents review their transcripts meant they were able to provide feedback on the presentation of their story; acknowledging that their expertise always remains theirs, even in a collaborative project. Respondents were further consulted about how they wanted their identity to be relayed in written communications, such as a specific or categorical identification of their disabilities, the use of pseudonyms, and terms they use to identify with their survivorship. A collaborative process was pertinent for me—I see it as an incredible privilege that people would choose to share their stories with me, thus it was important that they maintained control of their narrative as much as possible.

It will always be vitally important to me to be community informed and to acknowledge my non-expert position as a white woman when writing about cultural issues. Unexpectedly, when hearing the stories of respondents in this research—both from Māori and non-Māori respondents—issues of race were raised within the specificity of colonisation. In turn, I felt it was pertinent to seek further cultural supervision to assure that I understood the stories and that they were presented appropriately with respect to Māori history; I would have felt entirely uncomfortable trying to contextualise the harms against Māori from my position as a white woman. While I considered seeking a formal supervision relationship at this stage, I instead approached a Māori respondent, who during their interview had indicated they would be happy to assist further with the project. This mōhio (expert, wise person) read how I had discussed the stories and offered written feedback, as well engaging with me through discussion about how to appropriately represent the findings related to

Māori. Some of their key feedback included being clear about just how devastating colonisation was (and is) for Māori and using the right intensity of language to appropriately reflect this, i.e., terms such as “devastating” and “atrocity”. The mōhio further advised on the definitions of te reo terms used in the project, e.g., wairua. While they were offered koha (a gift or offering with connotations of reciprocity) for this extra time spent advising on the research, the mōhio declined. I remain immensely grateful for the time and expertise they so willingly shared with me—ngā mihi nui ki a koe (huge gratitude to you).

Sharing of Knowledge

An important part of procedural justice for psychologists working in this field extends beyond one’s own research project. *The Code of Ethics for Psychologists Working in Aotearoa, New Zealand (2002)*, outlines that “Psychologists have a responsibility to speak out, in a manner consistent with the four principles of this Code, when they possess expert knowledge that bears on important societal issues being studied or discussed” (principle 4.1.3; New Zealand Psychologists Board, 2002, p. 26). In line with this, throughout the project I engaged in sexual violence work in the community. For some time, I worked as a sexual violence crisis worker for a local sexual abuse agency, regularly engaging with survivors and service providers. Similarly, during the period I was writing this thesis Massey University undertook a critique and re-write of their sexual violence policies. I consulted with them throughout this process, using my understanding as both a student and researcher in this area to emphasise the importance of including policy that reflected intersectional identities in their guidelines. Finally, working with survivors became part of my clinical psychology internship experience.

The dissemination of my findings is a high priority for me, including through written summaries, conference presentations, and the sharing of my thesis with agencies who are willing to read it. I see this as honouring the respondents and their expertise, who shared their stories in the hope of improving lives of those impacted by sexual violence. While my career as a clinical psychologist will continue beyond, and likely somewhat separately from this project, I believe that merely concluding and filing my thesis away on a library shelf fails to honour those involved in this work. It would be a gross misuse of my privilege to let my passion and advocacy in this area end with the production of this thesis.

Method

The following section outlines the methods used throughout this project, which developed as a response to my methodological journey as discussed above. That being, drawing upon and integrating elements of intersectionality, social constructionism, humanism and narrative—combined with my response to respondents' stories—I was moved to use a deeply reflective narrative process. This section will outline details and steps I undertook during this reflective analytical journey.

Respondents

In qualitative research methods, a small number of respondents allows in-depth targeting of knowledge and experiences, careful comparisons within and across cases, and the use of close intuitive judgement and thorough analysis processes by the researcher (Crouch & McKenzie, 2006). Qualitative research of this nature is conducted ideographically, not nomothetically, where researchers are not seeking information that generalises to a population. Instead, a deeper, more nuanced understanding is sought, with the acknowledgement that we will only ever gather partial answers to the research questions. Such an approach recognises that while having some similarities, different individuals will always exist as unique people with unique life stories. In this way, a smaller number of in-depth stories are more valuable than a large number of stories shared at a surface level.

In total, seven respondents shared their experiences for this study. This number was determined collectively by the research team as an appropriate number for qualitative research positioned within a poststructuralist ideology, with the sample size not based on the number of respondents but on the importance and richness of the accounts shared (Braun & Clarke, 2006; Crouch & McKenzie, 2006). Respondents were all people who live with at least one self-identified marginalised identity; many with multiple marginalised identities. They were initially recruited as part of two respondent groups: either as a sexual violence service provider (key informant) or as disabled survivor of sexual violence. However, it quickly became apparent that these categories do not exist as separate entities, with many service providers also survivors, and vice versa. While not all service providers mentioned a personal history of sexual violence, it was never directly asked of them to disclose this. Thus, it is possible that even those who did not identify themselves as survivors may indeed have had this shared experience.

Specifically, respondents were all service providers in some capacity. This included four people who identified as both disabled survivors of sexual violence and service providers working in a support setting of some form. The remaining three respondents were service providers who did not disclose a lived experience of sexual violence. Respondents' workplaces spanned four specialist sexual violence—or combined sexual and domestic violence—services in the Te Whanganui-a-Tara (Wellington) region, alongside numerous other mental health and youth support services. Many providers worked in more than one place or had histories of working in other specialist services, reflecting the lack of specialist service providers working across these areas.

There were five cisgender female-identifying, one cisgender male-identifying, and one gender-diverse respondent. Two respondents were Māori, one was Samoan, one identified with an Indigenous culture from outside of Aotearoa New Zealand, and three identified as solely Pākehā. Respondents' workplaces spanned four specialist sexual violence—or combined sexual and domestic violence—services in the Te Whanganui-a-Tara (Wellington) region, alongside numerous other mental health and youth support services. Respondents were asked if there was a pseudonym they would like used to represent themselves in this research. Where they had no preference, one was selected by the researcher. More specific information about respondents has been withheld due to the small number of service providers working in these roles, meaning unique characteristics may make respondents identifiable. Multiple respondents reflected how vital the de-identification process was for them given the level of personal information they shared. Therefore, only brief introductions to each person are provided in Table 1, to give context to the narratives shared. These varied social locations of respondents are outlined to demonstrate how the social conditions of their lives differ, with those positioned further from the hegemonic norm categorised and marginalised more so than others.

Table 1

Self-Identified Respondent Demographics

Pseudonym	Current Role	Survivor/ provider	Gender and pronouns	Sexuality	Ethnicity	Disability (where applicable)
Ani	Specialist SV service	Provider	Cisgender female (she/her/hers)	Bisexual	Māori	Sensory disability
Natalie	Specialist SV service	Both	Cisgender female (she/her/hers)	Heterosexual	Pākehā	Physical disabilities
Rachael	Youth support	Both	Cisgender female (she/her/hers)	Queer	Pākehā	Physical and psychological disabilities
Joey	Specialist SV service	Provider	Cisgender female (she/her/hers)	Queer	Pākehā	Physical disabilities
Storm	Mental health service	Both	Cisgender Male (he/him/his)	Gay/ Takatāpui	Māori, Pākehā	Sensory, psychological, and learning disabilities
Aila	Mental health and disability service/s	Both	Gender diverse (they/them/theirs)	Bisexual	Indigenous (Non-NZ), Pākehā	Physical, neuro-developmental, and psychological disabilities
Mele	Specialist SV service	Provider	Cisgender female (she/her/hers)	Undisclosed	Samoan	Undisclosed/not applicable

Recruitment Procedures

Recruitment of service providers was undertaken through my previous work connections in the sexual violence sector, which spanned across services in Te Whanganui-a-Tara. Acquaintances were contacted to act as trusted intermediaries, who then suggested other well-connected service providers who may be interested in talking with me or whom could also then invite others to participate. No information about people who chose to participate was ever relayed back to intermediaries who invited others. Similarly, disabled survivors were recruited through trusted intermediaries that work as service providers or through my connections with the disability sector.

Upon invitation to participate, the individual was sent the appropriate information sheet (Appendices A and B) and consent form (Appendix C) via email. One respondent replied to the email with follow up questions, and all respondents' understanding of the information sheet and consent form was checked on the day of the interview. As outlined by Hydén (2014), “The research ethics underpinning the establishment of a relationally safe space understand consent as an on-going process that does not start and finish with the consent form” (p. 801). This was reinforced to respondents in several ways, such as via their ongoing collaboration in the production of their transcript, open line of communication with me, and ability to withdraw from the study until its completion.

Interview Techniques

Previous research suggests that rape survivors desire a sense of choice and control in the interview process (Campbell et al., 2009a). Taking this into consideration, I was highly selective in choosing my interview approach, eventually choosing to employ a teller-focussed interview style. Hydén (2014) describes that her teller-focussed interview style was born from her desire to “facilitate and support the research respondents—women, men and children—in formulating themselves in as genuine and multifaceted a narrative as possible” (p. 796). This resonated with my aspirations for the interview process, whereby I wanted to be as respondent-led as possible.

A teller-focussed approach can be characterised as a form of narrative interviewing which has emerged with a basis in feminist research and narrative theory itself (Hydén, 2014). Designed for interviews where structured or semi-structured questioning is “not enough” (Hydén, 2014, p. 810), the teller-focussed interview is beneficial for discussing topics of a sensitive nature. This interview style was born from qualitative research in interpersonal violence and is concerned with relational practice, positioning the researcher as a listener rather than a questioner (Hydén, 2014). Given the nature of sexual violence, whereby power and control are dominant features, positioning myself as equal to those I was speaking with was very important to me.

Pragmatically, the interviews were completed as a one-on-one, unstructured process. In a narrative-focussed interview, the researcher aims to ask questions that guide detailed accounts of experience or ideas. Hydén (2014), in summarising the work of Mishler (1986), suggests that “if we as researchers simply hold back in asking questions we are so eager to ask, our interviewees are likely to burst into storytelling” (p. 798). Therefore, in using a teller-focussed interview, the respondent, as the storyteller, is guided away from producing answers of shallow depth. Likewise, as facilitator, the interviewer participates in the conversation to assist in the co-construction of narratives, but leaves the conversation to be guided by what the teller sees as important. Hydén (2014) describes this as a complementary relationship, a joint production of narrative.

The Completion of Interviews

Interviews were conducted in person or via Zoom, with the locations selected by respondents to meet their accessibility needs. Care was taken to ensure respondent privacy at all locations, as well as researcher safety. Two interviews were conducted on Zoom, with six interviews occurring in person. Locations of interviews included respondents’ workplaces, the Massey University Psychology Clinic, and other private rooms in public venues, for example the Massey University library. Two interviews took place prior to the arrival of Covid-19, with six interviews occurring following the first Covid-19 lockdown in Aotearoa New Zealand.

Respondents were informed that interviews were likely to last one to two hours, but they could be stopped or paused at any time. In total, eight interviews were completed, including seven initial interviews and one follow up interview. The follow up interview was undertaken as a respondent who first shared her lived experience prior to Covid-19 then wished to update me on how life had changed for them with the arrival of the pandemic. Initial interviews ranged in length from 1 hour and 9 minutes to 1 hour and 44 minutes, with an average of 1 hour 20 minutes. The one follow-up interview completed had a length of 52 minutes. Despite many respondents becoming tearful, none chose to pause or end the interview at any time and I was always confident in their wellbeing and safety at the close of the interview. All respondents were contacted in the days following the interview to check in on their wellbeing, with none reporting distress of further concern.

Respondents were provided with NZ$30 worth of koha thanking them for their participation. Travel costs up to NZ$30 were also reimbursed, reflecting that disabled people often have higher than average travel expenses. Two respondents' koha was donated to a sexual violence charity at their request, a gesture I think reflects the generous nature of so many people who work in these services.

Transcription

Researchers' choices during transcription are vital in the broader constitution of narrative stories for analysis (Riessman, 2008). In including the interactional features of an interview—i.e., the speech of the interviewer and the interviewee—we acknowledge that narratives are co-constructed through the interactions of the conversation. Furthermore, the autobiographical depiction of 'self' depends on the social context in which stories are told; here, a formal research setting.

Transcripts are, in nature, partial, selective, and incomplete (Riessman, 2008). In this research, the content of the narratives, as opposed to a narrative's formal language features, formed the ‘data set’[9] for analysis. Therefore, the narratives were transcribed in a format that presented their message as clear and accessible, rather than including every phonological detail (Riessman, 2008).

Thus, in this research, interview recordings were transcribed intelligent verbatim. Intelligent verbatim transcription preserves the recorded spoken message while removing unnecessary utterances for a narrative analysis, i.e., where one’s individual speech characteristics are not being analysed. However, this is not to say that such utterances are never meaningful. Instead, in a narrative analysis of a structural nature, these are a vital part of the data set, indicating information such as when knowledge is not easily accessible to a person, topics that may be difficult to discuss, and other personal characteristics of their language such as natural stuttering.

For the present research, where their removal did not change the meaning or flow of the spoken text, unnecessary utterances included: stuttering, false starts, repeated words (except where used for emphasis), filler speech (e.g., um, ah), conjunctions that begin sentences (e.g., but, and), speaker idiosyncrasies (e.g., repeated use of like, kind of), and interjections of encouragement (e.g., mm-hm, mm-mm, uh-huh). The removal of any identifying information is indicated by expressing the category of that information in square brackets, e.g., [place name]. Square brackets are also used to add clarification when required, as well as indicating important tone, such as extended pauses, laughing, or crying, e.g., [laughs]. An ellipsis, e.g., ‘…’, indicates a speaker’s voice trailing off or a small section of speech was removed for conciseness in presenting the narrative. In recognising the co-construction of narrative, the interviewer’s voice is included.

Analysis

Firstly, it is essential to note that the analysis process does not occur in linear stages. Through the completion of interviews, the interviewer is already becoming aware of

---

[9] It sits somewhat uncomfortably with me to minimise people and their knowledge, experience, and stories, to a description as simple and impersonal as “data”.

narratives shared by respondents. Through the process of transcription, the researcher becomes familiar with the data and the narratives within. The researcher repeatedly returns to the original transcripts throughout the analysis process, perhaps examining them in a new light, with new knowledge, or from a new theoretical lens. For these reasons, the analysis is somewhat iterative; I do not believe results can be truly understood without keeping sight of the original conversations from which they formed.

After completing transcription, six of eight transcripts were returned to the individual respondents who had expressed a desire to review them before their use in the analysis. Following this review, respondents returned the transcript to me alongside a transcript release form (Appendix D) consenting to their de-identified quotes being presented in the research. The respondent who did not wish to review their transcripts—having participated in both an initial and follow up interview—signed the release form without doing so.

Identification of Narratives

Riessman (2008) explains that “the construction of a narrative segment for analysis—the representations and boundaries we choose—are strongly influenced by our evolving theories, disciplinary preferences, and research questions” (p. 11). The identification of narratives involves both theoretical and pragmatic considerations.

Theoretically, narratives are co-constructed by the researcher and storyteller. However, this co-construction is not an entirely implicit process, as various explicit elements assist in the co-production of narratives (Riessman, 2008). Firstly, the respondent is choosing what they share with me. As explained earlier, storytelling depends on the space in which a story is told and to whom the story is being told. Thus, why was it that the respondent was sharing that story, in that way, with me? Why was it important to them that the information was shared at that time? These questions demonstrate that the respondents’ stories and how they chose to tell them are the root of the narrative content. They needed to be the first consideration in co-construction, I was privileged with these experiences and knowledge, and that information is the priority.

Secondly, my own experiences, knowledge, and the theoretical basis of this study came into the co-construction. This background naturally influenced the way I heard and cared about the stories being told: did they align with the theoretical basis of the research? Did they align with what I believe as a disabled, feminist woman? These questions give way to two critical points. Primarily, I needed to acknowledge that this research is partial. While I can always prioritise the voices of respondents, if a story was not related to the broad topics of the project, it was excluded from the analysis. Secondly, I needed to be open to challenging my own beliefs. If a narrative was produced that did not align with my worldview but related to the aims or theory of the project, I needed to be open to hearing and analysing it. I think these considerations are all part of a researcher’s reflexive journey, with openness and honesty in these processes making the narrative enquiry more robust.

The pragmatic identification of narratives within a transcript depends heavily on a researcher's narrative framework. Narrative purists such as Labov (1966) examine narrative accounts consisting of six linguistic elements: an abstract, orientation, complicating action, resolution, evaluation, and coda. Others, such as Murray (2015), describe a narrative as having a beginning, middle, and end; marked by entrance and exit talk. However, Riessman (2008) argues for identifying less linguistically bound and less linear narratives. She believes that a narrative revolves around characters, setting, and a plot (Riessman, 2008). As discussed earlier, a Western view of storytelling provides “rules” for the structure of a story, neglecting narratives that do not align culturally. For this reason, Riessman (2008)’s approach, where narratives do not need to adhere to strict temporal or spatial rules, was appropriate for this research. This is because it is of imperative importance that the voices of non-Pākehā people living in Aotearoa New Zealand and disabled individuals, who may communicate through alternative means, are recognised as equally important whether or not they were structured through a dominant Western understanding.

While the practicalities of identifying narratives—as discussed above—were vital, it is also important to acknowledge how emotion was influential in guiding my analytical process. As I completed my interviews and engaged with the transcription process, I was deeply moved by what I was hearing, particularly the counter narratives which are less often heard. I quickly found that I was unable to separate out what I found from what I felt, and where the stories moved me to in terms of understanding and interpreting the experiences of respondents. In turn, being guided by where I was drawn to emotionally, and considering the emotional connection I had with respondents during the sharing of particular stories, also became an important element of identifying narratives. I think it is essential to acknowledge that emotion is a vehicle for communication, and sharing narratives which are likely to evoke emotional responses in others is also a way to emphasise these important counter narratives.

Analysis of Narrative

After identifying important narratives within each transcript, these were extracted into new Word documents for ease of use. A separate document was initially used for each respondent, to assist with clarity during this process. The narratives were then re-read to identify whether they related to pre-Covid-19 or post-arrival of Covid-19 with the decision to present these as two separate analyses owing to their unique content.

Next, the extracted narratives were read and considered across all the Word documents. This was to identify similar narratives discussed as important by multiple respondents or, alternately, presented conflicting views on similar topics. They were also considered within the project's background and concepts of intersectionality. As I deepened my familiarity with the stories I heard, I found that respondents shared experiences—albeit with unique complexities—wove into a larger, collective narrative, building off the similarities in what respondents shared with me. That being, the individual narratives intertwined into an integration of many stories, producing extended accounts of collective, unfolding journeys, which centred around several different themes. Practically, this was completed by moving the identified narratives into new Word documents, and rearranging the order of narratives so that they flowed from one story to another, surrounding a shared theme.

As part of the collective stories that were developing, I decided that the most appropriate way to present my interpretation was by including my personal voice, moments of reflection, and the previous literature that I felt connected to what respondents were sharing with me, within the collective stories themselves. When I reflected upon whether it was appropriate to present the narratives in this way, I felt the collective narratives were metaphorically reflective of the “real time” nature of the research, where we were all living in a developing crisis, and presenting narratives as an unfolding story—with real-time interpretation—was an appropriate parallel. Overall, my analysis was a deeply emotional and interpretative process, which had initial grounding in a thematic narrative analysis but moved to a far more reflexive place. As these larger collective narratives took shape, a process of editing and reviewing took place between myself and my supervisors. During that time, I frequently returned to the theoretical basis of my project and considered the historical contexts, dominant social narratives, and previous literature related to the stories respondents shared. I frequently returned to the transcripts, considering whether the way I was interpreting and representing respondents’ stories was reflective of how they initially shared their experiences with me, and how I imagined they would want them to be shared based on the connections we developed during interviews. Once I felt I had appropriately presented each of the collective narrative stories, descriptions of each collective narrative was added, before finally narratives were broadly named. More so than detailed titles which fully encapsulate each individual theme, these topic headings provide a starting place for the collective narratives that follow them; the storylines that change and develop as the story unfolds.

Literature Review Chapter One:

The Sexual Violence Landscape in Aotearoa New Zealand

As outlined in the prologue, this thesis now moves to a presentation of previous literature and analysis, in a chronological order reflective of before and after the arrival of Covid-19. The following section contextualises sexual violence in Aotearoa New Zealand before Covid-19 forced unprecedented change. While quantitative data do not reflect the lived experience of many survivors owing to the challenges faced in its collection—as will be discussed below—the information we do have assists to understand the scope of the problem when considered with a critical lens. I have never been one to identify closely with statistics, often feeling they erase the nuance and person behind them, yet am also conscious of how the “powers that be” need “objective” measures in order to prioritise care and funding. If such statistics (as flawed as they may be) can draw light to the issue, then their inclusion is paramount.

The Extent of the Issue

Sexual violence is a highly prevalent, harmful, and longstanding crisis for the people of Aotearoa New Zealand. The rate of sexual violence against women in Aotearoa New Zealand is reported to be as high as 16.4%, a staggering percentage that is more than twice the average worldwide prevalence of 7.2% (Abrahams et al., 2014). In 2020, 28% of surveyed people living in Aotearoa New Zealand reported experiencing intimate partner violence and/or sexual violence at least once in their lifetime (Ministry of Justice, 2020). Such rates equate to approximately one in three women (Fanslow et al., 2010) and one in six men (Fisher et al., 2008; Ministry of Women’s Affairs, 2012; Smith et al., 2017).

While these statistics are unquestionably astounding, accurately recording rates of sexual violence is fraught with difficulties. Owing to the stigma around sexual violence, many survivors will never come forward, anticipating a negative reaction or disbelief, or even as a resultant unawareness that what happened to them constitutes a crime (Rousseau et al., 2020). Due to this, all reported statistics are likely under-estimates (Fanslow et al., 2007).

While sexual violence reporting to police is increasing, it is still estimated that less than 10% of sexual violence incidents are ever reported to the criminal justice system (Ministry of Justice, 2019).

When considering quantitative data, where strict criteria are imposed for inclusion in the analysis, the way that such data are collected must be considered. In attempting to measure general prevalence across the population, randomly sampled phone and online surveys are useful, yet it must be acknowledged that these methods also exclude people without access to such technology. For example, while Mitra et al. (2011) used survey methodology in what is still understood to be some of the best disability sexual violence statistics available, they acknowledge the limitation that it did not include “institutionalised” (p. 494) adults; a group which primarily constitutes disabled people. However, the benefit of such studies is the large number of people they can often reach, with Basile et al. (2016) surveying 9086 women and 7421 men in the United States of America. Within Aotearoa New Zealand, the Ministry of Justice (2020) also employed this method.

Conversely to population-wide samples, other researchers choose to survey particular populations to try and understand the scope of issues for specific people. For example, Powers et al. (2008) recruited via disability organisations and disability equipment suppliers, purposively collecting information about the disability community. In collecting data about sexual assault on university campuses, Thursdays In Black (2017) and the Australian Human Rights Commission (2017) sampled recent or currently enrolled tertiary students. Similarly, Veale et al. (2019) collated the experiences of minority gender and/or sexuality identifying people living in Aotearoa New Zealand. Within Aotearoa New Zealand, the Dunedin Multidisciplinary Health and Development Study provides unique longitudinal data, but it has been well established that the cohort comprises significantly more Pākehā and economic advantage than what is representative of the wider Aotearoa New Zealand population (van Roode et al., 2009). Other local data are collated via official records, such as police or social services data (Ministry of Justice, 2019), where—as explained above—reports are likely underestimates of the extent of the issue. For all of these reasons, it is essential to augment our knowledge with the lived experiences of sexual violence survivors through qualitative methods, acknowledging that one in-depth story can be as meaningful as hundreds of single accounts.

“Defining” Sexual Violence

Recording rates are further complicated by varying legal and social definitions of sexual violence, which mean statistics are often not representative of the same populations, or comparable across studies. Worldwide, a difference in legislation compounds this issue; no two states in the United States of America have the same exact definition of sexual assault, and laws are constantly evolving (Bedera & Haltom, 2020). For example, marital rape was made illegal in Aotearoa New Zealand in 1985 but continues to be legal in an average of 58% of countries worldwide (UN Women, 2019).

Through a lens of social justice, it is pertinent that research focuses on what causes harm to, or the disempowerment of people; here, the sexually violent actions that forcibly or coercively remove one’s autonomy. Understandings of what constitutes sexual harm differ widely depending on which organisation, academic, victim, survivor, country, criminal justice system—or quite frankly—every person you ask and their positioning on the issue. While the rationale behind defining such concepts is more explicable from a criminal justice standpoint where categorisations are needed for determining legality, my stance within social constructionism is that definitions, for the most part, serve little utility[10]. I firmly believe that only defining sexual violence within concrete categories would fail to acknowledge the widespread harm that results from all forms of sexual violence. That being, harm can be caused irrespective of whether an act is reflected by a legal category, failing to acknowledge survivors’ diverse experiences appropriately. These views do not attempt to undermine those who proceed with the criminal justice process and find peace as a result, but rather hope to include the (much larger) majority who will never have their day in court.

---

[10] For more information on the legislation surrounding “Sexual Crimes”, this can be found within the New Zealand Crimes Act 1961 (No. 43, ss. 127-144c).

From the standpoint of promoting equity, if a person feels they have been sexually harmed, they are equally deserving of support, no matter how "harmed" society may deem they have been based on how much (or how little) information they have about what the person experienced. Each unique experience is equally worthy of being heard and must be treated as such—the "severity" of any sexually violent act can be entirely irrelevant to the level of ongoing harm one experiences, emphasising that supportive outsiders must take the lead from survivors, not vice versa (Robertson & Oulton, 2008). In championing the lived experiences of survivors, this research project will use the term "sexual violence" as an umbrella term for all forms of sexual harm that a person may have experienced. I have no intention to gate-keep who is a "true" survivor, nor whose stories are worthy of being shared.

The Impact of Sexual Violence

"Rape is a crime that hurts mind, body, and soul"

(Campbell et al, 2009a, p. 605).

The impact of sexual violence is widespread, causing personal, interpersonal, community, and societal level harms, and across all realms of psychological, emotional, physical, spiritual, and social wellbeing (Campbell, 2016). The recovery from sexual violence is unique for all survivors, with no two journeys being entirely homogenous, irrespective of whether they choose to engage in formal support and/or criminal justice processes (Campbell, 2016; Campbell et al., 2009a; Harding, 2020; Mossman et al., 2009b). Survivors have varying levels of social and formal support. Not everyone will experience the same forms of harm and the impacts may be apparent across different timelines for each survivor (Campbell, 2016; Campbell et al., 2009a; Harding, 2020).

Some heterogeneity in experience presents in considering how and when survivors report incidents of sexual violence, if at all (Mossman et al., 2009b). That being, some survivors report immediately or soon after an event, others report historical cases that now feel safer to talk about, and some never report to a formalised agency (Mossman et al., 2009b). A hesitance to seek support is understandable, given that almost all survivors interviewed by Campbell et al. (2009a) described stigmatised, negative, and victim-blaming reactions from friends, family, and healthcare providers when they disclosed their experience. This is concerning, as negative responses to the disclosure of violence are the single most significant predictor of ongoing psychopathology and suffering for survivors (Dworkin et al., 2019).

The ongoing psychological impacts of sexual violence are well documented. Research suggests that between 16-65% of women who are harmed by sexual violence will develop post-traumatic stress disorder, up to 51% will meet the criteria for major depressive disorder, 13-49% will become alcohol dependent, and as many as 19% may attempt suicide (Campbell et al., 2009b). Social harms are also well established; many survivors will face significant isolation from family and friends due to victim blaming, as well as experiencing self-blame and coping with physical injuries that may have occurred during their assault (Campbell et al., 2009b). As many perpetrators are known to the victim, they may have to continue to see the person who caused them harm, end mutual relationships, and face disbelief from acquaintances (Jordan, 2016).

Through their experiences of working face-to-face with survivors, sexual violence support workers explain that some survivors present with high levels of distress, while others "shut down" and may present as "fine" (Campbell et al., 2009b, p. 216), but below the surface, they are working hard to avoid their feelings and have a lot of need. Survivors are also likely to fluctuate between periods of feeling more or less well, with supports needing to be readily available at times of escalation (Campbell et al., 2009a).

Sexual violence survivors echo similar sentiments of recovery being a long, fluctuating, and individualised process. Talking about what interviewers need to know when talking to people harmed by sexual violence, rape survivors stress that recovery can be a long journey; emotions present differently for different survivors; sexual violence impacts multiple facets of survivors' lives; and that nobody can fully understand if they have not "walked in these [the survivors] shoes" (Campbell et al., 2009b, p. 604). Furthermore, because emotions present differently for different people, it should never be assumed that a survivor will appear a certain way (Campbell et al., 2009a).

Some survivors report that the experience of sexual violence changes one’s entire sense of self, that “you will never be the person you were before” (Campbell et al., 2009b, p. 605). The act of rape strips a person of their bodily autonomy, control, and dignity, with survivors describing this as an entirely “demeaning” (Campbell et al., 2009b, p. 605) experience. As a result, consensual sexual relationships can be negatively impacted, and there can be issues with trust in wider relationships (Campbell, 2016). Survivors may also face impacts on their ability to retain employment or study, at times leading to economic burden and thus further worsening the social conditions in which they live (Campbell, 2016; Campbell et al., 2009a).

Given these wide-ranging harms and the high prevalence rate of experiencing sexual violence, appropriate support services must be available to survivors. Access to equitable support following sexual violence is internationally acknowledged as a human rights issue (Campbell, 2016; Campbell et al., 2009a). However, Garcia-Moreno and Watts (2011) explain that Aotearoa New Zealand services continue to be inadequate, leaving survivors with unnecessarily high levels of ongoing harm. Furthermore, several large scale committees have stressed the importance of improving Aotearoa New Zealand’s sexual violence services, calling the current situation a failure of human rights (Ashton-Martyn, 2019). The United Nations Committee Against Torture (2015) have stressed particular concern related to the lack of appropriate sexual violence services to support Aotearoa New Zealand’s diverse communities, communities who experience unique forms of sexual violence, and thus, unique forms of ongoing harm.

The Services Available in Aotearoa New Zealand

The various supports offered by agencies in Aotearoa New Zealand include advocacy, crisis intervention, education and prevention, social work and counselling, health and medical support, support for friends and whānau (family), and support through the reporting and court processes (Mossman et al., 2009b). This support often involves both pastoral and pragmatic supports, such as offering comfort, but also arranging meetings on a survivor’s behalf (Mossman et al., 2009b). While the focus is often primarily on the survivor, providing support to loved ones is recognised as vitally important, with poorer social support a predictor of greater post-traumatic stress symptoms day-to-day (Dworkin et al., 2018).

Aotearoa New Zealand has a range of support services for sexual violence survivors, including specialist sexual violence agencies, mental health counselling services, medical services, Women's refuge organisations, Victim Support, medical service providers, and community agencies which include kaupapa Māori services (Mossman et al., 2009b; TOAH-NNEST, 2013). Unfortunately, the last detailed scanning of Aotearoa New Zealand services occurred in 2009 (see Mossman et al., 2009), and with no database collating the information of all services involved in this work, we cannot be sure of these numbers now. One new development in recent years is the launching of the national *Safe to Talk* helpline in April 2018, providing a 24-hour phone service for those needing support and information on sexual violence matters (Sepuloni, 2018).

Unfortunately, each of these services provides specific forms of support but often not the complete wraparound care that a survivor may need when seeking help. For example, medical service providers can treat injuries and collect medical evidence but have little-to-no involvement in ongoing care. The implications for survivors are: difficulty navigating who they should be approaching; having to tell and retell their story to multiple agencies; and the possibility of being lost in the cracks between services if referred on. In my personal experience, if someone has a negative experience with one agency, they are unlikely to seek support from another, and the centralisation of many of these processes would be highly beneficial.

Specialised Services

Given the wide range of services that work in *some* capacity with sexual violence survivors, it is hard to establish exactly how many services are available and in what scope. In 2009, Mossman et al. (2009b) identified 418 services that support sexual violence survivors in Aotearoa New Zealand. Of the 418 services, 43% of these responded to Mossman et al. (2009b)'s further questions about their organisation, with only one identified as catering to disabled people, one for queer people, two for ethnic, migrant, and refugee people, two for men, two for pacific peoples, and 16 for Māori. It is also notable that most services exist within urban areas, leaving support gaps in emotional and medical support for rural communities (Mossman et al., 2009b). I am hopeful that a broader range of services now exist, yet through my knowledge of the sector and how difficult it was to access specific supports when needed, I am doubtful much has changed.

This lack of specialised services is an urgent issue in Aotearoa New Zealand. On top of virtually no services catering to disabled survivors, there is no readily available information for disabled people to determine whether or not a service is accessible for their needs. When crisis support *has* been offered to disabled survivors in Aotearoa New Zealand, TOAH-NNEST (2013) describe issues in the ongoing support, with a lack of long-term support for the person or their family. For people requiring emergency accommodation following sexual violence, there are no fully accessible refuge centres (Human Rights Commission, 2021b). In 2019 one centre put in a wheelchair lift and wet floor bathroom but does not have a hoist for bed access or overnight staff for support. This continues to leave the “accessible” refuge entirely inaccessible for many disabled people. While we know that disability increases with age, most shelters will not accept women over 55 (Human Rights Commission, 2021b). With nowhere else to go, and no desire to move to residential care, this may mean that older women remain living with people who are harming them.

Kaupapa Māori interventions are often the most appropriate when working with Māori clients, yet very few specialised Kaupapa Māori services exist (Ashton-Martyn, 2019; Te Puni Kōkiri, 2010). Furthermore, there is a lack of appropriate resources that emphasise a te ao Māori view of sexual health and wellbeing, which are particularly inaccessible for those in rural communities (Te Puni Kōkiri, 2010). King (2019) outlines that not only are these services non-existent, but the alternate, Western models of healthcare imposed upon Māori can be culturally unsafe and are compounded by racial bias within services. Making changes in these spaces are incredibly difficult, as where disabled people are consulted, Māori often are not; and when Māori are consulted, tāngata whaikaha (Māori disabled people) are not (Human Rights Commission, 2021b; King, 2019). Such colonial structures have prevented the active participation and self-determination of both non-disabled and tāngata whaikaha Māori, placing the needs of tauiwi (non-Indigenous people living in Aotearoa New Zealand) above those of tāngata whenua (Indigenous peoples) and perpetuating oppression and inequity. This undermines the Crown's obligations under Te Tiriti o Waitangi (The Treaty of Waitangi), the United Nations Declaration on the Rights of Indigenous Peoples, and the United Nations Convention on the Rights of Persons with Disabilities (Human Rights Commission, 2021b; King, 2019).

Funding of Services

A key barrier to sexual violence service provision in Aotearoa New Zealand is the lack of total government funding. A report published in 2019 sampled 38 Aotearoa New Zealand sexual violence services, their annual contracted budgets, and the actual cost of funding their services (Ashton-Martyn, 2019). The results showed more than a NZD $7,000,000 gap where funding is not provided, with this being made up through donations and fundraising. This partial funding is described as causing a multitude of barriers within services: "partial funding hinders the capacity of people … to provide outreach to people who may need help, build relationships in communities where survivors may not be connected to services, or even meet existing demand" (Ashton-Martyn, 2019, p. 3).

To further complicate matters, it is also possible that there is an inequitable distribution of the available funding. Russell Smith, the co-director of the kaupapa Māori service Korowai Tumanako, has described how disproportionate levels of sexual violence funding is going to services that subscribe to Western treatment approaches (Ashton-Martyn, 2019). He states that "the current system for allocating funding is heavily pro-Western … recognising only those who use Western clinical approaches" (Ashton-Martyn, 2019, p. 21). In qualitative interviews conducted by Ashton-Martyn (2019), the Chief Executive Officer of a Wellington-based sexual violence service, stated, "It's easy for sexual violence to slip down the political agenda when there are issues as compelling as homelessness and family violence. But the demand for our services continues to rise" (p. 19). While any funding allocations made by government must reflect on each of these issues, not considering the disproportionate impact that sexual violence has on marginalised and often vulnerable people neglects to acknowledge the intersectionality of sexual violence survivors, who are more likely to be Māori, homeless, and/or involved in a domestically violent relationship.

Agencies and Processes

Te Ohaakii a Hine - National Network Ending Sexual Violence Together (TOAH-NNEST)

TOAH-NNEST is an umbrella network that supports specialist sexual violence services in Aotearoa New Zealand (TOAH-NNEST, 2013). Currently, they represent approximately 40 not-for-profit non-government organisations (NGOs), with associate members across a range of non-allied NGOs (TOAH-NNEST, 2013). They act as a voice for the sector, including the government, and offer sector support and development. They have a strong focus on meeting Te Tiriti o Waitangi obligations and are a valuable resource for Aotearoa New Zealand in moving to eradicate sexual violence (TOAH-NNEST, 2013). While there are no nationally mandated qualifications or competencies for working with disabled people, TOAH-NNEST has created a guideline to disseminate to those who wish to read it. Unfortunately, due to the nature of disabled survivors frequently being ignored, I feel the optional nature of accessing these guidelines will likely leave them underutilised.

The Accident Compensation Corporation (ACC)

Aotearoa New Zealand has a somewhat unique opportunity for survivors of sexual violence to be acknowledged as a “mental injury” and receive subsequently funded healthcare through the Accident Compensation Corporation (ACC). Such support may include psychological support, social and vocational rehabilitation, and/or financial compensation (Accident Compensation Corporation, 2021). To request support, the survivor must have experienced sexual harm that meets the criteria under the Crimes Act 1961, the injury must have occurred in Aotearoa New Zealand, and the survivor must demonstrate ongoing harms as a result of the event (Accident Compensation Corporation, 2021). Upon seeking initial support, the survivor can access up to 14 hours of therapy, 10 hours of cultural support, 10 hours of social work support, and 20 hours of family support, before deciding whether or not to continue with a formal assessment of their wellbeing which would permit further support and possibly financial compensation (Accident Compensation Corporation, 2021; Bradley, 2021).

However, this subsequent process to establish whether a mental injury has occurred is fraught with difficulty. Information gathered in 2021 demonstrated that less than 5% of claims made to ACC were accepted, reducing to only 3% for male survivors (Bradley, 2021). As part of the formal acceptance process, the survivor must be diagnosed by a psychologist or psychiatrist as having a mental health disorder, which for many can be pathologising a normal response to a traumatic event (Accident Compensation Corporation, 2021; Bradley, 2021). Further to this, the process of proving one's trauma is regarded as highly traumatic in and of itself. Natalie Thorburn, Women's Refuge New Zealand's principal policy advisor, is quoted as describing that:

> The onus to go through an assessment is offensive. The process forces women to talk about what happened to them so ACC can decide if it is truthful and whether they need support … it is rare for people to lie about abuse, and the obligations placed on victims makes it almost impossible for them to get the support they need (Bradley, 2021, para. 28-30).

In further concerning news, two significant ACC client data breaches were identified in 2021, being hugely traumatising for those involved (Radio New Zealand, 2021). Following this, an independent review into how ACC manages their client data has been announced (Radio New Zealand, 2021). I welcome this review.

The Criminal Justice System

While examining the criminal justice process is not central to the current thesis—being an issue that demands an in-depth exploration of its own—the inequity prevalent in this system needs to be noted as part of the broader societal landscape of discrimination and injustice. Using data based upon all sexual assaults reported to Aotearoa New Zealand Police between 2014 and 2018, the abysmal conviction rate is glaringly apparent. Of 23,739 cases reported to police, 31% of perpetrators were charged, 11% of these charges led to a conviction, and 6% of the perpetrators were then sentenced to a term of imprisonment (Ministry of Justice, 2019). However, when considering the estimate that only 10% of sexual violence is reported to police, the overall conviction rate can be approximated at 1%. In statistics that are upsetting yet not surprising, 87% of these cases were women, and 64% of the assaults happened when the survivor was younger than 17 years old (Ministry of Justice, 2019). Ethnicity data were not recorded for all people, and no disability data were reported at all, preventing consideration of how our court processes are even more inequitable for people who experience social marginalisation. With both survivors and support services describing the court process as revictimising (Maier, 2008), it begs considering how ethical it is to encourage survivors to report the crimes against them when the harms of court proceedings are well documented, yet justice is not.

Government Support and Legislative Changes

In 2018 the joint venture for family violence was established, bringing together key agencies to address family and sexual violence as an integrated response (New Zealand Government, 2021). Through their continued work and advocacy, in 2021, a budget of NZD $131.9 million over four years was announced to help break the cycles of violence in Aotearoa New Zealand, an encouraging response to increasing stress on the sector due to Covid-19 (Joint Venture, 2021). In December 2021, the Aotearoa New Zealand government, in collaboration with the joint venture, announced *Te Aorerekura* its first-ever national strategy to eliminate family and sexual violence (New Zealand Government, 2021). Its claims include: being the first to truly honour tāngata whenua in the conversation; being Te Tiriti lead and strengths-based; and having a stronger emphasis on primary prevention. It aspires to keep the government and successive governments accountable in using policy that promotes safety, inclusion, and equity (New Zealand Government, 2021). It reflects that compounding inequity is both a cause and consequence of sexual violence, and emphasises understanding family and sexual violence from a lens of dominant social beliefs, gender roles, and power differentials. It outlines a six-shift process described as specific and time-bound:

1. Towards strength-based wellbeing
2. Towards mobilising communities
3. Towards skilled, culturally competent, and sustainable workforces
4. Towards investment in primary prevention
5. Towards safe, accessible, and integrated responses
6. Towards increased capacity for healing

Whether or not family and sexual violence can be eliminated within a generation remains to be seen, yet these steps are incredibly encouraging and long overdue.

Alongside the 25 year plan, in December 2021, the reports *Whakamanahia Te Tiriti, Whakahaumarutia te Tangata (Honour the Treaty, Protect the Person)* and *Whakamahia te Tūkino kore Ināianei, ā Muri Ake Nei (Acting Now for a Violence and Abuse Free Future)* were released, for the first time shining a light on sexual violence in the disability community and for tāngata whaikaha Māori in Aotearoa New Zealand (Human Rights Commission, 2021a, 2021b). These reports have a sizeable intersectional focus and address the range of inequities that plague both sexual violence survivors in general, but especially those who live with compounding inequities. They ground the discussion within human rights legislation, including the Convention on the Rights of People with Disabilities (UNCRPD), the Declaration on the Rights of Indigenous Peoples (UNDRIP), and Convention on the Rights of the Child (UNCROC)—documents that the Aotearoa New Zealand Government have ratified, yet not fully realised at this time. While the articles in each of these documents do not need to be addressed all at once, the authors argue that we are grossly failing to meet our obligations across the board (Human Rights Commission, 2021a, 2021b). This can be extrapolated to mean that we are breaching the fundamental human rights of disabled people, tāngata whenua, and children in Aotearoa New Zealand, a large, yet arguably not unfounded claim.

In suggesting ways to rectify the identified issues, many recommendations are made which, as they quote, “reflects the extent of work to be done” (Human Rights Commission, 2021b, p. 50). For a detailed review of each of their recommendations, please refer to the reports; however, their key finding is the need for a twin-track approach whereby all services and information are accessible, and a variety of specialist prevention initiatives are made available (Human Rights Commission, 2021b). Importantly, all findings are closely ingrained with the promotion of Māori rangatiratanga (self-determination), being Te Tiriti lead, and the close involvement of tāngata whaikaha Māori. I find it incredibly encouraging that this issue is finally being taken seriously, centred within a human rights approach that demands equity and change across the board.

Literature Review Chapter Two:

The Disability Community and Sexual Violence

In 2013, approximately 1.1 million people living in Aotearoa New Zealand, or 24% of the population, self-identified as disabled within the realms of hearing, vision, physical, intellectual, psychological/psychiatric, and/or other uncategorised disability (Statistics New Zealand, 2013). The majority of disabled people are over 65 years of age, with rates of disability steadily increasing as life expectancy increases (Statistics New Zealand, 2013). In turn, the average age of the population is rising, concurrently increasing the prevalence of disability. As our last population-wide survey of disability data took place in 2014, in 2022, I anticipate our disabled population is now much larger—with this notable lack of recent data further reflecting the under-prioritisation of the disabled community.

