SURVIVORS' SILENCED NARRATIVES

by

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SSW, Humber College, 2013

BSW, Ryerson University, 2019

An MRP

presented to Ryerson University

in partial fulfillment of the

requirements for the degree of

Master of Social Work

In the program of

Social Work

Toronto, Ontario, Canada 2020

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ABSTRACT

Survivors' Silenced Narratives

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The re-victimization experienced by sexual assault (SA) survivors who engage with the mental health system post-assault is often wrapped in silence. They are stories that we never hear. Working from anti-colonial, anti-psychiatry and mad studies lenses, this master's research paper centres three narratives from SA survivors who have experienced the "second victimization" (Sabina & Ho, 2014) from the mental health system. The SA survivors are all living in Ontario, Canada and their stories highlight a deep-rooted flawed system built on colonial practices which have been curated to abuse power relations. This research exposes the silenced trauma and abuse endured at the hands of medical 'professionals' as well as a lack of understanding and empathy for the SA community.

ACKNOWLEDGEMENTS

I would like to acknowledge the many people who have inspired, influenced and been a part of the success of this research. First, thank you to the participants of this work who so graciously, and courageously shared their stories, it is with you that silenced voices can begin to be heard. This work is as much yours as it is mine. To Dr. Treisha Hylton, thank you for your life changing teachings on whiteness in undergrad, as those teachings have influenced and framed all of my work and everything I do. I am thankful to Dr. Abdul Gilzay and Dr. Kristin Smith for your letters of recommendation to this program- it is with your thoughtful words that I am here. To Dr. Purnima George thank you for your constant guidance and inspiration in the research process without your expertise this research would not have come to fruition. To Dr. May Friedman and Dr. Notisha Massaquoi, thank you for your critical teachings on marginalization and anti-oppressive practice (AOP). I am thankful to the 2019-2020 cohort for standing together, listening and supporting one another throughout this journey. And lastly, a huge gesture of gratitude to Dr. Jennifer Poole, my supervisor of this research. Your guidance and mentorship have meant everything to me, and this research would not be possible without your leadership. Thank you for your endless support and encouragement.

DEDICATION

I dedicate this work first and foremost to the sexual assault survivors who have endured the re-victimization of the mental health system; whose narratives have been silenced.

Your stories are valued, your voices are respected, I see you and I hear you.

I hope this research gives you strength in knowing you are not alone!

I dedicate this work to my Nonna (Teresa Catani) and Nonno (Ottavio Catani) who immigrated to Canada with my dad in the 1950's in hopes their children and grandchildren could pursue all their dreams. Thank you. Because of you, your granddaughter will be the first in the family to hold a Masters. And to my parents Julio and Vera Catani for their unwavering support, it is with them that all things are possible.

I dedicate this work to myself, a student with a learning disability who was told in various ways I would never succeed in post secondary education, a diploma and two degrees later- You did it!

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CHAPTER 1. INTRODUCTION

"Someone removed a condom when we were having sex" (River: 131-132). "It wasn't consensual, I didn't agree to that" (River: 135-136). "They held a gun to my head while sexually assaulting me and taunted me that I was going to die" (Melody Mars: 88-89). "I was actually taken by this person for three weeks" (Vivian: 15). These are the chilling words from three survivors who hoped that engaging with the mental health system would provide support and not further trauma.

My arrival at this research comes heavily influenced by these kinds of experiences with sexual assault (SA) and the mental health system. For me, the process of accessing mental health services post-assault was extremely traumatic, a narrative I have now come to understand as 'being silenced'. I thought if this is my experience it cannot be the only experience, there must be others. I wondered what their stories of being silenced were like, who they were as people and how they survived? These questions led me to engage with this important work and a long-silenced narrative which I felt finally needed to be exposed. What this work became was a centering of three stories from particular people in particular bodies in response to the question, "Can you tell me about your story accessing mental health services post assault? What was your overall experience?".

These stories are not representative of *all* experiences, as this Major Research Paper (MRP) will never claim to be, especially one limited by regulations, length and the Corona Virus (COVID-19). Because of all this, I knew this would not be an easy journey to embark on. When things got tough or too real, I often asked myself why I was putting myself through this or why I did not choose a more surface level topic. However, time and time again I always came back to the same image of a young girl traumatized, broken and weak with little will to survive. She was

me, and I was doing it for her and for all the others this work may reach who have felt broken, forgotten, unheard or purposely silenced. I was doing it for them, I was doing it for you.