Appropriate support must be available for disabled people across service domains. In statistics from 2018, disabled people living in Aotearoa New Zealand reported their overall life satisfaction as lower than non-disabled people living in Aotearoa New Zealand (McLeod, 2018; Statistics New Zealand, 2013). Furthermore, almost 25% of disabled adults rated their mental wellbeing as poor (McLeod, 2018). In line with these findings, it is widely acknowledged that disabled people receive poorer care than non-disabled people and experience discrimination when accessing healthcare services (Human Rights Commission, 2021b). Disabled people living in Aotearoa New Zealand are more likely to live in unhealthy and unaffordable homes; have lower educational attainment and employment and subsequently higher economic disadvantage; and are more likely to report being lonely and experience discrimination than non-disabled people (Statistics New Zealand, 2020). Disability advocates speaking to Robson (2016) explain: “the lack of resources is indicative of how little value people put on [disabled people], how little value people put on the people who work in [disability services]” (p. 21). This suggests the existence of widespread issues that underlay the way disabled people are treated. While experiences of disability are unique and wide-ranging, there are common threads of ableism that exist across multiple levels of society.

Statistics

While the following statistics are marred with inaccuracy due to the complexities involved in their collection, they are the best—albeit still very poor—available indication of how widespread sexual violence is within a community that is already subjected to social marginalisation. As knowledge develops, so will our understanding of the prevalence and forms of violence that impact disabled people.

Internationally, conservative estimates indicate disabled women are up to four times more likely to experience lifetime sexual violence than non-disabled women (Martin et al., 2006), with disabled men up to eight times more likely to experience lifetime sexual violence than non-disabled men (Powers et al., 2008). Disabled children are almost four times more likely to experience sexual abuse than non-disabled children, with this rate increasing to 4.6 times for children with psychosocial impairments (Hughes et al., 2012; United Nations Population Fund, 2018). One of the most commonly reported yet now dated statistics suggests that as many as 83% of disabled women will experience lifetime sexual violence (Stimpson & Best, 1991). With increasing recognition of the staggering rates of abuse that occurred in Aotearoa New Zealand state care, I would not be surprised if we soon learn this is an accurate statistic for the disabled people who were institutionalised against their will in the years proceeding Stimpson and Best's (1991) findings.

A dearth of Aotearoa New Zealand research explores sexual violence for disabled people. The limited findings available demonstrate that, as is the case internationally, sexual violence is disproportionately prevalent for disabled people living in Aotearoa New Zealand and tāngata whaikaha Māori (Human Rights Commission, 2021b). For example, more than one-third of sexual violence survivors interviewed by Kingi and Jordan (2009) self-identified as disabled, despite not being recruited on the basis of ability. In the 2019 Aotearoa New Zealand Family Violence Survey, 11.1% of disabled women reported experiencing non-partner sexual violence, with 5.6% of disabled men indicating the same (Fanslow et al., 2021b). Worryingly, research has demonstrated an overall increase in the rate of intimate partner violence in Aotearoa New Zealand between 2003 and 2019 (Fanslow et al., 2021a). The continued reluctance to make disability research a priority reflects the embedded ableism that needs shifting with urgency.

Sexual violence against disabled people is not an issue occurring only in institutions, nor only to disabled people without access to education. Within Aotearoa New Zealand, 2016 data suggest that 65% of tertiary students who identify as disabled had experienced sexual assault while in tertiary education, and 90% had experienced sexual harassment (Thursdays In Black, 2017). Worryingly these sexual assaults were not one-off events, most commonly re-occurring between two and five times (Thursdays In Black, 2017). These findings are supported by similar Australian data, where—although their overall prevalence rates are lower—disabled tertiary students are more likely to be sexually harassed and/or assaulted than non-disabled tertiary students (Australian Human Rights Commission, 2017). This suggests an additional layer of complexity, whereby the rates of assaults on students are huge but disproportionately so for disabled students.

However, additional difficulties exist in recording accurate statistics for disabled sexual violence victims/survivors beyond the difficulties previously described for the general population. Firstly, complexity is introduced when comparing sexual violence with factors or populations that are not stable over time (Basile et al., 2016). For example, when measuring the rates of sexual violence in the disability community, it must be considered that many disabilities are acquired rather than congenital; that being, a lifetime prevalence may reflect sexual violence that occurred before the onset of one’s disability (Basile et al., 2016). While such violence is unquestionably impactful no matter when it happens in one’s life, the specific impacts for disabled people are harder to understand without this differentiation.

Some statistics exist that attempt to take this issue into account. For example, Powers et al. (2008) suggests that approximately 24% of disabled men will experience sexual abuse within their lifetime, but in their survey, they recorded that only 52% of the reported incidents happened after their disability was acquired. Conversely, when looking only at past-year rather than lifetime data—i.e., while disabled—Basile et al. (2016) suggested that an average of 8.6% of all disabled men had experienced ‘sexual violence other than rape’ in the previous 12 months; a similar rate to the 9.9% of disabled women with the same experience. These differences demonstrate how gaps in our knowledge can easily remain, with no easy way to establish lifetime prevalence when controlling for the onset of disability.

As discussed previously, there are unique complexities for disabled people in reporting sexual violence, which is necessary if they are to be recorded statistically. Due to the discrimination and negative experiences that often result from living with a disability, disabled people are accustomed to having unmet health needs (Robson, 2016). In turn, advocates suggest that disabled people may tolerate sexual violence more often than non-disabled people, thus reporting it less frequently (Nannini, 2006). Furthermore, general population surveys may be difficult or impossible for disabled people to complete due to access needs not being met. Some disabled people are unable to communicate without the assistance of a care provider (who may be the abuser, or someone who the disabled person may not wish to disclose to), and sexual violence studies and services may not gather disability data (Plummer & Findley, 2012; Robson, 2016). For example, despite a detailed attrition report being released by the Ministry of Justice (2019), no disability data were reported and it is unclear if it is collected at all. The disaggregation of disability and ethnicity data are incredibly uncommon, preventing the analysis of this issue for specific groups (Human Rights Commission, 2021b). Likewise, disability data are not collected by Aotearoa New Zealand’s child protective services (King, 2019; Robson, 2016).

However, the issues with recording accurate data are not going unnoticed. King (2019) argues that not collecting disability data for children under the care of the state fails to uphold Aotearoa New Zealand’s obligations to protect children’s rights. Internationally, the United Nations (2017) report that the “the lack of reliable and comparable statistical data on sexual and reproductive health and rights of girls and young women with disabilities is alarming" (p. 19). Robson (2016) stresses similar concerns in the Aotearoa New Zealand context, given that policy and funding is often determined upon statistical data.

What is clear is that without a better understanding of how widespread and impactful sexual violence is within the disability community, the complexities will continue to put this issue into the too hard basket, perpetuating access barriers with no end in sight. However, what worries the Human Rights Commission (2021b) is that even when we know the extent of an issue, we have not seen "systemic or sustained action" (p. 34).

Barriers to Reporting Sexual Violence

Education

Reporting or seeking help following sexual violence requires that a person understands that what happened to them constitutes a crime, which may present a barrier for people with learning and/or cognitive disabilities or those with less access to education (Robson, 2016). In a survey of recent or current tertiary students in Aotearoa New Zealand, 11% reported being unsure if they had experienced sexual assault as a student (Thursdays In Black, 2017). When the survey question changed from a closed question related to whether one had experienced sexual assault, to selecting whether one had ever experienced specific items from a list of sexually violent behaviours, the number of people who responded affirmatively to having experienced sexual violence increased 71%, from 286 to 496 people (Thursdays In Black, 2017). As tertiary students, we can assume they have been privileged to a higher level of education—thus, access to a longer-term, mandated sexuality education programme due to the requirement to finish high school before attending university—than people living in Aotearoa New Zealand with lower educational attainment. This makes this finding particularly concerning.

Disabled people receive lower levels of education than non-disabled people, particularly in the areas of sexual and reproductive health (Robson, 2016; United Nations, 2017). Frequently, sexual health curriculums are not provided in special education services or are not offered in ways accessible to disabled people, with this inequity compounded for disabled girls who receive less sexual education than disabled boys (Hunt et al., 2021).

When sexual health education is provided in general education settings, it usually does not cater to specific aspects of sexuality for disabled people (United Nations, 2017). This lack of education for disabled people is particularly prominent in residential or institutional settings, for disabled people who are incarcerated, and for those who are homeless or experiencing severe poverty. Families in countries where education is not free may choose to withdraw their disabled child from school earlier to allow their non-disabled children better opportunities with the finances they have available (Hunt et al., 2021). These attitudes stem from capitalist views around disabled people and productivity, whereby disabled people are less capable of working and maintaining meaningful employment. These assumptions also stretch to disabled peoples' capacity to learn, meaning that they are seen as needing increased resources for teaching that are not worth the time or effort (Hunt et al., 2021).

Worryingly, poor access to education can increase a disabled person's vulnerability to sexual violence (United Nations, 2017). A lack of sexual education reduces one's knowledge about their body, social norms about sexuality and relationships, how to have safe sex, and, importantly, what would be considered abusive sexual contact (Hunt et al., 2021). For disabled people who are also marginalised in other ways, such as being homeless, the inequity associated with these social positions combines to further reduce their ability to access appropriate education (Braathen et al., 2021).

Social Stigma

Social and cultural barriers are perpetuated by dehumanising disabled people and by the desexualising of disabled bodies throughout all levels of theory, policy, and practice (Findley et al., 2016). Frequently, disabled women are not seen as requiring information about sexual health or as capable of making decisions related to their own reproductive and sexual rights (United Nations, 2017). Relatives, teachers, and healthcare workers are generally "anxious, untrained and unconfident" (United Nations, 2017, p. 7) in talking about sexuality with disabled people. Sexual health is seen as a taboo topic, with disabled women frequently categorised as either asexual or hypersexual (United Nations, 2017). Speaking from her experience as a self-identified 'fat woman', Royce (2020) goes as far as to say that non-normative bodies are considered “unrapable” (p. 191) and thus removed or rejected from conversations surrounding abuse. However, in contrast to these beliefs, research has demonstrated that the sexual needs and concerns of disabled people are similar to those of their non-disabled peers, reinforcing that appropriate discussion around disability and sexuality need to be undertaken with all people (United Nations, 2017). It is no longer acceptable to ignore the rights of disabled people to have healthy, informed, sexual relationships.

Stereotypes, stigma, and misconceptions of disability and sexuality reinforce the disempowerment and infantilisation of disabled bodies (United Nations, 2017). Subsequently, disabled people may experience lower self-esteem and a sense of bodily autonomy, reducing their ability to advocate for their sexual and reproductive rights (Plummer & Findley, 2012). Disabled women describe socialisation processes beginning as young children, designed to make them more compliant and agreeable in their personal cares (Saxton et al., 2001). However, they reflect that these processes emphasise vulnerability, leave them feeling disempowered, and feed into an imbalanced sense of power over their body (Saxton et al., 2001).

Gilson et al. (2001), as discussed in Plummer and Findley (2012), argue that not only do societal beliefs and socialisation processes create barriers that limit access to services, but rather, they enable an environment in which the abuse of disabled people can permeate. For example, disabled women frequently hear narratives of their bodies as unattractive and unworthy, preventing them from leaving abusive relationships for fear they will not find another partner (Plummer & Findley, 2012; United Nations, 2017). In this example, integrating these negative societal narratives has fostered an environment where people can abuse their disabled partners without specific repercussions; they become feared by those who depend on them but are rarely held to account for the harm they perpetrate.

A Lack of Educated Service Providers

There is evidence of overt discrimination and oppression of disabled people seeking sexual health services. Some service providers reject that supporting disabled people should be part of their job at all (Ride & Newton, 2018). Within Aotearoa New Zealand, Hager (2017) spoke with service providers and found that the disability and sexual violence sectors did not see their work as relevant to one another or, in fact, held an “almost total lack of interest in one another” (p. 113). This, in turn, prevents a collaboration that would be hugely beneficial for disabled survivors. Alongside having no interest in working across sectors, individually, they viewed the issue of sexual violence against disabled women as either not their issue or not an issue at all (Hager, 2017). I find this hugely frustrating as I believe that making things someone else’s problem does nothing but leave them entirely unaddressed.

Clearly, strong beliefs underpin a reluctance to work with, or even acknowledge, disabled survivors. Hunt et al. (2021) explain that these continued violations of disabled peoples’ rights to access sexual and reproductive health stem from deeply rooted societal assumptions, such as disabled people not being sexual beings or having the same needs as non-disabled people. Yet beyond this, even when people are not trying to be intentionally discriminatory, these societal attitudes mean that “prejudicial behaviour” (p. 124) continues, such as being surprised by disabled peoples’ requests for services (e.g., pregnancy testing), not offering them the same level of services as non-disabled people (e.g., free access to condoms), and making incorrect assumptions such as the person not being able to be sexually active (Hunt et al., 2021). These are grave findings as even if service provisions improve for disabled people, disparities in access will remain if such attitudes persist (Hunt et al., 2021).

In some circumstances, discriminatory attitudes are not an *intentional* disregard for the rights of disabled people; instead, poor care emerges due to a lack of education and awareness of disability issues (Hunt et al., 2021; Ride & Newton, 2018; Robson, 2016). Commonly, disability issues are not seen as important in broader society, thus not made a standard element in many healthcare curriculums, meaning sexual violence service providers are unfamiliar with the needs of disabled clients (Ride & Newton, 2018; United Nations, 2017). Service providers themselves are not naïve to these gaps in their knowledge; instead, a lack of resourcing leads to many gaps within organisations (Robson, 2016). In 2009, almost half (47%) of Aotearoa New Zealand sexual violence services rated their support of disabled survivors as average or less (Mossman et al., 2009a). Due to a lack of specialised services for disabled people, service providers suggest they are only able to provide “safety nets” (Robson, 2016, p. 23) within their service, lacking the “capacity or skill” (Robson, 2016, p. 23) to cater to the individual needs of disabled people. Australian health providers acknowledge that services are supporting disabled people “badly” or “not at all” (Ride & Newton, 2018, p. 314). Worryingly, despite being unable to cater to disabled survivors in their organisations, there is a lack of specialised services to refer to in Aotearoa New Zealand (Human Rights Commission, 2021b; Robson, 2016). I see this as a gross failure at the core of our services and one that is likely to continue until the lives of disabled people are valued equally to their non-disabled peers.

Accessibility

Disabled people commonly face wide-ranging accessibility issues that fail to meet their basic needs, including physically accessible spaces, transport, and alternative communication methods (Hunt et al., 2006; Plummer & Findley, 2012; Robson, 2016; United Nations, 2017). It is imperative to note that accessibility is highly variable between people. A one-size-fits-all approach will never be appropriate, with accessibility enhancement needing to be seen as a “process, not a one-time task” (Robson, 2016, p. 23). This means that, alongside gaining a good understanding of what accessibility looks like for different disabled people, we must also remain open to learning and adapting our world, being informed by the lived experience of our disabled peers. As sexual violence services learn and improve, they must remember to keep accessibility at the forefront so that disabled survivors can continue to grow with them.

Accessibility must be considered in all environments that play a part in the sexual violence support processes, such as counselling spaces, emergency housing, police stations, medical services, and courthouses (Robson, 2016). Examples of physical access needs include spaces needing to be wheelchair friendly (e.g., elevators, wide doorways), offering mobility parking, having lowered desks, disability-friendly exam tables, and mobility friendly bathrooms (Robson, 2016; United Nations, 2017). Transport can present a significant barrier, with transport costs often higher for disabled people, disabled people having fewer options for transportation, and services not always being on public transport routes (Robson, 2016). Commonly, access needs are not met; for example, while mobility impaired, disabled people seeking counselling have reported having appointments booked in upstairs rooms, and while visually impaired, being asked to complete questionnaires on paper (Hunt et al., 2006). These cause particular frustration for people when they have already communicated their access needs to the service (Hunt et al., 2006).

In addition to physical accessibility, inaccessible communication can present significant issues for disabled people wishing to seek support (Hunt et al., 2006; Plummer & Findley, 2012; Robson, 2016; United Nations, 2017). These include a lack of information provided in accessible formats, such as Easy-Read, Aotearoa New Zealand Sign Language, or Braille; a lack of translators or interpreters; and a lack of staff knowledge about language limitations and/or using alternative means of communication. Furthermore, a lack of accessible communication methods present barriers at all stages of a reporting process. It is not common practice for services to publish information about their accessibility, meaning survivors are unaware whether or not a service will cater to their needs (Robson, 2016). Some communication devices exclude vocabulary necessary for reporting, such as the word rape. In 2016, only three counsellors in Aotearoa New Zealand were proficient in Sign Language, limiting therapy opportunities for survivors who wish to undertake treatment in their first language (Robson, 2016).

Furthermore, given the small size of the Aotearoa New Zealand Deaf community, using interpreters to make reports or access services means disclosing information to someone the survivor may know. Many Deaf people also use family members as interpreters, which places the survivor in a position where they may have to share more information with that person than they would prefer (Robson, 2016). Addressing concerns such as these are pertinent, as they expose disabled people to breaches of confidentiality they may not wish to make. This has multiple implications, including underreporting due to a survivor feeling there is no easy way to communicate, and increased shame for survivors who have to tell people they otherwise would not have chosen to tell (Robson, 2016).

Barriers to accessible services are often compounded by a lack of resourcing within organisations (Robson, 2016). For example, a service may desire to convert its information into an Easy-Read format but not have the funding to do so. This again reflects the need for disability issues to be included within broader policy and funding. Within organisations, the policy must also promote accessibility, such as employing disabled staff; employing non-disabled staff who are confident and educated in disability issues or willing to upskill; and writing policies that promote and protect disabled people and their rights (Robson, 2016). I hope that by including service providers who are also survivors—with that duality being the case for four out of seven respondents in this research—these issues can be explored and understood from multiple perspectives, providing clear guidance for change.

Disbelief

Many disabled survivors fear that they will not be believed if they report the harm committed against them (United Nations, 2017). The perceived credibility of testimony is often determined by societal narratives of social class and status, thus labelling disabled people as unreliable due to their marginalised position within society (Smith, 2019).

Unfortunately, these concerns have an evidential basis. It has long been established that disabled peoples' evidential statements are considered less credible than those made by non-disabled people. For example, in examining attrition reports from Aotearoa New Zealand Police data, 87% of complaints made by people with "psychiatric disturbance" (Jordan, 2004, p. 37), and approximately 75% of complaints made by people with an intellectual disability, were viewed as false, or potentially false complaints by Aotearoa New Zealand Police officers. Of all complaints made by survivors with psychiatric or intellectual disability, only 13% were considered to be genuine complaints (Jordan, 2016). Australian data reflect similar findings, whereby people with a psychological disability are twice as likely to be deemed false complainants, with their reports the least likely to result in a criminal justice charge against the perpetrator (Murray & Heenan, 2018).

These low arrest rates and subsequent abysmal prosecution rates translate to perpetrators targeting disabled people—especially those with cognitive or sensory impairments—due to the belief their testimony will not be taken seriously (Jordan, 2016; Robson, 2016; United Nations, 2017). Thus, not only does the disbelief of disabled survivors prevent equitable justice outcomes, it also perpetuates inequitable vulnerabilities to violence.

Gatekeepers

Legally, most minors are considered to be under the care of a parent or guardian; thus, the adult has the responsibility for the child's decision making. In some countries, this translates to laws on mandatory reporting, where parents must be notified if their child seeks support from a sexual violence agency, and the agency can choose not to provide information or services to a minor (United Nations, 2017). Similarly, these practices can apply to disabled adults who have appointed guardians for their decision making. However, it is not uncommon that disabled people are perceived to lack capacity, even when they do not, due to having a disability (United Nations, 2017). When considering consent to medical procedures, the complexities around capacity increase—this will be discussed in more detail in a section to follow.

In other circumstances, carers and guardians can act as gatekeepers to accessing information and services, particularly if the disabled person relies on them for mobility and/or communication (Robson, 2016). As society often views disabled people as asexual, parents may prevent their disabled children from accessing education and resources related to their sexual and reproductive rights (United Nations, 2017). As emphasised by Hunt et al. (2021), a lack of education in these areas puts disabled people at increased risk of misunderstanding sexual experiences and unwittingly being victimised. In light of this, I believe that refusing to talk to disabled people about sexuality and bodily autonomy reinforces harmful stereotypes of disabled people as asexual, unattractive, unlovable, and, in turn- unrapable. When such stigmatising views are perpetuated within disabled peoples' own families, it is not hard to extrapolate an understanding of why they do not feel welcome within sexual violence services.

Unique Forms of Sexual Violence

As many as 53% of disabled people may experience sexual violence from personal assistance (PAS) providers (Powers et al., 2002), especially if there are multiple providers involved in their care (Plummer & Findley, 2012; United Nations, 2017). The reliance on other people for activities of daily living leaves disabled people vulnerable to being assaulted during personal hygiene routines, medical treatments, and while medicated (United Nations, 2017); with cares sometimes very intimate, and boundary confusions common (Plummer & Findley, 2012). These concerns are further compounded when the disabled person lives in a residential or institutional setting, with the increased number of PAS providers, and the higher needs of the disabled person (Plummer & Findley, 2012; United Nations, 2017).

When a PAS provider perpetrates sexual violence, this further increases difficulty for disabled people seeking support. These difficulties include: relying on a carer for communicative assistance, thus preventing them from calling for help independently; fear of retaliation if they are not kept safe after reporting; fear of losing support and assistive devices; fear of the next provider being more abusive than the last; and fear of being moved into an institution (Robson, 2016; Saxton et al., 2001; United Nations, 2017). Particular issues may be encountered when the PAS provider is a family member, such as fear of losing financial security if they rely on the carer for economic support; fear of their children being removed or becoming a single parent; increased fear of disbelief; and fear of losing their home without other accessible living arrangements (Robson, 2016; Saxton et al., 2001; United Nations, 2017).

Forced Medical Procedures

Forced or involuntary sterilisation, contraception, and termination of pregnancy are common forms of sexual violence that disproportionately impact disabled women, especially cognitively or psychosocially disabled women, and those living in residential or institutional settings (United Nations, 2017). Under the guise of being in a woman's best interest, a guardian may consent to such procedures on behalf of a disabled woman, even if she expresses a clear wish not to undergo them (United Nations, 2017). The impact of this issue on disabled people with uteruses who do not identify as female, i.e., transgender and nonbinary people, remains unknown.

The concept of ‘being in a disabled woman’s best interest’ is marred with inequity and ableism in itself, with disabled women often considered unfit for parenthood, incapable of managing menstruation, and unable to protect themselves from sexual violence (United Nations, 2017). Some terminations of pregnancies may be performed under the hidden guise of eugenics, with the fear of a disabled mother having a disabled child. Within violence services—which are often informed by feminist underpinnings that support the right to pregnancy termination—this may cause unintentional tensions between service providers and disabled women. This is because having a disabled child may be grounds for termination for non-disabled people, but not for many disabled people who value disabled lives as equal to non-disabled lives (Robson, 2016). Finally, there have also been reports of forced termination of pregnancy being used to control the over-population of residential care facilities; however, the country in which this is occurring was not reported (United Nations, 2017).

Although non-consensual sterilisation may seem like an archaic practice, intellectually disabled people in Aotearoa New Zealand, who are deemed to lack capacity, continue to undergo sterilisation procedures without their consent (Robson, 2016). The legal ground for this procedure is often cited as “if at risk of pregnancy from sexual assault” (Robson, 2016, p. 14). However, the sterilisation of a disabled woman does not reduce her risk of experiencing sexual violence nor decrease her right to protection from sexual violence (United Nations, 2017). Thus, it could be conceptualised that this practice deems sexual violence as an unavoidable reality, the outcome of which (the pregnancy) must be prevented rather than preventing the sexual violence itself. This, in turn, means that the perpetrator is left with no accountability while the victim is further harmed.

While forced contraception—most commonly implanted or injected—is frequently imposed upon disabled women for menstrual management, some women undergo a non-consensual complete hysterectomy (United Nations, 2017). The suggestion that disabled women are less capable of dealing with menstruation pain has no evidential basis, with this practice more likely reflecting ease on personal care requirements for their caregivers (United Nations, 2017). The practice of administering growth reducing hormones also demonstrates the carer's needs being put first, a practice which permanently alters disabled bodies and adds to the infantilisation of disabled people (United Nations, 2017).

The concept of capacity is in and of itself highly complicated. While it is perhaps *legal* to order a medical procedure on a disabled person for whom one is appointed guardian, is it *ethical* if the person can articulate that they disagree? Is it ever ethical if the practice is not improving the life of the disabled person but rather those around them, often informed by discriminatory views of disability? The United Nations (2017) emphasises that "the forced sterilization of persons with disabilities constitutes discrimination, a form of violence, torture and other cruel, inhuman or degrading treatment" (p. 11). That being, forced medical procedures are not only unethical but must be considered criminal. As one of their recommendations, the Human Rights Commission (2021b) has requested legislative change to prohibit non-therapeutic sterilisation, pharmaceutical, and surgical interventions of disabled bodies.

Summary

The lack of appropriate service provisions for disabled survivors increases the risk that supersedes that already part of their everyday experience of marginalisation.

In the Aotearoa New Zealand context, evidence would argue that we lack the ability to support disabled sexual violence survivors across the board. There are no disability-specific sexual violence services, and the general sexual violence services we do have struggle to cater to the individualised needs of disabled survivors. Behind all of this are the systemic attitudes, perceptions, and behaviours that disproportionately discriminate against disabled people in the realm of sexual violence and, ironically, prevent us from improving services that could intervene to change such attitudes.

Considering these facts, the present research will explore how these elements—the lack of appropriate support and the broader societal attitudes and treatment of disabled people—are interrelated. To do this, an understanding of the complexities that exist in the lives of disabled people, as well as in sexual violence services, is paramount. The lived experience of survivors and service providers, including several respondents who inhabit both spaces, will give meaning to this established background of inequity; attempting to understand what is most important to them from a position as an expert in their own lives.

Literature Review Chapter Three: Further Diversity (and Divisions) of Aotearoa New Zealand

As addressed above for disabled people, people from Aotearoa New Zealand's diverse community groups experience wide-ranging and multi-faceted forms of discrimination, both within wider society and sexual violence spaces. The marginalisation of people whose identities differ from the hegemonic norm is deeply ingrained into culture, with historic oppressions continuing to leave individuals at an increased risk of sexual violence and without adequate services available to support their diverse needs with humility and understanding (Human Rights Commission, 2021a, 2021b). However, this becomes further complicated when acknowledging that people do not fit neatly into imposed categorisations, i.e., are not confined to only one group in society. Finding adequate support becomes a particularly complex issue when people live with the intersections of the "-isms"—racism, classism, ableism, sexism, heterosexism, etc. While the predominant lens of this project is the intersection with ableism, the following section will outline key elements of discrimination that occur for various oppressed communities in Aotearoa New Zealand. I have chosen to do this as I believe that to understand the complex web that is woven when existing at multiple marginalised social locations, we must first understand the impact of sexual violence within each community.

Māori

Māori are the tāngata whenua (Indigenous peoples) of Aotearoa and continue to make up a large portion of the Aotearoa New Zealand population, despite colonisation causing widespread and arguably irreparable damage to te reo Māori (the Māori language) and te ao Māori (the Māori world). Specifically, in 2013 Statistics New Zealand outlined that 15% of the Aotearoa New Zealand population are Māori. Despite this, Māori have been excluded from conversations, strategies, statistics, plans, and policies across the board (Human Rights Commission, 2021a). Such exclusionary processes can be described as leaving services not only poorly designed for Māori but actively designed to "assimilate and dispossess” them (Human Rights Commission, 2021a, p. 1). While acknowledging the challenges that come from “just being Māori”, for tāngata whenua being Māori can also be conceptualised as their “greatest gift, and the source of our [their] unique strength” (Human Rights Commission, 2021a, p. 1). That being, their Māori identity is strong and important, and any negative stereotypes or treatment is imposed by outsiders, not an intrinsic part of being Māori.

Colonial Devastation

Issues of violence against Māori must be framed within the broader context of historical oppression, with Māori describing the violence now occurring within whānau as “the manifestation of the powerlessness and dispossession of colonisation” (Human Rights Commission, 2021a, p. 4). Colonisation and ongoing imperialism has had a devastating impact on Māori that is impossible to understate, stripping all political power and forcing dissemination of Eurocentric ideas that conflicted with tikanga and te ao Māori. With the arrival of European settlers to Aotearoa, Māori were violently removed from their land, forcing the separation of whānau and whakapapa (Human Rights Commission, 2021a). Subsequent policies across all governmental sectors have favoured the needs of tauiwi (non-Indigenous people living in Aotearoa New Zealand) and further disenfranchised Māori who were forced to abandon their traditional practices. This began from the signing of Te Tiriti o Waitangi (The Treaty of Waitangi), a founding document that Māori believed would protect their chieftainship, and the British believed would grant them sovereignty (Hemopereki Hoani, 2016). The difficulties resultant from this mistranslation and the Crown’s refusal to protect the rights of Māori were immense, and to this day, the loss of Māoridom has not been rectified (Hemopereki Hoani, 2016).

With a traditionally collectivist culture, the forced proliferation of Eurocentric, individualistic ways of living led to the disconnection of whānau (family), hapū (kinship group/sub-tribe), and iwi (tribe); preventing traditional tribal oversight and care central to the Mātauranga Māori (traditional Māori knowledge; Human Rights Commission, 2021a). This has caused harm for both the collectivist culture but also on an individual level, as described by Heke et al. (2019): “when the web of connections is strong, it nourishes individuals. When the web is weak or torn apart, the individual suffers” (p. 23). The devastation caused by colonisation, and the intergenerational impacts, continue to oppress Māori in unjust and inequitable ways.

Tāngata Whaikaha Māori

The term tāngata whaikaha Māori describes two or more Māori living with disability. The term “whaikaha” translates as “to have ability”, reflecting that within te ao Māori difference is framed as a strength rather than a deficit (Human Rights Commission, 2021b). While experiences of disability are unique and diverse, tāngata whaikaha Māori remain inherently connected as tāngata whenua, in a collectivist way that is not reflected by predominant, Westernised models of wellbeing (Human Rights Commission, 2021a). Most Māori consulted within the *New Zealand Disability Strategy 2016 to 2026* reported that they identify as Māori first, before identifying as disabled; with disability a colonial construct with negative connotations that do not fit within a Māori worldview (Human Rights Commission, 2021a).

Despite being the first peoples of Aotearoa New Zealand—who thus should be a priority across all realms of wellbeing—both tāngata whaikaha Māori and non-disabled Māori face wide-ranging health inequalities and live with poorer social conditions. As a whole, Māori have higher rates of disability, higher rates of suicide, and a shorter life expectancy than tauiwi (McLeod, 2018). While 24% of the general Aotearoa New Zealand population identify as disabled, when adjusting for differences in age profiles, 32% of Māori live with disabilities (Statistics New Zealand, 2013). Furthermore, the average age of tāngata whaikaha Māori is lower at 40 years compared to 57 years for Pākehā (Statistics New Zealand, 2013), with Māori having higher rates of disability within every age bracket (Winter et al., 2020). When comparing the treatment of tāngata whaikaha Māori to disabled Pākehā, this intersection presents further inequities, including less access to medical professionals, disability support services, and specialised equipment needed for day-to-day living (Human Rights Commission, 2021b). In wider-life, tāngata whaikaha Māori have lower educational attainment and labour force participation than disabled Pākehā, who are already underprivileged in these statistics (Human Rights Commission, 2021b). These barriers can be understood as existing secondary to colonisation and racism, underpinned by hegemonic, imperialist attitudes of who is important and who is not.

Sexual Violence towards Māori

Māori women are twice as likely as non-Māori women to be harmed by sexual violence (Ministry for Women, 2015). As the Māori population is younger than the non-Māori population, there is an increased vulnerability to sexual violence; with younger people more commonly sexually harmed than older people. Before colonisation, sexual violence in the Māori community did not exist to the same extent, with this going against the Māori worldview where the collective care of whānau was paramount and the responsibility of all people (Pihama et al., 2016). Due to this, all forms of violence impact not only the individual but also whānau and whakapapa (ancestry; Pihama et al., 2016). The proliferation of violence for Māori can now be attributed to this loss of collectivist awhi (care) and ability to exercise rangatiratanga (chieftainship; autonomy) in decision making (Human Rights Commission, 2021a).

The collectivistic harm of violence for Māori differs from the individualistic perspective of many Western sexual violence survivors, where the family may not be involved in support of the survivor, and individualistic treatments are used as the primary support intervention (Cripps & McGlade, 2014). In turn, only treating the individual fails to understand and acknowledge Indigenous views and understandings of the world. The principle of whakapapa means that Māori are connected to their past, present, and future whānau, with intergenerational trauma felt throughout the entire ancestry line (Ministry for Women, 2015). A conceptualisation of this intergenerational pain is the severing of ties between oneself, community, and the broader environment, with a loss of balance between the mental, spiritual, emotional, and physical world (Stevens & Windsor, 2014). This, in turn, renders individualised Western models of treatment predominantly ineffective for Indigenous populations (Cripps & McGlade, 2014). In summary, support services built upon colonial foundations are failing to support Māori in efforts of prevention and support following sexual violence, using systems that are not appropriate within tikanga and te ao Māori.

Concerningly, no specific research has been conducted into the rates, causes, or impacts of violence for tāngata whaikaha Māori (King, 2019). A study into the abuse of children in special education units, where almost half of the participating children were Māori, demonstrates disproportionate rates of disability and institutionalisation of tāngata whaikaha Māori (Briggs & Hawkins, 2005). When a study respondent was later asked why he did not report the abuse against him, he was quoted as saying, “it would be a waste of time. Cops wouldn’t believe a Māori kid in our town” (Briggs, 2006, p. 8), demonstrating the intersection of discrimination apparent even to the child. While our understanding of prevalence is lacking, there is no question that the intersection of abuse with racism, colonisation, intergenerational trauma, cultural disconnection, and ableism results in complex and compounding inequity; further disenfranchising Māori and perpetuating disconnection from whānau and whakapapa (Human Rights Commission, 2021a).

The Queer Community

Approximately 3.5% of people living in Aotearoa New Zealand identify with a sexual identity other than heterosexuality, with queer people rating their overall life satisfaction as lower than the heterosexual population (McLeod, 2018). Low life satisfaction may not be surprising, as 34.1% of gay/lesbian people and 39.3% of bisexual people reported at least one experience of discrimination in the previous year; staggeringly high rates indicative of an ongoing bias and stigma against this community (McLeod, 2018). In other local research, the Aotearoa New Zealand Crimes and Victims Survey (Ministry of Justice, 2020) reported that bisexual people living in Aotearoa New Zealand were almost 70% more likely than heterosexual people to be a victim of a crime, with gay and lesbian people nearly 40% more likely; although this did not reach statistical significance due to sample size. Nonetheless, I think that these disproportionate rates are entirely unjust and worthy of discussion.

While statistics of sexual violence in the queer community are under-reported, research suggests that as many as 50% of queer people will experience sexual violence. In work with our queer community, Veale et al. (2019) found that, since the age of 13, 50% of trans men, 55% of non-binary people, 33% of trans women, and 65% of disabled people had at least one person try and have sex with them against their will. Of those who acknowledged this experience had happened to them, they were twice as likely to have attempted suicide than peers who had not had this experience. The unfortunate reality is that many others have likely been lost to suicide already, with their voices never heard. What is particularly important to note here is that only 7% of respondents ever reported the sexual violence to the police, and only 11% to a sexual violence service, suggesting an incredible level of distrust in all formalised agencies. Of those who did seek informal support, 49% of people did not tell anyone immediately, being left to process the events alone in the immediate aftermath. When the survivors did then seek support, most commonly, this was from friends only (52%), with only 15% ever telling family members. This statistic does differ slightly for Māori survivors, who were more likely to seek support from whānau (30%), reflecting the cultural importance of whakapapa (Veale et al., 2019). This, again, demonstrates why Westernised models of care do not suit all survivors.

The reasons why the queer community may not seek formalised support reinforces the level of oppression they experience in their day-to-day lives. Research suggests that the Aotearoa New Zealand queer community avoids mainstream violence support services for worry that they will experience discrimination for their gender and sexual identities (Dickson, 2016). In Aotearoa New Zealand research by Dickson (2016), queer sexual violence survivors selected that they “considered it [the violence] minor”, “don’t know where to go for help”, and “don’t believe would be dealt with fairly” (p. 33) as the three top reasons for not seeking help following an experience of sexual violence. Of further concern, sexual violence crisis centre workers have acknowledged gender and sexual orientation biases within their services, which contribute to poorer care for queer people (Ullman, 2014). Without services opting to do better, it is unlikely our diverse communities will ever feel welcome, safe, and supported when seeking help.

Sandra Dickson, the project manager of *Hohou Te Rongo Kahukura* (Outing Violence, a research organisation supporting the queer community), described the dire need for better support for the queer community to Ashton-Martyn (2019). Issues include confidentiality given the small community, which increases the chance of victim-blaming and the likelihood of continued contact with their offender. When accessing services following sexual violence, she describes that “gender and sexuality diverse people are frequently pathologised when they go to mainstream services … they may be told they are queer or trans because they were sexually abused. They may be turned down completely” (Ashton-Martyn, 2019, p. 25). Finally, she stressed that “we often hear about the impact of stigma and discrimination on suicide rates in the queer community. Sexual violence is rarely mentioned in the conversation … providing better support could save lives” (p. 25). A quote like this is very poignant and should not be ignored when coming from the front line, where people see the devastating impacts of violence every day.

Culturally and Linguistically Diverse Groups

There are several culturally and linguistically diverse communities in Aotearoa New Zealand, including Pacific peoples, migrants, and refugees. Living in a country where the language and culture are unfamiliar can be a stressful experience, leaving such communities with unique vulnerabilities and needs in relation to sexual violence. In 2013 approximately 7% of the Aotearoa New Zealand population identified as being of Pacific Island descent (Statistics New Zealand, 2013) and up to 7% of Pacific people will experience sexual violence at some stage in their life (Campbell, 2016). If English is someone’s second language, this can present barriers to help-seeking; however, it is also acknowledged that specific cultural beliefs make seeking support hard for Pacific peoples. This includes that young Pacific women are taught to be respectful of elders and obey all requests, and the importance of the church and religion for many Pacific families making reporting particularly shameful (Campbell, 2016). Furthermore, among all of the diverse ethnic communities in Aotearoa New Zealand, Mayhew and Reilly (2007) suggest that Pacific peoples may be the least aware of sexual violence support services.

On top of culture and language barriers, people who have come to Aotearoa New Zealand as refugees are likely to need specialised support to address experiences of sexual violence. Pittaway and Bartolomei (2005) noted that as many as 86% of women who resettled in Australia as refugees had been subjected to sexual violence, many as a form of torture. Furthermore, Pittaway and Eckert (2013) explain that the refugee experience is underpinned by violent experiences, including torture, rape, and murder, either committed against them or viewed by them. I can only imagine how shattering such experiences would be for someone’s sense of self, likely making it even harder for them to seek support, with support services unlikely to have any refugee staff, despite the importance of representation.

Intersectional Statistics

Statistics of sexual violence against people who experience social marginalisation in Aotearoa New Zealand are important to consider, as they demonstrate the disproportionate impact of sexual violence on these communities. However, these are incredibly hard to come by, as ability and ethnicity data are often not extrapolated from research results. Thursdays in Black (2017) surveyed people who had studied at a tertiary institution in the previous five years. Of all people asked, a staggering 83% of students had experienced some form of sexual harassment. This included 89% of women, 55% of men and 92% of gender-minority students, a disproportionate rate that reflects the discrimination that continues to impact women and gender-minority people in particular. When examining this data in the context of ethnicity, 83% of Pasifika students and 86% of Māori reported being sexually harassed, yet this increased to 94% for Māori who also identify within a gender-minority, and 100% of students who identify as takatāpui. We have very few statistics that can compare this intersection of racism and heterosexism in this way, especially within Aotearoa New Zealand, and this apparent increase for people with multiple marginalised identities cannot be ignored.

Lived Experience of Intersectional Oppression

Much like the lack of statistics reflecting intersectional identities, scarce qualitative research has described the lived experience of people with multiple marginalised identities when seeking support, both within sexual violence and broader support settings.

The nature of living with multiple marginalised identities means that, when seeking support, people may encounter service providers unfamiliar with some or even all of their identities. Hunt et al. (2006) described the counselling experiences of women who identify as both lesbian and disabled, but not specifically seeking support for sexual violence. Using a phenomenological approach to gather the meanings within the women's experiences, the researchers found that being of these identities frequently complicated the women's experiences of counselling (Hunt et al., 2006). Respondents described the difficulty of finding counsellors familiar with issues important to lesbians, disabled people, and even more so, disabled lesbians. One respondent said: "I've never found anybody who could get the lesbian and disability pieces together" (p. 169). Given that we know that someone's intersectional experience of oppression is not just a sum of distinct parts, having no staff able to recognise the unique complexity that comes from this amalgamation is failing the person.

A straightforward solution to this problem would seem to be having more people with lived experience and diverse identities working in healthcare services. However, there are conflicting perspectives on whether people providing support should be community insiders themselves. While some respondents in Hunt et al. (2006) suggested that seeing counsellors who were part of their diverse community would be helpful, this was not the case for all. Those who advocated for community insiders frequently reported that "they [community outsiders] just don't get it" (p. 168), and many carried outdated and stereotypical beliefs about lesbianism (Hunt et al., 2006). However, others suggested that effective counselling skills were more important than someone being able to recognise the essential elements of their identity. These included qualities such as "acceptance, compassion, [and a] positive attitude" (Hunt et al., 2006, p. 167). The argument for the helpfulness of noncommunity counsellors has been echoed by disabled people who say “the most important aspect about accessibility is generally the attitude and that an agency sets a warm tone and welcoming presence to sexual assault survivors with disabilities” (California Coalition Against Sexual Assault, 2010, p. 5). Given that people with non-hegemonic identities often have lower education and employment rates, I think it would be a barrier if survivors only felt comfortable working with community insiders—the sexual violence sector is already significantly understaffed. However, I am also a strong advocate for increasing diversity in workplaces, not only for representation but in all planning and management levels, so that community outsiders can learn from lived experience.

A key element to working with diverse community groups is remembering that all people are individuals with their own beliefs and values despite their shared group status. The disabled lesbians interviewed in Hunt et al. (2006) suggested that to provide adequate support, counsellors must treat people as unique individuals, but this is not what is always occurring. In telling their personal experience, one respondent said:

> I think the first step is to really believe that the people that come through their door will come through with complexity and not be mono anything, mono cultural, monoracial, mono whatever … they need to sort of assume that people are going to bring them more than one piece. (Hunt et al., p. 167)

However, respondents worried that this is not the accepted norm. Rather their experiences of counselling had been informed by a primarily individualised Western model: “whether it’s counselling or whether it’s rehab … they really have this white model that everybody is white and straight and any deviation from that they kind of don’t get” (p. 167).

In failing to recognise the diversity of people entering services, many individuals experience discrimination when seeking support. These range from personal biases to accessibility needs remaining unmet. Experiences of discrimination were described by respondents in Hunt et al. (2016), who found counsellors were not always approachable or accepting of the person presenting to their service. One respondent reflected on this experience, explaining, “it was just sort of made very plain to me that I wasn’t wanted there”

(p. 169). Some service providers are likely aware of such barriers within their practices. When speaking to Australian sexual health service providers, Ride and Newton (2018) encountered respondents who spoke to the engrained biases that exist within services, such as heteronormativity. One service provider said: “often when we were thinking about people with disability as sexual beings, often the assumption was made that they were heterosexual … subject I guess to perhaps narrow perceptions of others around them that might make assumptions that limit opportunities” (p. 314). While awareness is a good first step towards understanding, there appears to be no evidence of movement to improve such biases. Likewise, identifying disabled people as sexual beings is good, yet failing to then understand what that sexuality means for them as an individual—and that disabled people can be queer, like any other person—prevents equitable care.