Originally, I wanted to focus my research on any experiences of survivor engagement with mental health post assault; positive, negative or both. However, after engaging with the literature I found, I realized the narratives of survivors' *negative* experiences with mental health services had not been documented (or at least in a way that was accessible to me). This posed a major gap in the research. When negative experiences were mentioned, the details were missing, such as how they were defining negative, if it included micro-aggressions or gaslighting for instance. I felt it was simply not enough to just state survivors' experiences as 'negative' or traumatizing without including their stories. I felt this was perhaps a strategic and systemic silencing method or too difficult of a topic to tackle. Regardless, it was then that I knew these narratives needed to be heard. So, heard they would be.

Throughout this research, it was imperative to me that survivors be the experts in this work. Their stories are the epistemology of this research. Yes, I have an insider's perspective, however, I am not the only perspective and thus am not the knower of this research. I have always felt I am learning with participants, and they would teach me more than I could ever know myself. With this, it was also crucial that I interrogate my own whiteness as the white researcher and my role within this power relation. Naming whiteness within research can disrupt white supremacy and its presumed 'racial neutrality' (Chadderton, 2012). Following this stance, it was important to me that I was transparent with my own whiteness in this research, locating myself as a white researcher.

However, I cannot escape my own whiteness in this research or the ways in which it seeks to protect and replicate itself. Adopting critical reflexivity is one essential way to examine

this replication as well as the unequal power relations which unequivocally affect knowledge production in research (Hunter, 2002). Naturally, I have carried my own assumptions about SA and accessing mental health services from my own experiences through a white lens and body. However, throughout this research I had to interrogate my own assumptions to create space for other realities to exist. Our understandings and perceptions of the world and society are heavily influenced by power which has the ability to coerce individuals to participate in things against their interest (Hunter, 2002). I really wanted to create a space where their stories could be shared in whichever way it came out for them with no limitations. I wanted the experience to feel open, safe and limitless. To do this, I worked from three theoretical places; Anti-Colonialism, Anti-Psychiatry and Mad Studies. I also worked with three survivors who shared their unique stories of SA, silencing and survival. The biggest surprise was that the storytellers all said that the SA was a preferred experience over the treatment endured by the mental health system. In this MRP, I detail how they came to that conclusion, what else they shared with me along the way and how I hope this may alter social work practice, discourses around consent and responses to care.

CHAPTER 2. LITERATURE REVIEW

The disciplines of sociology and psychology have contributed to the epistemological knowledge I reviewed for this MRP. A variety of journals such as, *Women & Therapy, Aggression, Maltreatment & Trauma, Sex Research, Traumatic Stress, Psychiatric Nursing, Violence Against Women, BMC Public Health, Trauma Violence & Abuse and Interpersonal Violence* were used to engage with the current literature. Although there is a vast array of journals that have contributed to this topic, most of their authors are white. Therefore, a large portion of this research has been conducted through a white Eurocentric lens. By largely excluding racialized researchers from the knowledge creation, their voices and ways of knowing are unheard. SA is an experience that can affect anyone, and thus the research should reflect multiple social locations. It is unclear if the researchers have any insider perspectives as they have not socially located themselves in their work.

Who and How are Individuals Affected

Sexual assault (SA) is a trauma which affects "1 in 3" women (World Health Organization, 2016) and "1 in 6" men (One in Six Project, 2016). In the LGBTQ community, the highest rates of sexual violence are experienced by transgender folx and bisexual women where forty-seven percent of transgender folx experience SA in their lifetime whereas forty-eight percent of bisexual women experience SA between the ages of 11 and 17 (Human Rights Campaign, 2020). Forty-seven percent of trans folx will experience a sexual assault in their lifetime and this number increases to forty-eight percent for Latinx folx and fifty-three percent for Black trans folx (Sexual Assault Centre, 2020).