While these lived experiences provide valuable insight into the experiences of people with marginalised identities in seeking support, the voices of disabled sexual violence survivors with multiple marginalised identities and their help-seeking experiences are yet to be gathered. The respondents who identified as disabled lesbians in Hunt et al. (2006) allow us to consider an intersectional perspective of mental health help-seeking but fail to address the unique nature of help-seeking for sexual violence. Likewise, the disability advocates and sexual violence workers interviewed in Robson (2016), addressed earlier in the literature review, provide important guidance about common accessibility barriers and gaps within services that alienate people with disabilities; however, the lived experience of accessing such services is neglected. Finally, Ride and Newton (2018) collate the perspectives of sexual health service providers in supporting disabled people but do not include the service user perspective nor examine sexual violence as a specific issue. It is clear that better, intersectional research that consists of the voices of both survivors and providers is imperative, and it is a strength of the current project that four respondents were both service providers and survivors themselves.

Conclusions and Introduction to the Present Research

A sexual violence worker speaking to Campbell (2016) described how “being responsive to different groups in the community is a journey, not a destination” (p. 242). What is apparent in the previous literature is that we are aware of barriers that exist for communities in their pursuit of equitable and appropriate sexual violence supports. However, disabled survivors’ lived experiences of navigating these barriers are not well represented, and the social structures that underpin the presence of these barriers are poorly explored. Furthermore, few, if any, studies have examined what it means to seek this support when someone is marginalised for being disabled while also having another diverse identity, neglecting the intersectional nature of peoples’ lives.

As being multiply marginalised changes one’s lived experiences in markedly different ways, hearing the voices of those with this lived experience is imperative and forms the basis of my research. Their knowledge will be vital in understanding how services can approach support in a holistic and community-informed manner for every survivor, taking into account the intersections of oppression they experience to tailor support in a way that promotes empathy, understanding, and humility. By also including service providers who experience marginalisation, we can contextualise this lived experience further, with these respondents providing an insider perspective of the gaps in services. While explicit research questions have not been posed, to allow the most important narratives of each individual to be shared in whichever way they wish, I broadly enquired into the importance, impact, and challenges of navigating sexual violence for disabled people who experience multiple layers of oppression.

Analysis Part One: An (Inequitable) Pre-Covid-19 World

The following chapter presents narratives shared by sexual violence survivors and service providers who have experienced what it means to be marginalised for living outside of the hegemonic norm. Throughout all the recounts to follow, the overarching narrative is one of power and control and how this contributes to an inequitable world. This extends to how sexual violence strips agency from survivors, how this power acts to marginalise certain people in particular, the lack of power some survivors have within their journey of healing, and the way these impacts carry on intergenerationally.

Four key narrative themes are presented in this chapter. Unlike a traditional thematic analysis whereby the recounts neatly fit an outlined theme, these topic headings provide loose guidance for the stories that follow, developing into complex storylines that stretch beyond what can be conceptualised by a title.

The first of these groupings is *1.1. Layers: Interwoven, Individualised Oppression*, which reflects how multiple oppressions amalgamate to add complexity to the lives of survivors with multiple marginalised identities. Following this, *1.2. Impact: Historical Harms and Modern Power Differentials* describes how sexual violence changes the lives of survivors living as non-dominant members of society, with social inequity underpinning the causes of, consequences of, and ongoing journey following sexual violence. *1.3. Barriers to Equity: It's Not Me, It's You* then outlines why inequitable care can stem from insufficient knowledge and having to keep other people comfortable, who are unsure how to accommodate diverse needs. Finally, *1.4. Access to Services: A Gendered World* describes the dichotomy whereby men can be survivors, yet society positions them as illegitimate victims, and non-cisgender women are not welcome in many spaces designed under feminist ideals.

1.1 Layers: Interwoven, Individualised Oppression

All respondents, including four providers who inhabit spaces both as providers and survivors, described discrimination as having layers of complexity, which compound when people walk within multiple marginalised spaces. This can be conceptualised as a practical demonstration of intersectional theory, with the matrix of oppression (racism, ableism, sexism, etc.) forcing not only the *addition* of oppression but the transforming of each individual “-ism” in a way that would not occur without these added complexities (Crenshaw, 1989).

The layers described by survivors and providers include patriarchal, hegemonic ideals that inform who can and cannot be a victim; ableist views that fail to see disabled people as worthy of support; and imperialism that devalues Māori. While individually each of these oppressions has been described in the literature (see Ride & Newton., 2008, Veale et al., 2019, and McBreen et al., 2012 as examples), here, respondents uniquely described how it is the cross-section of these oppressions that increase and change the levels of discrimination lived by survivors. Ultimately, they reflected that this means people with marginalised identities are receiving poorer support in sexual violence services because of the social structures that underpin every aspect of care.

Notably, the layers of complexity were framed as externally produced by others rather than the survivor themselves. Namely, these layers are dictated and reinforced by dominant social narratives, the people we interact with both in and outside of services, and the hegemonic group who live on the metaphorical higher rung of the social ladder. This is much like the social model of disability, whereby people become disabled by an inaccessible society instead of an individual difference (Sins Invalid, 2017). As the present research had the unique perspective of all service providers having experienced marginalisation in some form themselves, I ponder whether it is their specific shared experiences which underpin their externalised understandings, rejecting individual blame for social disadvantage.

In telling their stories, respondents frequently sat with me in shared spaces of providing care, surviving, and living in a world of sexual violence—mutual positioning I wanted to acknowledge. Upon our meeting, I spoke of my interest in this area and who I am as someone wearing personal, academic, and therapeutic hats in this space; with my own experiences of marginalisation motivating me to hear the untold—and/or often unappreciated, disbelieved, and overshadowed—stories. I asked respondents to begin sharing wherever felt right for them, asking a question similar to:

> Caitlin (researcher):
>
> Is there anything you want to start with, or that comes to your mind, when I mention that topic?

While most respondents then confidently began by speaking of an experience that came to mind, Rachael started by reflecting the complexity that exists within sharing narrative itself: where does a story begin, and where does a story end? That being, does her story start before the first time she was raped, owing to the presence of social structures that allowed it to happen? Or does it start during the event…even though that harm, in many ways, is a continuation that has actually never stopped? From my position, more so than just a beginning to the telling of her story, I read her ponderings as a wider consideration of at what stage she came to consider herself a survivor—of when she felt she was *allowed* to hold this title. That being, her story must fit within a more widely understood social narrative of survivorship, with her not permitted to hold agency over this determination herself as a young, queer, disabled woman.

> Rachael:
>
> Where does my story start? Does it start before? Does it start during? Is it a continuation?

Like Rachael—but in sharing their experiences of working with their clients, rather than their own stories of survivorship—service providers frequently began by reflecting upon who can and cannot “be” a survivor owing to identity. Specifically, service providers described the experiences of their clients who may be *perceived* as more vulnerable by people seeking to cause harm, but in turn, are not seen as entitled to support because their identity strays too far from the hegemonic group. Similar to other studies that explore the concept of a perfect/ideal victim as a construction that does not fit the majority (Bosma et al., 2018; Christie, 1986; Jordan, 2008), Natalie and Joey described how most of the survivors they work with would not fit this categorisation—and in considering our positions in the world, neither would Natalie, Joey, nor myself.

According to someone's sameness or difference from the norm, non-hegemonic survivors become illegitimate victims and their experiences are not believed nor taken as seriously as other survivors, thus hindering their healing journey. While much of the recent literature has examined the concept of an ideal victim within the criminal justice setting (Ricciardelli et al., 2021), service providers here described how being discredited as a legitimate survivor is relevant from the very beginning of one's journey, from whether they conceptualise an event as having been sexually violent, whether they feel worthy of support, to then whether or not they think they can—and actually can—access support that is suitable for their needs. Each of these considerations is important irrespective of criminal justice involvement, with comparable yet separate stories of harm coming from disbelieving and minimising survivors' experiences.

Despite the first representation of a socially accepted ideal victim being put into words by Christie (1986), it appears that in the past 35 years, little has changed in how survivors are categorised as legitimate or illegitimate based on their social position. Natalie described this experience in relation to women with intellectual disabilities, with her modern description reflecting many of the same elements as the ideal victim described in the 1980s. She discussed how disabled women's positions as illegitimate victims have minimised and even erased their experiences, making them feel unworthy of support services:

Natalie:

I think people feel like they can’t reach out for support if it didn’t fit into that [perfect victim] description. I feel that people aren’t sure that they can go to the police about that. I feel like there’s an expectation of how a survivor should be after that happens. If they’re not falling to bits all the time with snot-strings or something, that it couldn’t have really happened; they seem to be doing too well. To be a victim, you have to be real innocent and pure. ‘She’s never done a bad thing by anyone. The good girl.’ If they don’t fit that, then they feel like somehow they’re not entitled to get support.

As disabled myself and having worked within disability support services, I have observed how the othering of our non-conforming bodyminds discredits what we have to say and reduces who is willing to listen. When ableism due to our disability status then intersects with survivorship, the sexual violence is disputed and/or remains unheard; that being, disabled people cannot be ideal victims owing to their subjugated social position to begin with. Natalie mused over the purpose of these exclusionary categorisations and whom they serve, with it certainly not the survivors themselves. She suggested that the maintenance of these dominant narratives act to protect the hegemonic group just as much as they act to harm those pushed to the margins. That being, by continuing to discredit non-ideal victims, people with higher social positions—who are less likely to be harmed by sexual violence and less likely to be invalidated were this to happen—do not have to face the uncomfortable reality that sexual violence is indeed widely prevalent in the world in which they live. Likewise, maintaining a narrative of sexual violence as a non-issue for the majority removes the expectation that people would need support, permitting the maintenance of inadequate service provision:

Natalie:

It gets so much back to other people’s discomfort and then shutting it down for the survivor, which again we always talk about lots. Like, their reality being denied by somebody else because it doesn’t fit in with the other person’s world view or something.

I think sometimes people feel like, ‘Oh, they’ve got an intellectual disability. It won’t affect them. They won’t get it. They don’t get what’s really happened, so it won’t have an impact on them as well. They should just get over it and they’ll be fine.’ I feel like that’s an expectation. Whereas, it's like, people can feel stuff and get stuff at a deep level, but not necessarily be able to convey that to someone else. People feel it and they know it when they’ve been violated. I feel like everyone I’ve ever worked with who has an intellectual disability can feel it—they can feel the hurt at such a deep level. They’re just not communicating it in a way that other people do, necessarily.

Those who enforce these dominant narratives are those afforded power by the social structures in which we live. Social status as a determinant of victim-worthiness has been the case for some time. Christie (1986) explained that the reason wives who experienced abuse became increasingly able to “be” victims in the 1980s was owing to a status change, where more women became increasingly *affluent* enough to achieve the status, not because of a moral improvement which intrinsically valued women more highly. In a comparable way, it is clear to me that disabled people, especially those who experience multiple discriminations, hold low social status within our capitalistic society and are deemed as unimportant people whose safety and wellbeing does not matter. Thus, without a societal shift that sees marginalised people as valuable and meaningful to society, stratified social categorisations will continue to exist and prevent appropriate recognition and support for survivors on the metaphorical lower rungs of the social ladder.

In a reflection of these understandings, Natalie described that, at present, living with marginalised identities means there is limited respect for who one is as a person, with their poor treatment embedded in the social conditions of their everyday lives. Underpinning this marginalisation is ableist, racist, and heterosexist othering that prevents one from being socially legitimate, much like beaten wives before their change in social status. However, what has not been described as succinctly in previous literature is how, for people with *multiple* marginalised identities, the additional layers of discrimination accumulate to further ostracise, with sexual violence noted as having an increasingly devastating impact:

> Natalie:
>
> I think it [experiencing sexual violence as someone who already experiences discrimination] would just reaffirm that you’re not safe in this world, and that people don’t respect you as a human being; and that they will constantly violate you and reaffirm to you that you are not worthy–which is just devastating. I think even people with quite nice lives, or they’ve had relatively no trauma or whatever, still, self-esteem is a hard thing for humans–for humans to love themselves. But, when you’ve got all that other stuff thrown at you, I just feel like it's never going to be a good starting point for anybody and that those other things that happened will just set you back further and further.

Ani expressed that she was aware of the layers of complexity that come with her position as a queer, disabled, Māori wahine (woman), even before she began working in the sector. That being, as she has experienced the intersecting discrimination of racism, sexism, heterosexism, and ableism in other aspects of her life, she expected that this would be no different within the employment space—which has indeed been the case. However, I think it is also important to note that while she has described negative treatment from others based on who she is, this also uniquely positions her to support people who share these experiences and marginalisation, prioritising their needs and not letting one thing (e.g., mental distress) discredit their experiences of violence. However, in reflecting how the prioritisation of equity is not important for all people who work with survivors, Ani described that it is other people’s inability and even blatant unwillingness to work with all people that leads to poorer support, supporting the sentiments shared by Natalie. Her experiences also support findings of previous Aotearoa New Zealand research whereby sexual and reproductive health workers felt sexual violence against disabled people was not their issue to worry about, or, that it was not an existing issue whatsoever (Hager, 2017). Throughout our conversations, Ani's strong stance and passion for equity was clearly apparent, with her questioning why someone could ever be disbelieved or deemed less worthy of receiving support because of who they are. I see this as a further demonstration of how people who have experienced their own marginalisation are uniquely positioned to support others who share such experiences, valuing all people no matter their identity or experience:

> Ani:
> People with mental health issues are more likely to feel a lot more vulnerable, but they also present in a different way. So they might present as angry, or violent, or abusive, or drunk, or whatever way, and it is like well, that may be part of it. But I think what somehow precludes them from any assistance, is [people thinking] wow this person's file [history of previous contact with service], or this person's angry, or this person's a meth addict, but you know… all well may be true, but I don't understand how that somehow means they don't need this assistance. And a lot of the time it is our Māori people who are presenting this way because of all the reasons, all the reasons… [trails off; alluding to causes of Māori inequity], and they do have mental health issues, but it doesn't mean they haven't experienced domestic violence, it doesn't mean they haven't experienced sexual violence. I feel like in some cases people are quite dismissive, or very reactive, especially if it's like someone Māori, or Pasifika, and maybe with some communication issues.

In what I deem an incredibly sad reflection of our shared reality, every respondent that spoke with me described that their clients experience discrimination and/or that they have experienced it as survivors themselves. While this did not come as a surprise, it was disheartening to hear how normalised this was for respondents and survivors alike; making me now ponder whether such disclosures would be as shocking to those who have never been socially marginalised, or whether they live in blissful ignorance.

Whether the dominant group is aware of this or not, these discussions reflect the findings of previous research demonstrating the presence of widespread individual, social, and cultural barriers when accessing support; which not only prevent equitable access but allow abuse to permeate (Findley et al., 2016; Hunt et al., 2021; Plummer & Findley, 2012). In a poignant example that describes the extent of oppression that survivors face, Natalie explained that working with the impact of discrimination is *almost always* part of her therapeutic process. She eloquently described how the negative effects of sexual violence and discrimination are forced upon the survivor, reflecting their lack of control over the situation. Yet, in countering this harm, the fault should remain with the person who was sexually violent and the dominant group that maintain these oppressive practices.

> Natalie:
>
> I feel like so many of the conversations you have with clients are about shitty situations they've had where they've been discriminated against, or there's been barriers put in the way for them. A lot of the conversations I would have would be about empowerment, and again that self-worth. I try to show people that they are worth it, and that they're not the one with the problem; it's actually these other people with the problem, who are trying to put it onto them.
>
> I really see abuse as like that. There's the initial thing that happens, which is abusive; but then the abusive person actually leaves this horrible feeling of shame and blame with the person who has been abused. I almost feel like it's a twofold thing. I feel like, again, with discrimination and things like that, it's almost like the shame has been put on the people who are being discriminated against, where the shame needs to go back to the people who are discriminating against that person. Again, it's the power and control thing.

While Natalie did describe seeing advances happening in some areas of sexual violence service provision, much like the findings of Robson (2016) and the United Nations (2017), she did not see such progress being made in the disability space. She mused whether tackling embedded ableism to work equitably with disabled survivors is just too much effort, reflecting that wider society is prioritising their own comfort rather than addressing a challenge that can be confronting.

Natalie:

I think if you are disabled you're really at the bottom of the food-chain. I really feel like things haven't caught up with supporting people like that. It's great we've made advances with gender, cultural things and race—all of those things people are really examining in their work and how it impacts what they do with clients. But, I just feel like disabilities, some people don't want to deal with. I think it's something people like to tuck away. I think they can't handle sexual violence and that as well.

Natalie's observations have certainly been interesting for me to reflect upon in the time since we spoke, thinking about the many conversations I have had with friends, family, and academic peers during this project. While many people have asked about my research topic, very few then wish to discuss the details—their discomfort highly apparent. At times I have even found myself skirting around the question to avoid "bringing the mood down" at a dinner party, to avoid that I may trigger an unsuspecting person, or to avoid the hurtful conversations that can ensue when surrounded by those who are not situated in positions where they are comfortable with, nor practiced in, speaking about such issues. I actually feel a sense of shame in reflecting upon this avoidant behaviour now, questioning if my silence is fuelling this issue remaining unaddressed. However, I know that I must also recognise the burnout that I have faced in fighting for an issue so deeply tied to my identity that when this reality is questioned it has hurt to my very core. While many people I have spoken with, talks I have been to, and things that I have read *have* been incredibly thoughtful in their discussions of sexual violence and equity, as Natalie describes, they frequently continue to ignore disabled people as a topic worth mentioning. This is clearly just the beginning of a larger conversation, and one that requires disability allies to carry some of the burden, so we do not make disabled people carry this alone.

1.2 Impact: Historical Harms and Modern Power Differentials

The discrimination experienced by sexual violence survivors with marginalised identities is widespread, and in turn, there are wide-ranging consequences unique to these communities. However, these devastating harms are not a new phenomenon, with respondents often rooting their current concerns in events and systems that have oppressed and marginalised people throughout history. That being, historical and ongoing devastations, such as colonisation, introduced and reinforced power inequities between Māori and the Crown which continue to marginalise Māori to this day.

As two non-Māori women, Natalie and I spoke knowing that we have come to live in Aotearoa New Zealand at the expense of Māori sovereignty, with our whiteness a privilege that offers us power and continues to contribute to Indigenous marginalisation. We shared a mostly unspoken, but at times explicit, discomfort around our positioning as “experts” knowing that for Māori colonisation removed their opportunity for culturally and community led healing, with this replaced by services predominantly run by white service providers who have not shared their experiences. In my own reflection on this topic, racism, more so than any other “-ism”, reminds me how my identities can position me as both powerful and powerless in social standing. That being, while I understand marginalisation in other forms, racism is a harm from which I am protected, with the other side of the coin being that my whiteness has, and does, offer the opportunity to cause harm. Perhaps it is looking up from the bottom in some regards that make the view from the top particularly uncomfortable when I get to be there.

Multi-level inequities—including those of internal, interpersonal, institutional, and structural forms—lead to poorer outcomes for Māori in measures of health, wealth, and social wellbeing (Came, 2013; Human Rights Commission, 2012). Reflecting upon this, and in consideration of the higher levels of incarceration for Māori than Pākehā, Natalie described her thoughts around the higher prevalence of sexual harm both against Māori and perpetrated by Māori (Ministry for Women, 2015). Natalie’s assumptions about the higher prevalence of sexual violence within the Māori community were contextualised within discussions of ongoing colonisation harm and processes, whereby hurt people hurt people, and individual blame fails to capture the entire picture. In turn, the shared understanding between Natalie and I is that Pākehā must remain cognisant of our impact on Māori in understanding such statistics, with race-based blame only presenting more barriers to addressing sexual harm; not repairing those that colonisation imposed in the first place:

Natalie:

I feel obviously significantly sad about it [the higher rates of sexual violence for Māori]. I do think there's probably a big element of the impacts of colonisation in there, and I guess also how people feel constantly put down, or they're not worthy. When people feel like that, you can't always expect the best behaviour from people. If you constantly treat people like shit, or demoralise them, sometimes they just do crappy things. To me that just makes sense.

I think people do things that don't even fit with their moral code; like, I think people sexually harm people who don't actually think that's okay, but they still do it from maybe a reactive space, and their own hurt space–rather than actually thinking that's a good thing to do. I think people are quite good at splitting off those bits of themselves that do those awful things, because it doesn't fit with the rest of who they are as a person and their moral code.

As expressed by Natalie, when violence is introduced into a community—thereby also damaging the systems in place that prevented it and dealt with it—such violence is allowed space to replicate and spread. In the context of colonisation, this has produced a vicious cycle whereby Māori have become disconnected from their whānau, tikanga, and Māoridom, perpetuating further ruptures to the cultural systems and resulting in harm that prevent attempts at reconnection (Human Rights Commission, 2021a). In a direct reflection of how this continues to harm today, many respondents spoke of intergenerational trauma and how this impacts their sense of identity. Ani spoke of sexual violence as pervading her wider family and leading to a disconnect from her marae and Māoritanga, with her carrying the ongoing harms that sexual violence caused within her whānau, despite the sexual violence not having happened to her as an individual.

While not a topic I wish to delve too deeply into in writing, but one that did inform my position in hearing Ani's story and those like it, sexual violence has had an intergenerational impact within my own family. Before I was born, a family member had a partner raped and murdered by a stranger in a horrific, unprovoked attack, by a perpetrator who now remains one of Aotearoa New Zealand's longest-serving incarcerated people. Growing up, for many years the parental over-protection I perceived—such as my parents' unwillingness to allow me to run alone in the local park—was seen as a mere nuisance. It is only with age, knowledge, and hindsight I can now see how that event had ultimately impacted the way my parents see the world, as a dangerous place for their daughter to navigate. While this attack never impacted my own physical body it had flow on effects for me which may, intentionally or not, also impact the way I raise any future children of my own—trauma is an intergenerational river that runs deep.

Ani:

I hadn't realised it but like domestic violence and sexual violence was very much a narrative of my childhood but not of my life, if that makes sense.

Because it was in the generations before mine, so my parents had to—amazing women, amazing women [Ani was raised by two mothers]—they both experienced these things in their lives. So, they were adamant that their girls were not going to. So, I don't have a personal experience of sexual violence. But you know, definitely there's still a little bit of that trauma that goes through intergenerationally.

I think the way it was for us is that although we know our marae we were never allowed to go there, or spend much time there, outside of very restricted visits that included my parents sort of "eyes on at all times". Because their experience of it had been not

> something that they wanted us to be around, which I feel is great from a protective standpoint—we were really protected—but also, I feel there's a big loss that we didn't get to have that, which isn't their fault.
>
> Still now I wouldn't feel like I could just rock up to [name of marae]. It's not the same up north with [partner's] marae, I've been there, but it's not an everyday thing. I guess for some people going to marae would be like going to church, like that regularity. We would never have a normal marae, would never stay overnight at the marae as kids. And it is my option as an adult to do that, but I'm not sure that that's [the culture of sexual violence] completely gone yet. So, I don't know that I would just say to my [young child] "yeah go for it". Unfortunately. I think things are changing though, definitely the idea that that's [thinking it's okay to be inappropriate with children] normalised behaviour. Yes, slowly.

Further exploring the impact of colonisation, Storm reflected on how queerness—namely the rejection of anything other than cisgender, heterosexual identity—was impacted by colonisation and the introduction of Christian missionaries into Aotearoa New Zealand. Amongst the wide-ranging, imperialist harms of colonisation, tauiwi brought with them the Church's heteronormative views against queerness and further harmed Māori who have intersections with the queer world (McBreen et al., 2012). Despite the length of time that has passed since the arrival of European colonisers, the impact of this racism and heterosexism continues to be harmful for Māori to the present day (Human Rights Commission, 2021a; McBreen et al., 2012). The forbidding of takatāpui and/or queer identities precipitated knowledge gaps in the experiences of Māori tūpuna, alongside difficulty understanding whether the actions we *do* know about represented their true individual values, or instead reflected those imposed by the hegemonic group (McBreen et al., 2012). Storm spoke of the work being done to re-empower queer Māori, imparted through shared intergenerational knowledge that demonstrates how queerness is intrinsically linked to, and accepted within, te ao Māori:

Storm:

I would say there’s quite a number of layers to that [existing in the queer space and the Māori space]. I guess when you normally think of colonisation and coming through that, we think of a lot of narratives of Christianity that came through and was strongly indoctrinated within te ao Māori, because of the missionaries that were coming over. They were obviously wanting to implement their own faith on society, as a form of control. Then we suddenly have a universal religion, and then we’ve suddenly got a basis on which we can hang all our belief systems off and not see contrast, but instead see unity.

I think we’ve had a little bit of a renaissance within sexuality and gender identity among Māori communities. Thinking about the work of Elizabeth Kerekere, she’s done some really phenomenal work on bringing the language and making that more accessible to us, and showing where queer identities fit within the Māori culture historically; particularly thinking about pūrākau (Māori legend, historic stories) and thinking about those sorts of stories that get passed down, and where we see shifts from what we might consider to be dominant sexual and gender identities, particularly with thinking about takatāpui, which is quite a universal term now.

Similar sentiments were reflected by Mele around Pasifika cultures and who holds power to impart and legitimise knowledge. As comparable to Māori, European colonisers introduced religion into Samoa which conflicted with traditional tribal practices that were more liberal towards sexuality (Totua, 2020). Religion introduced rigid rules whereby women must be modest, and men hold the power within families and villages, ultimately making sex an entirely taboo subject. In modern times, Samoan survivors raised with these religious sentiments describe deep feelings of shame, guilt, and self-blame following sexual violence, for which they were not at fault (Totua, 2020). As Totua (2020) described, her own experience following sexual violence became a “grieving for my purity, a process that was reflective of the entrenched attitudes around sex in Sāmoa” (para. 23).

As both a Samoan woman and service provider, Mele reflected upon the need to balance respect of the Church and its practices while also challenging the harmful views around sex and womanhood that are detrimental to Pasifika survivors. As further layers of complexity, women hold less power within the Church and the Samoan chief system, which both remain largely patriarchally informed. She explains that within the modest and patriarchal views of the church, survivors have few approachable avenues for support and providers face barriers to making any meaningful change, with both survivors and providers being predominantly female and needing to appeal to male decision-makers.

In hearing Mele describe this, as well as the experiences of survivors navigating their right to support when their religious beliefs may foster self-blame, I found myself admiring the strength and self-control this must involve. As a non-religious person, when I have fought for survivors it has never been in conflict with something I cared about, and yet—even with fewer barriers to navigate—it has not been smooth sailing. I expect that the internal discord that comes with these two conflicting realities must be so incredibly difficult, and only truly understood by those who live it.

Mele:

It’s really hard. The Church plays a massive role in Pasifika culture and because of church and cultural traditions, consensual sex or just sex is not discussed openly, let alone non-consensual sex. Sexual violence is quite a taboo subject for Pasifika people and it can be hard to even start those conversations outside of the family. You could talk to a family about it and they could talk to their extended family, but it's not easy to openly discuss this with community groups. There have been times when [sexual violence prevention] groups have reached out, and these are Pasifika people going to Pasifika people, and they were not well received by community leaders. A lot of the leaders in the families and churches are male and access to their communities is through them. This can be difficult when

> protocol restricts sensitive conversations between men and women and especially when most of the leaders are men and our workforce is predominantly women.

The power and control that is displayed in some religious practices can be considered a clear example of patriarchal power in modern society (Obelkevich & Roper, 2013). However, examples of embedded patriarchal systems exist in many spaces, yet are less acknowledged, despite their ability to harm those unable to be powerful under such systems. Within the context of sexual violence, autonomy is stripped from the survivor, who then may have to navigate systems of power such as the criminal justice system, medical system, and even wider support services (Kingi & Jordan, 2009). While each of these spaces should prioritise a survivor’s autonomy, the person must still navigate systems and processes controlled by decision-makers other than themselves.

Speaking as a survivor of sexual violence, Aila described learning that their previous medical professional had been grooming and sexually assaulting his patients, particularly those who had mental health difficulties or other perceived vulnerabilities. This was a case with much public interest and was publicised widely in the media, a tough experience for Aila not only as a stark reminder that sexual violence can impact any of us in any space, but that disabled people can have increased exposure to sexual predators owing to our higher healthcare usage. Even while not directly abused by the medical professional, the breach of this supposedly safe relationship still led to adverse outcomes for Aila and their wellbeing. Aila further reflected that accountability is often lacking in situations such as this—where the perpetrator is someone held in high community standing—which reinforces systems that continue to prioritise the wellbeing of the powerful and ignore the needs of those stripped of their power.

> Aila:
>
> That just felt so close to home for me. It was like, ‘Fuck, if I hadn’t have transferred when I was 12, 13, 14 or whatever, would that have been me?’ I just wept and wept. It was just so awful. I was so angry, like *so* angry, that somebody could use such a sacred position of intimacy, safety and community to do that to people. Honestly, it was like a train hit me and just sent me out of my body for a few weeks. It was so terrifying. I had a pap smear soon after that. And, I’ve never had problems with pap smears, never had an issue. It was a woman and I cried. It really affected me. I kind of challenge it—I’ve got a male doctor and he is amazing. Almost every appointment I’m conscious and I’m looking out for the signals and I’m worried. He’s really lovely and quite warm, but sometimes I’m like, ‘Argh, too warm,’ and I get kind of spooked. I think it's going to affect me forever probably, just that having happened and knowing that men hold positions of power like that in society and get away with that kind of shit.

Similarly, Natalie described elements of power and control that proliferate in various forms for disabled people, including within medical settings. These situations include the dynamics between personal assistance providers and disabled people, the disbelief that disabled people are sexual beings, and the autonomy for disabled people to make their own choices regarding sexual and reproductive health (Powers et al., 2002; Robson, 2016; United Nations, 2017). She reflected on the reproductive rights of disabled people to have children—i.e., that many people think they should not—as well as the hegemonic beliefs of disabled people as undesirable and thus unrapable; as has been described for other marginalised people, e.g., fat women (Royce, 2020). Notably, she reflected that such harms occur as rejecting the sexual and reproductive rights of disabled people is beneficial for the *carers,* not for the disabled person. This adds explicit consideration to the findings of previous research that reflects people do not want to care for disabled survivors (Hager, 2017), in that it is not only a devaluing of disabled lives but also stems from prioritisation of their own needs over those of the disabled person. As many service provider relationships are vitally important for the day-to-day lives of disabled people—support that many will require for their entire lives—the abuse of this powerful relationship is particularly harmful, with disabled people needing to continue with such processes even if prior experiences were traumatic for them:

> Natalie:
>
> For people with disabilities and stuff like that, when I worked in that area, I really found a lot of the caregivers didn't want them to connect with other services, or talk about what had happened to them… Often, whoever was caring for them, didn't want to deal with it, and kind of wanted them to shut-up about it. So, they'd kind of discourage them from talking about it to people.
>
> I feel like there can be these strange power dynamics that exist between the person who's caring for the person with the disability. Sometimes I wonder if they resent caring for that person sometimes, and they just don't want to have to put extra effort in. Or, they're embarrassed by their lack of being able to protect or care for that person, to have prevented that from happening. Their own shame.
>
> I've often pondered that too. I'm like, if you care about someone, why wouldn't you want them to get the best support, right? I feel like a lot of the people I worked with, with a disability, the people who were caring for them, it was kind of in a begrudging way.
>
> I get so upset about this *[tearful].* Also, people can feel scared of thinking that there's anything sexual that ever happens to people with a disability. Like, there's something about that, that they can't quite… get. Like, I feel for a lot of my clients, there was this fear about them having sexual relationships. I can understand you worry about what could happen, what if this person gets pregnant and how would they take care of the baby or whatever. But, they still are sexual beings—people are, right? So then is it okay to deny

that part of someone, just because you're uncomfortable with it, or you don't want to deal with it? I found that really hard to sit with.

I had a client who really wanted to have a baby but was being told by aunty that she would never be able to have a baby because of her disability. She would have made a really great mum. They were worried about guys taking advantage of her and stuff like that, but some of the stuff they'd say to her just made her so fearful of guys. It wasn't even founded. She had experienced sexual violence, but that had been responded to and the police had been involved. She'd been protected. I kind of felt like they just fed in more to that fear, and then they stopped her from feeling safe in herself. She would feel quite gross when a guy even just looked at her on the street, which then would make her feel awful about herself. I don't think that was good for her in the end.

Then also people telling her that she can't have a baby when she really wanted a baby. I imagine that would just be gutting. Taking away the choices and not even recognising that they [disabled people] can be sexual beings, often denying the sexual violence, or not letting them talk about it or get the support. This person was then sexually harassed at her day-base. That was really hard trying to get her support for that, because people just didn't want to deal with it. Then they'd say awful things to her like, "Why would anyone sexually harass you? You're not pretty," and stuff like that. Like, horrible shit.

Through the respondents' accounts of modern power differentials, it is clear to see how survivors continue to be harmed. However, as a counter-narrative (Andrews, 2004; Bamberg & Andrews, 2004) that differs from the majority, Aila described how they conceptualise their family's intergenerational trauma as a way to draw resilience in their own life. I like to consider that narratives like this—that reframe the negative experiences that were meant to harm them—as an act of defiance, as an ultimate reclamation of stolen autonomy. This is not to diminish the experience of those who struggle to be strong in the face of adversity; instead, I see it as a collective act of resistance for all survivors. Being able to continue living in the face of unthinkable tragedy, no matter what that living may look like, reflects the immense strength held by survivors.

Aila:

One of the things that has been quite central to my healing, I think, in the last year or so, has been to think about things like all of the people that survived for me to be alive today, and how meaningful that is. How many people in my whakapapa are rooting for me. So, when I do have those kind of suicidal thoughts and things like that, that can be a real anchor to be like, "Hang on, we're survivors. I come from a real chain of survivors. Like, we've survived some pretty crazy shit." I do find that really comforting.

1.3 Barriers to Equity: It's Not Me, It's You

Widespread barriers for disabled survivors were discussed by survivors and service providers alike, with these not being factors intrinsic to the person but rather imposed by society's inability to accept non-hegemonic ways of being. Natalie spoke of disabled survivors being discouraged from reporting violence in the first place, owing to the uncomfortableness of the situation for their carers; a further example of gatekeeping as described by The United Nations (2017) and how this perpetuates harm. She spoke of the accessibility needs of her clients when engaging with services, such as their ability to travel on public transport and having the energy to attend appointments. I related a lot to Natalie's story, having experienced these barriers both in my own life and when working with disabled survivors, such as the Deaf woman I spoke of in my prologue and Hannah (pseudonym) who I speak of in my case study to follow. While physical accessibility barriers such as these have been explored in the Aotearoa New Zealand context previously (Robson, 2016), Natalie's reflections are unique in that they consider broader barriers that exist outside of the violence services themselves yet can equally limit access to these services. For example, she described the need for employers of disabled people to allow them some flexibility in their workday, considering the extra time and difficulty disabled people have when navigating an inaccessible public transport system.

> Natalie:
>
> I guess the physical thing is definitely hard, like the client I said who her employers were dicks. For her, when we were initially at the first stage of setting up an appointment for her before she came to see me, we had a lot of conversation about her mobility and how she would get here, and what time she could get here. Usually we don’t see people after five, but I knew for her it would be really hard for her to get out of work, walk to a bus, get on a bus which could be really busy with pushy people, get off the bus and then walk here. I said I would be happy to see her a bit later. So, I made the appointments later, so that she could have time to get there. That was something for her, because of her work; but, also combined with the fact she couldn’t actually just physically rush anywhere.
>
> I think she had been having trouble trying to find a place [for support] she could get to within those hours, if that makes sense. I’ve had clients with injuries and stuff like that, but usually I just try and be flexible, or make them comfortable in a space.

Previous research has described how disabled survivors often face situations where embedded power structures prevent them from exercising autonomy (Robson, 2016; Sins Invalid, 2017). Storm, who is hearing impaired, reflected upon the power that service providers have to make spaces accessible—or not—for their clients. He shared a story of working with a Deaf and blind client. He described how, if he had been unable to meet their accessibility needs, the support process would have served no purpose, which, in turn, may have left this person without support at all. I believe Storm’s narrative here is incredibly pertinent, reflecting that an inaccessible space is the fault of a *provider,* not of the survivor; in a reflection of the social model of disability (Hughes, 2010). While the social model of disability is gaining recognition, I would argue it is still predominantly only understood—or held as important by—those who live with disability themselves. Thus, I ponder whether it is

Storm's insider-status that allowed him the foresight to consider these needs of his client in such a meaningful way, and I anticipate I would not have garnered an equally thoughtful response from most non-disabled providers.

> Storm:
>
> I can remember working with a client and she was Deaf and blind. She came in and she could hear with a special hearing aid, but you had to be really close to her. Normally what I would do is position myself across from the client I'm working with, but actually during that session I just went and sat next to her, so I could speak into her ear, to make it easier for her to hear. Things like that. Just recognising if I'm not communicating with you effectively, then what's the point of us even being in the room right now.
>
> I think it's important to afford space for accommodation and adaptability. With some clients that I've worked with I offered shorter sessions to accommodate the fact that it is quite laborious. For one particular client who had chronic fatigue, I offered a phone consult, because I didn't want to have them come into the office, because that would use up a lot of their spoons[11] for the day, and they needed those spoons to do other things. So, I did phone consults for them. I go to clients houses as well, who find it difficult to leave their space in order to meet me at my office; so I do home visits as well.
>
> I think the best thing would be acknowledging the barriers and just going in and not be so hesitant to accommodate. A lot of people will just make the appointment and then they ask the person to come in at the same time. I like to ask what would work best for them? How am I going to be able to meet your needs in the easiest and most convenient way? So,

---

[11] The spoon theory is a conceptualisation of disabled people's energy and ability on a given day, whereby they have a set number of "spoons" which are then used up during their day-to-day tasks.

> they’re not scared. It is time consuming to have to go to a client’s house, but it means that there’s more of a better therapeutic process in the end.

As queer survivors of sexual violence, Rachael and Aila both described experiences of support that were inappropriate. Firstly, Rachael spoke of waiting a year to seek psychological support which reflects the lack of importance placed by the Aotearoa New Zealand Government in making support available to those who need it, a reality that the Mental Health Foundation argues is remaining unaddressed (Foon, 2021). This is something that, as a current mental health service provider, I am now on the other side of as part of my everyday reality. I work predominantly with disabled clients and I am forced to turn away more referrals than I can accept—while knowing that local private practices are so full that they have closed their waitlists—leaving highly distressed people not only without my support but without any service’s support. This truly goes against every fibre of my being, yet I remain just one tiny voice in the calls for change that do not seem to be making progress fast.

Unfortunately, when Rachael did finally access support, she shared her experience with a psychologist who did not understand the term queer and inferred inappropriate—even harmful—conclusions from their ignorance. It is incredibly discouraging to hear that Rachael experienced this, with her lived experience adding further weight to the findings of Dickson (2016) whereby queer survivors avoid support services for fear of discrimination, with some having their queerness blamed on their abuse. I am ashamed that such poor treatment would come from someone of my own profession. When Rachael was telling her story, it was clear that this was with me positioned as a listener, but one who is a clinical psychology trainee. She shared this with the understanding I would take her experience away as a reflection of poor practice, with the hope of me making positive changes within this profession.

Rachael:

When I moved to Wellington I was on the waiting list forever- 12 months, I think. The first person that I saw, I was just hoping that she was going to be good. She was this really glamorous French woman. I think I said, just in passing, that I was queer. She was like, "What does queer mean?". "Queer – it means that I don't necessarily identify with specific gender, and I don't necessarily identify with specific sexuality. I like queer. It's ambiguous. I'm queer." She said, "Oh you're a lesbian." I was like, "I don't mean lesbian, but let's just shelve that for the time being," and then I continued talking about what I was looking for, and what sort of work I wanted to do with my post-traumatic stress disorder. She kept saying, "Do you think it has something to do with being a lesbian… so you were raped by a man, does that affect your sexuality?…"

And, so I'm just like, 'Nah. There's too much self-directed learning that needs to go on.' It was because she was so confident as well. Like, I was a book that she hadn't read.

Rachael's story demonstrates how ignorance can lead to harm, with knowledge of specific communities as necessary for accessibility as any physical supports may be—a sentiment initially also shared by disabled lesbian women speaking to Hunt et al. (2006). Not only that, but when such ignorance is not addressed with an attempt to upskill and remain community informed, I would consider this unsafe and unethical professional practice. While perhaps a harsh critique, Ullman (2014) established that many service providers are already aware of the gender and sexual orientation biases that exist within services, and with this understanding in mind, I see this continued poor care as an intentional disregard rather than an oversight. Likewise, Aila spoke of a therapist who was not only unhelpful for them but who led to a *worsening* of their wellbeing overall through not considering how specific therapeutic modalities may or may not be suitable for individual clients. This is a stark reminder of why individualised support must be available, with no two experiences ever identical.

Aila:

Then also in the therapy room, I think with people that are prone to disassociation and trauma, you do have to come at it from a really different angle. She did a couple of things that made me real uncomfortable. She would leave heaps of silence and just kind of look at me and wait. It made me feel really unsafe and she wasn't especially warm. She was really into dissociation, every few minutes she'd be like, "How present are you? Rate it out of ten." It would just make me dissociate more, because I just felt so observed and on the spot.

So that didn't go very well, and of course when we tried to start talking about trauma, I actually had this massive response and kind of regressed, like into my little kid-self almost for a week or so, and just became really not all good.

Experiences of being misunderstood and mistreated appear to have the ability to reinforce the harms of sexual violence rather than ameliorating them, in another example whereby poor outcomes are a direct fault of someone other than the survivor. Rachael described how, when she was not listened to by her psychologist, this reinforced the feelings of self-blame that she had developed following the violence against her. Previous research has demonstrated the commonality of self-blame when seeking support services, even dubbing this a second rape and describing how this leads to the objective worsening of health outcomes (Campbell et al., 2001). I am saddened, yet again, that support can lead to *negative* outcomes more so than just failing to help. It is incredibly vital that the support system do better to assist survivors on their healing journeys.

Rachael:

I don't know if she was just ticking boxes or whatever, but I never felt like I was listened to. During that year I realised how triggering that would be, to feel that I wasn't being heard, and how that would then be a recurring theme since the assault. I felt for the longest time it was my fault and I'm clearly not communicating externally as best as I could and as articulately as I could, so it's my fault.

From where I sit now, it is hard to know what the answer is to improving survivors' access to appropriate support. Perhaps it is more workers with an insider status; where more disabled providers like Natalie and Storm could allow a better understanding of accessibility; a queer therapist may have better understood Rachael's identity; and a provider with a history of their own mental distress may have better identified they were harming Aila. Respondents in previous research have argued that general compassion and effective counselling skills are what is needed, rather than insider-status (Hunt et al., 2006), yet how do we help people to understand the intricacies of marginalisation when society continues to suggest that doing so is not worth the time? Perhaps greater representation within the support sector is the answer to changing *wider* understandings of diverse communities and creating societal-level change that sees everyone as equal, rather than just for upskilling service providers. Overall, what is clear from these narratives is that is that there is no easy answer, but that change needs to happen.

1.4 Access to Services: A Gendered World

A common element coming from survivors' and providers' stories is a sense of "man-hating" that was passed down to them by family who had been harmed. While born from lived experience for many, for others, such attitudes likely stem from a resistance to patriarchal ideals and early, more radical feminist practices. However, this narrative exists alongside the increasing awareness that men are also impacted by sexual violence, leading to a dichotomy whereby the men who need support cannot access it (Donne et al., 2018).

Ani spoke of how “man-hating” impacted her upbringing, the way she looks at society, and in turn, the way she chooses to raise her children. However, she also spoke of actively challenging that belief—a resistance to the dominant narrative proliferated within society, creating a counter-narrative more reflective of her experience (Andrews, 2004; Bamberg & Andrews, 2004)—and the way she grew from such reflections to raise children that she is proud of. In reflecting upon this, “man-hating” is something I have navigated in my world as a service provider, especially when working closely with survivors. Hearing multiple stories a day of women’s experiences of being harmed by men was often incredibly difficult and altered the way I looked at the men around me. Like Ani, I have had to actively resist these narratives to be able to walk alongside the many wonderful men in my life who are indeed amazing advocates for women, and to counter the narrative that all men are rapists. I see the active dismantling of these beliefs as vital if we are to acknowledge male survivors and give them the appropriate care that they deserve.

Ani:

My biological mum, she experienced that whole family experience—violence, and that’s both domestic violence and sexual violence—in just a crazy level from early childhood right the way through to adulthood. And that was always in the background, we knew that, just because my parents wanted us to have an awareness. Maybe it was a little bit of a hyper-awareness. It took me a long time to realise not all men were rapists, because that's kind of how we were brought up a little bit.

So I did have that, I know how much it had affected my parents and the decisions that they made, and the decisions that they tried to make for us, but I also saw how those decisions, while I wasn't personally affected by sexual violence- I realise that it sort of factored into how I looked at society as a whole and how I brought up my girls, and how I wanted to bring up my girls. It was about reining-in some of that man-hating thing. But making them conscious of their place in the world, and their allowing to be in the world,

> and consent, and all those sorts of questions. My parents with their influence, and then me with my influence, and then now we have these amazing confident girls who are pretty much out there waving the feminist flag but love their dad and all that sort of thing.

Storm, who as a gay man experiences life in many ways differently to Ani, also spoke of themes of man-hating, but more so a distrust than hatred. As a cisgender man himself, it is particularly pertinent that these thoughts exist even for Storm, who—as he acknowledges himself—holds privilege owing to his gender. However, I think that what is important is his particular identification of men in *authority.* This reflects that although most men are more powerfully positioned than women, men who identify with other marginalised identities and/or have been impacted by violence are not afforded the same opportunities to be powerful. Thus, they are subsequently deemed as more trustworthy and safe by other marginalised people:

> Storm:
>
> My mum, me knowing of the sexual violence that she went through, and having that modelled to me as a distrust towards men, I've always had a distrust towards men as well – particularly men in authority. I don't really trust men in authority. It's a pretty global rule for myself. That's a really black and white way of stating it. I do obviously have a lot more nuance, but as a general rule of thumb of myself, I don't trust anyone in authority. I feel more comfortable around women. I feel safer, so I tend to keep my circles mainly around women. I think it runs true for my mum as well, because of the violence that she experienced.

Aila described explicit memories of being actively warned that men would harm them, but also how their own experiences of violence have heightened this worry and distrust. The impacts of this are wide-ranging, presenting as difficulties in working with men as a service provider and hypervigilance in everyday life. Beyond my earlier reflections of being a service provider in relation to how I position men in the world, Aila’s experience has made me reflect upon the #MeToo movement and the impact of feeling unsafe within the workplace. As explained by many strong women before me, feeling unsafe at work stretches far beyond being physically violated by a colleague or boss; more than a snide comment; more than the immediate moment (Kessler et al., 2020; Wexler et al., 2019). When sexual violence is deeply embedded in our society, a distrust and sense of unsafety can be triggered by “seemingly innocent” (to the person causing harm) acts.

Aila:

Like I said before, it's [the way their mother was harmed by men, and Aila’s own experiences of sexual violence] really affected my relationships and my perspective on men. I always say I’ve got a ‘guilty until proven innocent’ attitude with men. I don’t trust them. That’s hard in my work. As you know I’m a mental health provider, in a number of ways. I have to really work with that.

It's complex feelings. It's not just like, ‘I’m angry,’ but it's also, ‘I’m threatened, or I’m scared, or I’m angry, or I’m all of them.’ My fucking radar for stuff is just so up high. Even the other day, I was working with my supervisor. I was out in a [shared space] when I laughed and I snorted. Then, when I went back into his office, “Was that you snorting out there while you laughed? That’s adorable.” I just bristled. I was like, ‘Fuck, what does that mean? What do you want from me?’ It was just like immediately this shift into, ‘Am I unsafe?’

Then I had to kind of talk myself down and go, ‘Look, it's probably just friendly,’ but there’s always that thing in the back of my mind of like, ‘No, it might be a predator. Watch out.’ I guess that’s one way it affects me. And, definitely there’s anger there. And, a protectiveness— particularly around younger women.

It is undeniable that the powerful roles men hold in the workplace—statistically much higher than that of women—contribute to the frequency of sexual abuse in this setting and to poor handling of abuse complaints (Wexler et al., 2019). Rachael described the experience of being sexually assaulted by one of the highest positioned men at her workplace and how his privileged position, compared to her role, prevented her from receiving adequate support. People did not intervene despite being present; she was told she was blowing things out of proportion owing to an earlier experience of sexual violence; her power to decide what happened following the assault was stripped from her to protect his anonymity; and she had little friend or familial support. She reflected upon how her friends' privilege acted as a safety net that Rachael did not have—much like Natalie's earlier discussions whereby those who do not need to be aware of sexual violence in their world will happily remain ignorant—with it finally taking a friend who worked in the sexual violence sector to intervene and stop her from ending her life. It seems to me that all parties other than Rachael herself were protected following the event that harmed *her,* demonstrating how power can be used to strip autonomy and agency from survivors of lower comparable social standing.

Rachael:

It was a whole day of drinking and I just remember this cold feeling, and 'He's not listening to me. Not any part of what I'm saying is registering in his head right now. All my colleagues are seeing what's going on right now. They're seeing that I'm not having fun, hearing me tell him to stop and they're not doing anything. They're watching and enabling.'

Then began this big internal process where directly above me my supervisors were mostly male, apart from one female, but the female over-compensated. She told me that I was just quite sensitive. She said, had I not been raped earlier in the year, I wouldn't have gone forward with this internally. That was the end of my career at that particular workplace. I would just have panic attacks whenever he was around.

> I wanted the choice [about how she told her story] and I guess, had my outside of work friends been a bit more receptive, or open to having a conversation… because, it seemed like they didn’t really want to hear about it either. I look back it now and all my friends at that time, their parents were doctors and there was just a different level of risk. There was a sense of security, I think, for a lot of my peers at that time, that I really only noticed in retrospect. Like, if they mess up, or something goes wrong, they’ve actually got that support. If they lose their job, or if something happens. Medical costs, start-up/education costs... living allowances get paid.
>
> Essentially, I had to leave my life in [city]. I had a nervous breakdown completely. None of my friends [there] were supporting me whatsoever. My friend who works at [sexual violence service in another city], he came up to [city] and said, “How about you don’t remove yourself from the world, and you just remove yourself from [city].” He flew up and packed up my car with my cat and all my belongings, and we drove down the country. He effectively saved my life.

A fear, hatred, and/or distrust of men is uniquely positioned within the world of sexual violence, where men are most commonly the perpetrators of harm yet also experience sexual violence themselves (Donne et al., 2018). This presents a dichotomy whereby the additional power that men are afforded through patriarchal social structures also then prevents them from being thought of as legitimate victims who need support. Here, their male privilege prevents access to spaces and support, whereas in other settings this allows additional access not always available to women and non-cisgender men.

Within this gendered understanding of men not being victims of sexual violence, anyone other than cisgender female survivors historically have not had the same access to sexual violence services (Dickson, 2016; Donne et al., 2018; Veale et al., 2019). In speaking with me, this trend was reflected by multiple service providers who described that the feminist roots of their organisations mean that male and transgender survivors continue to be unwelcome, or had only recently had spaces made available to support them. This reflection came from respondents of many genders, including men, women, and non-binary people, demonstrating the issue is not one solely perceived—or held as important—by men themselves. Joey spoke of how men had previously been unwelcome at her organisation but that things are changing, albeit cisgender males continue to be unwelcome for the most part. I think this is interesting, as while it does acknowledge that women and other genders are more frequently impacted by sexual violence than men, this continues to reinforce the narrative that cisgender males are solely perpetrators, never victims, and cannot seek support following sexual violence.

Joey:

Initially our agency only worked with women. It was a woman only space, but obviously times change, we weren’t comfortable with that. Like one day, in our old building we had women only spaces signs everywhere, and I went out to the lobby and there was this guy with a pushchair, and I was just like, “Oh, do you want to come in?” and he goes, “Oh no, I can’t,” and he pointed to the sign and I was just like, “Oh, hang on.” And I just took the sign down, said, “Come in, have a cuppa,” and then I went into [name] who was the coordinator at the time and said, “I’ve just taken down the women’s only space sign,” and she was like, “Good, take them all down,”. That was huge, like our governance group had been… it was really hard fought space, it was really important at the time [to the governance group] that it was women only.

So it involved big discussions about changing it. So now we are primarily women and gender minorities, so anyone who identifies as any way other than a cis male we can work with. That’s pretty much us really. We’re just kind of growing slowly and it’s been amazing this last couple of years.

While Natalie’s organisation does at times work with men, her experience is that the sector continues to be fraught with issues for male survivors. She reflected upon the ideals of modern feminism whereby women should be held as equal alongside men, rather than any attitudes of man-hating that prevent men from accessing services when needed. She framed the exclusion of men from sexual violence support settings as a form of violence in and of itself. In her experience, the dominant narrative of men as perpetrators has meant that even when services *are* available, men do not feel welcome, even feeling like “criminals” for accessing them. When they do access services, she described that many men do not have the emotional vocabulary to voice their experience, reflective of a machoistic culture that devalues men talking about feelings (Donne et al., 2018) whereby men cannot be emotional and are thus uneducated and unpractised in doing so. In this way, the dominant social narratives are not only preventing access to support services but are then making healing difficult for male survivors within those spaces.

Natalie:

I still think there’s some gender issues. Coming from a feminist perspective, where it's “I don’t want to work with men, and also don’t want to work with anyone who’s trans”. They will only want to work with someone who was born biologically as a female. I do think there are places like that still around. I know of a few, and that doesn’t sit right with me. I still think there’s that issue.

Obviously, I said before about the impacts of that real old-school feminist approach, and sexual violence and the impacts of that; but, I can also see how that’s impacted male clients. It's hard for men to sit in the space as a person who is usually the perpetrator, but also a victim. Like, often, society or however we are told, you can’t be both. But, again, sexual violence—everything—is really complex, life is complex.

> For a lot of men coming to us, it's really hard for them to even walk in the door. They feel like they're an asshole and they feel like they're a perpetrator. I had one client who would not sit in the waiting room. I would have to go get him outside, because he didn't want to sit in the waiting room – because he didn't want to upset women. I had to do a lot of work around him; like, "You have every right to be here." So, for him, it was really hard, because he knew that he was seen as a perpetrator, but he was also—and sorry, I keep changing the terminology—but also a survivor, in that by being in that space he's never been given the language to be able to talk about what's happened to him emotionally.
>
> I find a lot of male clients go into great detail about what happened to them, because they don't have the words, they can't talk about their emotions. They can't talk about the impacts. Where women will talk about that more rather than details.
>
> It's almost like our ideas in society of men—and terrible ideas about men—has actually silenced them or not given them the ability to even express themselves about what's happened to them. I almost feel like it's an extra layer to the abuse. It's almost like the stigma has created this other layer of trauma for them, if that makes sense.
>
> As a feminist, I find that really hard, because I don't like seeing male clients be like that with me.

In a lived experience of many sentiments shared by Natalie, Storm explained that being both male and gay meant he did not feel welcome in any sexual violence services and thus never sought help from a specialist agency. Unfortunately, this reflects the experiences of gay men in other research whereby respondents felt that they should not seek support because of this dual identity (Donne et al., 2018). However, what was not described as a barrier to help-seeking by the men in Donne et al. (2018)'s research was Storm's description of being cognisant of not taking up space in services designed to support women. I think this is reflective of both Storm's desire to aid those with lower social standing but also an unintentional internalisation of the dominant narrative whereby women are the only "worthy" survivors.

When reflecting on reasons why men might not access services they are entitled to, the dominant social narratives clearly come through in Storm's description; e.g., beliefs men cannot (and should not) be victims of sexual violence and that they are undeserving of support (Donne et al., 2018). Interestingly, previous research suggests that people who hold more powerful social positions are more likely to endorse rape myths of this kind, and men at a greater frequency than women (Gravelin et al., 2017). In his subjugated social position as a gay Māori man these are not beliefs Storm holds himself. However, their proliferation across society means that he still felt undeserving of support because of the mere *existence* of such beliefs. This suggests that male survivors at all levels of the social ladder may be negatively impacted by dominant social narratives that position them as unworthy victims. Therefore, to see meaningful change I believe we must not only work to make men feel welcome in sexual violence services, but work to address the broader social narratives that maintain the patriarchy.

Storm:

I guess for me, within social media and just what we know about rates of sexual violence, we know that it more commonly happens with women. I think for me, there was a sense of this happened to me, but this is not my space to be within.

I had sexual abuse happen against me, but I shouldn't be part of the services that women receive, because I don't want to take their space. I don't want to infringe upon those services, when it's so vitally needed for women to have those services for them. And, I don't want to infringe upon that. So, I think a lot for me was, where do I put myself in order to get the help I need, without taking up space for women who need them?

I think also, and this doesn't run true for me, but I can imagine that some men might frame it as a women's problem, therefore it shouldn't have happened to me. That doesn't run true for me, but I think being a queer male I know there's a lot of sexual abuse that occurs within the queer community. I think I've got that mentality, but I can imagine for maybe someone cisgender and heterosexual that they might think that as well – "This shouldn't have happened to me, this is a women's problem. Shouldn't be something that I have had to have experienced."

I think shame narratives [are highly prevalent] of course. When we think about gender power dynamics, men experience sexual abuse. If we think about really gross social norms about hierarchy and men being on a different hierarchy from women, that perhaps it would be framed or internalised as weakness upon the male's part. "I've been violated and I'm a male and I shouldn't have been violated."

For me, it was maybe I just didn't want to conquer space that should be for people who need it. I didn't know where to channel myself basically.

Joey discussed her experiences working with transgender clients in a service that was not traditionally organised to be able to support them. She described how being transgender leads to unique complexities in how one processes their sexual violence if this occurred when they were living as a gender they are not. Not only that, but as most sexual violence services were designed for cisgender women, accessing a service that is both welcoming and able to meet their needs can be challenging; a finding supportive of previous research (Dickson, 2016; Veale et al., 2019). Encouragingly, Joey spoke of her organisation actively dismantling policies that promote heterosexism and cisgenderism, although wider societal attitudes will take longer to shift:

Joey:

I think it would be really hard if you don’t identify as the gender you were assigned, and if that abuse happened when you were the different gender, then it’s really hard to talk about the healing. And everyone’s different, but we’ve had cases, like a trans man come in and want to be with us, because his abuse happened when he was identified as a woman, or as a little girl, and so it was like for him that healing had to be done, kind of talked about as a girl and to be in a feminine space and so he didn’t want to go to [male only service]. And it’s just about, what do you need? And we’ll just try and do that and be that I guess.

I think it definitely brings up different dynamics and I think the queer community’s really small as well, that often they’ll know other people and it can make it really hard to avoid certain situations. God, small communities!

I think it takes a lot of courage to then come through [our service] and it must be quite challenging for them [gender minorities] in the way that they see themselves as well. At the time [of working with a trans client] we hadn’t quite developed our gender minority, diverse kind of policies, and put that towards our governance group to get approved and stuff, so it was quite early days as well. But, if someone wants to come to us we’ll work with them. We don’t really care what our policy is really. Us on the frontline we don’t care. It’s not for us to turn someone away. If they feel this is the right space for them, then this is the right space for them.

While men would not usually be considered a marginalised group, the gendered understandings of sexual violence mean that male survivors are illegitimatised in this context and I believe do in fact experience discrimination as a result. What is interesting to reflect on is how the combination of other mistreated identities (e.g., being disabled and a survivor) interlink to mean one experiences *additional* harm; yet being male, in most circumstances other than sexual violence, would be protective. What this reinforces is that social standings and treatment of each commonly-marginalised group can change considerably depending on context, with people positioned as more or less subjugated depending on the dominant narratives about who is important in that space. I believe this is important to be mindful of in walking alongside survivors, with each person existing both as an individual but also a person within a wider social world that changes how they understand their experience.

Literature Review Chapter Four:

The Aotearoa New Zealand Response to Covid-19

The following literature review covers the Covid-19 pandemic until the end of 2020, reflecting the state of knowledge that service providers and survivors had when interviews were undertaken. Due to the delay of information being produced while the pandemic continues to unfold, more recently-published literature is included, but only that which is reporting on information relevant to the situation in 2020.

Introduction

Coronavirus disease—henceforth referred to as Covid-19—is caused by the severe acute respiratory coronavirus 2 (SARS-CoV-2), first identified in Wuhan, China, in December 2019 (New Zealand Government, 2022; University of Auckland Public Policy Institute, 2022). Reflecting the fast-growing worry for the devastating impact the virus may have, The World Health Organisation labelled Covid-19 as a “Public Emergency of International Concern” in January 2020 (World Health Organization, 2020) before upgrading their classification to “Pandemic” in March 2020 (World Health Organisation, 2020). By January 2022, almost five-and-a-half million people had died due to Covid-19 worldwide (World Health Organization, 2022), with unprecedented levels of disability among its survivors (Taquet et al., 2021).

Aotearoa New Zealand’s response to the first wave of the Covid-19 pandemic has been endorsed as among the best in the world (Beattie & Priestley, 2021; Binny et al., 2021; Jefferies et al., 2020). Reasons for success include a widespread trust in Prime Minister Jacinda Ardern, a science-led policy approach, the somewhat late arrival of the virus in comparison to other countries, and the country being made up of islands making border control measures easier to facilitate (Beattie & Priestley, 2021; Binny et al., 2021). Daily briefings provided by Jacinda Ardern, the Director-General of Health, Dr Ashley Bloomfield, and other senior members of cabinet assisted the government to communicate their strategy, updates, and clear policy initiatives to the Aotearoa New Zealand public (Beattie & Priestley, 2021). The government engaged in an empathetic communication style, encouraging people to “be kind”, motivating solidarity among the public as a “team of five million” to “fight the virus”—now praised as a key reason why people living in Aotearoa New Zealand adhered to the strict lockdown measures imposed (Beattie & Priestley, 2021). Apparent during these briefings was the inclusion of accessible measures, including Aotearoa New Zealand Sign Language, in the hope of all people living in Aotearoa New Zealand having access to the information required to keep themselves safe (Beattie & Priestley, 2021).

At the height of Aotearoa New Zealand’s 2020 crisis, daily cases peaked at 8.5 infections per million people (Jefferies et al., 2020). Modelling based upon international outcomes now suggest that without the lockdowns imposed on Aotearoa New Zealand we may have seen as many as 31,905 deaths by the end of 2020 (Binny et al., 2021). Instead, the country’s total remained at 25 deaths at that time (University of Auckland Public Policy Institute, 2022).

While the distribution of cases per ethnicity remained proportional to the wider Aotearoa New Zealand population in May 2020 (Henrickson, 2020), more severe outcomes—i.e., hospitalisation or death—from Covid-19 infection were recorded for people aged over 80, those in elderly care facilities, those who acquired Covid-19 in the community, Pacific peoples, and Asian ethnicities when compared to younger, Pākehā Aotearoa New Zealanders, and those who contracted Covid-19 abroad (Jefferies et al., 2020). As the vast majority of cases in Aotearoa New Zealand were in people returning home from overseas, Covid-19 was most commonly seen in European/Pākehā people of higher socioeconomic status, reflecting their financial ability to have been travelling overseas (Jefferies et al., 2020). In community-acquired cases, as opposed to cases in returned-travellers, women, Pacific, and Asian peoples were disproportionately infected; which Jefferies et al. (2020) hypothesised was due to the high numbers of these groups working in institutional settings, e.g., elderly care homes and hospitals. Promisingly, Māori were not disproportionately infected during this first wave of Covid-19 in Aotearoa New Zealand (Jefferies et al., 2020).

Alert Level Strategy

Despite some international criticism, the Aotearoa New Zealand Government decided to implement a strategy to *eliminate* Covid-19, as opposed to *managing* it in the hope of developing herd immunity. Given the unprecedented scale of the pandemic, Aotearoa New Zealand did not have existing guidelines for the management of such an event, instead using established yet insufficient influenza protocols until specific plans could be produced (Jefferies et al., 2020). The New Zealand Government (2022) reported that they created the Covid-19 guidelines based upon developing scientific knowledge and analysis of the overseas responses—having the time to do this was a clear benefit to Aotearoa New Zealand that was not afforded to many countries that became quickly overwhelmed by the virus.

On the 21st of March 2020, Jacinda Ardern announced the Alert System, a four-tiered response for eliminating Covid-19. Briefly, the four levels included Level 1 (Prepare), Level 2 (Reduce), Level 3 (Restrict), and Level 4 (Eliminate/Lockdown), which were cumulative guidelines that permitted or restricted local movements, inter-regional travel, and general contact with others (New Zealand Government, 2022). Different regions in the country could be placed at different levels depending on their current community spread, with inter-regional travel forbidden.

For the purposes of the current project, an understanding of what Alert Levels 3 and 4 meant for those living in them is particularly important. These Levels provided the highest restrictions on movement and connections with other people, the largest work and financial burden, and the closure of services. Due to this, these Levels had the largest impact on people's wellbeing, the proliferation of violence, and access to support. A summary of Levels 4 and 3 are provided below.

Alert Level 4 (New Zealand Government, 2022)

At Level 4, all non-essential businesses had to close. Essential services included supermarkets, medical services (including pharmacies), and petrol stations. Other food providers—not including restaurant or fast food services—could sell uncooked food items, provided they were delivered by non-contact means. All schools and childcare centres were closed. People were only permitted to socialise with their “bubble”, i.e., their immediate household members, with very limited exceptions which could extend the bubble to include an isolated, vulnerable person or someone to care for children if the parents were considered essential workers. All travel, except for collecting essential items or exercise within one’s local area, was forbidden. The reprioritising and rationing of medical services was undertaken, with medical staff redeployed to more in-need areas. In 2020 people living in Aotearoa New Zealand spent a total of 33 days at Level 4.

Alert Level 3 (New Zealand Government, 2022)

At Level 3, slightly more movement was permissible than at Level 4. Restaurants and fast-food services could provide takeaway, non-contact services. Other businesses could operate if they were contactless, with medical services still encouraged to use virtual consultations wherever possible. Working and learning from home was highly encouraged, with schools still closed with the exception of children up to Aotearoa New Zealand Year 10 who were unable to study from home. Inter-regional travel continued to be mostly forbidden, except where special permissions were issued. Gatherings of up to 10 people were permitted for funerals, tangihanga (Māori death services), and weddings. Finally, people at risk of severe illness—i.e., those with medical conditions and/or the elderly—were encouraged to remain isolated at home. In 2020, the Auckland region spent a total of 48 days at Level of 3 and the rest of Aotearoa New Zealand 19 days.

Covid-19 in Aotearoa New Zealand: A Timeline

The first case of Covid-19 in Aotearoa New Zealand was confirmed on the 28th of February 2020, approximately three weeks after Aotearoa New Zealand had closed its borders to non-citizens and residents (New Zealand Government, 2022; University of Auckland Public Policy Institute, 2022). Strict quarantine rules were imposed at the border, meaning that any person returning home to Aotearoa New Zealand would be required to stay in a managed isolation hotel for 14-days and test negative for Covid-19 before their release.

On the 23rd of March 2020, as Covid-19 was beginning to spread more widely, Level 3 was announced which placed heavy restrictions on day-to-day life via a stay-at-home order, commonly termed “lockdown” (New Zealand Government, 2022; University of Auckland Public Policy Institute, 2022). Only two days later a move to Level 4 was announced, preceded 12 hours earlier by a National State of Emergency announcement that allowed the government extra power in determining subsequent actions. The first death from Covid-19 in Aotearoa New Zealand followed shortly after this, on the 29th of March (New Zealand Government, 2022; University of Auckland Public Policy Institute, 2022). Understandably, community fear was high at this time.

Daily case numbers continued to fluctuate for several months, with the country remaining at Level 4 for more than a month, before moving back to Level 3 on April 30th. On May 4th Prime Minister Jacinda Ardern announced there were no new cases that day and Aotearoa New Zealand had successfully eliminated Covid-19, leading to a flurry of international media attention (New Zealand Government, 2022; University of Auckland Public Policy Institute, 2022). The national state of emergency was lifted on May 13th 2020, as the immediate threat of Covid-19 seemed to have dissipated. The country then remained at Alert Level 2 for several months, before new cases emerged in Auckland and this region returned to Level 3 lockdown from August 12th, remaining at this Level until the 30th of August (New Zealand Government, 2022; University of Auckland Public Policy Institute, 2022). Owing to Auckland being the primary point of entry into Aotearoa New Zealand from overseas and being the largest city in the country, it has borne the brunt of the pandemic and spent longer in lockdown than any other region.

Covid-19 and Māori: a Culturally Equitable Response?

Historically, Māori as tāngata whenua of Aotearoa New Zealand lived free from the impact of colonial introduced diseases (Pihama & Lipsham, 2020). However, in relation to the Covid-19 pandemic Mason Durie—a highly respected kaumatua and Māori academic—explained that “This is not the first epidemic that we have endured” (Durie & Naera, 2020, 3:46). Following the invasion of European settlers, the decline in the Māori population as a result of disease and conflict was close to 60% (Pool, 2015). As summarised by Pihama and Lipsham (2020), the impact of pandemics upon Māori can be larger than what they may initially seem. While Pool (2015) argued that the introduction of disease was an unintentional consequence, others such as Walker (2004) suggested this undoubtedly intersected with other inequities making it harder for Māori to survive the further consequences of colonisation, including war. Therefore, these cumulative impacts have been widespread and devastating, above and beyond the health risks imposed by viral illnesses alone.

The inequities faced by Māori during pandemics are longstanding. During the smallpox epidemic of 1913 there were no Pākehā deaths, yet 55 Māori died of the virus (Durie & Naera, 2020). Similarly, in the measles epidemic of 1938, the death rate among Pākehā was 1.07:10,000 compared to 24:10,000 for Māori (Durie & Naera, 2020); and in the 2009 influenza pandemic Māori had a mortality rate 2.6 times higher than non-Māori (Khieu et al., 2017). Having no natural immunity to these imported viruses contributed to such statistics, yet the lack of appropriate medical care, social impacts of colonisation, and the systemic racism that underpins such issues cannot be ignored (Durie & Naera, 2020; Pool, 2015). These inequities have been a longstanding issue and were well established before Covid-19, thus ignoring them as part of Aotearoa New Zealand's response is not reflective of ignorance but blatant unwillingness to protect Māori.

With the arrival of Covid-19 in Aotearoa New Zealand, Māori were acutely aware that an all-inclusive approach designed to serve people living in Aotearoa New Zealand as one population would fail to protect their wellbeing (Pihama & Lipsham, 2020). Durie and Naera (2020) cite that the trends we have seen in earlier pandemics—socio-economic disparities, limited access to early healthcare intervention, and poorer general health outcomes—are reasons to anticipate that Covid-19 would disproportionately impact Māori (Durie & Naera, 2020). Similarly, there is a disproportionate number of tāngata whaikaha Māori within the wider disability community, with disability also impacting Māori at younger ages on average (Human Rights Commission, 2021a). As a result, the vulnerabilities exacerbated by Covid-19 would be missed in a government response that only classifies age as a risk factor in those above 70-years (Pihama & Lipsham, 2020). With an alternative view, Durie and Naera (2020) pondered the possibility that the Māori population's lower average age would be protective, given that older age is a predictor of poorer outcomes from Covid-19 illness. Either way, Covid-19 was not expected to impact Māori in the same ways as non-Māori, making a one-size-fits-all model of care entirely inappropriate (Durie & Naera, 2020; Pihama & Lipsham, 2020).

Throughout history, Māori have had to combat the lack of appropriate Crown responses to epidemics by establishing their own models of care, guided by mana motuhake (self-determination; Pihama & Lipsham, 2020). With the arrival of Covid-19 in Aotearoa New Zealand, a national Māori pandemic response group, *Te Roopu Whakakaupapa Urutā* (Te Roopu), was quickly established to lobby the government to prioritise their obligations to protect Māori under Te Tiriti o Waitangi and the UNDRIP (Pihama & Lipsham, 2020). Since then, Te Roopu have worked to promote iwi-led responses to the pandemic, which undoubtedly contributed to the positive outcomes for Māori during the first wave of Covid-19 where we did not see disproportionate rates of infection (Jefferies et al., 2020). Pihama and Lipsham (2020) grouped iwi-led responses into three key domains: rāhui (temporary prohibition), tikanga (traditional customs), and manaakitanga (hospitality, kindness, support), each contributing to whānau ora (familial wellbeing). Tikanga practices also underpinned the decisions made around both rāhui and manaakitanga.

In reclaiming the language within a cultural understanding, the government concept of lockdown was reframed by Māori as a rāhui, a practice of limiting access that was already ingrained within tikanga to protect or honour people, places, and resources when required (Pihama & Lipsham, 2020). During the rāhui, iwi established protective boundaries and checkpoints between regions to protect people from outsiders who could have brought Covid-19 into their communities (Pihama & Lipsham, 2020), especially in areas that were yet to see Covid-19 infection (Durie & Naera, 2020). Despite these boundaries being designed to protect both tāngata whenua and tauiwi, such processes were not government-funded and were paid for by the iwi themselves. Furthermore, iwi faced widespread criticism, with some calling their checkpoints illegal, failing to respect Māori autonomy in their choice to protect their community (Hurihanganui, 2020, May 1). In 2021, when the Aotearoa New Zealand Police endorsed such checkpoints, David Seymour—the leader of ACT, a conservative opposition political party—went as far as to say that “a group of thugs threatened to break the law and instead of arresting them, the police have thrown their hands up in the air and said – if you can’t beat em, join em” (ACT New Zealand, 2021, para. 4). Even without the blatant discrimination in calling Māori “thugs”, the anti-checkpoint rhetoric represented not-so-thinly veiled racism and a lack of care for Māori wellbeing.

Throughout the rāhui and time that followed, Te Roopu and iwi worked to adapt and maintain tikanga practices while protecting the hauora (wellbeing) of Māori (Pihama & Lipsham, 2020). This meant placing some usual protocols within the rāhui restrictions—e.g., discouraging hongi, a greeting that involves the pressing of noses—and guiding others in novel ways, such as the online streaming of tangihanga (Durie & Naera, 2020; Pihama & Lipsham, 2020). Finding ways to establish connection was vital, as in a reflection of their traditionally collectivist culture Durie and Naera (2020) state, “if whānau are not connected then whānau are more vulnerable” (16:28).

In a difficult decision for whānau, given the cultural significance of remaining connected with the community, and in turn demonstrating the lengths that Māori were willing to take to protect their collective wellbeing, Māori themselves chose to close marae (meeting houses) during the lockdown (Durie & Naera, 2020). Among the processes to promote whānau ora, in prioritising manaakitanga, iwi delivered hygiene and food packages to whānau in need, ensuring connectedness, especially for kaumatua and kuia (elders; Durie & Naera, 2020). While the government eventually contributed NZD$15 million towards these practices, this only occurred after Māori-led responses were already well underway (Durie & Naera, 2020).

While having to change tikanga practices was an unfortunate outcome of the rāhui, allowing Māori the autonomy to decide and direct many of the practices was key to their self-determination. Iwi responses for Māori, by Māori, undoubtedly contributed to the outcomes from the first wave of Covid-19 where we did not see disproportionate rates of infection among tāngata whenua (Durie & Naera, 2020). Responses that place Māori leadership at the centre are vital to whānau health (Durie & Naera, 2020), and Indigenous knowledge must be upheld as legitimate and important.

Moving forward, Pihama and Lipsham (2020) outlined three things that need to guide the government response to improving Māori health equity. Firstly, abandoning the one-size-fits-all approach that neglects the specific needs of Māori; secondly, fixing inequities in the health system by addressing systemic and structural racism; and thirdly, collaborating with Māori at all levels of government, including in responses to broader issues—e.g., economic instability—that disproportionately impact Māori. Failure to do so will likely see catastrophic and inequitable outcomes for Māori while Covid-19 circulates Aotearoa New Zealand, and beyond. There has perhaps never been a more pertinent time to address historical and perpetual harm caused to tāngata whenua.

Impact on Hauora (Wellbeing)

As stated by Jefferies et al. (2020), in the first wave of Covid-19 in Aotearoa New Zealand, Māori did not experience a disproportionate infection rate. However, the lockdown/rāhui had its own impact on individual hauora and whānau ora, which must be considered in preparing for future events (Houkamau et al., 2021). Between April and November 2020, Māori responded to an online survey about their lockdown experiences across multiple Alert Levels (Houkamau et al., 2021). Māori were asked about how the pandemic had impacted them and their whānau, how the pandemic changed us as a society, and what support whānau might have needed going forward.

In responses related to their wellbeing, 25.4% of respondents reported that the pandemic put their relationships under stress (Houkamau et al., 2021). They described feelings of isolation and loneliness, as well as being unable to engage in their everyday activities. The authors explain that some of the most poignant responses came from kaumatua, who were restricted from seeing their mokopuna (grandchildren). One respondent described the symbolic severing of family ties, explaining, “The lockdown has torn into the fabric of our family by us not being able to associate” (Houkamau et al., 2021, p. 9). On the other end of the spectrum, some respondents described that spending too much time with their whānau was also causing tension in relationships.

Encouragingly, 19.5% of respondents reported that their family relationships were strengthened and improved, some even rebuilding previously fraught relationships (Houkamau et al., 2021). Even for the respondents who described positive relationships overall, they still found that the relationships could sometimes become strained, reflecting that this was an issue that was likely happening for the majority of whānau during rāhui. However, overall, spending meaningful time with whānau was a positive for many Māori.

In a reflection of collectivist wellbeing above the individual, many Māori reflected a deep concern for the wellbeing of their whānau, above and beyond their own health. For those who lost loved ones during the restrictions, many reported distress about being unable to attend tangihanga in person, describing that these processes are usually “really huge for Māoridom” (Houkamau et al., 2021, p. 15). Undoubtedly, being unable to grieve for one’s deceased loved ones would have also been distressing for non-Māori, yet the more established rituals involved in tangihanga—described as *The Ultimate Form of Māori Cultural Expression* (Nikora et al., 2010, title)—means that this issue has likely been underrepresented in its impact.

Sadly, 19.65% of Māori reported that they had decreased psychological health, including sadness, depression, exhaustion, stress, and worry during rāhui (Houkamau et al., 2021). Many cited financial stress as an element contributing to this, especially for those with a loss of employment; 9.7% of respondents reported adverse economic outcomes as a result of lockdown/the rāhui. Alternately, 17.1% reported that their mental wellbeing improved, with the time to stop and reflect on their lives and the world, live at a slower pace, and be philosophical about the meaning of life—all cited as beneficial for their psychological health (Houkamau et al., 2021). Notably, most people who reported positive impacts on their mental health were not experiencing financial strain, suggesting this is a critical factor in predicting mental distress.

During the pandemic, the majority of external support for Māori came from within the whānau (58.99%). However, sadly, 31.43% reported they had no support, an unfortunate reflection on how many Māori have been disenfranchised and separated from their whānau and culture. Alongside this, 25% were being supported by government agencies such as Work and Income New Zealand (WINZ) or receiving the wage subsidy after a loss of employment (Houkamau et al., 2021). It is unknown how many others would have benefitted from this help but could not access it.

Thinking about the impacts of the pandemic on broader society, 25.8% of respondents hoped we would see a kinder, more tolerant, and united Aotearoa New Zealand (Houkamau et al., 2021). This large portion of respondents probably reflects that in pre-pandemic life, Māori did not feel this existed in Aotearoa New Zealand, likely due to experiencing everyday racism that continues to marginalise them. Similarly, 10.75% hope we will better connect with nature, with 5.25% wanting us to shift away from individualism, greed, capitalism, and consumerism (Houkamau et al., 2021). A move towards a more individualistic society has previously been shown as a factor in the disenfranchisement of Māori (Human Rights Commission, 2021a), thus it emerging as a theme among these findings further illustrates its ongoing impact.

When asked what Māori need moving forward in Aotearoa New Zealand's Covid-19 response, answers unsurprisingly focussed heavily on equity issues. They suggest that ongoing financial support, such as jobs that pay fairly or wage support for those who lose their jobs, is imperative (Houkamau et al., 2021). Likewise, Māori want support for educating their tamariki (children), in accessing healthcare including mental health support, care for kaumatua and kuia, and more transparent rules around tangihanga and tikanga protocol (Houkamau et al., 2021). Importantly, these are not requests they see as being above and beyond what is already provided to non-Māori, but rather are supports framed as "the same support as every other New Zealander who needs it, mentally and financially if required" (Houkamau et al., 2021, p. 30).

In reflecting on the limitations of the study, at that time only 0.03% of Māori reported that someone in their whānau had contracted Covid-19 (Houkamau et al., 2021). While this is an incredibly positive outcome, it is possible that when this rate inevitably increases, so will negative impacts on the wider wellbeing of Māori, meaning that we do not yet fully know how Covid-19 will impact this community as the pandemic progresses. Furthermore, to date, there does not appear to have been any in-depth qualitative research undertaken specifically with Māori to gather their lived experiences during the lockdown. While statistical information is important and does provide us with an idea of the prevalence of issues for Māori, people's stories provide contextual information that is irreplaceable and should be a priority moving forward in our Covid-19 response.

Disability and Covid-19: Unique Issues

I wish to pre-empt this section with some personal reflection. While this entire thesis has dealt with issues of a highly sensitive nature, as a disabled person living in a world where Covid-19 is still unfolding—yet in a country where thus far the impacts have been minimal—I continue to fear for my safety *(as of January 2022).* The horrific experiences that disabled people overseas are facing are quite unimaginable, and despite my undying passion for advocacy, I had to take time away from this topic to manage my wellbeing. I wrote to our Disability Commissioner, Paula Tesoriero, in early 2020 asking for clarity around whether my life and the lives of all disabled people living in Aotearoa New Zealand would be protected from the atrociously unjust medical triage practices occurring overseas (to be discussed further later in this chapter). At that time, we had no answers aside from her assurances that she would do all she could to ensure our lives were valued. To date, we are lucky that our healthcare system has not been overwhelmed by Covid-19 to an extent that these unjust measures have been implemented. I can only hope that by the time the healthcare system surpasses its capacity, we are more prepared than overseas nations and can be guided by equitable care and practice.

The Impact on Disabled People Living in Aotearoa New Zealand Thus Far

Disabled people have long been classed as "vulnerable" by society, with them quickly being labelled "at risk" of Covid-19 (Perry et al., 2020). However, such classifications are rooted in ableism which fails to value the lives and safety of disabled people, reducing appropriate care, access, and prioritisation of their needs; in turn, *creating* these vulnerabilities rather than them being an intrinsic part of disabled life (Perry et al., 2020). Researchers argue that a failure to recognise and incorporate disability rights into healthcare practices perpetuates conscious and unconscious biases and results in unmet health needs (Perry et al., 2020; Sabatello et al., 2020). Owing to the limited proliferation of the Covid-19 virus in Aotearoa New Zealand until early 2022, most of the impact has occurred because of the country's response plan and associated lockdowns rather than widespread infection. Several key issues are relevant: wellbeing during lockdown, access to PPE, and medical triaging.

Lockdown

During the lockdown in 2020, weekly surveys were answered by disabled people living in Aotearoa New Zealand, their family and whānau, and personal assistance providers/carers (Office for Disability Issues, 2020a). Notably, these reflect the voices of disabled people who were able to respond to the surveys at the time, possibly missing the experiences of disabled people with less access to technology or more difficulty with independent communication.

In the early stages of the pandemic there were significant concerns about getting accessible information to the disability community—information vital for keeping all people safe. While Aotearoa New Zealand Sign Language and Easy-Read documents were produced to aid with this, there was often a delay in their creation (Perry et al., 2020). When asking disabled people about their experience with finding the information they needed, results showed that in the first week of lockdown (April 17-24, 2020) disabled people indicated it was 'very easy' to find information about Covid-19 (Office for Disability Issues, 2020a). However, when asked how easy it was to understand the information they found, the majority rated that 'I find it okay', as opposed to finding it 'easy' or 'very easy'. While it is encouraging that the disabled people surveyed were able to access and understand information for the most part, the information not being presented in a way to make it easily understandable may have meant that crucial information was missed.

Within the same survey, respondents were asked about their safety and wellbeing each week. The majority of disabled respondents (up to 50%) endorsed the option that they felt 'mostly safe' and were 'mostly doing well' during the first week of lockdown[12] (Office for Disability Issues, 2020a). However, this contrasted with the responses of disability service providers, where only 40% felt that the disabled people they work with were 'mostly safe', with none endorsing them as 'very safe' during the entire lockdown period (Office for Disability Issues, 2021). My interpretation of this finding is that disabled people perceived themselves as being safer than their carers perceived them to be. This difference in responses is perhaps a reflection of the lower quality of living when compared to the general population that many disabled people had to endure even before the arrival of Covid-19, meaning that what their carers perceived as unsafe may have already been a regular part of the disabled person's life that they had become accustomed to.

In the middle weeks of the lockdown (28 April-6 May 2020), critical concerns for the disability community included monetary stress, lack of respite, difficulties with transport and shopping, increased anxiety and mental distress, and family pressure (Office for Disability Issues, 2020b). Sadly, disabled respondents reported that they did not feel listened to, felt stigmatised, and felt they were living in poverty (Office for Disability Issues, 2020b). Reduced services, including respite care, social isolation from their community, and ongoing lack of essential personal protective equipment (PPE) were prominent concerns (Office for

---

[12] The options included feeling 'very safe', 'mostly safe', 'sometimes safe sometimes unsafe', 'mostly safe', and 'not at all safe'. In terms of wellness, the options included 'I am doing very well', 'doing mostly well', 'doing okay', 'not doing very well', and 'doing very badly' (Office for Disability Issues, 2020a).

Disability Issues, 2020b). Disabled people believed that better access to technology, more priority being given to their needs, and better employment opportunities would be beneficial for alleviating their concerns (Office for Disability Issues, 2021). Given that many of these issues were prevalent before lockdown and remained ignored, I am dubious we will see any extra priority given to them now.

Unfortunately, in information gathered over the same period, the Health Quality and Safety Commission (2020) noted that during lockdown disabled people were more likely to live in areas of high deprivation and more likely to report that they were unable to access healthcare than non-disabled people. The reasons cited for this were concerns about catching Covid-19, worries about Alert Level rules, and not believing they were sick enough to deserve care. Additionally, disabled people were more likely to report that their individual and/or cultural needs were not met during appointments (Health Quality and Safety Commission, 2020); a sad finding given there is a disproportionate number of tāngata whaikaha Māori among the disability community. Once again, this suggests that people with multiple marginalised identities receive less equitable support and care, only marginalising them further.

Despite these difficulties, some positives were reported by the disability community as a result of lockdown. These positives included more time spent with family and whānau, kindness from the community around them, and the broader use of technology which was already a vital part of some disabled people’s daily communication (Office for Disability Issues, 2021). It is interesting to see that some of the benefits being reported here represent factors usually neglected by wider society, e.g., easy access to alternate communication means, as opposed to anything that could be considered novel to non-disabled people. I see this as reflective of how little value there is placed on disabled lives and their inclusion in wider society, in that they were unable to accommodate these accessibility needs before they also became required for non-disabled people.

Access to Personal Protective Equipment

A lack of access to personal protective equipment (PPE) was an issue for disabled people and their carers throughout the entirety of the 2020 lockdown (Office for Disability Issues, 2021), meaning that disabled people had decreased access to safe care (Human Rights Commission, 2020). For the disability community this is not only an inconvenience but can present a severe health risk. In the weekly surveys, 44% of disabled people who completed the standard-version survey, and 37% the Easy-Read survey, indicated that they disagreed or strongly disagreed that they had access to the PPE needed to keep themselves and others safe (Office for Disability Issues, 2020a). Service providers corroborated this, with 36% endorsing that they did not have the required equipment. Reasons cited for this was the PPE being out of stock or only available in the incorrect sizing (Office for Disability Issues, 2021).

A lack of appropriate PPE puts disabled people at increased risk of catching Covid-19, above and beyond the usual risks associated with poor hygiene (e.g., infection). In turn, this also endangers the personal care providers. There are reports from within Aotearoa New Zealand that disabled people had to sew their own PPE (e.g., masks) out of old clothes, or even stopped external care providers assisting them for the entirety of lockdown, instead relying on family and whānau (Perry et al., 2020). Failing to prioritise the safety of disabled people in their daily cares is an example of a clear inequity in our Covid-19 response and must be addressed with urgency. Failure to do so may lead to increased infection rates in disabled people, of whom some will be more vulnerable to severe consequences from Covid-19.

Medical Triage: Eugenics Repackaged?