Although there is a vast amount of research on SA, little research focuses on the experiences of mental health service seeking post-assault for survivors. Thus, this research

intends to bridge this gap with a focus on the intersections of SA, madness and sanism; where I as the researcher will provide an *insider's perspective*. Specifically, this research will focus on the (mis)connection between SA and mental health interventions. Often the mental health system can be degrading and traumatizing for many which can deter individuals from accessing it. What this literature will reveal is that those who do access mental health interventions post assault often experience further trauma and little, if any care. In reviewing the current literature, I have identified a variety of common themes which are: the *impacts of sexual assault*, the *experiences with service seeking* & the *resistance to poor treatment.*

Theme 1: Impacts of Sexual Assault

Through the medical model lens, the traumatic experience of SA increases psychopathology (Price, Davidson, Ruggiero, Acierno & Resnick, 2014). Many victims experience prolonged symptoms which interfere with functionality and overall quality of life (Price et al, 2014). The result of SA often leads to the development of post-traumatic stress disorder (PTSD), depression, suicidal ideation, medical issues, substance abuse and socialization problems (Richer et al, 2017). The physical and psychological distressing effects of SA contribute to decreased daily function and highlight the importance of treatment (Weist et al, 2014). Socialization adjustment issues, low-self-esteem and heightened psychological symptoms are frequently experienced by SA survivors (Starzynski, Ullman & Vasquez, 2017). Links between sexual violence and damaged mental health, especially, anxiety, depression and PTSD, are strongly intertwined (Tarzia et al, 2018). Although victims can experience such pain, little is understood about the reasons that encourage or deter individuals from seeking treatment (Price et al, 2014). The literature clearly documents both the physical and psychological damages SA possess on its victims.

An additional impact of SA which was also noted in the literature, is an individual's relationship to sex post assault. The literature states that a variety of sexual issues arise for SA survivors such as, "sexual dysfunction" & lower "sexual satisfaction" (O'Callaghan, Shepp, Ullman & Kirkner, 2018). The most common sexual issues identified were fear of sexual experiences, arousal and desire dysfunction (O'Callaghan et al, 2018). Not only has the literature highlighted physical and emotional affects but it has outlined the damage SA can have on an individual's relationship to sex post-assault. Another impact that was explored pertained to SA survivors' experiences participating in trauma-informed research. The initial assumption was that such research could pose potential harm. However, victims reported their experiences answering the research questionnaires as a positive experience (Nielsen, Hansen, Elklit & Bramsen, 2016). Although the participation in trauma informed research was regarded as positive, the most common theme throughout the current literature was the severe impacts SA has on individual's ability to function successfully in life following their SA.

Theme 2: Experiences with Service Seeking

Another theme in the literature I reviewed was SA survivors' experiences seeking service, avoiding service & their experiences with service providers. Although SA survivors experience psychological symptoms, less than 35% seek mental health services (Starzynski et al, 2017). Women's perceptions of their experience with service providers are linked to their well-being and their attempts to seek further service (Gagnon, Wright, Srinivas & DePrince, 2018). The negative realities experienced by women stem from victim blaming, stigmatization of SA, differential treatment after disclosure of SA, acts of distance and not providing basic medical services (Gagnon et al, 2018). Women who present as highly traumatized and distressed may experience harmful treatment from mental health professionals who lack training in SA

(Starzynski & Ullman, 2014). The damaging treatment from mental health systems is regarded as the "second victimization" (Sabina & Ho, 2014). The literature is consistent in outlining the damage SA has on individuals and the potential further traumatization which can be experienced at the hands of service providers.

Although SA survivors can have negative experiences with mental health services, they can also avoid service all together. Richer et al (2017) believes avoidance of service can occur in drug facilitated sexual assault (DFSA) as survivors' memories are impaired and they fear the inadequacy to describe their assault to police and medical care providers. According to Price et al (2014) others who have not used mental health services prior to their SA may be less likely to seek service post-assault. Individuals with a history of to mental health service seeking may find comfort in accessing service with a provider with which they already have an established relationship (Price et al, 2014). Another factor of service seeking was based on racial factors. At substantial high rates, African American women (in the US) were less likely to obtain services from SA crisis centres or counselling (Weist et al, 2014). Barriers such as, confidentiality and familial support for African American women were identified in their desire to seek service (Weist, et al, 2014). Factors of substance and race both influenced individuals' ability to seek mental health services.