Owing to the overwhelming burden on the healthcare system overseas, guidelines of care and prioritisation, or “rationing/triaging” have been produced, outlining who should be provided ventilator support and who should not when severely unwell with Covid-19 (Perry et al., 2020; Sabatello et al., 2020). Such policies unfairly discriminate upon disabled people who may live with conditions that lower their Clinical Frailty Score (CFS)—a calculation used for making such decisions—yet who do not actually represent frail people (Perry et al., 2020). Thus, prioritisation is occurring based upon measures of health which could be considered entirely irrelevant for this group (Perry et al., 2020; Sabatello et al., 2020). For example, Washington State has limited life-saving care for people with losses in cognition, a form of disability which for many people has no physical bearing on their ability to survive Covid-19 infection when provided equitable care (Sabatello et al., 2020). In the United States of America, and even as close as Australia, there have been reports of widespread do-not-resuscitate orders being placed (by others) on disabled people in care homes (Chen & McNamara, 2020; Owen, 2020), meaning that no attempt to save their lives would occur in the event of severe illness.

The implementation of the CFS for Covid-19 care rationing was supported by the National Institute for Health and Care Excellence (NICE) and recommended to the National Health Service (NHS) in the United Kingdom in March 2020 (Owen, 2020). However, following the outcry from disabled people and disability organisations and numerous legal challenges, the guidelines were updated but continue to include comorbidities as a key component of risk scoring—a factor that disproportionately impacts disabled people (Owen, 2020; Perry et al., 2020). Decisions around which disabled lives are worth saving are based upon ableist assumptions that disabled people live a lower quality of life than non-disabled people and have less social and economic purpose to wider society (Perry et al., 2020; Sabatello et al., 2020). These practices inherently tell disabled people they are not as important or valued as non-disabled peers, walking a fine line towards eugenics—whether intentionally or not. Many medical and disability care professionals have reported finding such practices morally distressing (Perry et al., 2020), as do I.

Owing to this, measures to prevent bias in medical rationing decisions need to be put in place with urgency (Sabatello et al., 2020). While some disabled people are involved in advisory roles on medical panels, often being the sole person with access needs means they are commonly overruled, making their attempts to protect disabled lives somewhat futile—their presence being virtue signalling more so than serving any actual utility

(Sabatello et al., 2020). The likelihood of survival from Covid-19 needs to be calculated with objective information about the impact of co-morbidities, not erroneous and generalised perceptions of vulnerability (Sabatello et al., 2020). Fortunately, such crisis capacity guidelines have not yet been required in Aotearoa New Zealand. Nonetheless, their proliferation overseas has instilled widespread fear among disabled people and their families. It remains to be seen how much the Aotearoa New Zealand medical system will value our lives once Covid-19 places unprecedented strain on our hospitals.

An Influx of Disability

During the lockdowns in Aotearoa New Zealand, elective testing, surgeries, and procedures were stopped, as were "non-essential" health services such as physiotherapy (Human Rights Commission, 2020). Unfortunately, the delaying of medical care has seriously impacted the disabled community and people's health more widely. It is estimated that almost half of all new cancers that would have been diagnosed over the lockdown period were missed, with 1031 fewer new diagnoses being reported over the 2020 lockdown period than in the prior year (Hunt, 2021). While by October 2021, rates of cancer diagnosis had returned to normal, it is reported that many diagnoses have come far too late for those affected, with some people now terminal (Hunt, 2021). Thus, these devastating impacts suggest that the protection from Covid-19 has come at the expense of lives lost to other means.

Long Covid

Given the exceptionally large number of people being infected with Covid-19 worldwide, we are also seeing a huge number of survivors. Unfortunately, the impact of Covid-19 does not always stop with the end of one's viral period, with unprecedented rates of new disabilities being attributed to "long Covid". Long-Covid, now only receiving recognition after those affected have been calling desperately for validation and assistance, is described as when the symptoms of one's Covid-19 infection persist beyond the point one should have recovered (Taquet et al., 2021). In a medical system that is already stretched, and in a society which only minimally supports disabled people to live their day-to-day lives, we are not prepared for the influx of disability that will follow the Covid-19 pandemic as a result of long-Covid (Hall, 2021).

Little is known about long-Covid thus far, with wide-ranging symptoms and differing duration of symptoms preventing a clear definition or diagnostic criteria. However, it is clear that it is impacting a substantial portion of Covid-19 survivors, with a recent study suggesting as many as 37% of people post-infection have at least one persisting symptom between a three- and six-month follow up (Taquet et al., 2021). Common symptoms being reported include pain, fatigue, and anosmia (loss of smell), which can have significant impacts on one's quality of life (Sudre et al., 2021; Taquet et al., 2021). Interestingly, to date, the identified predictors of long-Covid include a higher body mass index, female sex, and older age (Sudre et al., 2021). Thus, the intersection of disability with fatphobia/sizeism, sexism, and ageism will likely lead to under-resourcing of long-Covid. From an alternative perspective, people who have been long overlooked in our healthcare system—notably the myalgic encephalomyelitis/chronic fatigue syndrome community, who share many symptoms with long-Covid sufferers—are hopeful that new attention will be paid to their needs (Hall, 2021). It remains to be seen how Aotearoa New Zealand will address this issue as our rates of infection increase. If as many people are impacted by long-Covid as initial suggestions indicate, the issue of disability may not be as easy to ignore as it has been to date.

Impact of Lockdown on Marginalised People Living in Aotearoa New Zealand: A Qualitative Review

While the Covid-19 lockdown undoubtedly saved the lives of many people living in Aotearoa New Zealand, to date, we cannot be sure of the broader impact on communities that are already pushed to the margins of society. In the first study of its kind conducted shortly following the 2020 lockdowns, a qualitative study of 27 low-income people living in Aotearoa New Zealand explored their perception of the Covid-19 response and the impact of lockdown on their wellbeing (Choi et al., 2021). These low-income respondents included those living in refuges, institutionalised settings, and cars during the lockdown; who were also solo parents, refugees and asylum seekers, disabled, and chronically ill people (Choi et al., 2021). None of the respondents reported experiencing violence during the lockdown, although they were not explicitly asked. Key issues discussed included fear about Covid-19, negative experiences with services, negative impacts on mental health, and financial difficulties. Such findings are supported by survey data of the general population over lockdown (Every-Palmer et al., 2020), with respondents in both studies also finding “silver linings” (Every-Palmer et al., 2020, p. 1) among the difficulties. To date, other qualitative studies have asked children aged 10-13 years (McNeill & Gillon, 2021) and “older” (p . 23) people living in Aotearoa New Zealand aged 55-85 (Stephens & Breheny, 2021) about their lockdown experiences; however, at this time lived-experience research remains scarce.

Following the 2020 lockdown, low-income people living in Aotearoa New Zealand reported significant anxiety around catching Covid-19, but also fear of passing it on to vulnerable family members (Choi et al., 2021). Some of the respondents lived with chronic health conditions or had a partner with one, which greatly concerned them. Even when accessing essential care, they reported heightened anxiety; for some meaning they intensely restricted their movements, not leaving the confines of their residence. One respondent described that it was incredibly difficult to access healthcare for their chronically ill partner: they had no vehicle of their own; there were changes to public transportation rules and availability; and they believed that healthcare services were restricted (Choi et al., 2021). Similarly, for older people living in Aotearoa New Zealand, themes of “strain and worry” (p. 3) centred around fear about their safety, their families’ safety, and being singled out as vulnerable to the virus (Stephens & Breheny, 2021). They felt isolated from loved ones and had difficulties accessing supermarkets and medical services, leading to anxiety and worry, especially among those with pre-existing mental distress, essential workers, and those who care for others. People being unable to access services may have led to poorer health outcomes for these communities, both physically and mentally.

Unfortunately, most of the low-income people living in Aotearoa New Zealand interviewed reported that lockdown had a significantly negative impact on their mental wellbeing (Choi et al., 2021). This was particularly true for people already experiencing mental distress before the pandemic, which became exacerbated by the restrictions—findings also reflected in the older population (Choi et al., 2021; Stephens & Breheny, 2021). From an alternative perspective, respondents who had already experienced significant loss and trauma in their lives reported that Covid-19 was less of a concern for them, feeling that they had already been through hard times before and were thus prepared for the challenges ahead (Choi et al., 2021). Similarly, a strong sense of resilience emanated from the older respondents' accounts, with them drawing upon previous adversities and crises that they had survived, such as the Canterbury earthquakes (Stephens & Breheny, 2021).

Those who lost their jobs due to lockdown experienced notable increases in mental distress, reporting that having less financial stability, as well as less social connection without being in employment, was negatively impactful for them (Choi et al., 2021). With the wide age range included in the study, while some were retired, most of the older respondents were employed and shared similar fears about the loss of jobs (Stephens & Breheny, 2021).

While the majority of both low-income and older respondents reported that they coped financially during lockdown, a disproportionate number of low-income Māori struggled with this (Choi et al., 2021). For some, it became as dire as having to choose to either pay their bills or for their medication, unable to afford both (Choi et al., 2021). Despite reporting they coped financially, the majority of low-income respondents accessed food banks during lockdown, noting difficulties with accessing supermarkets for food (Choi et al., 2021). This suggests that their definition of financial health differs from the wider population—who may not be used to living with such little money and thus would have defined this circumstance as dire in comparison—reflecting low-income populations' remarkable ability to cope with adversity. Some of the older population spoke of the extra government financial support being helpful, notably the increased rate of the Winter Energy Payment (Stephens & Breheny, 2021). However, for some older respondents their day-to-day circumstances did not change as they were already beneficiaries, and life continued somewhat as usual.

The social isolation of lockdown was challenging for people to manage. Some reported having to break restrictions to see friends or family because they could no longer cope but then felt guilty about doing so (Choi et al., 2021). One Māori respondent described how distressing it was having to attend a tangihanga online rather than in person (Choi et al., 2021). For older people living in Aotearoa New Zealand living in residential care, or who remained at home with partners in residential care, this meant a seven-week separation from their loved ones who were isolated for their protection (Stephens & Breheny, 2021). Children aged 10-13 also reported that being separated from their friends was one of the top adverse outcomes from lockdown, alongside boredom and having to do online rather than in-person learning (McNeill & Gillon, 2021). One low-income respondent reported no access to the internet, further limiting the ability to connect with others in any capacity (Choi et al., 2021). However, I imagine the extent of this problem has been significantly underestimated at this time, with people unable to access the internet also unlikely to be engaged with academic research.

Despite the worsening of peoples' mental health, very few low-income respondents reported accessing mental health support, using self-help techniques instead (Choi et al., 2021). For some people this was because there was a lack of awareness about what services were available, for others it was not wanting to add additional burden to the healthcare system (Choi et al., 2021). Rather than formal support services, older respondents described that they received a range of community support, stretching from the individual level, whereby friends and family would deliver groceries and check in on wellbeing, to the broader societal and government level whereby daily updates helped them "feel part of 5 million whānau" (Choi et al., 2021, p. 5). The personal and collective resilience demonstrated by our communities is remarkable.

Unfortunately, some of the low-income respondents who did seek formal support during lockdown were met with negative experiences (Choi et al., 2021). Some report being discriminated against when trying to seek financial help from WINZ, with their desperation for food and subsequent frustrated demeanour on the phone meaning that they were treated negatively and even hung up on by WINZ staff. One respondent who lived in an institutional care home for the duration of lockdown felt fearful and distrustful of the care home overall and was ill-treated by staff. The respondent reported an understanding that “you don’t complain unless you have somewhere else to go” (Choi et al., 2021, p. 59), a sad sentiment given access to other living arrangements was limited at that time. Another low-income person spent their entire lockdown homeless and living in their car, not feeling safe in the residence where they were previously residing (Choi et al., 2021). While the Aotearoa New Zealand government placed almost 4000 people living in Aotearoa New Zealand into “Covid-19 motels” as part of the pandemic response, at a cost of NZD $76 million, they were unable to account for the living situations of 42% of people once they left the facility (Cooke, 2021). This raises the question: if we were able to house such a significant portion of our homeless population in a pandemic, and at such short notice, why is the crisis of homelessness not enough for this to be a priority under normal circumstances?

Silver Linings

Despite the wide range of difficulties experienced during lockdown, multiple studies show that people experienced several “silver linings” at this time (Every-Palmer et al., 2020, p. 1) For many older respondents, there was a sense of enjoyment stemming from the lockdowns (Stephens & Breheny, 2021). They describe the chance to reflect, garden, complete household tasks, and spend more time with their families. More broadly, they enjoyed the quieter environment, reflecting back to the past when there was a less commercialised and slower-paced society. Even though respondents were isolated from their loved ones, many felt a shared sense of community with their neighbours by waving at them each day. One respondent noted, “It was so relaxing to have the 7 weeks at home and ‘smell the roses’” (Stephens & Breheny, 2020, p. 5). Aotearoa New Zealand children identified that having more flexibility in their day—especially the ability to sleep in—more access to screen-time to see friends and family, and less schoolwork were beneficial parts of the lockdown (McNeill & Gillon, 2021).

While lockdown presented many challenges, respondents described being appreciative of the Aotearoa New Zealand Covid-19 response, especially when considering the virus' impact overseas (Choi et al., 2021). While a couple of low-income respondents expressed government distrust, the majority were full of praise for the response and stated that were it to happen again, the government should continue with "exactly how they did this. They did excellent" (Choi et al., 2021, p. 62). In particular, they praised the calm and personable manner of Jacinda Ardern and Dr Ashley Bloomfield, alongside feeling that they truly valued the lives of people living in Aotearoa New Zealand.. People who do not have English as a first language praised the use of subtitles and Aotearoa New Zealand Sign Language during daily briefings, as it allowed them better access to information (Choi et al., 2021). Given that the interviewed communities are some of those we would expect to have the most negative outcomes from Covid-19, it is heartening to see that people found positive elements over this time.

Summary

Aotearoa New Zealand did a remarkable job of controlling the first wave of Covid-19 in 2020. However, owing to the limited number of infections in 2020, the most significant impact on the community was as a result of the response plan, i.e., the lockdowns. Therefore, it is vital to hear the lockdown experiences of Aotearoa New Zealand's diverse communities, who are frequently underserved by government policy and response. Pandemics exacerbate existing inequity, and the voices of those who live this are vital in ensuring all people are adequately and fairly supported going forward (Choi et al., 2021; McNeill & Gillon, 2021; Stephens & Breheny, 2021).

Māori have been neglected within Aotearoa New Zealand's one-size-fits-all approach to Covid-19, yet iwi-led responses have had a remarkable impact on keeping Māori safe during the first wave (Durie & Naera, 2020; Pihama & Lipsham, 2020). Unfortunately, Māori wellbeing has been significantly impacted on an individual level, as well as broader whānau wellbeing as a result of the rāhui, which caused separation within communities and disruption to tikanga protocol (Houkamau et al., 2021). Going forward, Māori are hopeful that they will be prioritised in our Covid-19 response, receiving the same care as non-Māori people living in Aotearoa New Zealand (Houkamau et al., 2021). Addressing systemic racism and the underserving of our tāngata whenua must become a priority.

Inequity for disabled people living in Aotearoa New Zealand is apparent in surveys undertaken during the lockdown, where they described having adequate—yet not good—understanding of information, feeling stigmatised and unsupported, and having serious concerns about a lack of PPE to keep them safe (Office for Disability Issues, 2021). Overseas, medical triaging is founded upon biased, ableist attitudes, instilling fear among people living in Aotearoa New Zealand about what is to come (Perry et al., 2020). Prioritising the wellbeing of disabled people going forward will require the valuing of disabled lives as equal to non-disabled lives within all areas of service provision.

Reflecting the way that people who experience multiple inequities are further subjugated than people who inhabit just one marginalised space, the low-income respondents interviewed by Choi et al. (2021) included people who lived with multiple subjugated social positions, e.g., did not have permanent housing, while also being disabled, refugees, and/or solo parents. Without directly hearing the unique experiences of these groups, there is no plausible way of understanding the adversities they faced as the “isms” (racism, sexism, ableism, etc.) pushed them to the margins of the Covid-19 response.

Alongside the inequities reported by disabled people living in Aotearoa New Zealand and prevalent among respondents speaking to Choi et al. (2021), ageism has been cited as a significant contributor to the treatment of older adults during lockdown and the wider Covid-19 pandemic (Stephens & Breheny, 2021). Narratives of older lives as vulnerable and disposable are prominent, which are not only highly upsetting but also fail to reflect the diversity of people and experiences within this population (Stephens & Breheny, 2021). For example, the older population were estimated to make up approximately 25% of the Aotearoa New Zealand workforce in 2020 thus stereotyping the elderly as retired and isolated is ignoring a large portion of their daily experiences and may have neglected the economic pressure they faced during the lockdowns (Stephens & Breheny, 2021). There is likely a further group of older people living in Aotearoa New Zealand who live with intersecting marginalisation, including significant disability, lack of access to communication and technology, and living within abusive homes; voices that are yet to be heard.

Age is impactful on every end of the spectrum, and children's experiences of lockdown can be considered unique again, having the least autonomy of any group in their decision making. While few children reported familial difficulties to McNeill and Gillon (2021), the authors discuss the concern that relationship breakdowns and adverse outcomes from lockdown disproportionately impact lower-resourced families, those with existing relationship difficulties, and those with higher levels of pre-lockdown stress (McNeill & Gillon, 2021). Therefore, children living in these circumstances likely had increased adverse outcomes from lockdown, yet their voices remain missing from the conversation.

With Covid-19 likely to remain in our lives for a long time to come, research must continue to collect the lived experience of all people in Aotearoa New Zealand. Notably, the stories of disabled, Māori, and queer people living in Aotearoa New Zealand have not explicitly been sought at this time. While research with some of these communities does indeed present more difficulties than with the hegemonic population, neglecting their inclusion only perpetuates the barriers imposed and reinforced by society and our Covid-19 response.

Literature Review Chapter Five: Violence in Crisis Situations

"What will it take for us to acknowledge that, as with COVID-19, we have a pandemic of sexual violence rippling throughout our nation?"

(Jordan, 2020, para. 12).

Researchers suggest that Covid-19 is mimicking the conditions seen in other disasters, causing a cascading vulnerability previously demonstrated during war and large-scale crises, including an increased rate of domestic and sexual violence (Morley et al., 2021; Parkinson & Zara, 2013). Within an Aotearoa New Zealand context, following the Canterbury earthquake of 2010, the number of family violence incidents reported to police increased by 53% (Lynch, 2010). Similarly, following the significant floods of Whakatane in 2010, police reported a two-fold increase in reports, with domestic violence services reporting a three-fold increase in demand, demonstrating that reporting to police remains lower than other services even during a disaster (Houghton, 2009). While many researchers cite situational stress as the reason for such increased rates, Houghton (2009) argues that disasters amplify the stratifications seen between genders—where women have lower social and economic standing than men—and that a loss of control over one's daily life is regained by victimising women. In the wake of the Canterbury earthquake and Whakatane floods, several factors were cited by service providers as precipitants to increased violence, including shelters being overwhelmed, childcare services being closed, and the shame of relying on external agencies to meet basic needs (Houghton, 2009; Lynch, 2010). As will be discussed, these reasons reflect what is being reported due to Covid-19, suggesting we learnt little from these previous crises.

Increased Violence During Covid-19

Internationally, research has shown increases in domestic and sexual violence rates during Covid-19. Near the start of the pandemic, the United Nations Population Fund (2020) estimated that six months of lockdowns would lead to an increase of 31 million cases of gender-based violence worldwide. As predicted, increases in violence have been documented both in countries of high economic standing and those with fragile financial stability, reflecting that violence against women is a global issue and happens at all levels of society (Kourti et al., 2021).

In China, where Covid-19 first impacted, police saw a tripling in domestic violence incidents during February 2020, 90% of which they attributed to the Covid-19 pandemic (Wanqing, 2020). While the dramatic rates being reported in China should have been a warning to other countries of what was to come, it appears that not enough emphasis was placed on preventing this as rates have since increased globally. Kourti et al. (2021) conducted one of the first systematic literature reviews to estimate whether gender-based violence increased globally due to the pandemic, collating papers published between December 2019 and July 2020—the first eight months of the pandemic (N = 32). Within the United States of America, intimate partner violence increased as much as 27% in some states (Kourti et al., 2021). Closer to home, in Australia between March and April 2014-2018, the average rate of domestic violence was 26:100,000 people, yet for the same months in 2020 the rate more than doubled to a staggering 57.5:100,000 (Kourti et al., 2021). Researchers worldwide are reporting a doubling in the rates of violence, although gathering exact numbers remains difficult (Morley et al., 2021). While Aotearoa New Zealand prevalence data are noticeably missing from the conversation, an online survey in April 2020 found that 9% of respondents had experienced some form of violence over the lockdown period (Every-Palmer et al., 2020). While we do not know what proportion of these people sought help for the harm they experienced, following the end of Alert Level 4, services reported an increase in reporting from people who had felt it was unsafe to do so during the lockdown, bringing to light a hidden epidemic that was occurring behind closed doors (Human Rights Commission, 2020).

In the first three months of the Covid-19 response in Aotearoa New Zealand, the police reported that domestic and sexual violence calls remained much the same, other than a slight increase during the first week (Human Rights Commission, 2020). This reflects the pattern emerging globally whereby *reporting* of violence decreased during lockdown, with increased rates afterwards—such findings were also demonstrated in surveys conducted in the United Kingdom, Switzerland, Germany, and Australia (Johnson et al., 2020; Kourti et al., 2021; Morley et al., 2021).

When looking at patterns of reporting in a wider sense, decreased reporting seems to have occurred at all levels of service provision, including to psychosocial services, police and legal services, and medical services, suggesting that interventions were reduced across the board (Johnson et al., 2020). As seen by the Aotearoa New Zealand Police, the number of people contacting specialist violence and refuge helplines also decreased at Level 4 (Human Rights Commission, 2020). Similarly, in the Australian and Aotearoa New Zealand context, reporting of domestic violence in the hospital setting reduced significantly in 2020 and social workers hypothesised this was due to Covid-19 screening questions replacing the standard domestic violence screens usually completed in emergency departments (Alston et al., 2021). On a more encouraging note, in cases where violence was picked up in the emergency department, it was observed that staff reacted better and the survivors received better care, likely due to there being fewer other people in the hospital to attend to (Human Rights Commission, 2020). Unfortunately, a decrease in reporting does not mean a reduction in occurrence; letting one crisis overtake another does not seem an appropriate response.

Within the justice system, courts saw a 47% decrease in protection order applications—reflecting the added barriers of this process at the time—but of those that were made, there were 35% more urgent applications than before lockdown (Human Rights Commission, 2020). I ponder two possible explanations for this: either people were tolerating less severe forms of violence, thus decreasing the proportion of reported cases comparable to severe violence; or all violence experienced during lockdown was more severe than usual. Unfortunately, Aotearoa New Zealand sexual and domestic violence services have reported seeing an escalation in violence, including more cases involving sexual violence and strangulation (Human Rights Commission, 2020). There also appears to have been an increase in repeat occurrences of violence, with repeat abusers being bailed for crimes where they would usually have remained in custody, owing to fears about crowding in corrections services (Human Rights Commission, 2020). A sexual and domestic violence service worker speaking to the Human Rights Commission (2020) described the experience of one client who following a severe assault was granted a protection order, whereas prior to lockdown the perpetrator would have been charged and removed for this offence. Unfortunately, while these attempts were to protect incarcerated people from Covid-19, it appears this came at the expense of women's and children's safety.

Reflecting the intensification of violence and the established link between domestic violence and homicide, the rate of femicide in the United Kingdom during March 2020 increased three-fold on the previous 10-year average, with concerning increases also documented in Turkey, Argentina, and Spain (Kourti et al., 2021). In Aotearoa New Zealand, the media reported three women being killed in domestic violence incidents during Alert Level 4 (Human Rights Commission, 2020). Being unable to address family violence to the extent that we are then unable to protect the lives of those being harmed is a gross failure of our Covid-19 response.

Child Abuse

The closure of schools led to a worrying decrease in the reports of child abuse (Human Rights Commission, 2020; Kourti et al., 2021), with teachers in the United States being the largest professional group to report child welfare concerns (Kourti et al., 2021). In March 2020, there were 67% fewer reports of child abuse in the United States than in March of the previous year, and 41% fewer reports in the United Kingdom (Kourti et al., 2021). Likewise, Aotearoa New Zealand saw a drop in reports of concern (Human Rights Commission, 2020). This is worrying, as comparable to the adult statistics, decreased rates do not represent a reduction in harm towards children, merely a reduction in the rates of reporting.

Within Aotearoa New Zealand homes where the abused parties were unable to seek help, parents have now reported that children were subjected to physical, verbal, and psychological abuse, as well as neglect, refusal to access medical care, and refusal to allow them to participate in online learning over lockdown (Human Rights Commission, 2020). However, the rates of such violence remain unknown at this time. Therefore, without accurate reporting to establish the increased rates of harm, this must be considered via other means: for example, there was a significant increase in abusive head traumas presenting to London hospitals compared to the previous three-year average (Kourti et al., 2021). Similarly, in Aotearoa New Zealand, youth support helplines (Youthline, Shine) experienced an unprecedented increase in demand, including increased reporting of sexual, physical, and psychological violence (Human Rights Commission, 2020). However, due to the anonymous nature of these services, such support calls do not necessarily lead to any intervention to decrease the harm occurring to the child; this means for many, this violence would have continued throughout the lockdown period.

Despite the increased level of calls, Aotearoa New Zealand service providers are now explaining that some children found themselves unable to reach out for help, as those in the care of abusive parents could not use phones or computers without parental supervision (Human Rights Commission, 2020). Others argue that campaigns advising children how to seek help if they were subjected to violence were predominantly missing from the Aotearoa New Zealand media, meaning that those who wanted to seek help may not have known how (Human Rights Commission, 2020). When considering some children were unable to seek help and others may not have known how, we can assume that number of children in need of support was much higher than that estimated by the increased levels of help-seeking. Just how pervasive violence was for Aotearoa New Zealand children during lockdown may not be known until the long-term impacts present themselves in years to come.

These worrying reports beg the question, why were we unable to keep children safe in their homes? In Aotearoa New Zealand, children under custody arrangements to see both parents had to continue this arrangement during lockdown—including staying with parents who may have a history of abuse or neglect—where the child would now be isolated without other supervision (Human Rights Commission, 2020). Likewise, women subjected to violence over lockdown have now described that they chose not to pursue protection orders against their perpetrators for fear that a parenting order would be placed by them at the same time, thereby forcing the child to spend time alone with the perpetrator (Human Rights Commission, 2020). Overall, such findings and widespread concerns demonstrate that rates of child abuse have likely increased, yet the means of monitoring child wellbeing—and thus the recording of child abuse statistics—have decreased. This raises concerns both for the welfare of the affected children but also in that a lack of accountability may mean the intensity of the unreported violence increases, causing exponentially devastating harm.

Media Response

In the first few weeks of lockdown there was growing concern that the public was unaware that violence services were operating and that they were allowed to leave their bubbles to seek support (Human Rights Commission, 2020). In light of this, a campaign of media awareness was introduced, encouraging neighbours to look out for each other and spot the signs of violence. However, following the lockdowns, women have reported to services that they still did not leave their homes for fear of public shaming, catching Covid-19, and being arrested; violence organisations' calls for loosening of their restrictions to be able to access such people went unheard (Human Rights Commission, 2020).

Away from the media, the government and support agencies were discussing strategies that could be implemented for women to access the violence services (Human Rights Commission, 2020). Some ideas included tents being set up outside supermarkets or having Covid-19 testing station staff screen for domestic violence. Unfortunately, as there was not already a plan established for such circumstances, none of these options could be implemented quickly enough to make a difference (Human Rights Commission, 2020). Organisations have been described as grappling with their options as there was no clear guidance, with some even unsure whether or not they were considered essential services themselves (Human Rights Commission, 2020). These plans must be put in place now to prepare for any future lockdowns.

The Impact on Marginalised People

Surveys of Survivors

In the first large-scale survey of its kind, researchers from the Australian Institute of Criminology surveyed 15000 Australian women to enquire how violence during Covid-19 is impacting different demographics (Boxall & Morgan, 2021). The survey asked about experiences of physical/sexual violence (P/SV) and coercive control within the last three months, perpetrated by a person they had been in an intimate relationship with during the previous twelve months—including current and previous partners. What is unique about the research is the comparison between respondents to explore how violence impacted each community differently, instead of trying to estimate the overall prevalence of violence.

In line with pre-pandemic research suggesting people who experience marginalisation in their day-to-day lives also experience higher rates of violence, all of Boxall and Morgan's (2021) outlined groups experienced higher rates of violence than their more privileged peers. Aboriginal and Torres Strait Islanders were 4x more likely to experience P/SV than non-Aboriginal Australians and more than 2x more likely to experience P/SV and coercive control collectively. Similarly, women who were non-Native English speakers experienced 1.3x more P/SV; however, they did not appear to experience higher rates of coercive control. Interestingly, while people with lower levels of education (9 years or less) were more likely to experience P/SV, they were not more likely to experience coercive control. The authors hypothesise that this is because, stereotypically, we see P/SV occurring at higher rates in underserved communities, with coercive control more prevalent in higher socio-economic households (Boxall & Morgan, 2021).

Women classified as having a "restrictive health condition" experienced 3x more P/SV, 3x more coercive control, and 2.2x more combined violence than non-health impacted women (Boxall & Morgan, 2021). Owing to the need to self-report the survey data, these statistics exclude disabled women who are not independent with communication, with rates possibly higher in these people. While the survey did not extrapolate data to include people with multiple marginalised identities, I hypothesise that the survey data could highlight how intersecting marginalisations may exponentially increase the likelihood of experiencing violence as a disabled woman in lockdown. For example, the survey found that women who lived with their partners during lockdown were more likely than others to experience P/SV, and as many disabled people require daily cares, the proportion of disabled women living with their partners may be higher than non-disabled peers. Likewise, women experiencing extreme financial distress were 10x more likely to experience P/SV and 9x more likely to experience coercive control, with the level of financial stress producing a linear relationship with violence. Disabled women are less likely to be employed and have lower incomes than non-disabled women, with this further compounded by the pandemic when those with compromised immune systems had to isolate beyond what was required of the general population. Therefore, it can be assumed that many disabled women would be experiencing financial stress during Covid-19, thus increasing the likelihood of violence in their lives. Alongside this, inaccessible housing and inadequate resourcing has been a longstanding issue for disabled people, only amplified by the pandemic (Human Rights Commission, 2020).

Before the pandemic it was established that younger people experience higher rates of sexual violence than older people, with this trend appearing to continue during the pandemic. Australian women aged 18-24 reported 8x more P/SV than women aged over 55, and 6x more coercive control (Boxall & Morgan, 2021). While such findings are perhaps protective of the disabled population who tend to have a higher average age than non-disabled people, if the trends in Australia reflect Aotearoa New Zealand, then Māori would be disproportionately impacted due to their younger average age. Similar research being conducted in Aotearoa New Zealand would be beneficial to explore these intersections further.

Surveys of Providers

While Boxall and Morgan (2021) surveyed people impacted by violence, similar surveys are also being undertaken with support services. In a survey of Australian sexual and domestic violence service providers that took place in March 2020, respondents were asked how Covid-19 has impacted their practice, with the chance to contextualise answers with qualitative responses (Morley et al., 2021). Overall, 86.5% of the providers indicated that Covid-19 had increased the complexity of client needs. Comparable to the findings of Boxall and Morgan (2021), of the communities the service providers work with, 30% identified that an increase in violence was particularly impacting the disability community; while 47% identified culturally and linguistically diverse (CALD) communities, 32% Aboriginal and Torres Strait Islanders, and 10% the queer community as the same. One service provider explained that a client's health status had meant her ex-partner could "regulate her autonomy" (Morley et al., 2021, p. 211). As she relied on him for dropping off food—being too immune-compromised to access supermarkets safely herself—she was left feeling "stuck with no other options for support" (Morley et al., 2021, p. 211). Worryingly, Covid-19 also produced new forms of violence that the providers had not seen before, including the weaponising of Covid-19 as a way to monitor someone's movements closely, to demand a home to stay in during isolation periods, and forcing people to remain in unsafe relationships owing to reduced social support and increased financial stress. While a key aim of lockdowns is to protect people, and specifically vulnerable people, the authors concede that "many women are anything but safe in their own residences during the pandemic" (Morley et al., 2021, p. 211).

Limitations of Covid-19 Data thus far

Accurate collection of statistics in the sexual violence field is fraught at the best of times, with the difficulties only amplified during a pandemic. To date, little-to-no in-depth qualitative research has been undertaken, with researchers deeming it unethical to disrupt essential workers when the sector is already incredibly stretched. Thus, most research has been collected via population surveys which can have numerous limitations. For example, most surveys require respondents to have access to a phone or computer, meaning that, in general, respondents are of a higher socioeconomic status. Likewise, those who did complete the surveys may still have been living in unsafe situations and could not accurately report the harm they were experiencing. Other prevalence rates are collected by analysing the number of people contacting service providers and/or police, which subsequently excludes survivors who were unable to, or chose not to, access support. Likewise, many studies do not extrapolate into specific forms of violence, rather collating all types of violence under categories including “intimate partner violence”, “gender-based violence” or “family violence”. Finally, many multiply marginalised people fail to have their voices heard individually in statistics such as sexual and domestic violence, instead being aggregated into categories with all survivors/victims in the general population. While understanding the statistical prevalence of violence is important, so is the lived experience of those impacted by this double-crisis. It is likely that we will only have a better picture of the impact of Covid-19 on the sexual violence sector once the world reaches a “new normal”—when that may be is entirely undetermined.

Barriers to Help Seeking for Violence During Covid-19

Unfortunately, already-marginalised people are further forced to the periphery as additional supports (e.g., additional medical cares and translation services) may be needed to report violence against them during a time when overall access to support has decreased (Morley et al., 2021).

Financial Stress

In Aotearoa New Zealand, during Level 4 lockdown, more than 50% of the workforce was impacted to some degree, with 25% entirely unable to work (Human Rights Commission, 2020). The change in work status and subsequent increased financial hardship faced by many during the pandemic has directly impacted a survivor’s ability to seek help (Morley et al., 2021). While many have lost jobs or had reduced work hours, female-dominated work industries were disproportionately affected by lockdowns and travel restrictions, including the hospitality and retail sectors (Boxall & Morgan, 2021). Alongside this, there was increased violence in temporary migrant families, who were particularly impacted by job losses (Human Rights Commission, 2020).

Unfortunately, financial stress occurring during the pandemic has added difficulties beyond what are apparent under usual circumstances. While the economic gaps between men and women have increased, the access to formal and social supports to facilitate women's independence has decreased (Morley et al., 2021). That being, during times of economic stress women are less likely to report abuse perpetrated by partners owing to having no financial means to leave, or having to return to a violent relationship after having no way to support themselves (Boxall & Morgan, 2021; Morley et al., 2021).

Housing Instability and Refuge Capacity

Entwined with financial stress, housing instability has been prominent throughout the Covid-19 pandemic, with survivors no longer able to afford to pay for their housing, having no housing options, or ending up locked down in emergency accommodation after leaving their partners (Human Rights Commission, 2020). The National Collective of Independent Women's Refuges in Aotearoa New Zealand reported an estimated 15-20% increased demand for their services during the first few months of 2020 (Human Rights Commission, 2020). As part of this heightened need for safe accommodation, the lack of emergency housing was highlighted as a significant issue, and those who did have access had increased concerns about Covid-19 transmission in community shelters. Comparably, for those seeking shelter with loved ones, some found that friends and family did not want to open their homes for fear of the virus (Human Rights Commission, 2020). While the government allocated an extra NZD $12 million in government funding to support services and refuges, it appears it was not a fix-all; services were still overwhelmed, and this was exacerbated by issues accessing PPE which prevented safe care (Human Rights Commission, 2020).

Even where shelters may have had available rooms, some people faced additional barriers to accessing them. For example, some shelters only accept women over the age of 18, meaning women with children were forced to stay in abusive environments instead of leaving their children behind and at further risk of harm (Human Rights Commission, 2020). The Human Rights Commission (2020) also notes that Aotearoa New Zealand's lack of accessible refuges for disabled people would have presented a barrier to anyone seeking to leave violence, but there were no data collected about this issue, with disabled voices remaining unheard in the conversation once again. Similarly, transgender women report feeling unsure whether they are welcome in refuges, uncomfortable in single-sex shelters, and feeling unsafe when accessing services for fear of discrimination (Human Rights Commission, 2020), forcing them to remain in dangerous living situations. In a declaration that I think further addresses the inequity women have in seeking support, the Māori Women's Welfare League complained that women and children were being forced to leave their homes rather than the people perpetrating violence (Human Rights Commission, 2020). This point reflects the lack of accountability that many perpetrators have, which was further amplified by the lockdown conditions that forced women to take actions they otherwise may not have needed to do with such haste. Each of these issues highlight the extra inequities people who experience marginalisation face during times of crisis, above and beyond those of the hegemonic population.

Interestingly, specialist service providers reported that for the women who did seek help, it was most commonly for assistance with managing violence in the home as opposed to leaving home—a trend not typical before the pandemic (Morley et al., 2021). Unfortunately, the fear about leaving violent relationships was perhaps not unfounded, as women who had left their partner were 3x more likely to experience physical/sexual abuse than women still with their partners, suggesting those who do leave may not, in fact, be safer in the pandemic climate (Boxall & Morgan, 2021). In the Aotearoa New Zealand context, women who were separated from people harming them reported feeling unsafe to seek support for fear of retribution, which could include the perpetrator harming children who remained in shared custody arrangements (Human Rights Commission, 2020). With Covid-19 likely to remain prominent in our community for some time to come, protecting people who wish to escape violence needs to become a priority and be addressed with urgency.

Changes to Service Provision, Telehealth

Access to support for violence during the lockdown period was limited by changes to service provision itself, with service closures, reduced capacity, a transition to telehealth, and policy changes all presenting barriers (Human Rights Commission, 2020; Morley et al., 2021). Even when services were available, clients have now reported to providers that they were afraid to leave their homes for fear of catching Covid-19, fear of breaking government rules, and a lack of transport options to get them somewhere safe (Alston et al., 2021).

As part of needing to physically distance from clients to protect against Covid-19 infection, with a transition to telehealth mandatory for many workers, service providers describe significant barriers to equitable care. Firstly, being unable to conduct home visits and face-to-face care caused considerable concern for the wellbeing of both current clients and new clients seeking support (Alston et al., 2021). Workers described that making a meaningful connection with the client was more difficult, as was establishing empathy, reading non-verbal cues, and assessing safety (Alston et al., 2021; Morley et al., 2021). As a result of school closures clients could often not speak frankly owing to a child being in the home (Morley et al., 2021). Even more worryingly, service providers described that when using telehealth, they could not be sure that a perpetrator was not present in the residence with the client, perhaps putting a survivor more at risk than not seeking help at all (Alston et al., 2021). Even making a phone call or reaching out to services also relies on someone having access to a phone or computer, alongside the internet, and this access is not something all people living in Aotearoa New Zealand have (Human Rights Commission, 2020). Therefore, this digital divide further marginalises people in impoverished and/or rural communities who have less access to technology.

Telehealth also presents unique issues in gathering sexual violence evidence during forensic medical exams (Johnson et al., 2020). Doctors in the United Kingdom reported that the doctor-patient relationship was much more strained, which is unfortunate given the personalised nature of the work often undertaken with severely traumatised people (Johnson et al., 2020). Additionally, doctors found it harder to see physical signs of abuse on camera, meaning vital evidence may have been missed, and the self-swabbing that survivors were required to do may not have been as reliable as that done in-person by the doctor. Finally, genitalia were never viewed by the doctor over telehealth due to privacy concerns. This is entirely understandable, but does mean that injuries may have been missed. When there are too many limitations for telehealth to take place, there was some face-to-face care arranged; however, the time together was very restricted, also leaving the possibility of missed evidence. Owing to these limitations, the doctors have called on stakeholders to prioritise medicolegal aspects of care as of equal importance as medical care for those who wish to undertake them (Johnson et al., 2020).

Wellbeing of Clients and Providers

A survey of Australian and Aotearoa New Zealand social workers conducted between October-December 2020 outlined that practice concerns in their work are not only worrying but present significant ethical dilemmas that need to be navigated (Alston et al., 2021). The key themes discussed included the heightening of inequities, with significant increases in violence seen across *all* areas of social work, not just specialist services. Similarly, there have been significant increases in mental distress among clients, including eating disorders, self-harm, panic attacks, depression, and anxiety, yet no increased access to mental health support (Alston et al., 2021). These data are further supported by the findings of Every-Palmer et al. (2020), where 30% of Aotearoa New Zealand respondents reported moderate-to-high levels of distress during lockdown. Perpetuating this, the isolation of clients from their support networks meant that they had to manage alone, with Māori workers noting that this is particularly impactful on Māori who cannot see their whānau (Alston et al., 2021). In seeing these increased needs, social workers had to delicately balance client care with the risk to their safety. Among all of this, they received little-to-no praise in the media at a time when other healthcare workers were being hailed as heroes (Alston et al., 2021).

Each of these factors had an impact not only on the wellbeing of clients but also the wellbeing of the providers themselves. Of the social workers surveyed, 58% reported that they had already worked in a disaster environment in the previous 10 years, such as the Canterbury Earthquakes or Australian bush fires (Alston et al., 2021). Sadly, 38% of those also reported that they had not yet recovered from the impact of working during those crises, with Covid-19 now layering extra burden upon overstretched workers. In relation to Covid-

19, the social workers reported difficulty juggling work and childcare duties when children were at home, their fear around their personal and family safety, and their own mental and emotional distress (Alston et al., 2021). Within a work context, they described being unsure how to manage an increased workload without extra resourcing—while 88% reported working at an essential service, only 44% had been given any additional funding (Alston et al., 2021). Some services faced staff redeployment meaning that they were stretched even further, and managers noted the increased need to support their staff as well as their clients. On a positive note, while overseas it is widely reported that social workers feel they have a lack of knowledge and training about managing in a Covid-19 world, as well as a lack of PPE, 80% of social workers surveyed in Australia and Aotearoa New Zealand felt that was not of concern here (Alston et al., 2021). This is likely a result of Covid-19 being slower to impact Aotearoa New Zealand, and at that stage to a lesser extent than overseas, meaning practice has been modelled upon what has worked internationally. Nonetheless, if we do not better support essential workers, the resounding impact on an already burnt-out workforce will be disastrous.

Evidential Collection

While to-date, forensic medical evaluations (FMEs) have been able to continue face-to-face in Aotearoa New Zealand—albeit while restricting them to as few as possible (Human Rights Commission, 2020)—this may not always be the case if Covid-19 is to overwhelm our healthcare system. In the United Kingdom, during the first six weeks of lockdown there was a 50% reduction in the number of people being referred for FMEs (Johnson et al., 2020). However, much like the fallacy of reduced violence over this time, it is likely that as many survivors as usual, if not more than usual, were sexually harmed but unable to access such services. Barriers to this service occurred at multiple levels: for example, if survivors were unable to report their violence at all—perhaps owing to the perpetrator remaining in the home with them—then no referral could take place. However, this decrease can also be attributed to policy changes. On a smaller scale, this included decisions like support people not being able to attend the appointments with the survivor

(Johnson et al., 2020), with some likely feeling unable to undertake such an invasive process alone. However, two major policy changes were also made.

The first major policy change that contributed to a reduction in FMEs was the decision not to freeze any samples that a survivor did not want immediately analysed (Johnson et al., 2020). This is a process usually offered if a survivor is unsure whether or not they wish to pursue legal action in the immediate aftermath of an assault, a time when making informed decisions can be markedly difficult. As the Covid-19 virus is not destroyed by freezing, it was deemed unsafe for this storage practice to continue, with the fear of reintroducing the virus in future if samples of Covid-19 positive survivors are processed (Johnson et al., 2020). While I understand the need for such safety measures to be put in place, I believe such practices also undermine survivors' autonomy in choosing the sequence of events that follow an assault.

A further element of the reduction in completed FMEs can be explained by a change in policy around who was referred for FMEs, with survivors only being offered this process in cases of stranger and intrafamilial assault (Johnson et al., 2020). For other cases, such as partner or acquaintance assault, the referral for FME was made on a case-by-case basis, such as if the police felt it necessary to prove that sex had taken place (Johnson et al., 2020). However, the subjectivity of this process raises concerns for me. It is well established that survivors with marginalised identities are more frequently disbelieved when reporting the violence against them; I fear that an inequitable response in evidential collection may have occurred. This would, in turn, hinder these survivors in their pursuit of justice if choosing to undertake legal action, impacting upon the survivor's healing journey, and preventing accountability for people who cause harm.

Access to Sexual and Reproductive Health Services

As part of the reduced availability of medical services in lockdown, people's access to sexual and reproductive health services was reduced, including the insertion or removal of implanted contraceptive devices and limited access to pregnancy terminations (Human Rights Commission, 2020). While the contraceptive pill could be provided via a faxed prescription, not all people felt safe leaving their home to collect medicines nor may have had the transport or access to do so (Human Rights Commission, 2020). Alongside this, the care that was available varied inequitably by region: while a law change allowed early access to pregnancy termination over the phone, this service was only offered in some regions (Human Rights Commission, 2020). While inequitable access to medical services is nothing new, if a process is deemed important enough to be offered in some locations, it should be offered for all. Failing to do so only further marginalises people already facing barriers to equitable care.

The Present Research

The current research represents a unique opportunity to share the voices of socially marginalised service providers and sexual violence survivors following the first Covid-19 lockdowns in Aotearoa New Zealand, in contrast to interviews taken shortly before its arrival. In the pre-Covid-19 narratives—shared in two interviews that took place prior to the arrival of Covid-19, and when respondents interviewed during Covid-19 reflected on life before the pandemic—survivors and providers reflected widespread inequity in sexual violence care in Aotearoa New Zealand. The following chapter will explore what has changed in the sexual violence sector since the arrival of Covid-19 and whether previously outlined issues have changed as a result.

Analysis Part Two: The First Wave of Covid-19

The emergence of Covid-19 in Aotearoa New Zealand provoked shifts across the sexual violence sector, from changes in the process of day-to-day working through to movement in the broader socio-political landscape. During the initial wave, sexual violence was described as a “pandemic within a pandemic” (Evans et al., 2020, p. 1), where one can no longer be examined in the absence of the other. This description seems to aptly fit the experience shared by providers over this period, whereby they had to navigate two crises simultaneously.

The following chapter is a journey through the first wave of Covid-19, or “alpha”, with the stories shared during interviews following the first lockdown in Aotearoa New Zealand. Fear and worry for people who have and/or may experience sexual violence filters through the discussion at every stage, but especially when the survivors already experienced marginalisation in their pre-Covid-19 lives. The under-serving of the sexual violence sector before Covid-19 rendered services ill-prepared for the influx to come. In turn, the government’s response was not fast enough to address service providers’ concerns, leaving survivors without adequate support and providers without adequate resourcing as the pandemic progressed.

Owing to the novel nature of the providers’ experiences during Covid-19, our deeper understanding of what this means for survivors will likely develop further in years to come. Nonetheless, the societal structures and dominant systems of belief that have long marginalised people remain embedded in the Covid-19 response.

The narratives of service providers—some of whom are survivors themselves—are grouped within five sections. Firstly, *2.1. Locked Down, Locked Out, or Trapped in?* describes how lockdown was not a safe place for all people, leaving some locked out of support services and trapped in with perpetrators. Next, *2.2. Compounding Inequities* describes how the undercurrents of power and control, racism, ability, and sexism that respondents so explicitly articulated prior to Covid-19, are now contributing to the lockdown, post-lockdown, and ongoing experiences of survivors and providers. Following this, *2.3. Telehealth or Radio Silence?* discusses the digital divide and how telehealth was appropriate for some clients but inappropriate for others, with similar issues reflected by the providers. *2.4. Hope and Opportunity* then outlines silver linings that some respondents found, especially within the breaking down of ableist attitudes and practices. Finally, *2.5. A New Normal: Where to From Here?* ponders what the future holds for the Aotearoa New Zealand sexual violence sector and what changes service providers hope will continue following our Covid-19 response.

2.1 Locked Down, Locked Out, or Trapped In?

On the 23rd of March 2020, just over one month following the first case of Covid-19 being detected in Aotearoa New Zealand, the country moved into Level 3 lockdown (New Zealand Government, 2022; University of Auckland Public Policy Institute, 2022). A shift to Level 4 followed 48 hours later, with lockdown persisting until the 13th of May 2020. People were mandated to stay home and have very restricted contact with the outside world throughout this almost two-month period. However, essential services, including sexual violence services, remained (differently) operational.

I did not work as a service provider at all during this first wave, having incidentally finished a student placement the day that the first case of Covid-19 was announced in Aotearoa New Zealand. I left the hospital right as their confusion and fear truly hit, then hid at home in my own fear for the majority of lockdown. Like many disabled people, this was a time of immense stress and uncertainty for me, yet one that also allowed the pace of my life to slow for a while. When speaking to providers following lockdown, I observed that many of them remained in that state of high stress, and I want to acknowledge the emotion behind many of the narratives I will soon share. These sexual violence service providers did not have the opportunity to hide away as I did, instead putting their own concerns aside to continue to support those who needed it most—they are heroes in my eyes and their stories should be read through that lens, frustration, emotion, and all.

Owing to the unique nature of Covid-19, when it arrived in Aotearoa New Zealand service providers had no framework upon which to base their expectations and adapt their practice. Mele, Ani, and Joey, who each worked as essential workers in specialist sexual violence services during the lockdown, described similar experiences in relation to who was seeking support during this time. What they described to me was their understanding of the ongoing high-level need for support, knowing that violence was continuing behind closed doors, but that few people were seeking this support out. Those who did seek support during lockdown were described by providers as more distressed than what services generally saw pre-Covid-19, often navigating complex social situations and unable to access support in their usual ways. These findings support what has been reported overseas (Kourti et al., 2021), as well as the initial indications from other Aotearoa New Zealand violence services (Human Rights Commission, 2020), acknowledging that sexual violence has indeed remained a pandemic within a pandemic.

Ani, who worked predominantly in the crisis space during this time, described her experience where even the service’s regular callers were no longer making contact, suggesting people who did call for support were “trapped” and highly distressed. She reflected that lockdown had amplified stress for people already struggling, and she had concerns that she could not provide them with the level of support they needed as she does not have specific mental health training. This reflects the increased mental distress that survivors of sexual violence had at this time—when access to support was unfortunately restricted—as before Covid-19 she competently and confidently performed her role without requiring this level of training. Ani’s stories here as a sexual violence service provider are invaluable, as while the worsening of mental health following lockdown has been reported for people living in Aotearoa New Zealand in general (Every-Palmer et al., 2020) as well as social worker clients across settings (Alston et al., 2021), the impact of this on sexual violence survivors specifically remains unquantified. Given that sexual violence rates are higher for people who are often marginalised by society—including people who live with mental distress—I fear this intersection may mean that survivors' mental wellbeing is even worse than that of other groups, yet remains unheard and underacknowledged.

Perhaps owing to the lack of privacy many people had when living at home during lockdown, Ani further described that the clients seeking support were remaining anonymous when they called, with it unsafe for the providers to call them unless pre-arranged. This also reflects the experience of helplines aimed at Aotearoa New Zealand children and adolescents, who reported that more young people were calling but doing so with absolute anonymity (Human Rights Commission, 2020). Ani described that the people who were ringing were the clients in very "volatile" situations, suggesting that their circumstances were so dire they were likely putting their safety at risk to seek support. Unfortunately, this volatility appears prominent, with widespread reports that violence increased in intensity, including rates of strangulation, which is of grave concern[13] (Glass et al., 2008; Human Rights Commission, 2020). The bravery of those who sought help under such circumstances needs to be commended, while also acknowledging the many people who were unable to do so—I can only hope in future that all survivors will be safe and supported to report if they wish to do so.

Ani:

In terms of Covid, it was really tough because we couldn't go out … we didn't do police work anymore so we basically were just virtual or on the phones. [There were] Not as many calls, like the regular people even, but the calls that did come in were more worrying. A lot of anonymous people who were really just trapped and quite big mental health issues, like suicidal. I think for people already in volatile situations, this just amped it up.

---

[13] A previous experience of non-fatal strangulation increases one's risk of subsequently dying by homicide by seven times and is acknowledged as one of the largest predictors of escalating domestic violence (Glass et al., 2008).

> It was a very quiet period. The fact is we couldn't do much anyway, knowing that we're not trained counsellors, which is what a lot of people need. The people that were ringing up were ringing up anonymously. I'm thinking of one particular case where—because this person was in such a volatile situation—they weren't giving their name, or they'd ring and hang up, and they couldn't talk for long periods of time, so [team leader] was having to contact them at pre-arranged times when they would be able to get out and be by themselves. Even across with [another sexual violence support service] as well, it was a quiet time… less work overall but the ones that were coming through were really volatile situations. Otherwise, my experience of it was it was creepy quiet.

Joey, who worked more in long-term care and support as opposed to the crisis space, reflected that she did not see large decreases in client numbers but that the way she was working changed. That being, clients who would usually have long conversations with her were suddenly only speaking for short periods. Like Ani, Joey uses the word "trapped" to describe clients during lockdown and suggests that regular clients could not access their usual support to the same extent, as they did not have the privacy to do so.

Joey continuing to speak with her clients—albeit only in shorter conversations—differs from Ani's "creepy quiet" experience, which I think may reflect the differences in their roles. Ani worked predominantly in a crisis space that supports many people reporting abuse and/or seeking support for the first time. In contrast, a large part of Joey's role was a survivor's ongoing support once in her service. Research has not yet explored how patterns of contact may differ within the sector, with this finding—whereby there are significant differences in the experiences of Ani and Joey within the same sector—highlighting the pitfalls of quantitative research which has thus far been unable to tease apart these intricacies. While these findings must be considered preliminary, I interpret that Joey and Ani's different experiences suggest that the drop off in client contact was particularly pertinent for *new* clients, possibly reflecting that they may not have known *how* to reach out for support during the lockdown; a concern that service providers indeed raised, but that could not be addressed quickly enough (Human Rights Commission, 2020).

Reasons for decreased reporting of new violence likely include that some survivors had no privacy at home to make such calls, or even more worryingly, the abuse may have been ongoing and making such a call would put their safety at high risk. These concerns have been cited as an ethical issue for social workers in Aotearoa New Zealand and Australia (Alston et al., 2021) and reported as an issue impacting children and adults alike (McNeill & Gillon, 2021). Ultimately, an inability to access help when desired represents a near-complete removal of survivors' autonomy at this time, and I fear what resulting harms may be seen going forward.

Joey:

It was kind of strange. At first we didn't [see any drop off], but instead of having hour long appointments, the phone calls might be five minutes, ten minutes. And I think it was hard because people were trapped in a house together. They couldn't go out and have that privacy, so I think it was part of that. There wasn't fall off, as in no contact, but the contact was definitely different. I think the therapists, they did more Zoom, and I think it worked a little bit better maybe. But for the social workers, we definitely noticed a fall off just in the length of time each interaction would be. From about an hour to sometimes five-minute calls and maybe 20 minutes or 30 minutes at the most kind of thing.

The word "trapped", used by Ani, Joey, and Storm, is an incredibly powerful representation of what lockdown meant for many people. It was not until I reviewed the transcripts that I noticed how many respondents had used this word, which I see as reflecting the lack of opportunity for people to seek help as opposed to them not desiring to. I now also reflect upon this word in considering the anti-lockdown sentiment of some people and how they may have, even when living in safe and healthy conditions, considered themselves “trapped”—a total disregard for others’ situations that now sits very uncomfortably with me when considered within this wider context of violence.

In considering my first point, a sentiment reflected by all providers—both within the sexual violence specialist services and wider mental-health support—was fear about what lockdown meant for people in unsafe environments; concerns echoed across the world (Alston et al., 2021; Choi et al., 2021; Kourti et al., 2021; Morley et al., 2021). Worries shared by respondents here included new abuse being perpetrated in the home, survivors being locked down with existing perpetrators, and survivors on their healing journey having to live with people who complicate this process. There was a particular concern for people who experience marginalisation, including Indigenous, queer, disabled, and financially stressed people, who we now know did indeed experience more physical/sexual violence and coercive control during the lockdowns in Australia (Boxall & Morgan, 2021). Alongside this, the isolation felt by many people was prominent yet presented an even more significant concern for those already experiencing distress, with social support an important coping mechanism for many people (Morley et al., 2021).

Joey discussed issues that were top-of-mind for her, in her support of the queer community. In a reflection of intersectional difficulties, Joey discussed how returning to a family unaware or unaccepting of one’s survivorship could be incredibly upsetting in itself, yet the added discrimination against a client’s queerness would compound this issue. To further intensify things, the lockdown prohibiting free movement also impacted peoples’ coping strategies and meant those stuck in hostile environments had reduced opportunity to leave. While increased rates of violence have been reported by queer people in the Australian lockdown (Boxall & Morgan, 2021), this specific consideration offered by Joey appears to be a novel finding.

Interestingly, Joey’s concerns were something that, at that time, had not been said by her clients. However, as a member of the queer community herself, Joey used her insider-status to identify concerns that may present for her clients, such as the additional stressors placed on queer people at home compared to their heterosexual, cisgender peers.

I believe this is an example of why diverse representation in services is so essential; peoples' needs remain unique even within a crisis, and these considerations will remain top of mind for community insiders who best understand their diversity—and entirely disregarded by those who do not.

Joey:

I could only imagine what it would have been like. I know some people had to go back to their family homes. If you weren't out [in regards to gender and/or sexuality] or anything like that it would have been hideous going back home. I think it's hard enough going back home as an adult anyway. If you're going back home and still not out, or if your family doesn't accept you it would have made it really hard. If you were allowed to go back home. So although I can't recall any feedback from our clients I can only imagine it would have been really hard for a lot of people.

I think most of our clients were okay. Some of them did have to go back home to Mum and Dad, and they didn't know about their experiences [of sexual violence], so they were kind of like, well what's going on? Why are you being triggered? Because I think it was really triggering for survivors. That whole lack of control over being allowed to do anything. Not having that free will to go out and go for a walk, or, if you've got anxiety and part of your plan is to go down to the beach or go for a swim or something like that. All of that is gone. And so I think it was really triggering for survivors. And if you do then have to go back into an environment where they didn't know about your experiences and didn't understand why you weren't coping, I think that would have been really hard and we did definitely have a few clients like that.

While some people were forced to live in unsafe homes during lockdown, what was also present within the conversations I had was that not everyone would have a family home—or material housing of any form (Choi et al., 2021)—to go to at all. Aila lived in a shared flat during the Covid-19 lockdown and reflected on how they would not have been able to return to their family home even if they had wanted to; a complex issue also described by low-income people living in Aotearoa New Zealand to Choi et al. (2021). Housing instability is an issue that has been raised repeatedly in relation to lockdown (Human Rights Commission, 2020); yet here, Aila is drawing on the systemic issues behind this that were present for them even before Covid-19. They reflected that their family is full of love but due to under-resourcing—the causes of which are deeply engrained in systems of oppression—they are unable to support Aila during challenging times. Additionally, when Aila has seen many people that *do* have such support available, it presents a stark contrast that is upsetting, demonstrating a sad irony whereby those who need the support are often those with barriers to receiving it. It seems to me that despite the colloquial sayings such "love is all you need" or "love conquers all", love without resourcing presents barriers to just how far familial support can go and leaves Aila alone during times of distress:

Aila:

Since I left home really, I haven't been able to go back home. It's just not an environment where I can go back to safely. My dad's maybe I could, but I just don't really want to.

Both my mum and dad downsized when I moved out, so there's never been a room for me since I was 17. At times that's really been hard to deal with mentally, because I've seen so many of my friends when they are having down times, hard times, breakups, when they're ill or whatever, they go back and live with their parents, and that's never been there for me. That's not an option. When I was suicidal last year I asked to go back home and I was told, "No," I can't. "No, that's not an option."

It's hard to verbalise sometimes feeling like you don't have a home, like you don't have the same fall-back that other people do. It's not any fault of my family; like they love me and I love them, but they don't have the resources to hold me in a way that most people's parents do. That's something I will struggle with I think indefinitely.

Aila, as a person in their late 20s, is at an age where dominant narratives suggest they should be independent and no longer receive the support of their parents—a message I certainly hear strongly in my own life being of similar age to Aila. In contrast, children and adolescents are often seen as *requiring* parental support, yet may be living in unsafe homes with limited alternative options (Human Rights Commission, 2020). This lack of autonomy is an issue that is particularly pertinent for children and adolescents, who may not have any means to leave an abusive home without seeking support (Human Rights Commission, 2020), even requiring the intervention of government services to change their living arrangements. I see this as differing from adults who, when adequately resourced and supported, can make their own decisions around where they live and what services they want to be involved in their care. Worryingly, research emerging from Australia is indeed showing that young people experienced more violence during the Covid-19 lockdowns (Boxall & Morgan, 2021); for Aotearoa New Zealand children, this included physical, psychological, and verbal abuse (Human Rights Commission, 2020). It remains to be seen to what extent children were sexually harmed and the impacts on their ongoing wellbeing, yet in considering the intergenerational impacts of violence described by respondents pre-Covid-19, I anticipate these will be wide-ranging and longstanding.

In a dichotomy perhaps unique to Aotearoa New Zealand's lockdown environment, Storm shared an experience where the requirements of keeping a young client safe—i.e., informing their parents that a family member had harmed the teenager—would have caused additional stress within the lockdown environment rather than keeping them safe. Like Ani and Joey, he described that this would have left his client with a sense of being "trapped" due to the lockdown restrictions, with their age presenting barriers by dictating which decisions they were permitted to make for themselves. Storm further pondered the confusion faced by clients in not knowing what services were open and available under the lockdown rules, undoubtedly presenting further barriers to accessing care for those who needed it. This was especially true for those who already had added barriers to accessing information.

In an interesting further reflection of what lockdown meant for the wider population, Storm suggested that freedom of movement is something non-disabled people take for granted. This comparison perhaps reflects that our ableist society has long “trapped” disabled people who, because of imposed access barriers, have had their freedom of movement limited even before Covid-19. The lockdown then brought that to light for people who had never experienced limits on their access—whether this would have increased their empathy towards disabled people, or only acted to increase their individual frustration, is difficult to determine.

> Storm:
>
> [Referring to lockdown] It is really triggering, particularly if the abuser is within the household with that person. Their means of escape might feel quite limited. I worked with a teenager who had been abused by a family member and they hadn’t disclosed to anyone and that kind of became a tricky situation to navigate within the Covid-19 lockdown.
>
> Obviously, [them] being a teenager I needed to mention this information particularly to the parents, but I also needed to take into consideration the fact that lockdown was happening. I can imagine it would create a space of claustrophobia and being trapped. I think we take our physical freedom quite for granted. Those of us who are privileged enough to have mobility, we take it for granted. So, when that’s hindered, even within the ability to leave your house… yeah.
>
> I guess thinking about whether or not it's appropriate to ring the services within an emergency situation. Can I call up a service and can they come to the house, where we have these bubble rules going on? I know things like that would have gone through my mind, if I was thinking about accessing services [for myself] under the Covid-19 situation.

In Aotearoa New Zealand, the lockdown meant the closure of some services and widespread confusion about which services remained open for people to access support (Human Rights Commission, 2020). However, service providers highlighted how not all forms of support are appropriate for all people, and the restricted access over this time closed many doors—literally and figuratively—for those needing help in a specific way.

Rachael described that even with the knowledge that police were always available, they were not an appropriate option for some of the young people she worked with. Within Aotearoa New Zealand, Māori, in particular, have a fraught relationship with police owing to longstanding systemic racism within the criminal justice processes (Came, 2013; Human Rights Commission, 2012). Likewise, disabled people—especially those with psychological or developmental conditions which are otherwise not "visible"—have not always been acknowledged or appropriately supported by police, leading to inappropriate responses. The low rates of reporting to police for sexual violence for *all* survivors, irrelevant to identity, are suggestive of the stigma around sexual violence reporting (Ministry of Justice, 2019; Rousseau et al., 2020). For people who are additionally subjected to discrimination as a result of how they are socially categorised, this intersection is more likely to lead to negative experiences if they do seek police support. Thus, it is evident why non-police support services are preferable—if not the only safe option—for some survivors.

I wish to be upfront in my positioning here, having myself had conversations with police in my role as an advocate that left me disturbed. This includes: a *female* member of the specialist sexual assault team telling me that, in relation to a survivor who was assaulted while unconscious, "often people think they were raped when they have blacked out but actually they consented before that and just can't remember"; when I was asked to stop a survivor taking so many breaks while having an evidential video interview completed, because their distress was "taking too long"; when hearing a leading *male* defence attorney saying he would never encourage his daughter to go to court because the process is usually far worse for survivors than the outcome could ever be for perpetrators. These experiences—I think understandably—mean I too hold doubts about how well survivors are supported in the criminal justice system. On the other side of this, I have also hugged and cried happy tears with survivors following the sentencing of the person who harmed them, seeing just how impactful and important that was for them. Thus, when used appropriately, there can be benefit—I am just dubious of how many survivors must be mistreated for one to have a positive outcome.

During lockdown, for Rachael and the young people she worked with, not reporting to police meant having to wait until appropriate support services opened again. I can only imagine the anguish and sense of powerlessness felt by survivors at that time, especially if the perpetrator remained in the home.

Rachael:

I was supporting our coach in the regions to support a young person who was the eldest in her family, and never spent much time at home; and neither did her younger siblings who she more or less cared for. Physically and sexually abusive household that they were forced to be locked down in during this time. She reached out at 17 to our coach who is 23. Walking alongside this process, when literally the services in the communities are closed, during the lockdown period. The police were always available, but a lot of our rangatahi [young people/adolescents] have a mixed relationship with police.

In a lot of the cases, they were the only available service if there was immediate danger. Problematic - just no easy solution to answers. Sitting with the uncomfortability and keeping the lines of communication open, and making sure that the services (once they were open) are made aware [that the young person requires support].

Following lockdown, Ani, Mele, and Joey each described an unprecedented influx of people needing support, which has now overwhelmed the already-stretched sector and amplified the issues that came from sexual violence being under-prioritised as an issue before Covid-19. Reflecting upon my own experience of how the caseloads held by service providers prior to Covid-19 were bordering on unsafe, I cannot fathom how they are managing this increased demand.

Unfortunately, the reality of this has meant that survivors who reported to services post-lockdown could not necessarily access the care they needed. Mele described survivors being told to ring multiple providers in the hope of finding anyone with availability, in a process that is not only incredibly discouraging, but that I worry may make one feel undeserving of care whatsoever. For service providers, the areas that support is needed broadened, yet no extra financial support was provided to the services to meet this expansion, with a lack of funding reported by social workers across multiple support sectors (Alston et al., 2021). For a sector that was stretched even before Covid-19, I fear this may lead to disastrous levels of burnout for providers and more survivors unable to access support.

Mele described how lockdown led to this increased wave of reporting, which in a way I see as reflective of both positive and negative reasons. For one, the increased emphasis on wellbeing meant that survivors felt they deserved to seek support for historical abuse, which I think is a silver lining among the gloom. This may be a finding unique to Aotearoa New Zealand’s Covid-19 response, which emphasised empathy and kindness as critical elements to getting through the pandemic (Beattie & Priestley, 2021). However, in a much less positive sense, for others it is likely they were then able to move away from the person harming them and safely make the required calls.

Mele:

When we came out of lockdown it was still quite slow in the first couple of weeks but now it’s just full on busy. We’re *really* busy. We had 30 referrals in a fortnight and our counselling waitlist is closed. When I say closed, it means no new clients are being added but there are people already on it. Those people have been waiting for months and most have nowhere else to go so they wait. Services are stretched right across the city and they are inundated with people looking for support. A lot of those services are referring every client to us that mentions sexual violence, even if that is not the client's main concern at the time. We are supporting people with their formal police interviews at least 4 or 5 times a week when previously it was once or twice.

Researcher (Caitlin) asks: Do you think the increase in work has been related to lockdown?

Yes, the lockdown has definitely contributed to it. People have been stuck at home and had the time to think about their wellbeing and the harm that they've experienced. Some of them had these realisations that, 'Actually I wanna do something. This has actually been quite harmful.' Also there was the other side of it where there were people at home with their perpetrators or in a home where they just couldn't ring or reach out because it either wasn't safe or there was no privacy.

2.2 Compounding Inequities

This research appears to be novel in its qualitative discussion of compounding, intersectional inequity specific to the sexual violence context. In our discussions, both survivors and providers—including those who are both—drew their worries back to the power imbalances that perpetuate sexual violence and how the inequities experienced through marginalisation have been compounded by Covid-19, reflecting the quantitative findings of Boxall and Morgan (2021). Discussions centred around practical factors such as job losses and more mouths being home to feed, but especially how these changes were even more impactful for already marginalised communities. Mele spoke about the lack of access to sexual violence services in regional centres and how they will now be struggling further due to the overwhelming increase in need that is being seen nationwide—as someone who grew up in Taranaki (a rural region in Aotearoa New Zealand), this is a reality I am all too familiar with. Looking at it from a bigger picture, Rachael described how lack of access to communication, education, social support, and secure housing perpetuates distress and are underpinned by issues resulting from poverty and colonisation. Centring abuse and harm within this broader landscape paints a compelling picture when compared to the privileged, hegemonic population's concerns during lockdown:

> Rachael:
>
> I was really grateful when the mainstream news started to talk about domestic abuse and sexual violence rates going up, because of course, that was many people's reality. I was so sick of hearing about people whining that their golf courses had closed down, or bored families making orientation courses across their Grey Lynn households. It was just so far from the realities of too many.
>
> Our most vulnerable pre-Covid, are just going to continue to be further isolated, especially because of the digital divide. … Reception, infrastructure, privatisation of telecommunications and everything is shocking. Especially if that's where we continue to focus on the future of education.
>
> And education in all ways through tertiary, through secondary, but also education in terms of the social skills; like the mates and dates programme that ACC rolled out. They're really crucial and vital social skills that young people learn and practice, and crunchy stuff that is important to understand how people operate. Those experiences would just not happen if people are having to learn solely from home. There's a lot to unpack there. …
> Housing crisis, everything, as you talked earlier with the intersectionality. This specific kind of violence is all interlocked with everything—poverty and the effects of colonisation. It's only going to get worse. I think we're in a little bubble right now.

Much like Rachael, all providers spoke with me through a shared lens of social justice and advocacy for the people they work with. Ani talked about her experiences of supporting women in emergency housing during lockdown—which saw an increase of 15-20% over this time (Human Rights Commission, 2020)—and the impact of lockdown on the wellbeing of people who were housed there. Using emergency housing is already representative of the level of difficulty one is experiencing in their day-to-day life, yet due to Covid-19 those requiring assistance lost further access to their familial and social support. For wāhine Māori, who are unfortunately over-represented among women who require emergency housing, the loss of whānau support is particularly impactful. Ani reflected that these intertwined experiences then led to increased mental distress for the women she worked with:

> Ani:
>
> Because I was an essential worker I got out and about. I wasn’t just stuck at home the whole entire time. But it was so hard for those women [in emergency housing] to get through the idea that, no you couldn’t just go out and meet people and do those things. In the [emergency accommodation] it was just the idea that, we’re just gonna go and see whānau and it’s like, “But you can’t. I’m sorry but you really can’t.” It’s like you’ve gotta make the call now. You’ve gotta either decide that you’re gonna go and stay there for the entirety of lockdown or you stay here and you can’t make those visits. For them, depression just skyrocketed and mental health was a huge issue. That manifested in real violent outbursts. There was a lot of pseudo-counselling on our part but then trying to reach out to different organisations.
>
> It was tough on the women not seeing family, not being able to be with that family, or that whānau. But not having that option of going to stay there because that’s why they’re in [emergency housing]. Obviously if it was an option they would be there. Then cutting those supports. It was really isolating, which if you have mental health issues, or dealing with addiction and those sorts of things, it’s just going to make it a million times worse.

Unfortunately, Ani—whose undying passion for work in this sector is eminent—described having to resign from a service, in part due to their handling of Covid-19. The choice of this service to close their doors during lockdown went strongly against her moral code, especially within her frameworks of te ao Māori, given it was a service that was meant to be dedicated to the needs of wāhine Māori. She suggested that women were labelled in a stigmatising manner within this service, among other issues that she decided not to touch on further owing to privacy concerns. Interestingly, she initially asked me to remove all mention of this experience from the transcript of our conversation but later contacted me again saying that she changed her mind, and this information is important to share—acknowledging we perhaps need to rock the boat a little to see positive change. This further reminds me of comments from other service providers, including Natalie expressing that *"I'm so glad this is anonymous"* (de-identified), which I believe shows providers wish to bring light to the issues yet remain afraid of backlash. I indeed know that some of the thoughts I have shared in this project will upset people who wish to maintain the status-quo, yet I choose to remain provocative—albeit to an extent, needing to balance my advocacy with my identity and professionalism as a registered healthcare practitioner—so that these issues can have the recognition they deserve.

In demonstrating that workplace issues are not new, Ani described that the difficulties she faced in this role existed before Covid-19 but that the pandemic exacerbated them. This suggests to me that changes need to be made within services above and beyond an increase in funding—which was all that was provided to them during the pandemic, if even that—as money is not enough to fix embedded discrimination. Unfortunately, this struggle remains a familiar story with service providers who have all the support in the world to give, within a system that prevents them from doing so. Without systemic change to better support survivors *and* providers, discriminatory and unfair treatment of both groups is likely to continue.

Ani:

I resigned from [Māori support service]. Just my own personal thing, I was horrified that [the service] was empty. It was empty during lockdown. I asked, I think, a few too many questions. I just was being annoying. My family has been involved in [the service] for a long time so I was excited to be working there and some of the things that I saw and some of the practices… as a wahine Māori I was a little bit shook by, or disappointed by I think is a better way. Some of the way we labelled our woman, etc. [Prior to Covid] I was already, maybe in the managers face a bit too much. I thought the best thing to do was to resign because I was getting quite frustrated by it. You know in yourself when you're doing this sort of thing you can only bang your head on a wall so many times. The wall is not gonna move.

2.3 Telehealth, or Radio Silence?

A prominent narrative described by every provider was their experience of shifting to working via telehealth. While telehealth's flexibility for providers and survivors who have access needs was praised—indeed, making many aspects of my own disabled life much easier—its challenges were also highlighted (Alston et al., 2021). The stories shared by respondents around telehealth tended to focus on either the practicality of its use or the inequity it perpetuated for clients with limited access to technology. Providers spoke of people doing telehealth from cars or from park benches because there was nowhere safe in the home to have these conversations, which were discussions I frequently heard colloquially from service providers in other healthcare settings at the time too.

Unsurprisingly, the communication issues that exist because of the underserving of marginalised communities continued to be an issue during lockdown. Two providers described language barriers and difficulty accessing interpreters during this time, reflecting intersecting barriers to support culturally and linguistically diverse (CALD) communities. In Mele's experience, she reflected how being non-English speaking cannot always be corrected by a direct translation, with cultural needs underpinning all interactions. In an experience shared by Mele, and one that is also frequently reported among other CALD peoples and the Deaf community, a family member was the most accessible person for translation, yet this was not possible owing to privacy and the young person's safety. Additionally, in this circumstance, Mele described how the power imbalances between Samoan men and women, and the need to honour men's authority, meant that communication was a delicate balance of the survivor's needs with cultural sensitivity. This is yet a further example of how the underserving of communities through racism, ableism, and sexism remains an issue during Covid-19; one crisis simply does not replace another.

> Mele:
>
> We had a Pacific Island family who were in need of assistance. A young girl had been sexually abused and someone needed to tell her parents. The father was open to talking with us because the mother was ill, but he couldn't speak English very well. The only person that could translate was her brother but he was really young so asking him was not an option. We had a staff member who could speak their language but she was a young female. A young Pasifika woman telling a Pasifika man that his female child had been sexually abused is a very difficult conversation. There was a lot to consider here as their culture dictated the appropriateness of who should go, what is said and how it's said, all while remaining respectful to him and providing support.

Joey reflected similar issues in accessing appropriate communication within her role, especially when CALD communities are small and know one another. If a survivor's only option for translation was a community-insider who also knows their family, especially in communities where speaking about sexual violence is taboo, Joey worried that survivors would be unable to speak freely. I myself have supported a non-English speaking survivor with the help of the translator who knew the client from their community, but who was the only available person, making me relate closely to Joey and Mele's concerns. Additionally, Joey discussed that finances present a barrier to accessing translators for clients, an issue that existed before and will likely persist post-Covid-19. When sexual violence services are already chronically underfunded, the more “unique” needs—i.e., those that are vitally important but not often used for people from the hegemonic group—are likely to be under-prioritised, leaving diverse survivors without appropriate access to care:

Joey:

I think there can be issues, especially around some of the smaller communities, where everyone knows each other, and then feeling free to disclose and talk freely, especially if you’re going on to therapy sessions, like that could be really problematic. And then of course the cost of it as well, which is really big for small agencies.

Mele reflected that some of these financial issues can be avoided when working with police as they have their own translation service. However, as discussed earlier not all survivors—especially those from communities distrustful of police because of previous harm—wish to be engaged in the criminal justice process and thus are disadvantaged in their ability to access communicative assistance. This presents further barriers to access, which I fear will only become more deeply engrained with the influx of survivors and subsequent thinning of available funding.

Alternatively, like the research of Every-Palmer et al. (2020)—as discussed later in the section *2.4 Hope and Opportunity*—Mele described a silver lining that has come from a move to telehealth. In relation to accessing translators, Mele discussed that telehealth allowed new opportunities to access appropriate therapy. In particular, CALD survivors have been able to undertake treatment with counsellors nation-wide, meaning that they could be matched with someone who also speaks their language in a meaningful demonstration of how barriers can be broken down by simple changes in policy[14].

---

[14] Prior to Covid-19, ACC would not fund telehealth for survivors, with all care needing to be provided in-person where available.

Mele:

The good thing about telehealth (online support) is that it’s enabled us to connect clients to counsellors all over the country. That’s been amazing. We supported an Italian woman who spoke little English and we could not quickly find an Italian speaking counsellor locally but via telehealth we were able to connect her with someone on the other side of the country. If we can't find anyone in our network, we use organisations like Easy Speak or Interpret.Org. Even these services are busy and when booking we have to hope that (1) they have someone who speaks the required language, (2) that they’re available, and (3) which is just as important, is that the person is someone who is able to receive and translate sensitive information.

Throughout our conversation Storm described his telehealth experiences in an intricate weave of reflection, discussing how working online/over the phone presented unique difficulties for Māori clients. He recounted the challenges faced in accessibility for his clients, their therapeutic relationship, and cultural responsiveness when communication kanohi ki te kanohi (face to face) is preferred.

Specifically, Storm reflected that the digital divide, which disproportionately impacts Māori, was an issue for him; and in whānau that did have devices, the children were often still reliant on their parents for access to these. Alongside cultural practices that mean face-to-face care is more appropriate for Māori clients, he noted difficulty with empathy and being able to gauge the health of one’s mauri (material symbol of one’s life principle and source of emotions). He worried that working with children and adolescents on the phone may mean that building a relationship was difficult or that they would be unfairly labelled as non-engaging, which is a stigmatising label in healthcare settings. Arguably, these concerns were not given adequate attention in wider media in relation to Covid-19, with telehealth perhaps having a more significant impact on Māori clients than Pākehā. If telehealth continues as a regular therapeutic practice method, Storm’s reflections suggest that deeper cultural considerations are required.

Storm:

I did do telehealth. [It was] Hard. I worked within a kaupapa Māori service. A lot of my clients didn’t have access to computers so I relied quite heavily on the phone. I was also working within a [child-focussed] service. Some of the children and adolescents that I was working with didn’t have phones, so became quite reliant on the parents handing over their mobile phones to the kids so I could give them therapy. Tricky.

Also trying to find that empathetic element. I know for myself, my empathy emerges when I see people, and when I wasn’t able to see my clients and only could hear them on the phone, I found myself becoming less empathetic. It's not because I was more punitive towards them or anything like that; it was more I couldn’t pick up on emotions as well within their voice. [As someone who is hearing impaired] I’m really dependent on my sight when it comes to empathy, body language and reading facial expressions. So, that became really hard. I could tell they were going through tough situations, but trying to draw on that emotional aspect that I normally do a lot for the work I do, was really hard. Wanting to be just like, ‘Man, can you send a photo of you so I can see how upset you are?’ Obviously super inappropriate and I didn’t ask anyone to do that, but felt like saying that at certain times.

I think communication over the phone is… there’s a certain level of respect that comes with seeing someone and being with them face-to-face. I think what I noticed with my service was that Māori… and this runs true for myself, is that physical expression of emotion is quite prominent. I find when I do express emotions it usually is quite a physical thing for me, which is why when I experienced the sexual violence I did and I wasn’t able to physically express it, I was like, “Oh, something’s blocked, something’s not going right.” I think having that face-to-face and being able to connect in that real tangible eye contact manner, and being able to be in their presence and understand what their mauri is doing in relation to yours in front of you, is really important.

Particularly with children and adolescents when we're thinking about language and how that develops. Maybe the vocab isn't quite up to scratch of where a clinician needs it to be, but their physical presence is so important. With your teenager who doesn't talk on the phone, you think, 'They're not engaging.' All those yucky terms. But in actual fact, if you had them physically in front of you, what you might see is that you've got a really flat teenager who's just head down, hoodie up, and just feeling so woeful.

I think particularly for Māori that's really important. Our stance represents a lot about who we are and how we hold ourselves, particularly in relation to emotions.

On the other end of the phone, Aila's therapy continued during Covid-19 and they described the challenges involved in their transition to telehealth from a service-user perspective. While they found they were able to prioritise their wellbeing more in general, in relation to therapy specifically, Aila found telehealth blurred the boundaries of care between their therapist and themselves while feeling less supportive overall. Therefore, on one hand, lockdown appears to have allowed survivors the opportunity to use their coping skills and thrive in their self-care; yet, on the other hand, it may have been much harder on people who use regular therapy as part of keeping themselves well:

Aila:

I kept to my group homework like an A-plus student. Had my yoga every day. I cooked and ate much better than I usually do. I really learnt to look after myself. My other therapist also phoned in – my private one phoned in every two weeks I think, which was good. Weird though, like definitely weird to have. I think particularly for me, as someone who has attachment issues—and I do find it hard to hold boundaries with her in particular, I see her as a really maternal figure—that it did feel vulnerable, and it did feel really intimate. I saw her dog. There was that little part of me, I guess that inner child that was like, "You're my mum now. Can I come over now? I've seen your room."

So, that was kind of odd, but it still worked alright. I definitely prefer being in the room with her. I think a good therapist does hold a space in a physical sense, and that presence is like a bit of a hug. There wasn't that same sense over Zoom, but it still was definitely way better than nothing.

Alongside clients' needs, what was also reflected by providers was that telehealth was not a good fit for all staff. Social workers have shared similar sentiments in general settings (Alston et al., 2021); however, the specific nature of sexual violence support means there are some unique considerations for these providers. Work within sexual violence can be sensitive, and like the blurring of boundaries described by Aila, the lockdown meant bringing this work into their home environment. Mele reflected that for providers who lived alone, this was particularly difficult because the clients were "in" the providers' homes when none of their loved ones could be. This contributed to difficulties with separating work and home life, impacting the wellbeing of providers. Mele further describes that while the portability of telehealth is helpful, it also meant that disconnecting from work was more difficult. In a way that succinctly sums this up, I remember seeing a quote that stuck with me around this time—*you are not working from home, you are living at work.*

Mele:

The one thing that was hard, where staff struggled was bringing their work into their homes by way of device. The after hours team was used to this as they are based at home but for the week day staff it was a different story. Some staff weren't used to having their client work online in their private space. Particularly for people who either lived alone in small apartments or were in a house full of kids who were being home-schooled and had other family members also working from home. Having their clients in their home was a new way of working and some found it hard to separate what was previously separated by a physical building. One person who talked to clients by phone said she felt like she was carrying the person around. That was different. At first it was kind of cool, then after a while it was like, “Oh no, this is not working for me. I don’t want this person, this thing, or reminder with me everywhere I go.”

In a reflection from providers that demonstrated how they too require support, alongside struggling with telehealth, some providers explained they were not in a well-enough place to provide support at all. In the public discussion of essential services, much attention and praise went to the medical field with little emphasis upon broader supports. Social workers have specifically spoken about feeling left out of the healthcare-hero narrative (Alston et al., 2021), which has made me ponder who else we have failed to acknowledge over this time. As a result, these “other” support workers had to juggle changes in their work environment, worry about their clients, and worry about the health of themselves and their families, without much recognition of their contributions and how challenging this was. This multitude of personal and professional concerns within the sexual violence sector reflect those shared by social workers in other settings, suggesting this was a widespread experience important to note (Alston et al., 2021). Understandably, these challenges meant that some providers’ wellbeing suffered, and choosing to step away from work at that time was a necessary form of self-care. In one example of this, Aila opted not to work as a provider over that time, explaining:

Aila:

No, I elected not to. I could have. My work was obviously an essential service. But, I just felt that it was that whole thing; I always think of that in aeroplanes where they’re like, “Put your own mask on before you put someone else’s on,” and I was like, “My mask is not on!” Like, I cannot hold space for people right now, because I’m really struggling. That just wouldn’t be sensible. So, over level three and four I just told my boss, “look, I can’t.”

Due to the under-prioritisation of an incredibly stretched sector, staff stress and burnout was an established issue in the sexual violence sector even before the pandemic. In one demonstration of the effects this can have on services, Mele discussed the sectors high staff turnover prior to Covid-19, but especially after its arrival. While staff redeployment has been discussed as a common issue impacting service provision (Alston et al., 2021), choosing to end one's employment in the sexual violence sector, owing to pandemic stress specifically, has been less explored to date. This is likely an issue that needs investigating, given it is being described by Mele and a personal experience of Ani.

Work during the pandemic has undoubtedly been incredibly scary for providers. Joey spoke of the fear that surrounded essential work when there remained great uncertainty about the nature of Covid-19. This was especially impactful for Joey who is disabled herself, where the balance of her own safety and her clients' needs was challenging to navigate. Being conscious of my own fear at that time, without even needing to consider the health of others, means I have particular respect and compassion for Joey's experience; I am unsure how I would have coped with this in a way that I could be useful for anyone else. While Joey did manage this as best she could, addressing this fear will likely be a critical factor in maintaining provider wellbeing and reducing sector turnover.

Joey:

I worried that [another organisation] had stopped doing those supportive [medical exams] during that time. I just thought, "Well there's PPE. Hospitals work, why can't we do that?" But at the same time I was also like, "Oh yeah, I don't want to be in there." Because at the beginning you didn't know what was gonna happen. You didn't know how big it was going to get and you saw on TV all these disasters happening overseas and it was like, what if that happens here? Like my health isn't great, I catch everything that goes around. I feel like my immune system is compromised. So part of me was like, "Yeah, I don't want to go support," but the other part of me was like, "I feel like we should still be supporting at these appointments and these things."

Despite the concerns, Joey spoke of her organisation's preparedness and how this allowed her to feel safe and supported. Despite widespread shortages, they had access to the required PPE, which was not the case for all services. She discusses how this response was led by fantastic management within her service, who also prioritised the wellbeing needs of their staff within their response. This demonstrates the need for an appropriate pandemic response both for the needs of clients but also the needs of staff:

Joey:

We were really well prepared, our pandemic plan was amazing. [Name], who's now the [managerial position], she had a pandemic plan pretty much straight away, like weeks out, months out even. So we started preparing early on, we were getting masks when there was still masks in the shops. We had gloves. We had all kinds of stuff. We had an idea of who needed help, who didn't, how we would work. We bought laptops for staff to have at home, and then, so by the time it was actually lockdown we were just ready to go.

It was so amazing. We'd already had a day all working at home just to test how we would work remotely. We've had to have people come in and upgrade all our IT stuff. So we were so well prepared, and it was mainly because [name] saw it coming. She was following it early on when it was still just in China, and she basically was like, "Nah, this is gonna go all over," and she just had it all under control and that gave us all the confidence to go, "Yep, we're gonna be okay," and we knew [wider organisation] would look after us. They made it really clear early on that if any of us got sick they were going to support us no matter what. No matter how long it took. No matter if we had leave or not. We wouldn't be using up our holiday leave, it would just be sick leave, and then after that they would still pay us. So it was just like, okay, well no matter what happens we know that we're gonna be fine.