Theme 3: Resistance to Poor Treatment

Much of the current literature on SA has documented its impacts and the service seeking experience however, another recurring theme is survivor's resistance to poor treatment. A form of resistance to poor treatment has been highlighted in SA survivors' recommendations of service. The recommendations survivors noted were availability of more of a variety of SA services and increased advertising of current services (Gagnon et al, 2018). Recommendations

for training and education for professionals, access to peer support groups so survivors can engage with one another and more available, affordable and visible services within communities (Gagnon et al, 2018). Another study which focussed on college campus SA outlined several service suggestions brought forth by the students. Recommendations for easily accessible services, orientations of campus SA services, awareness events and updated online resources were requested (Sabina et al, 2014). Suggestions for better marketing strategies to broaden the public's knowledge on SA services specifically for African American women (Weist et al, 2014) was also noted. The consensus throughout the literature identified needs for improved training on SA for professionals and increased advertising of current community services. SA survivors' voices within the current literature highlights a clear resistance to under trained professionals and lack of knowledge of the services available.

Knowledge Paradigms

The knowledge presented thus far is not neutral but linked to particular epistemological paradigms. Epistemology is the way in which we comprehend the world around us through frameworks and perspectives (Absolon, 2011). I argue that most of the knowledge reviewed on SA sits within an interpretive paradigm. Interpretive social science focuses on human interactions and the way in which individuals construct and sustain their social worlds (Neuman, 2013). The studies used in this literature review focus on the realities of SA and how this type of trauma influences the human experience post assault (Starzynski et al, 2017). Using an interpretive paradigm lens, researchers can allow participants to find socially constructed meanings. For instance, Weist et al (2014) used an interpretive paradigm to examine the encounters of African American and white women's experiences accessing SA services post-assault. The interpretive paradigm was important to apply here as race played a role in the

differential experiences of SA survivors. Using the interpretive paradigm allowed room for multiple realities to exist.

Although most of the studies use the interpretive paradigm, one study made good use of the critical paradigm. The critical social science paradigm uses social transformation to critique and reveal inequality through power relations (Neuman, 2013). For instance, Gagnon et al (2018) chronicle SA survivors' positive and negative experiences with service providers and use that information to suggest recommendations to professionals, bringing some agency to the SA survivors. Since SA is a complicated event that is unique to each person, the interpretive paradigm is a useful theoretical framework. This epistemological paradigm allows for multiple social realities which avoids limiting or flattening personal stories and experience. With this paradigm, researchers can acknowledge that reality is not universal. However, a critical approach is also a strong choice for SA research. This approach creates the opportunity to acknowledge multiple oppressions experienced through SA and the possibility of making change.

Reviewing all this substantive and theoretically informed literature, there is a gap in the research pertaining to the specific and detailed experiences of individuals who have lived through SA. Importantly, the literature is mostly lacking in detail on the experience of re-traumatization through 'service'. The intention of this research is to bridge this gap and centre the stories of survivors who have tried to get care post SA. However, due to page restrictions and the guidelines of this paper, this literature review is limited in depth and scope and could benefit from more social work scholarship. Through a qualitative approach to inquiry using narrative research, this MRP is intentional in giving space to detailed stories. In doing so, I invite narrative resistance or the lived stories of individuals that resist dominant cultural narratives (Mckenzie-Mohr and Lafrance, 2017). The dominant discourse in the literature is that negative experiences

in service seeking exist; however, the details of those narratives are missing in the literature I read. As an insider to the re-victimization of mental health services, whose story has not been represented in the literature reviewed, I know there are others with similar experiences. This MRP seeks to bring those silenced narratives to the centre.

CHAPTER 3. THEORETICAL FRAMEWORK

The theoretical frameworks I have used to guide this research are a combination of, Anti-Colonialism, Anti-Psychiatry and Mad Studies. I arrived at these theories through a critical examination of the intersecting oppressions faced by folx who encounter the mental health system generally and because of SA survivors' experiences of that system specifically. Through my learning in this MSW program, I had become more familiarized with Anti-Psychiatry and Mad Studies which produced a deeper understanding of my own experiences and with this, I felt these theories would guide my research. Originally, I had planned to focus solely on Anti-Psychiatry and madness, however, as I engaged more with these theories, I realized I needed additional theoretical perspectives which interrogated the whiteness and colonial project at the root of sanist practices. I specifically, did not choose any feminism theories including intersectional feminism because of its history of unexamined whiteness and tokenism (Bilge, 2013) as well as its lack of attention to issues of concern to mad and anti-psychiatry advocates. Since the combination of the theories I chose challenges whiteness and psychiatrization I knew it would create space for new narratives to emerge in the research.