2.4 Hope and Opportunity

Intertwined throughout these narratives of forced change, stress, and difficulty, were some beautiful stories of resilience and positivity, experiences dubbed as “silver linings” (p. 1) by Every-Palmer et al. (2020). Flexibility is described as a core part of this, with ACC allowing flexibility in the use of telehealth services and the government providing increased and less ring-fenced funding to services. There was also a sense from those with disabilities that lockdown meant that people were more understanding of what their day-to-day life looks like, and likewise, their lifestyle was suddenly “allowed”. Aila described how their slower-paced, self-care focussed lifestyle was validated by wider society, which due to widespread ableism, was not usually the case. This allowed them to prioritise their wellbeing and look after themselves better than before lockdown. As a disabled person, the consumeristic, money and productivity led society that was prioritised before the arrival of Covid-19 did not fit Aila’s needs, with the slower, wellbeing-led priorities of lockdown fitting with the pace of expectations that were preferable for them. This was also my own experience, for the first time being able to fully guide my days based on levels of pain and energy, without feeling guilty for doing so—with this shared sentiment bringing us closer together. Our shared experience also reflects the sentiments shared by older people living in Aotearoa New Zealand speaking to Stephens and Breheny (2021), who are another group significantly impacted by the capitalist social narratives of required productivity and ableism.

Aila:

I would never want to belittle the tragedy that Covid has been, but honestly, it was an opportunity for me. Because, as I said, having that kind of orientation where you are, prone to self-sabotage and you are prone to devaluing your needs, or in kind of favour of productivity or giving, when your productivity or giving is kind of blocked, then there was a lot more room for me to feel okay about looking after myself, and to feel that was allowed.

Similarly, as a disabled woman, Joey reflected how this newfound understanding, whereby there are altered expectations for achievement, benefitted her within her workplace. She reflected that, previously, she felt shame and guilt over lowered productivity when compared to non-disabled colleagues, with stress then perpetuating a worsening of her condition in a vicious cycle. This reflects my understanding whereby the dominant cultural narrative equates productivity with worth and disabled bodies as subsequently unworthy. Therefore, when Covid-19 gave workers “permission” to focus on themselves, Joey felt more accepted. This breaking down of ableist, consumeristic work culture was a ‘silver lining’ for disabled workers and one I hope can continue moving forward.

Joey:

It’s quite nice. Especially this whole, if you’re sick don’t come in at all. It’s like, oh, yeah actually that’s really nice. Because I’ve had [physical disability] all my life. I think I got my first serious bout of it about 17. Like I’ve had periods of time where I didn’t work for five years at a time and I always felt that, people would go, “Oh, what did you do with your day,” and I would be like, “Oh, I didn’t do anything actually today. Didn’t manage anything.” And I felt such shame over that and when stress happens my [physical disability] flares up, and stuff like that. So, over Covid, and especially because I was working from my laptop on my lap or not having a good setup, I was starting to have pain and so it was quite nice just to have no expectations of having to go anywhere, do anything. Yeah it was nice, in some ways.

However, reflecting the heterogeneity of disability and experience, a positive experience was, of course, not the case for all disabled people. Rachael described that being locked down meant her pain increased, and she became very isolated. This is an issue that I imagine was incredibly widespread for disabled people and will only become apparent in time to come. However, despite her isolation and increased pain, she reflected an incredible resiliency where she framed lockdown as preparation for overcoming future challenges, much like the older people living in Aotearoa New Zealand who drew on their experience of previous trauma to help them cope with Covid-19 (Stephens & Breheny, 2021).

> Rachael:
>
> What I'm currently navigating, and this is all very relevant to Covid-19 as well, is during lockdown I was in an apartment which was maybe twice the size of this teeny-tiny interview room, maybe three times. But, one room, my view was into a backpackers. I couldn't see the sky. I solo isolated for 58 days. It was challenging. I also felt at some points this is a great mental challenge for me. I do like to push myself; just to sort of make sure that when the world ends, or when something bad happens (as it always does, bad things always happen) I'm just that much more independent and resilient and know that I can do this. I'll just think, "I isolated for 58 days, I can get through this."
>
> … I was 'diagnosed' with fibromyalgia at the start of the year and I was starting to feel some pain from it. But, during Covid-19 it escalated incredibly. Working from home and doing everything from home; six months of working in this tiny little apartment.

2.5 A New Normal? Where to From Here

The final narratives that were central to Covid-19 encompassed the uncertainty of looking towards the future and where things will go from here. Ani described not knowing what the "new normal" would look like, making us ponder when and if there may ever be a stable "normal" again. There was a large sense of foreboding among both providers and survivors that things are going to be worse before they get better, especially for the communities impacted by compounding, intersectional inequities.

Rachael reflected that on an individual level, we are likely to see widespread harm and distress, including human rights violations against people who need the most protection. In a demonstration of how different forms of discrimination can intersect to lead to further harm, she predicted how rising economic instability, job losses, and increased tensions will in turn exacerbate power imbalances already present in society. Worryingly, these are most likely to impact people who are already marginalised, meaning the impacts of Covid-19 may not end with the pandemic itself but be seen for years to come.

Rachael:

Our most vulnerable pre-Covid, are just going to continue to be further isolated. …

We're going to hear a lot more before we hear a lot less. I guess that's going to be like with everything in Covid. We're going to hear a lot. There's going to be some horrific stories that start coming out that are already coming out over this year, with this lockdown, internationally. I can't imagine some of the human rights violations and atrocities that will be going on, and people are desperate and have that additional pressure put on.

In terms of like predictions, I think we're in a honeymoon period now. There will be some organisations that will survive or close down by the end of the calendar year, and then there's the end of the financial year 30 June next year we'll see a lot of stuff winding up. The loss of a lot of jobs and livelihoods. Government subsidies are not going to continue forever. There are going to be some really dire consequences and that's just going to heighten relational tensions and upset the power and imbalance further. I think that's reflected in everything. Power imbalances is really what the core to rape culture is, and certain validations and authority; and systems and cultures in every way. Unfortunately, it does mean that some sections of society experience some pretty harmful, physical, emotional, psychological ramifications because of it.

Respondents' stories of hope looking forward centred around the increased resourcing of the sexual violence sector that came because of Covid-19. This included increased funding that can also be more flexibly used and the ability to highlight and address the inequities that exist in a society positioned to maintain sexual violence. However, I feel it is vital that improvements are recognised for what they are: merely a delayed response to the systemic and widespread barriers that should have been addressed before Covid-19, not some wonderful gift that exceeds what survivors deserve. Ani was hopeful that this care for communities who have been long underserved would continue, with more support available and higher representation of marginalised voices in places that matter. Ani's words of hope were strong, as was her faith in younger generations who will continue this fight long after we, as current providers, are gone. I hope her predictions are correct and sexual violence can remain a priority in the conversations going forward.

Ani:

[In terms of government response] I don't think Covid-19 necessarily highlighted anything other than how quickly we could respond. The amount of rough sleepers on the street – I think it's a unique set of circumstances in terms of hotels becoming available. The thing is that there is the opportunity for a lot of these social problems to be looked at in a real fresh different way and it just seems like if we can continue that upward trajectory, that would be amazing. If they [the Labour Party] do get to stay in for a little bit longer then there might be a chance of that continuing in terms of looking at funding, looking for mental health, for sexual violence services, for family violence services, for more collaboration across the board. Even Corrections, that sort of stuff. But because of our three-year cycle, I think it makes it problematic cause then they've gotta start pulling back. Then the other thing is that maybe people having had this taster, doesn't actually necessarily affect their day to day lives as much. Helping other people, it lifts us all up. I'm such a hopeful person.

There is a real need for… we don't have the people on the ground. I know that for the District Health Boards, certainly [location] are saying, "Oh yeah, we want Māori and Pasifika, oh but you need to have this much experience." And then hiring from overseas? I think we need to invest more in that infrastructure. That would be where I'd put funding. If you have support workers… cause a lot of the support workers are that sort of demographic. Then put money into upskilling your workforce maybe. I think definitely younger generation; I think it just gets better. The younger people are always the hope. We keep on seeing that over and over again, just that the change will come.

Conclusion

now
is not the time
to be quiet
or make room for you
when we have had no room at all
now
is our time
to be mouthy
get as loud as we need
to be heard

A poem from *The Sun and Her Flowers*
Rupi Kaur (2017, p. 227)

The Beginning of the End

In trying to conclude what is this complex, intertwined reflection of many years work, I feel it is only appropriate to go back to the beginning. At its core, this research was born from my desire to empower people who, through no fault of their own, are deemed as unworthy, lesser, even illegitimate; whose autonomy has been coercively or forcibly removed; and whose discrimination and poor social conditions are so embedded in our history that society fails to even question their unjust treatment. As a disabled woman, I have been marginalised by dominant social systems that decide I am worth less than my peers, yet from this subjugated position I have clawed my way to yell from the rooftops that we deserve better—whether I am being heard is another question entirely.

In 2018 my eyes were opened when I began to work in the sexual violence sector, watching disabled survivors navigate a system wholly undesigned to support them. Sitting in clinics, hospitals, at police stations and in court with people at times entirely broken by their experience, both physically and mentally, I watched the embedded, oppressive social systems—patriarchy, rape culture, colonialism—in action; how they allow sexual violence to permeate our society in the first place, then also stop survivors from healing. This was especially true for survivors who experience marginalisation in multiple ways, our queer, Indigenous, disabled, migrant whānau, whom I discovered were not only being underserved within support services but were being left out of the research and conversations on how we change this. I felt drawn to this topic, without leaving anyone behind.

A Pathway to Methodology

With an understanding that sexual violence disproportionately impacts minority and marginalised communities, gathering and exploring the experiences of those underserved in society was vital to exploring how and why this is the case. In turn, intersectionality became a core guiding principle, providing a framework to understand the unique experiences of people who inhabit marginalised social locations and to, as described by Grabe (2020), "privilege the standpoint of the activists" (p. 6). Importantly, intersectionality places blame for any harm that people experience within the systems of power that act to categorise, marginalise, and dehumanise them, rather than ever being the fault of the individual for being who they are. In turn, intersectionality became a way for me to honour the uniqueness of people and all their intersecting social identities—including making space for pride in their individual identities—while still acknowledging the dichotomy that such groupings exist because of social categorisations which are often more harmful than not.

By firmly acknowledging that people live socially unequal lives and that hierarchical social categorisations lead to unjust, harmful outcomes for those on the lower rungs of the social ladder, I decided that the unheard, minority, and marginalised voices must be prioritised in my research. This provided the insider view of issues that the majority group can only see from their rose-tinted social location. In turn, elevating these long-silenced voices became an act of resistance against the power structures which push certain people to the margins of society, determining who is worthy and who is not. I sought not only to have underserved people as full participants, but as experts creating a voice for collective mobilisation.

It was pertinent that my methodology reflected social-justice-informed principles central to my position as a researcher. In revisiting the details, seven people spoke with me during eight unstructured, teller-focussed interviews (see Hydén, 2014), sharing deep, personal stories of their lives. While recruited as either key informants (sexual violence service providers), or disabled survivors of sexual violence with multiple marginalised identities, these categorisations became obsolete as many respondents embodied both locations. Respondents—as under-respected experts in themselves, their experiences, and the sector—held many identities; as queer, Māori, Samoan, Indigenous, disabled, female, male, and non-binary peoples. Owing to the onset of Covid-19, respondents shared details of their lives, work, and survivorship both before Covid-19 and post-arrival of Covid-19, excluding two interviews that had taken place before its arrival. Epistemologically, drawing from social constructionism aspired to hold all respondent experiences as equally real and important, while acknowledging we can only ever provide partial answers to research questions and these conversations must remain ongoing (Burr, 2015; Riessman, 2008). In line with this, the stories provided by respondents then formed the content for analysis, completed through a reflexive narrative analysis, which included a high level of thoughtful interpretation; presenting a woven integration of larger collective narratives.

Findings

Pre-Covid-19 Stories

In the analysis of pre-Covid-19 voices, shared during two interviews undertaken prior to Covid-19, and reflections of life prior to the pandemic by those who were interviewed after the arrival of Covid-19, both service providers and survivors alike spoke of a world that is inequitable for people harmed by sexual violence. Underpinned by hegemonic ideals, the "-isms" oppressed people with non-dominant identities—especially those who inhabit multiple marginalised social locations—and inform widespread narratives that allow sexual violence to proliferate society, prevent equal and appropriate access to support, and perpetuate ongoing harms for the individual and future generations.

Firstly, respondents described how the *layers (1.1)*[15] of harm accumulate and change one's experience of sexual violence, where survivors with multiple marginalised identities

---

[15] Italicising the abbreviated titles alongside the theme numbers is a way of representing the themes throughout the conclusion

are positioned by society as non-ideal (Christie, 1986), illegitimate victims. Embedded ableism and racism categorise non-disabled, non-white survivors as lesser than the hegemonic group, thus a non-priority for care. Subsequently, service providers and survivors alike spoke of how this socially imposed subjugated position left them disbelieved, disempowered, and even excluded from support services, with the dominant narrative acting to protect the comfort of powerfully positioned people just as much as it works to disempower those with poorer social conditions. Service providers' narratives were shared from a space of both hurt and confusion as to why survivors continue to be treated in this way.

Respondents then spoke of how *historical harms (1.2)* have informed the modern systems that continue to marginalise survivors with non-hegemonic identities. They described how modern sexual violence is rooted in historical oppressions, whereby power and control have harmed those who inhabit social locations which are not afforded power. They described how colonisation has torn away at the very essence of Māoritanga, with many people now carrying the intergenerational trauma of sexual harm within their family and whānau; with sexual violence thus perpetuating cycles of familial and cultural disconnect. Similarly, patriarchal, gender-based power doctrines—such as some religions—have caused the erasure of Māori queerdom (McBreen et al., 2012) and the sexual autonomy of Samoan women (Totua, 2020). Similarly, modern power structures both exist within, and inform how healthcare is performed—with these policies embedded in ableist attitudes, harming disabled people who rely upon others for care. Ultimately, the respondents' narratives described how we got where we are because of where we came from, yet much of wider society continues to blame individuals and neglect the broader picture; a total rejection of intersectionality and interwoven systemic injustice.

As a result of these embedded structures, several *barriers (1.3)* perpetuate inequities in sexual violence support and prevent improvements, supporting the sentiments of previous research (see Powers et al., 2002; Robson, 2016; United Nations, 2017). These barriers were framed as imposed by people who inhabit privileged and powerful social locations, and the wider, inequitable world, rather than a survivor's individual diversity being the cause. In navigating such difficulties, survivors spoke of feeling unable to access services that can meet their needs appropriately, unwelcome in services because of who they are or how the services were structured, and even unworthy of help because of who society positions as a deserving victim. Service providers echoed these worries, using their insider status to share stories of meeting accessibility needs, reflecting upon their own poor experiences of support, and arguing that inappropriate support can not only lead to unmet needs but indeed cause further harm.

A gendered world (1.4) reflected the dichotomy whereby men are exclusively positioned as perpetrators, not victims, thereby excluding transgender and male survivors from support services designed under feminist principles. 'Man hating' was a sentiment shared by women and people from other marginalised social locations alike, with men in authority understood as especially harmful; their powerful positioning in a patriarchal society protecting them from accountability in situations such as workplace assault. Conversely, being a male survivor places one in a *further* subjugated position, rather than their gender being protective as it may be in other, male-dominated settings. While service providers described steps towards making sexual violence support more accessible to men, others described how the machoistic and patriarchal social structures prevent men from being emotional and healing even within those spaces, supporting the findings of Donne et al. (2018). Ultimately, the patriarchal structures that underpin sexual violence against women appear to also uniquely harm men in this setting.

Peri-Covid-19 Stories

My second analysis, exploring how Covid-19 has changed the landscape of sexual violence for marginalised survivors in particular, highlighted four key narratives shared by respondents. Firstly, the *lockdowns (2.1)* in Aotearoa New Zealand happened without precedent, leaving services without a clear path to respond. Providers spoke of seeing an initial reduction in people seeking help but then an unprecedented influx of need. This has overwhelmed the sector, which due to the under-acknowledgement of sexual violence as an issue, was inadequately resourced even before the pandemic. Respondents spoke of survivors being “trapped” in their homes, experiencing escalating and new sexual violence, but with a reduced capacity to access support—these concerns have been similarly echoed around the world (Alston et al., 2021; Kourti et al., 2021). This was additionally concerning for people already living with poorer social conditions in their lives, with the pandemic amplifying the embedded inequities in healthcare, housing, and general support, adding further voice to the findings of Boxall and Morgan (2021). This reduced access to support thus led to decreased autonomy in choosing how one responds to sexual violence, the harms of which are still emerging.

The pre-Covid-19 results of this project demonstrated the inequities that exist for people who experience multiple layers of discrimination, with the peri-Covid-19 stories highlighting the *compounding of these inequities (2.2).* Providers spoke of how the additional barriers to housing, finances, education, and access to care—issues embedded within unequal power structures—became even more of an issue for those struggling pre-pandemic. Providers themselves spoke of immense stress, even leaving jobs, because of the increased and changed needs of their clients which some workplaces were unable to handle appropriately. These issues existed before Covid-19 but became exacerbated with its arrival. The stress on providers is clearly emerging in the literature (Alston et al., 2021; Human Rights Commission, 2020), however, the impact that a decreased specialist workforce will have in an already stretched sector remains to be seen.

Being unable to see clients face to face meant a transition to *telehealth (2.3),* which was described as either beneficial for clients or as a barrier to care. Providers spoke of difficulties accessing translators, part of which was owing to a pre-existing lack of funding to support these diverse needs. While being able to access counsellors nationwide has improved access to therapy for some survivors, others spoke of the digital divide meaning that their clients did not have access to technology to use such services; with some survivors reporting that telehealth did not feel like an equally beneficial mode of therapy for them. Likewise, a Māori provider spoke of how cultural concerns in the use of telehealth have gone unaddressed—as well as Māori being disproportionately impacted by the digital divide—as another example of tāngata whenua being left behind in the Covid-19 response. Additional to client needs, telehealth was discussed as not being beneficial for all staff, with some finding it blurred the boundaries between home and work. Similar to the overseas literature, staff stress and burnout were highlighted as key issues, with some already feeling unable to support others during lockdown and others becoming increasingly stressed due to Covid-19 (Alston et al., 2021).

However, Covid-19 was not entirely terrible for the sector and providers, with respondents describing some silver linings (see also Every-Palmer et al., 2020). Providers and survivors alike spoke of *hope and opportunity (2.4)* that may come from Covid-19, including increased and more flexible funding and a better understanding of the needs of disabled people. This included both disabled clients and disabled staff, who had previously faced ableist barriers positioning them as less useful than their peers. The final narrative spoke of the possibility of *a new normal (2.5)* and whether this is even possible. Respondents spoke of how we have not yet seen the devastating impact of the pandemic on marginalised people and that the worst may be yet to come. However, on a positive note, providers hoped that we might see increased prioritisation and funding of the sector moving forward, promoting meaningful change in the future.

Implications

The narratives shared by survivors and providers were wide-ranging, but I see them as having one ultimate implication: the interlocking social structures that underpin sexual violence, and categorise and marginalise people who differ from the hegemonic norm, need to be addressed for meaningful change to be made. This must occur on both an individual and structural level, including a change in individual attitudes, social norms, and more equitable social policy. As part of this, the sexual violence sector in its entirety—including the valuable, skilled experts working within it—needs to be valued more highly and to be supported to make the changes necessary to support all survivors, no matter who they are.

From what I perceive as many meaningful findings in this research, why is it that I suggest this as the single key implication? This is because, overall, this research indicates that without addressing embedded ableism, racism, sexism, heterosexism, cisgenderism—and the many others—survivors with these identities will *never* be seen as legitimate; their diversity will *never* be celebrated nor appropriately cared for; and their needs will *never* become a priority for funding. When the sexual violence sector remains chronically underfunded, understaffed, and undervalued, the needs of the majority will continue to overshadow the needs of the few, with diversity being othered and placed in the "too hard basket". The arrival of Covid-19 only highlighted why these systems need addressing; people who are socially subjugated and marginalised were disproportionately impacted by the pandemic, including sexual violence survivors generally, but especially those who already lived with difficult and unjust social conditions. Sexual violence service providers *want* to do better but are working within a system that fails to protect their wellbeing and acknowledge their expertise and importance. The service providers whom themselves have experienced marginalisation should lead this charge, acknowledging their experience as legitimate expertise that the hegemonic group cannot fully understand without walking in their undervalued shoes. Changes *can* be made, and that starts with valuing all people.

Reflections and Limitations

On reflecting on the methodology and limitations of my project, I grieve for the voices that could not be heard. Disabled people who do not communicate with able-bodied methods, while not specifically excluded from the research, remain unlikely to participate in such studies due to their access needs. Many disabled people use specialised communication devices that would require a carer to translate, thus jeopardising their privacy. Similarly, survivors who have court-appointed welfare guardians could not participate in this project due to concerns about their ability to consent. However, I fear that disabled people who require welfare guardians experience sexual violence that remains especially unvoiced, likely perceived as vulnerable by people who seek to harm. Finally, as with all sexual violence research, there is a contingent of survivors who are not heard. This includes those who do not consider themselves survivors because society has told them they are not; those who do not feel they are worthy as survivors; those who continue to be harmed and are not safe to speak; and those who have lost their lives. While unable to be included, each of these groups have remained top of mind for me throughout this process, with the hope that improvements for *some* survivors will lead to meaningful change for *all* survivors.

I must also reflect upon the dual positioning of training in clinical psychology while undertaking a project of this nature, which walks the line of calling services not just unhelpful, but at times harmful. I think it is important to clarify that *all* of the service providers in this research were incredibly passionate, thoughtful, intelligent experts who cared deeply for their clients. They shed real tears for survivors, for their frustration at how they have been unable to help in a system that does not allow it, and for their fear—or indeed acknowledgement—that they themselves are burning out. Any faults within their services reflect the chronic underfunding and understaffing of the sector due to survivor needs remaining unprioritised, with these barriers only worsening because of Covid-19. In a well-resourced sector, these remarkable providers would undoubtedly be shining lights for all survivors who walk alongside them. Their passion will forever inspire me in my work as a clinician.

Avenues for Future Research

Several avenues for future research emerged during this process. From the bigger picture, to be able to dismantle the systems that continue to discriminate against non-hegemonic survivors, it is going to be essential to understand what is perpetuating such systems. Why are people—especially those from the hegemonic group—uncomfortable speaking about disability and sexuality; about men as victims of sexual violence; of Māori as victims of a system that oppresses them and dismantles their support structures? It will be important to establish a method to take this widespread discomfort and transform it into genuine care and empowerment for our diverse communities. Continuing to hear the voices of people with lived experience will be paramount in doing so, those with feet-on-the-ground (i.e., the service providers and people with lived experience) must guide the implementation of change.

The other, perhaps most apparent space for continued research is within the space of Covid-19. We do not yet know what the impacts of this pandemic will be long-term on our diverse whānau. The initial harms and inequity resulting from the pandemic are emerging, but the long-term consequences remain to be seen. Will this become another historical harm slotted away and ignored for its effects on social inequity? I remain hopeful it will not, and instead, it will highlight the dire need for change in the sexual violence sector and for all survivors. I hope this remains a prominent conversation in the coming years, and all marginalised people are given ample opportunity to share their experiences and prevent the repeat of these harms in the future. I remain optimistic that I can continue to be part of this prominent conversation in the years to come.

References

Abrahams, N., Devries, K., Watts, C., Pallitto, C., Petzold, M., Shamu, S., & Garcia-Moreno, C. (2014). Worldwide prevalence of non-partner sexual violence: A systematic review. *The Lancet*, *383*(9929), 1648-1654. https://doi.org/10.1016/S0140-6736(13)62243-6

Accident Compensation Corporation. (2021). Integrated services for sensitive claims (ISSC) operational guidelines. https://www.acc.co.nz/assets/contracts/issc-og.pdf

ACT New Zealand. (2021, 4 December). *Police commissioner bullied by iwi* [Press Release]. https://www.scoop.co.nz/stories/PA2112/S00039/police-commissioner-bullied-by-iwi.htm

Allen, B. J. (1996). Feminist standpoint theory: A black woman's (re)view of organizational socialization. *Communication Studies*, *47*(4), 257-271. https://doi.org/10.1080/10510979609368482

Alston, M., Irons, K., Adamson, C., Boddy, J., Fronek, P., Briggs, L., . . . Hazeleger, T. (2021). Australian and New Zealand social workers adjusting to the COVID-19 pandemic. *British Journal of Social Work*, *52*(4), 1859-1877. https://doi.org/doi.org/10.1093/bjsw/bcab163

Anderson, G. D., & Overby, R. (2021). The impact of rape myths and current events on the well-being of sexual violence survivors. *Violence Against Women*, *27*(9), 1379-1401. https://doi.org/10.1177/1077801220937782

Andrews, M. (2004). Counter narratives and the power to oppose. In M. Bamburg & M. Andrews (Eds.), *Considering counter narratives narrating, resisting, making sense* (Vol. 4, pp. 1-7). John Benjamins Publishing.

Andrews, M., Squire, C., & Tamboukou, M. (2008). *Doing narrative research* (2 ed.). SAGE Publications.

Appleton-Dyer, S., & Field, A. (2014). *Understanding the factors that contribute to social exclusion of disabled people*. https://www.odi.govt.nz/assets/Guidance-and-

Resources-files/Understanding-the-factors-that-contribute-to-the-exclusion-of-disabled-people-November-2014.pdf

Armstrong, E. A., Gleckman-Krut, M., & Johnson, L. (2018). Silence, power, and inequality: An intersectional approach to sexual violence. *Annual Review of Sociology*, *44*(1), 99-122. https://doi.org/10.1146/annurev-soc-073117-041410

Ashton-Martyn, M., Hartendorp, K., O'Connell Rapira, L., Boniface, L. (2019). *For the wellbeing of New Zealanders: An urgent call for full funding for sexual violence prevention and support services*. https://medium.com/actionstation/for-the-wellbeing-of-new-zealanders-dbc74f8b87dc

Australian Human Rights Commission. (2017). *Change the course: National report on sexual assault and sexual harassment at Australian universities*. https://humanrights.gov.au/our-work/sex-discrimination/publications/change-course-national-report-sexual-assault-and-sexual

Bamberg, M., & Andrews, M. (2004). *Considering counter-narratives: Narrating, resisting, making sense* (Vol. 4). John Benjamins Publishing.

Basile, K. C., Breiding, M. J., & Smith, S. G. (2016). Disability and risk of recent sexual violence in the United States. *American Journal of Public Health*, *106*(5), 928-933. https://doi.org/10.2105/AJPH.2015.303004

Beattie, A., & Priestley, R. (2021). Fighting COVID-19 with the team of 5 million: Aotearoa New Zealand government communication during the 2020 lockdown. *Social Sciences and Humanities Open*, *4*(1), 100209. https://doi.org/10.1016/j.ssaho.2021.100209

Bedera, N., & Haltom, T. (2020). Virtual issue: Sexual violence. *Social Problems*. https://academic.oup.com/socpro/pages/sexual_violence_vi

Bhopal, K. (2010). Gender, identity and experience: Researching marginalised groups. *Women's Studies International Forum*, *33*(3), 188-195. https://doi.org/doi.org/10.1016/j.wsif.2009.12.005

Binny, R. N., Baker, M. G., Hendy, S. C., James, A., Lustig, A., Plank, M. J., . . . Steyn, N. (2021). Early intervention is the key to success in COVID-19 control. *Royal Society Open Science*, *8*(11), 210488. https://doi.org/10.1098/rsos.210488

Bosma, A., Mulder, E., & Pemberton, A. (2018). The ideal victim through other(s') eyes. In M. Duggan (Ed.), *Revisiting the 'ideal victim' developments in critical victimology* (pp. 27-41). Policy Press.

Boxall, H., & Morgan, A. (2021). Who is most at risk of physical and sexual partner violence and coercive control during the COVID-19 pandemic? *Trends and Issues in Crime and Criminal Justice*(618), 1-19. https://doi.org/10.3316/informit.721300968536971

Braathen, S. H., Carew, M. T., Chiwaula, M., & Rohleder, P. (2021). Physical disability and sexuality, some history and some findings. In X. Hunt, Braathen, S.H., Chiwaula, M., Carew, M.T., Rohleder, P., Swartz, L. (Ed.), *Physical Disability and Sexuality* (pp. 27-51). Palgrave Macmillan. https://doi.org/10.1007/978-3-030-55567-2_2

Bradley, A. (2021, 18 May). Sexual abuse: Only 5 per cent of claims make it through accident compensation corporation system. *NZ Herald*. Retrieved 30 March 2022, from https://www.nzherald.co.nz/nz/sexual-abuse-only-5-per-cent-of-claims-make-it-through-accident-compensation-corporation-system/YUPY3SVAVV3WT7YA3BXABVJ26I/

Braun, V., & Clarke, V. (2006). Using thematic analysis in psychology. *Qualitative research in psychology*, *3*(2), 77-101. https://doi.org/10.1191/1478088706QP063OA

Briggs, F. (2006). Safety issues in the lives of children with learning disabilities. *Social Policy Journal of New Zealand*(29), 43-60. https://doi.org/https://link.gale.com/apps/doc/A155750014/AONE?u=anon~701d62cd&sid=googleScholar&xid=b4342265

Briggs, F., & Hawkins, R. (2005). Personal safety issues in the lives of children with learning disabilities. *Children Australia*, *30*(2), 19-27. https://doi.org/10.1017/S103507720001066X

Brown, P. (2017). Narrative: An ontology, epistemology and methodology for pro-environmental psychology research. *Energy Research & Social Science*, *31*, 215-222. https://doi.org/https://doi.org/10.1016/j.erss.2017.06.006

Burr, V. (2015). *Social constructionism*. Routledge.

Came, H. (2013). A fair go for all: A problematic contribution to anti-racism praxis in Aotearoa. In R. Scherman, Krgeloh, C., Nayar, S (Ed.), *Walking the talk: The 2012 collection of oral presentations from the AUT school of public health and psychosocial studies*. Auckland University of Technology. https://openrepository.aut.ac.nz/handle/10292/6394

Campbell, L. (2016). Sexual assault support service for Canterbury: Research to inform design. https://www.avivafamilies.org.nz/resources/file/picker/5e2682303adeb.pdf

Campbell, R., Adams, A., Wasco, S., Ahrens, C., & Sefl, T. (2009a). Training interviewers for research on sexual violence: A qualitative study of rape survivors' recommendations for interview practice. *Violence Against Women*, *15*(5), 595-617. https://doi.org/10.1177/1077801208331248

Campbell, R., Dworkin, E., & Cabral, G. (2009b). An ecological model of the impact of sexual assault on women's mental health. *Trauma Violence and Abuse*, *10*(3), 225-246. https://doi.org/10.1177/1524838009334456

Campbell, R., Wasco, S. M., Ahrens, C. E., Sefl, T., & Barnes, H. E. (2001). Preventing the “second rape” rape survivors' experiences with community service providers. *Journal of Interpersonal Violence*, *16*(12), 1239-1259. https://doi.org/doi/abs/10.1177/088626001016012002

Chen, B., & McNamara, D. M. (2020). Disability discrimination, medical rationing and COVID-19. *Asian Bioethics Review*, *12*(4), 1-8. https://doi.org/10.1007/s41649-020-00147-x

Choi, K., Giridharan, N., Cartmell, A., Lum, D., Signal, L., Puloka, V., . . . Kvalsvig, A. (2021). Life during lockdown: A qualitative study of low-income New Zealanders' experience during the COVID-19 pandemic. *New Zealand Medical Journal*, *134*(1538), 52-67. https://www.ncbi.nlm.nih.gov/pubmed/34239145

Christie, N. (1986). The ideal victim. In E. A. Fattah (Ed.), *From crime policy to victim policy: Reorienting the justice system* (pp. 17-30). Palgrave Macmillan. https://doi.org/10.1007/978-1-349-08305-3_2

Collins, P., & Bilge, S. (2016). *Intersectionality*. Polity Press.

Collins, P. H. (1990). *Black feminist thought: Knowledge, consciousness, and the politics of empowerment* (Vol. 138). Routledge.

Collins, P. H. (2015). Intersectionality's definitional dilemmas. *Annual Review of Sociology*, *41*(1), 1-20. https://doi.org/10.1146/annurev-soc-073014-112142

Cook, K. (2008). Marginalized populations. In L. M. Given (Ed.), *The SAGE encyclopedia of qualitative research methods* (pp. 495-496). SAGE Publications.

Cooke, M. (2021, 29 July). Ministry has no clue on where 42 percent who left Covid-19 motels went. *Radio New Zealand*. https://www.rnz.co.nz/news/national/447978/ministry-has-no-clue-on-where-42-percent-who-left-covid-19-motels-went

Cotter, M. J. (2007). The influence and effects of discriminatory language in New Zealand. *The International Journal of Language, Culture and Society*, *22*, 52-56.

Crenshaw, K. (1989). Demarginalizing the intersection of race and sex: A black feminist critique of antidiscrimination doctrine, feminist theory and antiracist politics. In K. Bartlett, Kennedy, R. (Ed.), *Feminist Legal Theory* (pp. 57-80). Routledge. https://doi.org/10.4324/9780429500480

Cripps, K., & McGlade, H. (2014). Indigenous family violence and sexual abuse: Considering pathways forward. *Journal of Family Studies*, *14*(2-3), 240-253. https://doi.org/10.5172/jfs.327.14.2-3.240

Crouch, M., & McKenzie, H. (2006). The logic of small samples in interview-based qualitative research. *Social science information*, *45*(4), 483-499. https://doi.org/10.1177/0539018406069584

Dalziel, L. (2001). The New Zealand disability strategy: Making a world of difference: Whakanui oranga. *Wellington: Ministry of Health*. https://www.odi.govt.nz/assets/New-Zealand-Disability-Strategy-files/nz-disability-strategy.pdf

Dickson, S. (2016). Building rainbow communities free of partner and sexual violence. *Te Hohou Te Rongo Kahukura*. http://www.kahukura.co.nz/wp-content/uploads/2017/07/Building-Rainbow-Communities-Free-of-Partner-and-Sexual-Violence-2016.pdf

Dolan, I. J., Strauss, P., Winter, S., & Lin, A. (2020). Misgendering and experiences of stigma in health care settings for transgender people. *Medical Journal of Australia*, *212*(4), 150-151. https://doi.org/10.5694/mja2.50497

Donne, M. D., DeLuca, J., Pleskach, P., Bromson, C., Mosley, M. P., Perez, E. T., . . . Frye, V. (2018). Barriers to and facilitators of help-seeking behavior among men who experience sexual violence. *American Journal of Men's Health*, *12*(2), 189-201. https://doi.org/10.1177/1557988317740665

Durie, M., & Naera, M. (2020, May 25). *Kōrero with Sir Mason Durie* [Video]. Youtube. https://www.youtube.com/watch?v=hZBqnXFwls0&ab_channel=mhfnz

Dworkin, E. R., Brill, C. D., & Ullman, S. E. (2019). Social reactions to disclosure of interpersonal violence and psychopathology: A systematic review and meta-analysis. *Clinical Psychology Review*, *72*, 101750. https://doi.org/10.1016/j.cpr.2019.101750

Dworkin, E. R., Ullman, S. E., Stappenbeck, C., Brill, C. D., & Kaysen, D. (2018). Proximal relationships between social support and PTSD symptom severity: A daily diary study of sexual assault survivors. *Depression and Anxiety*, *35*(1), 43-49. https://doi.org/10.1002/da.22679

Evans, M. L., Lindauer, M., & Farrell, M. E. (2020). A pandemic within a pandemic - intimate partner violence during Covid-19. *New England Journal of Medicine*, *383*(24), 2302-2304. https://doi.org/10.1056/NEJMp2024046

Every-Palmer, S., Jenkins, M., Gendall, P., Hoek, J., Beaglehole, B., Bell, C., . . . Stanley, J. (2020). Psychological distress, anxiety, family violence, suicidality, and wellbeing in New Zealand during the COVID-19 lockdown: A cross-sectional study. *PloS One*, *15*(11), 1-19. https://doi.org/10.1371/journal.pone.0241658

Fanslow, J., Malihi, Z., Hashemi, L., Gulliver, P., & McIntosh, T. (2021a). Change in prevalence of psychological and economic abuse, and controlling behaviours against women by an intimate partner in two cross-sectional studies in New Zealand, 2003 and 2019. *British Medical Journal*, *11*(3), e044910. https://doi.org/10.1136/bmjopen-2020-044910

Fanslow, J., Robinson, E., Crengle, S., & Perese, L. (2010). Juxtaposing beliefs and reality: Prevalence rates of intimate partner violence and attitudes to violence and gender roles reported by New Zealand women. *Violence Against Women*, *16*(7), 812-831. https://doi.org/10.1177/1077801210373710

Fanslow, J. L., Malihi, Z. A., Hashemi, L., Gulliver, P. J., & McIntosh, T. K. D. (2021b). Lifetime prevalence of intimate partner violence and disability: Results from a population-based study in New Zealand. *American Journal of Preventive Medicine*, *61*(3), 320-328. https://doi.org/10.1016/j.amepre.2021.02.022

Fanslow, J. L., Robinson, E. M., Crengle, S., & Perese, L. (2007). Prevalence of child sexual abuse reported by a cross-sectional sample of New Zealand women. *Child Abuse and Neglect*, *31*(9), 935-945. https://doi.org/10.1016/j.chiabu.2007.02.009

Femifesto. (2015). *Use the right words: Media reporting on sexual violence in Canada.* https://www.femifesto.ca/wp-content/uploads/2015/12/UseTheRightWords-Single-Dec3.pdf

Findley, P. A., Plummer, S. B., & McMahon, S. (2016). Exploring the experiences of abuse of college students with disabilities. *Journal of Interpersonal Violence*, *31*(17), 2801-2823. https://doi.org/10.1177/0886260515581906

Fisher, A., Goodwin, R., & Patton, M. (2008). *Men & healing: Theory, research, and practice in working with male survivors of childhood sexual abuse*. The Cornwall Public Enquiry. https://doi.org/10.1.1.378.1369

Foon, E. (2021, 12 March). Mental health system struggles: 'Its really difficult to get into services'. *Radio New Zealand*. https://www.rnz.co.nz/news/national/438264/mental-health-system-struggles-it-s-really-difficult-to-get-into-services

Garcia-Moreno, C., & Watts, C. (2011). Violence against women: An urgent public health priority. *Bulletin of the World Health Organization*, *89*(1), 2. https://doi.org/10.2471/BLT.10.085217

Gergen, K. J. (1985). Social constructionist inquiry: Context and implications. In *The social construction of the person* (pp. 3-18). Springer.

Gilchrist, K. (2010). "Newsworthy" victims? Exploring differences in Canadian local press coverage of missing/murdered aboriginal and white women. *Feminist media studies*, *10*(4), 373-390. https://doi.org/10.1080/14680777.2010.514110

Gilmour, J. (2019, 31 August). Rape is not 'sex', and 'broken hearts' don't cause murder. Women are dying – and language matters. Retrieved 05 December 2019, from https://www.theguardian.com/books/2019/aug/31/is-not-sex-and-broken-hearts-dont-cause-women-are-dying-and-language-matters

Gilmour, J. [@JaneTribune]. (2021). *Ruok @couriermail? I thought maybe you aren't, so I fixed it for you.* Twitter. https://twitter.com/JaneTribune/status/1397343235354226694?cxt=HHwWjMCryZyRruQmAAAA

Glass, N., Laughon, K., Campbell, J., Block, C. R., Hanson, G., Sharps, P. W., & Taliaferro, E. (2008). Non-fatal strangulation is an important risk factor for homicide of women. *The Journal of Emergency Medicine*, *35*(3), 329-335. https://doi.org/10.1016/j.jemermed.2007.02.065

Grabe, S. (2020). Research methods in the study of intersectionality in psychology: Examples informed by a decade of collaborative work with majority world women's grassroots activism. *Frontiers in Psychology*, *11*, 1-13. https://doi.org/10.3389/fpsyg.2020.494309

Gravelin, C. R., Biernat, M., & Baldwin, M. (2017). The impact of power and powerlessness on blaming the victim of sexual assault. *Group Processes & Intergroup Relations*, *22*(1), 98-115. https://doi.org/10.1177/1368430217706741

Greijer, S., & Doek, J. (2016). Terminology guidelines for the protection of children from sexual exploitation and sexual abuse. *ECPAT International and ECPAT Luxembourg*. https://www.ohchr.org/sites/default/files/Documents/Issues/Children/SR/TerminologyGuidelines_en.pdf

Hager, D. (2017). *Not inherently vulnerable: An examination of paradigms, attitudes and systems that enable the abuse of dis/abled women* [Doctoral Dissertation, University of Auckland]. https://researchspace.auckland.ac.nz/handle/2292/36826

Hailes, H. P., Ceccolini, C. J., Gutowski, E., & Liang, B. (2020). Ethical guidelines for social justice in psychology. *Professional Psychology: Research and Practice*, *52*(1), 1-11. https://doi.org/10.1037/pro0000291

Hall, M. (2021, 27 November). Is long Covid a new type of chronic fatigue syndrome? *Radio New Zealand*. https://www.rnz.co.nz/news/what-you-need-to-know/456714/is-long-covid-a-new-type-of-chronic-fatigue-syndrome

Harding, K. (2020). Victim. In S. Dickey (Ed.), *Pretty bitches: On being called crazy, angry, bossy, frumpy, feisty, and all the other words that are used to undermine women*. Reed Business Information.