Often the institution of mental 'health and illness' is not questioned and is difficult to dispute thus, I wanted to use theories that interrogated these systems. As a whole, the mental health system is upheld by eurocentrism which is put in place to label individuals into categories in an effort to justify violence and dehumanizing practices (Joseph, 2015). The inhumane practices of categorizing and labelling people often stigmatize these individuals, othering them in society. This stigma is based on intolerance and is used to mark individuals as defective or lacking in some area (Large & Ryan, 2012). The stigma placed on those deemed mentally ill stems from prejudiced beliefs which then leads to discrimination towards this community. The

discrimination aimed at individuals with mental health has been coined as 'sanism' by legal scholar Morton Birnbaum (1963) and further detailed by Michael Perlin (Perlin, 1999). The root of sanist practices come from whiteness and dominant discourses produced by colonialism. To combat these deep-rooted practices, I have turned to Anti-Colonialism as a baseline theory to ground this research and deconstruct the colonial system we are all forced to survive in.

Anti-Colonialism

To comprehend anti-colonialism, we must first understand colonialism. The concept of colonialism is understood as, "…the conquest and control of other people's land and goods" thus creating, "…the most complex and traumatic relationships in human history" (Hiddleston, 2009, p. 2). The purpose of such an agenda is to dominate and destroy original communities by creating new communities, rules and systems designed to subordinate the other (Hiddleston, 2009). These colonial practices are upheld and molded by white Eurocentric ideologies (Hiddleston, 2009). Anti-Colonial theory allows for a deconstruction of these white supremist, prejudiced ideologies. This entails viewing individuals' experiences from a lens which considers the colonial impact. Consequently, Anti-Colonialism focuses on resistance to colonialism (Hiddleston, 2009) and white Eurocentric practices that cause further harm to individuals.

Prior to engaging in anti-colonial resistance, we need to acknowledge what Singh (2018) describes as the continuing 'aftermath' of colonization (Barker, Hulme & Iverson, 1996). Like Singh (2018), my research focuses on the *after* period of abuse specifically, the *after* period of SA survivors' experiences with the mental health system. Before I can engage in a state of anti-colonial resistance, I must hear the 'aftermath' lived stories of survivors. Singh (2018) states, "…like abuse, we may never see an end to colonialism" (p. 15). With this statement, it is imperative to acknowledge the never-ending cycle of abuse experienced by SA survivors and

thus the importance of hearing their lived narratives. Grounding my research in creating the space for the 'aftermath' to be explored is essential to beginning an engagement with resistance. We cannot resist if we have not acknowledged what happened.

With resistance, anti-colonialism fosters resilience through understanding and the development of necessary coping skills and harm reduction approaches to healthcare (Hartmann et al, 2019). This resistance and resilience is exactly where I wish to situate my research. Using the lens of anti-colonial theory will allow for a resistance to colonial violence (Hartmann et al, 2019) as well as a resistance to whiteness in my work. Hartman et al (2019) identifies three anticolonial remedies for responding to clinical health which are: *Healing Trauma*, *Promoting Resistance* and *Practicing Survivance.* Each of these prescriptions are in line with what I feel is an appropriate response to SA survivors' potential experiences accessing mental health services post assault. *Healing Trauma* acknowledges historical trauma as a 'clinical condition' caused by colonialism and looks at colonization as a "traumatic past event" in need of repair through trauma treatment to produce overall wellness (Hartmann et al, 2019, p. 12). Interconnected with historical trauma, SA is a traumatic event in need of trauma treatment to create overall wellness and optimal health. However, as cited in this literature review, current mental health treatment for SA survivors can cause further trauma and damage.

Where healing trauma is not possible or made more difficult through mental health interventions, the second anti-colonial remedy is *Promoting Resilience.* This stage asks us to develop coping skills and harm reduction strategies to produce resilient outcomes (Hartmann et al, 2019). The final remedy category is *Practicing Survivance* which acknowledges the colonial project as an attempt to erase certain people and understands that wellness is a concept to be locally defined (Hartmann et al, 2019). SA survivors are often excluded from their treatment

plans and this stage acknowledges that their wellness should be defined by the community of survivors not problematic systems like the institution of mental health. These anticolonial responses to clinical health care which Hartman et al (2019) has been created, in response to Indigenous communities' experiences in health care mirror SA survivors' potential experiences accessing mental health interventions. First SA survivors are asked to heal trauma, be resilient and survive all while exposed to a colonial system which is set up to produce further harm. Thus, leading us to an anti-psychiatry framework.