Health Quality and Safety Commission. (2020). The health care experience of disabled people during COVID-19: Summary of findings from the COVID-19 patient experience survey. https://www.hqsc.govt.nz/assets/Health-Quality-Evaluation/PR/PES/COVID-disability-report_final-for-website_161221.docx

Heke, I., Rees, D., Swinburn, B., Waititi, R. T., & Stewart, A. (2019). Systems thinking and indigenous systems: Native contributions to obesity prevention. *AlterNative*, *15*(1), 22-30. https://doi.org/10.1177/1177180118806383

Hemopereki Hoani, S. (2016). Te arewhana kei roto i te ruma: An indigenous neo-disputation on settler society, nullifying Te Tiriti, 'natural resources' and our collective future in Aotearoa New Zealand. *Te Kaharoa: The eJournal of Indgenous pacific Issues*, *9*(1). https://doi.org/10.24135/tekaharoa.v9i1.6

Henrickson, M. (2020). Kiwis and COVID-19: The Aotearoa New Zealand response to the global pandemic. *The International Journal of Community and Social Development*, *2*(2), 121-133. https://doi.org/10.1177/2516602620932558

Houghton, R. (2009). Everything became a struggle, absolute struggle’: Post-flood increases in domestic violence in New Zealand. In E. Enarson, Dhar Chakrabarti, P. G. (Ed.), *Women, gender and disaster: Global issues and initiatives* (pp. 99-111). SAGE Publications. https://doi.org/https://dx.doi.org/10.4135/9788132108078

Houkamau, C., Dell, K., Newth, J., Mika, J., Sibley, C., Keelan, T., & Dunn, T. (2021). *The wellbeing of Māori pre and post Covid-19 lockdown in Aotearoa/New Zealand*. https://cdn.auckland.ac.nz/assets/psych/about/our-research/MIFAS/Tech-Docs/MIFAS-Covid-19-2021-Report.pdf

Hughes, K., Bellis, M. A., Jones, L., Wood, S., Bates, G., Eckley, L., . . . Officer, A. (2012). Prevalence and risk of violence against adults with disabilities: A systematic review and meta-analysis of observational studies. *The Lancet*, *379*(9826), 1621-1629. https://doi.org/10.1016/S0140-6736(11)61851-5

Hughes, R. (2010). The social model of disability. *The British Journal of Healthcare Assistants*, *4*(10), 508-511. https://doi.org/10.12968/bjha.2010.4.10.79078

Human Rights Commission. (2012). A fair go for all? Rite tahi tatou katoa? Addressing structural discrimination in public services. https://www.indigenousjustice.gov.au/resources/a-fair-go-for-all-rite-tahi-tatou-katoa-addressing-structural-discrimination-in-public-services/

Human Rights Commission. (2020). Submission of the New Zealand Human Rights Commission for the special rapporteur on violence against women, its causes and consequences: The impact of COVID-19 and the increase of domestic violence against women. https://www.hrc.co.nz/files/5515/9468/2462/FINAL_HRC_Submission_to_the_Special_Rapporteur_on_womens_rights.pdf

Human Rights Commission. (2021a). Honour the treaty protect the person. https://www.hrc.co.nz/files/6016/3822/4741/Honour_the_Treaty_Protect_the_person_Violence_and_abuse_of_tangata_whaikaha_Maori_FINAL_English.pdf

Human Rights Commission. (2021b). Whakamahia te tūkino kore ināianei, ā muri ake nei: Acting now for a violence and abuse free future. https://www.hrc.co.nz/files/9316/3822/4755/Acting_now_for_a_violence_and_abuse_free_future_FINAL.pdf

Hunt, B., Matthews, C., Milsom, A., & Lammel, J. A. (2006). Lesbians with physical disabilities: A qualitative study of their experiences with counseling. *Journal of Counseling & Development*, *84*(2), 163-173. https://doi.org/10.1002/j.1556-6678.2006.tb00392.x

Hunt, T. (2021, 20 September). Missing lockdown cancers yet to be measured, but history paints ominous picture. *Stuff*. https://www.stuff.co.nz/national/health/coronavirus/126427049/missing-lockdown-cancers-yet-to-be-measured-but-history-paints-ominous-picture

Hunt, X., Swartz, L., Braathen, S. H., & Rohleder, P. (2021). Sexual and reproductive health: Layers of (in) access. In X. Hunt, Braathen, S. H., Chiwaula, M., Carew, M. T., Rohleder, P., Swartz, L. (Ed.), *Physical Disability and Sexuality* (pp. 115-130). https://doi.org/10.1007/978-3-030-55567-2_8

Hurihanganui, T. A. (2020, May 1). MPs' questioning of legal iwi checkpoints 'really is racism'. *Radio New Zealand*. https://www.rnz.co.nz/news/te-manu-korihi/415617/mps-questioning-of-legal-iwi-checkpoints-really-is-racism

Hydén, M. (2014). The teller-focused interview: Interviewing as a relational practice. *Qualitative Social Work*, *13*(6), 795-812. https://doi.org/10.1177/1473325013506247

Jefferies, S., French, N., Gilkison, C., Graham, G., Hope, V., Marshall, J., . . . Priest, P. (2020). COVID-19 in New Zealand and the impact of the national response: A descriptive epidemiological study. *Lancet Public Health*, *5*(11), e612-e623. https://doi.org/10.1016/S2468-2667(20)30225-5

Johnson, K., Green, L., Volpellier, M., Kidenda, S., McHale, T., Naimer, K., & Mishori, R. (2020). The impact of COVID-19 on services for people affected by sexual and gender-based violence. *International Journal of Gynaecology and Obstetrics*, *150*(3), 285-287. https://doi.org/10.1002/ijgo.13285

Joint Venture. (2021). Budget 2021 summary of initiatives. https://www.beehive.govt.nz/sites/default/files/2021-05/Budget%202021%20FVSV%20Summary%20of%20Initiatives%20FINAL.pdf

Jordan, J. (2008). Perfect victims, perfect policing? Improving rape complainants' experiences of police investigations. *Public Administration*, *86*(3), 699-719. https://doi.org/10.1111/j.1467-9299.2008.00749.x

Jordan, J. (2013). From victim to survivor-and from survivor to victim: Reconceptualising the survivor journey. *Sexual Abuse in Australia and New Zealand*, *5*(2), 48. https://doi.org/doi/10.3316/informit.832896370790754

Jordan, J. (2016). Beyond belief? *Criminal Justice*, *4*(1), 29-59. https://doi.org/10.1177/1466802504042222

Jordan, J. (2020, 22 May). The shocking truth about our sexual violence statistics. *Stuff*. https://www.stuff.co.nz/national/crime/121583579/the-shocking-truth-about-our-sexual-violence-statistics

Josselson, R., & Lieblich, A. (2001). Narrative research and humanism. In K. J. Shneider, J. Pierson & J. Bugental (Eds.). *The handbook of humanistic psychology* (2nd ed., pp. 275 289). Sage.

Kessler, A. M., Kennair, L. E. O., Grøntvedt, T. V., Bjørkheim, I., Drejer, I., & Bendixen, M. (2020). The effect of prototypical #MeToo features on the perception of social-sexual behavior as sexual harassment. *Sexuality & Culture*, *24*(5), 1271-1291. https://doi.org/10.1007/s12119-019-09675-7

Khieu, T. Q. T., Pierse, N., Telfar-Barnard, L. F., Zhang, J., Huang, Q. S., & Baker, M. G. (2017). Modelled seasonal influenza mortality shows marked differences in risk by age, sex, ethnicity and socioeconomic position in New Zealand. *The Journal of infection*, *75*(3), 225–233. https://doi.org/10.1016/j.jinf.2017.05.017

King, P. (2019). Māori with lived experience of disability, part I: Wai 2575,# b22. https://forms.justice.govt.nz/search/Documents/WT/wt_DOC_150437272/Wai%202575%2C%20B022.pdf

Kingi, V. M., & Jordan, J. (2009). Responding to sexual violence: Pathways to recovery. https://women.govt.nz/sites/public_files/pathways-to-recovery-pdf_0.pdf

Kosanic, A., Hansen, N., Zimmermann-Janschitz, S., & Chouinard, V. (2018). Researchers with disabilities in the academic system. *American Association of Geographers Newsletter*, 1-3. https://doi.org/10.14433/2017.0042

Kourti, A., Stavridou, A., Panagouli, E., Psaltopoulou, T., Spiliopoulou, C., Tsolia, M., . . . Tsitsika, A. (2021). Domestic violence during the COVID-19 pandemic: A systematic review. *Trauma, Violence & Abuse*, 1-27. https://doi.org/10.1177/15248380211038690

Labov, W. (1966). *The linguistic variable as a structural unit*. U.S. Office of Education.

Lynch, K. (2010, 08 September). Huge jump in domestic abuse following quake. *Stuff*. http://www.stuff.co.nz/the-press/news/christchurch-earthquake-2011/canterbury-earthquake-2010/4105777/Huge-jump-in-domestic-abuse-following-quake

Maier, S. L. (2008). “I have heard horrible stories...” rape victim advocates' perceptions of the revictimization of rape victims by the police and medical system. *Violence Against Women*, *14*(7), 786-808. 10.1177/1077801208320245

Martin, S. L., Ray, N., Sotres-Alvarez, D., Kupper, L. L., Moracco, K. E., Dickens, P. A., . . . Gizlice, Z. (2006). Physical and sexual assault of women with disabilities. *Violence Against Women*, *12*(9), 823-837. https://doi.org/10.1177/1077801206292672

Mayhew, P., & Reilly, J. (2007). New Zealand crime and safety survey 2006. https://www.ojp.gov/ncjrs/virtual-library/abstracts/new-zealand-crime-safety-survey-2006

McBreen, K., Waitaha, K. M., & Tahu, N. (2012). Ahunga tikanga and sexual diversity. *Te Wananga-o-Raukawa*. https://www.researchgate.net/publication/235664484_AHUNGA_TIKANGA_AND_SEXUAL_DIVERSITY

McCracken, G. (1988). Nine key issues. In *Qualitative Research Methods: The long interview*. SAGE Publications. https://doi.org/10.4135/9781412986229

McLeod, K. (2018). *Our people-multidimensional wellbeing in New Zealand*. https://www.econstor.eu/handle/10419/205390

McNeill, B., & Gillon, G. T. (2021). Lockdown experiences of 10–13 year olds in New Zealand. *New Zealand Journal of Educational Studies*, *57*(1), 173-189. https://doi.org/10.1007/s40841-021-00237-w

Ministry for Women. (2015). Wāhine Māori, wāhine ora, wāhine kaha: Preventing violence against Māori women. https://women.govt.nz/documents/w%C4%81hine-m%C4%81ori-w%C4%81hine-ora-w%C4%81hine-kaha-preventing-violence-against-m%C4%81ori-women-2015

Ministry of Justice. (2019). Attrition and progression. Reported sexual violence victimisations in the criminal justice system. https://www.justice.govt.nz/assets/Documents/Publications/sf79dq-Sexual-violence-victimisations-attrition-and-progression-report-v1.0.pdf

Ministry of Justice. (2020). New Zealand crimes and victims survey key findings. https://www.justice.govt.nz/assets/Documents/Publications/Cycle-4-Core-Report-v0.20-20220628.pdf

Ministry of Women’s Affairs. (2012). Lightning does strike twice: Preventing sexual revictimsation.

https://women.govt.nz/sites/public_files/Lightning%20does%20strike%20twice_2012%20report.pdf

Mishler, E. G. (1991). *Research interviewing*. Harvard University Press.

Mitra, M., Mouradian, V. E., & Diamond, M. (2011). Sexual violence victimization against men with disabilities. *American Journal of Preventive Medicine*, *41*(5), 494-497. https://doi.org/10.1016/j.amepre.2011.07.014

Morley, C., Carrington, K., Ryan, V., Warren, S., Clarke, J., Ball, M., & Vitis, L. (2021). Locked down with the perpetrator: The hidden impacts of Covid-19 on domestic and family violence in Australia. *International journal for crime, justice and social democracy*, *10*(4), 204-222. https://doi.org/10.5204/ijcjsd.2069

Mossman, E., Jordan, J., MacGibbon, L., Kingi, V., & Moore, L. (2009a). Responding to sexual violence: A review of literature on good practice. https://women.govt.nz/sites/public_files/responding%20to%20sexual%20violence%20literature-review%20on%20best%20practice-pdf.pdf

Mossman, E., MacGibbon, L., Kingi, V., & Jordan, J. (2009b). Responding to sexual violence: Environmental scan of New Zealand agencies. https://women.govt.nz/sites/public_files/environmental-scan.pdf

Muehlenhard, C. L., & Kimes, L. A. (1999). The social construction of violence: The case of sexual and domestic violence. *Personality and Social Psychology Review*, *3*(3), 234-245. https://doi.org/10.1207/s15327957pspr0303_6

Mullaly, R. P. (2007). *The new structural social work*. Oxford University Press.

Murray, M. (2000). Levels of narrative analysis in health psychology. *Journal of Health Psychology*, *5*(3), 337-347. https://doi.org/10.1177/135910530000500305

Murray, M. (2015). Narrative psychology. In J. A. Smith (Ed.), *Qualitative psychology a practical guide to research methods* (Vol. 3). SAGE Publications.

Murray, S., & Heenan, M. (2018). Reported rapes in Victoria: Police responses to victims with a psychiatric disability or mental health issue. *Current Issues in Criminal Justice*, *23*(3), 353-368. https://doi.org/10.1080/10345329.2012.12035929

Nannini, A. (2006). Sexual assault patterns among women with and without disabilities seeking survivor services. *Women's Health Issues*, *16*(6), 372-379. https://doi.org/10.1016/j.whi.2006.10.001

National Academies of Sciences, E., & Medicine. (2018). Addressing the social and cultural norms that underlie the acceptance of violence: Proceedings of a workshop—in brief. https://pubmed.ncbi.nlm.nih.gov/29697230/

New Zealand Government. (2021). Te aorerekura. https://www.violencefree.govt.nz/assets/National-strategy/Finals-translations-alt-formats/Te-Aorerekura-National-Strategy-final.pdf

New Zealand Government. (2022). *Unite against COVID-19*. https://covid19.govt.nz/

New Zealand Psychologists Board. (2002). Code of ethics for psychologists working in Aotearoa/New Zealand. https://www.nzccp.co.nz/assets/Uploads/Code-of-Ethics-English.pdf

Nikora, L. W., Te Awekotuku, N., Rua, M., Temara, P., Maxwell, T. K., Murphy, E., . . . Moeke-Maxwell, T. (Eds.). (2010). *Tangihanga: The ultimate form of Māori cultural expression-overview of a research programme*. Ngā Pae o te Māramatanga.

Obelkevich, J., & Roper, L. (2013). *Disciplines of faith: Studies in religion, politics and patriarchy*. Routledge.

Office for Disability Issues. (2020a). How is life going for the disability community? (first survey). https://www.odi.govt.nz/guidance-and-resources/survey-response-week-one/

Office for Disability Issues. (2020b). How is life going for the disability community? (second survey). https://www.odi.govt.nz/assets/Uploads/2020-05-15-How-is-Life-Going-for-the-Disability-Community-Analysis-Second-Survey.docx

Office for Disability Issues. (2021). Reporting back on our 'how's life going for the disability community' survey. https://www.odi.govt.nz/whats-happening/message-from-minister-sepuloni/

Owen, P. (2020, 20 September). ‘Frail’ people like me should not be denied lifesaving Covid care. https://www.theguardian.com/world/2020/sep/29/frail-people-like-me-should-not-be-denied-lifesaving-covid-care

Parkinson, D., & Zara, C. (2013). The hidden disaster: Domestic violence in the aftermath of natural disaster. *The Australian Journal of Emergency Management*, *28*(2), 28-35. https://www.researchgate.net/publication/288432753_The_hidden_disaster_Domestic_violence_in_the_aftermath_of_natural_disaster

Perry, M., Jones, B., Ingham, T., & Mirfin-Veitch, B. (2020). “At risk" and" vulnerable"! Reflections on inequities and the impact of COVID-19 on disabled people. *New Zealand Journal of Physiotherapy*, *48*(3), 107-116.

Pihama, L., & Lipsham, M. (2020). Noho haumaru: Reflecting on Māori approaches to staying safe during Covid-19 in Aotearoa (New Zealand). *Journal of Indigenous Social Development*, *9*(3), 92-101. https://journalhosting.ucalgary.ca/index.php/jisd/article/view/70788

Pihama, L., Te Nana, R., Cameron, N., Smith, C., Reid, J., & Southey, K. (2016). Māori cultural definitions of sexual violence. *Sexual Abuse in Australia and New Zealand*, *7*(1), 43.

Pittaway, E., & Bartolomei, L. (2005). Refugee women at risk-evaluating a un program. *The Sydney Papers*, *17*(3-4), 103-113. https://doi.org/10.3316/agispt.20060381

Pittaway, E., & Eckert, R. (2013). Domestic violence, refugees and prior experiences of sexual violence: Factors affecting therapeutic and support service provision. *Improving Responses to Refugees with Multiple Trauma*, 10-13.

Plummer, S. B., & Findley, P. A. (2012). Women with disabilities' experience with physical and sexual abuse: Review of the literature and implications for the field. *Trauma, Violence & Abuse*, *13*(1), 15-29. https://doi.org/10.1177/1524838011426014

Pool, I. (2015). Colonization and development in new zealand between 1769 and 1900. In Y. Charbit, Pool, I. (Ed.), *Demographic transformation and socio-economic development* (Vol. 3). Springer.

Powers, L. E., Curry, M. A., McNeff, E., Saxton, M., Powers, J. L., & Oschwald, M. (2008). End the silence: A survey of abuse against men with disabilities. *Journal of Rehabilitation*, *74*(4), 41.

Powers, L. E., Curry, M. A., Oschwald, M., & Maley, S. (2002). Barriers and strategies in addressing abuse: A survey of disabled women's experiences. *Journal of Rehabilitation*, *68*(1), 4.

Radio New Zealand. (2021, 8 November). Linda clark to head ACC client information and privacy review. https://www.rnz.co.nz/news/national/455198/linda-clark-to-head-acc-client-information-and-privacy-review

Ricciardelli, R., Spencer, D. C., & Dodge, A. (2021). “Society wants to see a true victim”: Police interpretations of victims of sexual violence. *Feminist criminology*, *16*(2), 216-235. https://doi.org/10.1177/1557085120970270

Ride, G., & Newton, D. C. (2018). Exploring professionals' perceptions of the barriers and enablers to young people with physical disabilities accessing sexual and reproductive health services in Australia. *Sexual health*, *15*(4), 312-317. https://doi.org/10.1071/SH17106

Riessman, C. K. (2008). *Narrative methods for the human sciences*. SAGE Publications.

Robertson, N., & Oulton, H. (2008). Sexual violence: Raising the conversations, a literature review. https://researchcommons.waikato.ac.nz/bitstream/handle/10289/995/Robertson?sequence=1

Robson, E. (2016). “Everything, with us” working with people with disabilities. http://toahnnestgoodpractice.squarespace.com/inclusive-practice#/supporting-survivors-in-pacific-communites-1-1/

Rousseau, C., Bergeron, M., & Ricci, S. (2020). A metasynthesis of qualitative studies on girls' and women's labeling of sexual violence. *Aggression and Violent Behavior*, *52*, 101395. https://doi.org/10.1016/j.avb.2020.101395

Royce, T. (2020). Unrapeable? Rape myths and fat women. In G. C. Becker & A. T. Dionne (Eds.), *Rape culture 101* (pp. 191-204). Demeter Press. https://doi.org/10.2307/j.ctv12sdxdg.14

Sabatello, M., Burke, T. B., McDonald, K. E., & Appelbaum, P. S. (2020). Disability, ethics, and health care in the COVID-19 pandemic. *American Journal of Public Health*, *110*(10), 1523-1527. https://doi.org/10.2105/AJPH.2020.305837

Salem, S. (2016). Intersectionality and its discontents: Intersectionality as traveling theory. *European Journal of Women's Studies*, *25*(4), 403-418. https://doi.org/doi.org/10.1177/1350506816643999

Sandoval, C. (2013). *Methodology of the oppressed* (Vol. 18). University of Minnesota Press.

Saxton, M., Curry, M. A., Powers, L. E., Maley, S., Eckels, K., & Gross, J. (2001). “Bring my scooter so i can leave you” a study of disabled women handling abuse by personal assistance providers. *Violence Against Women*, *7*(4), 393-417. https://doi.org/10.1177/10778010122182523

Schiff, B. (2012). The function of narrative:: Toward a narrative psychology of meaning. *Narrative Matters*, *2*(1), 33-47. https://journals.lib.unb.ca/index.php/NW/article/view/19497

Sepuloni, C. (2018). *Official launch of safe to talk he pai ki te kōrero* https://www.beehive.govt.nz/release/official-launch-safe-talk-he-pai-ki-te-k%C5%8Drero

Sexual Assault Kit Initiative. (2020). Victim or survivor: Terminology from investigation through prosecution. https://sakitta.org/toolkit/docs/Victim-or-Survivor-Terminology-from-Investigation-Through-Prosecution.pdf

Sins Invalid. (2017). *Skin, tooth, and bone-the basis of movement is our people: A disability justice primer* (Vol. 25). Taylor & Francis.

Smith, O. (2019). Narratives, credibility and adversarial justice in English and Welsh rape trials. In *Rape narratives in motion* (pp. 71-99). Springer International Publishing. https://doi.org/10.1007/978-3-030-13852-3_4

Smith, S. G., Basile, K. C., Gilbert, L. K., Merrick, M. T., Patel, N., Walling, M., & Jain, A. (2017). National intimate partner and sexual violence survey (NISVS): 2010-2012 state report. https://www.cdc.gov/violenceprevention/pdf/nisvs-statereportbook.pdf

Soklaridis, S., Zahn, C., Kuper, A., Gillis, D., Taylor, V. H., & Whitehead, C. (2018). Men's fear of mentoring in the #MeToo era—what's at stake for academic medicine. *New England Journal of Medicine*, *379*(23), 2270-2274. https://doi.org/10.1056/NEJMms1805743

Statistics New Zealand. (2013). Disability survey: 2013. https://www.stats.govt.nz/assets/Uploads/Disability-survey/Disability-survey-2013/Disability-survey-2013-additional-documents/Disability-Survey-2013.pdf

Statistics New Zealand. (2020). Measuring inequality for disabled New Zealanders: 2018. https://www.stats.govt.nz/reports/measuring-inequality-for-disabled-new-zealanders-2018

Stephens, C., & Breheny, M. (2021). Diverse experiences among older adults in Aotearoa/New Zealand during COVID-19 lockdown: A qualitative study. *Australasian Journal on Ageing*, 23-31. https://doi.org/10.1111/ajag.12995

Stevens, I., & Windsor, A. (2014). *Moving from te po (night) and into te ao (light): An indigenous framework to support Māori males who have been sexually abused in New Zealand* [Masters Thesis, Auckland University of Technology]. https://openrepository.aut.ac.nz/handle/10292/10812

Stimpson, L., & Best, M. C. (1991). Courage above all: Sexual assault against women with disabilities. https://riseupfeministarchive.ca/activism/organizations/disabled-womens-network-dawn-canada/dawn-courageaboveall-report-sexualassault-toronto-1991-ocr/

Sudre, C. H., Murray, B., Varsavsky, T., Graham, M. S., Penfold, R. S., Bowyer, R. C., . . . Canas, L. S. (2021). Attributes and predictors of long COVID. *Nature Medicine*, *27*(4), 626-631. https://www.nature.com/articles/s41591-021-01292-y.pdf

Sutherland, G., McCormack, A., Easteal, P., Holland, K., & Pirkis, J. (2016). Media guidelines for the responsible reporting of violence against women: A review of evidence and issues. *Australian Journalism Review*, *38*, 8-17. https://ssrn.com/abstract=2832441

Taquet, M., Dercon, Q., Luciano, S., Geddes, J. R., Husain, M., & Harrison, P. J. (2021). Incidence, co-occurrence, and evolution of long-COVID features: A 6-month retrospective cohort study of 273,618 survivors of COVID-19. *PLoS Medicine*, *18*(9), e1003773. https://doi.org/10.1371/journal.pmed.1003773

Te Puni Kōkiri. (2010). Tiaki tinana: A case study on creating conversations about sexual violence. https://www.tpk.govt.nz/documents/download/262/tpk-tiaki-tinana.pdf

Thursdays In Black. (2017). "In our own words" : Student experiences of sexual violence prior to and during tertiary education. https://d3n8a8pro7vhmx.cloudfront.net/thursdaysinblack/pages/61/attachments/original/1503538050/ONLINE_VERSION_-_part_2_%281%29.pdf?1503538050

TOAH-NNEST. (2013). *Te ohaakii a hine - national network ending sexual violence together*. https://toah-nnest.org.nz/

Totua, L. (2020, 23 March). Sāmoan sex talk: Bc fuck Margaret Mead. https://www.salient.org.nz/features-2020/smoan-sex-talk-bc-fuck-margaret-mead

Ullman, S. E. (2014). Interviewing therapists about working with sexual assault survivors: Researcher and therapist perspectives. *Violence Against Women*, *20*(9), 1138-1156. https://doi.org/10.1177/1077801214549639

UN Women. (2019). Families in a changing world: Progress of the world's women 2019-2020. https://data.unwomen.org/progress-of-the-worlds-women

United Nations. (1998). Women 2000 sexual violence and armed conflict: United nations response. https://www.unwomen.org/en/digitallibrary/publications/1998/4/women2000-sexual-violence-and-armed-conflict-united-nations-response

United Nations. (2017). Report of the special rapporteur on the rights of persons with disabilities, sexual and reproductive health and rights of girls and young women with disabilities, a/72/133. https://digitallibrary.un.org/record/1301518?ln=en#record-files-collapse-header

United Nations Committee Against Torture. (2015). Concluding observations on the sixth periodic report of New Zealand. https://www.hrc.co.nz/files/2814/3192/5666/CAT_Report_May_2015.pdf

United Nations Population Fund. (2018). Women and young persons with disabilities. Guidelines for providing rights-based and gender-responsive services to address gender-based violence and sexual and reproductive health and rights. https://www.unfpa.org/sites/default/files/pub-pdf/UNFPA-WEI_Guidelines_Disability_GBV_SRHR_FINAL_19-11-18_0.pdf

United Nations Population Fund. (2020). Impact of the COVID-19 pandemic on family planning and ending gender-based violence, female genital mutilation and child marriage. https://www.unfpa.org/resources/impact-covid-19-pandemic-family-planning-and-ending-gender-based-violence-female-genital

University of Auckland Public Policy Institute. (2022). *COVID-19 timeline tracking key events in NZ and international milestones*. https://www.policycommons.ac.nz/covid-19-policy-resources/covid-19-timeline/

van Roode, T., Dickson, N., Herbison, P., & Paul, C. (2009). Child sexual abuse and persistence of risky sexual behaviors and negative sexual outcomes over adulthood: Findings from a birth cohort. *Child Abuse and Neglect*, *33*(3), 161-172. https://doi.org/10.1016/j.chiabu.2008.09.006

Veale, J., Byrne, J., Tan, K. K., Guy, S., Yee, A., Nopera, T. M.-L., & Bentham, R. (2019). *Counting ourselves: The health and wellbeing of trans and non-binary people in*

Aotearoa New Zealand. Transgender Health Research Lab. https://countingourselves.nz/community-report/

Walker, R. (2004). *Ka whawhai tonu matou: Struggle without end, 1990*. Penguin.

Wanqing, Z. (2020, 03 March). Domestic violence cases surge during COVID-19 epidemic. *Rising Tones*. https://www.sixthtone.com/news/1005253/domestic-violence-cases-surge-during-covid-19-epidemic

Wexler, L., Robbennolt, J. K., & Murphy, C. (2019). #MeToo, time's up, and theories of justice. *University of Illinois Law Review*, 45. https://illinoislawrev.web.illinois.edu/wp-content/uploads/2019/03/Robbennolt.pdf

Winter, S., Pirsoul, N., & Noonan, R. (2020). The royal commission of inquiry into historical abuse in state and faith-based care: A preliminary review. https://cdn.auckland.ac.nz/assets/auckland/arts/our-research/research-institutes-centres-groups/ppi/ppi-reports/complete%20report%20Winter.pdf

World Health Organisation. (2020, March 11). WHO director-general's opening remarks at the media briefing on COVID-19. https://www.who.int/director-general/speeches/detail/who-director-general-s-opening-remarks-at-the-media-briefing-on-covid-19---11-march-2020

World Health Organization. (2020, 11-12 February). COVID 19 public health emergency of international concern (PHEIC). Global research and innovation forum: Towards a research roadmap. https://digitallibrary.un.org/record/3859866?ln=en

World Health Organization. (2022). *WHO coronavirus (COVID-19) dashboard*. Retrieved 07 January 2022 from https://covid19.who.int/

Zosky, D. L., & Alberts, R. (2016). What’s in a name? Exploring use of the word queer as a term of identification within the college-aged LGBT community. *Journal of Human Behavior in the Social Environment*, *26*(7-8), 597-607. https://doi.org/10.1080/10911359.2016.1238803

Appendix A

Information Sheet for Survivors

How can sexual violence survivors be best supported, when they experience multiple forms of discrimination?

Participant Information Sheet for Survivors

Personal Introduction

Kia ora (hello). My name is Caitlin Helme and I am a clinical psychology doctorate student at Massey University, Wellington. As part of my studies, I am researching sexual violence in New Zealand.

I am interested in the experiences of people who might have experienced discrimination because of their identity. For example, being disabled, queer, Māori, a Pacific person, and/or identifying with another community that experiences a lot of discrimination.

Before I give more detail about my research, I would like to tell you about me and why I am doing this project.

I grew up in Ngāmotu (New Plymouth), with a family very engaged in disability services. I then studied in Québec (French Canada), Ōtepoti (Dunedin), and now Te Whanganui-a-tara (Wellington). I speak English as a first language, conversational French, and basic te reo Māori. I identify as disabled, living with two chronic illnesses.

I have volunteered and worked in areas related to youth support, disability support, mental health, and more recently sexual violence. I recently worked as a crisis worker at the Wellington Sexual Abuse HELP Foundation.

I am passionate about social justice and equality. It is important to me that we can give a voice to people who have traditionally been unable to share their experiences, because of discrimination.

My supervisors for this project are Professor Mandy Morgan, Dr Leigh Coombes, and Dr Simon Bennett. They are all part of the School of Psychology at Massey University.

An invitation to participate:

You are invited to take part in an interview study on supporting sexual violence survivors, who have multiple identities and experience discrimination. **Whether or not you take part is your choice.** If you don’t want to take part, you don’t have to give a reason and there is no disadvantage to you. It is okay if you do want to take part now, but change your mind later.

This Participant Information Sheet will help you decide if you would like to take part. It describes why we are doing the study, what your participation would involve, what the benefits and risks to you might be, and what would happen after the study ends.

We will go through this information with you and answer any questions you may have.

You do not have to decide today whether or not you will participate in this study. Before you decide you may want to talk about the study with other people, such as whānau (family), friends, cultural advisors, or healthcare providers. Feel free to do this!

If you agree to take part in this study, you will be asked to **sign a Consent Form.** You will be given a copy of both the Participant Information Sheet and the Consent Form to keep. If you wish to bring a support person along to your interview, they will also be asked to sign a consent form.

We are hoping to interview 8 people total for this study, and 12 people total for the entire project. This might seem like a small number, but less people mean that we can focus on your knowledge and experience in greater detail.

This document is **14** pages long. Please make sure you have read and understood all of the pages.

I am happy to answer questions you and any support people have, at any time.

Who can participate in this study?

We are looking for people who have experienced sexual violence some time in their life. These people will also have a self-identified disability of any kind. They will also either be Queer, non-Pākehā, and/or be part of another group that faces a lot of discrimination.

The most important thing to us is your safety. For this reason, there are 4 extra criteria about who can or cannot participate:

1. You must **not** have experienced any form of sexual violence in the **last two years**
2. You cannot be living with, or be cared for by someone, who has **ever** been sexually violent towards you
3. You must be at least **18 years old**
4. **You must be able to provide your own informed consent, therefore, cannot have a legally appointed Welfare Guardian**

Supporting you to participate:

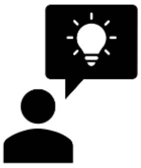
- If required, communication services can be arranged by you, or on your behalf. These might include formal sign language interpreters or peer interpreters.
- The interview will be completed at a location accessible to you, which is safe for both of us
- You may bring a support person to the interview
- Verbal recordings of all forms can be played to you, and emailed to you to keep

- All forms have been produced in an Easy-Read format
- If you are unable to physically complete the forms, you may give your verbal consent on an audio-recording

Why are we doing this study?

We hope in the future we can improve the care that people receive following sexual violence. It is important that the support available matches who someone is as a person.

To do this, we will be looking to learn a few important things. We also want to learn whatever you want to tell us. Some examples are:



1. We want to know what happened after people were sexually assaulted, and what support they had (if any)
2. We want to know about good experiences, and bad experiences
3. We want to know what people think can be better when getting support
4. We want to know why better support is not currently available, to meet everyone’s personal needs
5. We want to know what people who provide the support are currently doing
6. We want to know what people who provide support think they can do to make things better for survivors

What will I have to do, if I choose to participate?

The interview:

- We will gather information in this study by talking to you about your experience and knowledge. We will do this in a **one-on-one interview**. You will guide the conversation, choosing what to talk about.
- You do not have to answer any questions or talk about anything you do not want to.
- **We do not expect you to share details about sexual violence you have experienced, unless you think it is important to do so.**
- The interview may last as long as you need, up to 2 hours. You can stop or pause the interview at any time.
- The interview will be audio-recorded if this is okay with you. This recording will then be transcribed (written out word for word) by the lead researcher.
- If you do not want the interview audio-recorded, I will ask if it is okay for me to take notes instead.
- During transcription of audio-recordings, all identifying information (like names and places) are removed. You will be given a fake name for the purpose of the study.

- Once the typed transcript is completed, you will be invited to review it for accuracy. You may delete, add, or change anything you said.
- You will be asked to sign a “transcript release form”, which allows us to use your interview for our research.
- Once you have signed the transcript release form, the audio-recording will be permanently deleted.
- To protect your information, all digital documents will be password protected. All printed information will be stored in a locked filing cabinet at Massey University. We will keep the study documents for five years, then destroy them.

What would I get for participating?

You would be given NZ$30 worth of supermarket vouchers to thank you for participating. A small amount of food and drink will be shared at the interview, if you wish.

Reimbursement for travel expenses related to this study are also available. The researcher will discuss and arrange this with you.

What are the benefits and risks of this study?

- By sharing your experience and knowledge, you will help us learn how to better support sexual violence survivors in the future. Particularly, survivors who have a range of identities that experience discrimination.

- The nature of sexual violence is distressing. It might feel embarrassing or shameful to talk about. It is possible that sharing your story will bring up a range of emotions for you. To check you are okay, the lead researcher will contact you to see how you are a few days following the interview. The lead researcher can also complete referrals to a formal support service, if you so wish, or provide you with these details.

What are my rights?

- Participating in this study is **voluntary**. It is your choice to participate and no one should force you to.
- You may ask questions about the study, at any point in the study
- You have the right to not answer any questions that you do not want to
- You may withdraw from the study at any time before you sign the transcript release form
- You may ask for the audio-recorder to be turned off at any time during an interview
- You are able to edit your transcript, or choose not to have it used at all, until you sign the transcript release form.
- You have the right to access all of the information about you collected for the study
- You have the right to access a summary of the study findings, and to provide feedback about the study

What happens after the study, finishes? What happens if I change my mind?

- All documents will be kept in locked storage located at Massey University. They will be stored for five years, then they will be destroyed.
- If you no longer want to participate, all of the information you gave us will be immediately destroyed. The one time this may not be possible is if your transcript was already used in our results.
- If you wish to see the results of the study, these can be emailed to you when they become available, we can meet and discuss them, or we can talk over the phone. Your feedback on the study is also welcomed.

Who approved this study, and who is paying for it?

- This study is being done by researchers at Massey University and funded by Massey University.
- This project has been reviewed and approved by the Massey University Human Ethics Committee: Southern A, Application 19/40. If you have any concerns about the conduct of this research, please contact Dr Negar Partow, Chair, Massey University Human Ethics Committee: Southern A, telephone 04 801 5799 x 63363, email humanethicsoutha@massey.ac.nz.

Who do I contact for more information, or if I have concerns?

If you have any questions, concerns, or complaints about the study at any stage, you can contact:

Caitlin Helme
Clinical Psychology Doctorate Student
Lead Researcher
Caitlin.helme.1@uni.massey.ac.nz

Professor Mandy Morgan
Professor of Feminist Psychology
Project Supervisor
Phone: 06 356 9099 extension 85058
Email: c.a.morgan@massey.ac.nz

If you want to talk to someone who is not involved in the study, you can contact an **independent health and disability advocate** on:
Phone: 0800555050
Email: advocacy@advocacy.org.nz

For 24/7, Sexual Violence Support, you can call:

Safe to Talk – Kōrero mai ka ora (nationwide)
Phone: 0800 044 334

or

The Wellington Sexual Abuse HELP Foundation
(Wellington region)
Phone: 04 801 6655 extension 0

Appendix B

Information Sheet for Key Informants

How can sexual violence survivors be best supported, when they experience multiple forms of discrimination?

Participant Information Sheet for Key Informants

Personal Introduction

Kia ora (hello). My name is Caitlin Helme and I am a clinical psychology doctorate student at Massey University, Wellington. As part of my studies, I am researching sexual violence in New Zealand.

I am interested in the experiences of people who might have experienced discrimination because of their identity. For example, being disabled, queer, Māori, a Pacific person, and/or identifying with another community that experiences a lot of discrimination.

Before I give more detail about my research, I would like to tell you about me and why I am doing this project.

I grew up in Ngāmotu (New Plymouth), with a family very engaged in disability services. I then studied in Québec (French Canada), Ōtepoti (Dunedin), and now Te Whanganui-a-tara (Wellington). I speak English as a first language, conversational French, and basic te reo Māori. I identify as disabled, living with two chronic illnesses.

I have volunteered and worked in areas related to youth support, disability support, mental health, and more recently sexual violence. I have also worked as a crisis worker at the Wellington Sexual Abuse HELP Foundation.

I am passionate about social justice and equality. It is important to me that we can give a voice to people who have traditionally been unable to share their experiences, because of discrimination.

My supervisors for this project are Professor Mandy Morgan, Dr Leigh Coombes, and Dr Simon Bennett. They are all part of the School of Psychology at Massey University.

An invitation to participate:

You are invited to take part in an interview study on supporting sexual violence survivors, who have multiple identities and experience discrimination. **Whether or not you take part is your choice.** If you don’t want to take part, you don’t have to give a reason and there is no disadvantage to you. It is okay if you do want to take part now, but change your mind later.

This Participant Information Sheet will help you decide if you would like to take part. It describes why we are doing the study, what your participation would involve, what the benefits and risks to you might be, and what would happen after the study ends.

We will go through this information with you and answer any questions you may have.

You do not have to decide today whether or not you will participate in this study. Before you decide you may want to talk about the study with other people, such as whānau (family), friends, cultural advisors, or healthcare providers. Feel free to do this!

If you agree to take part in this study, you will be asked to **sign a Consent Form.** You will be given a copy of both the Participant Information Sheet and the Consent Form to keep. If you wish to bring a support person along to your interview, they will also be asked to sign a consent form.

We are hoping to interview 4 people total for this study, and 12 people total for the entire project. This might seem like a small number, but less people mean that we can focus on your knowledge and experience in greater detail.

This document is **14** pages long. Please make sure you have read and understood all of the pages.

I am happy to answer questions you and any support people have, at any time.

Who can participate in this study?

We are looking for people who work in sexual violence services to act as “key informants” for our study. They will also either disabled, queer, non-Pākehā, and/or identify with another community that experiences discrimination. They will have experience supporting someone with a disability.

The most important thing to us is your safety. For this reason, there are 4 extra criteria about who can or cannot participate:

1. It is not necessary for you to have experienced sexual violence yourself in order to participate. If you have, you must **not** have experienced any form of sexual violence in the **last two years**
2. You cannot be living with, or be cared for by someone, who has **ever** been sexually violent towards you
3. You must be at least **18 years old**
4. You must be able to provide your own informed consent, therefore, cannot have a legally appointed Welfare Guardian

Supporting you to participate:

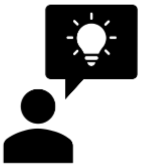
- If required, communication services can be arranged by you, or on your behalf. These might include formal sign language interpreters or peer interpreters.
- The interview will be completed at a location accessible to you, which is safe for both of us
- You may bring a support person to the interview
- Verbal recordings of all forms can be played to you, and emailed to you to keep

- All forms have been produced in an Easy-Read format
- If you are unable to physically complete the forms, you may give your verbal consent on an audio-recording

Why are we doing this study?

We hope in the future we can improve the care that people receive following sexual violence. It is important that the support available matches who someone is as a person.

To do this, we will be looking to learn a few important things. We also want to learn whatever you want to tell us. Some examples are:



1. We want to know peoples' thoughts about sexual violence in communities who experience a lot of discrimination
2. We want to know about good experiences, and bad experiences people have had supporting survivors
3. We want to know what people think can be better when someone accesses support
4. We want to know why better support is not currently available, to meet everyone's personal needs
5. We want to know what people who provide the support are currently doing
6. We want to know what people who provide support think they can do to make things better for survivors

What will I have to do, if I choose to participate?

The interview:

- We will gather information in this study by talking to you about your experience and knowledge. We will do this in a **one-on-one interview**. You will guide the conversation, choosing what to talk about.
- You do not have to answer any questions or talk about anything you do not want to.
- **We do not expect you to share details about sexual violence you have experienced, unless you think it is important to do so.**
- The interview may last as long as you need, up to 2 hours. You can stop or pause the interview at any time.
- The interview will be audio-recorded if this is okay with you. This recording will then be transcribed (written out word for word) by the lead researcher.

- If you do not want the interview audio-recorded, I will ask if it is okay for me to take notes instead.
- During transcription of audio-recordings, all identifying information (like names and places) are removed. You will be given a fake name for the purpose of the study.

- Once the typed transcript is completed, you will be invited to review it for accuracy. You may delete, add, or change anything you said.
- You will be asked to sign a “transcript release form”, which allows us to use your interview for our research.
- Once you have signed the transcript release form, the audio-recording will be permanently deleted.
- To protect your information, all digital documents will be password protected. All printed information will be stored in a locked filing cabinet at Massey University. We will keep the study documents for five years, then destroy them.

What would I get for participating?

You would be given NZ$30 worth of supermarket vouchers to thank you for participating. A small amount of food and drink will be shared at the interview, if you wish.

Reimbursement for travel expenses related to this study are also available. The researcher will discuss and arrange this with you.

What are the benefits and risks of this study?

☺

- By sharing your experience and knowledge, you will help us learn how to better support sexual violence survivors in the future. Particularly, survivors who have a range of identities that experience discrimination.

☹ ☎

- The nature of sexual violence is distressing. It might feel embarrassing or shameful to talk about. It is possible that sharing your story will bring up a range of emotions for you. To check you are okay, the lead researcher will contact you to see how you are a few days following the interview. The lead researcher can also complete referrals to a formal support service, if you so wish, or provide you with these details.

What are my rights?

- Participating in this study is **voluntary**. It is your choice to participate and no one should force you to.
- You may ask questions about the study, at any point in the study
- You have the right to not answer any questions that you do not want to
- You may withdraw from the study at any time before you sign the transcript release form
- You may ask for the audio-recorder to be turned off at any time during an interview
- You are able to edit your transcript, or choose not to have it used at all, until you sign the transcript release form.
- You have the right to access all of the information about you collected for the study
- You have the right to access a summary of the study findings, and to provide feedback about the study

What happens after the study, finishes? What happens if I change my mind?

- All documents will be kept in locked storage located at Massey University. They will be stored for five years, then they will be destroyed.
- If you no longer want to participate, all of the information you gave us will be immediately destroyed. The one time this may not be possible is if your transcript was already used in our results.
- If you wish to see the results of the study, these can be emailed to you when they become available, we can meet and discuss them, or we can talk over the phone. Your feedback on the study is also welcomed.

Who approved this study, and who is paying for it?

- This study is being done by researchers at Massey University and funded by Massey University.
- This project has been reviewed and approved by the Massey University Human Ethics Committee: Southern A, Application 19/40. If you have any concerns about the conduct of this research, please contact Dr Negar Partow, Chair, Massey University Human Ethics Committee: Southern A, telephone 04 801 5799 x 63363, email humanethicsoutha@massey.ac.nz.

Who do I contact for more information, or if I have concerns?

If you have any questions, concerns, or complaints about the study at any stage, you can contact:

Caitlin Helme
Clinical Psychology Doctorate Student
Lead Researcher
Caitlin.helme.1@uni.massey.ac.nz

Professor Mandy Morgan
Professor of Feminist Psychology
Project Supervisor
Phone: 06 356 9099 extension 85058
Email: c.a.morgan@massey.ac.nz

If you want to talk to someone who is not involved in the study, you can contact an **independent health and disability advocate** on:
Phone: 0800555050
Email: advocacy@advocacy.org.nz

For 24/7, Sexual Violence Support, you can call:

Safe to Talk – Kōrero mai ka ora (nationwide)
Phone: 0800 044 334

or

The Wellington Sexual Abuse HELP Foundation
(Wellington region)
Phone: 04 801 6655 extension 0

Appendix C

Participant Consent Form

Participant Consent Form

I have read, have had read to me, or have had interpreted to me in my first language, and I understand the Information Sheet. I have had the details of the study explained to me, any questions I had have been answered to my satisfaction, and I understand that I may ask further questions at any time. I have been given sufficient time to consider whether to participate in this study and I understand participation is voluntary and that I may withdraw from the study at any time until I sign the transcript release form.

I agree/do not agree to have my interview audio-recorded

☐ **YES** **or** ☐ **NO**

I agree to participate in this study under the conditions set out in the Information Sheet

☐ **YES** **or** ☐ **NO**

When the study is finished, I want to be contacted about the results

☐ **YES** **or** ☐ **NO**

Declaration by participant:

I hereby consent to take part in this study.

Name: ____________________

Signature: ____________________

Email (optional): ____________________

Date: ____________________

Appendix D

Transcript Release Form

How can sexual violence survivors be best supported, when they have identities that experience discrimination?

Authority for the Release of Transcripts

Please read this form and ask any questions you may have before signing.

1. **I confirm that I have had the opportunity to read the transcript of the interview conducted with me and make any changes that I desired.**
2. **I confirm that once I sign this form, I am unable to make further changes to my transcript.**
3. **I agree that the edited transcript and extracts from this may be used in reports and publications arising from the research.**

4. **I understand that from here on out, I may be unable to withdraw my transcript from the study, as the data may have already been used. If I wish to do so, I will contact the lead researcher and discuss this.**

Name: ______________________________

Signature: ______________________________

Date: ______________