Anti-Psychiatry

To center my theoretical lens in opposing traditional mental health practices, I have engaged with anti-psychiatry frameworks. Since the current literature identifies the harm in mental health services, an anti-psychiatry lens will create space for new perspectives to emerge. To understand anti-psychiatry, I think it is important to first understand psychocentrism and its complexities. Psychocentrism is the understanding that, "…human problems are due to a biologically-based flaw or deficit in the bodies and/or minds of individual subjects" (Rimke, 2016, p. 5). Psychocentrism is built on the idea that human problems are individual and not socially or economically charged (Rimke, 2016). Therefore, psychocentrism assumes all mental health issues are due to some individual defect and not a social injustice. Consequently, anti-psychiatry rejects the notion of psychiatry all together. The anti-psychiatry perspective is heavily influenced by the denial of 'mental illness' as a whole with the view that communities should adopt alternatives that are led by survivors (Reaume, 2002). This practice of anti-psychiatry gives agency back to the service user and balances out unhealthy power relations often found in the institution of mental health. Within this framework, service users' experiences in the psychiatric system have been described by two terms: psychiatric 'consumer' vs. psychiatric

‘survivor’ (Joseph, 2015). The psychiatric ‘consumer’ is understood as an individual who had choice in their treatment and engagement with psychiatric services whereas, the term psychiatric ‘survivor’ implies individuals endured or survived something imposed (Joseph, 2015). Survivorship is where I intend to center my research to expose the narratives of stories unheard by psychiatric survivors at the intersection of SA.

In adopting an anti-psychiatric framework and focussing on survivorship, I have also found it important to deconstruct sanism which acknowledges the discrimination experienced by those living with mental health (Large & Ryan, 2012). Historically, racialized, colonized, psychiatrized and disabled people have been vilified and othered by deeming them “childlike as a metaphor” (Mills, 2018, p. 504). To be considered “child-like as a metaphor” (Mills, 2018, p. 504) is to be seen as a child, an individual who does not possess adult-like thinking and thus should be treated as a child. These practices demean those who are labelled ‘mentally ill’ as to be treated childlike implies that these individuals are incapable of making decisions or being involved in their treatment plans. Additionally, microaggressions are another way in which sanist practices are carried out with those deemed mentally ill. Microaggressions are discriminatory verbal and non-verbal communications that present negative messages to marginalized folx who are the target (Gonzales et al, 2015). Microaggressions are a unique form of discrimination as they can occur consciously and unconsciously in subtle ways however have lasting damaging effects (Gonzales et al, 2015). People with mental health diagnoses have been a targeted marginalized group who experience microaggressions (Gonzales et al, 2015). Some common themes of microaggressions experienced by those living with mental health are: the invalidation and minimization of mental health diagnosis, the assumption that they are inferior, shaming of mental health, and being treated as ‘second class citizens’ due to their mental health diagnosis

(Gonzales et al, 2015, p. 239). These are sanist practices upheld by white Eurocentric ideologies which often degrade and damage service users.

Mad Studies

Although anti-psychiatry does a great job in framing this research, I felt it was important to engage Mad Studies as a final theory encompassing a foundation of compassion. Madness works from the lens that individuals should be understood through their societal context economically and socially rather then reduced to symptoms (Menzies, Reaume & LeFrançois et al, 2013). Avenues of support of mental suffering should be framed in humanitarian and holistic viewpoints (Menzies et al, 2013). Mad theory allows space to resist mental symptomology and pathologizing service users. Originating from survivor initiatives, mad studies denies biomedical approaches which label folx mentally ill and instead adopts a madness framework (Beresford, 2019). However, in doing so Mad Studies recognizes the term 'Mad' can produce anguish and fear among those termed mentally ill while simultaneously providing resistance to the medical model (Bruce, 2017). As a means of solidarity madness was revered as a means to critique actions bestowed on those deemed insane (Lewis, 2016). To disrupt dominant approaches to social and psychic organization understandings of madness is used to subvert medicalized notions of psychosis (Lewis, 2016). In this work, it became increasingly important that a madness framework was adopted in understanding and unravelling survivors' stories. We are not the sum of our symptoms but rather a product of an unjust system which mad studies works to untangle and meet with compassion, empathy and resistance.

Mad studies pinpoint the challenges mad folx encounter from oppressive, societal power relations that produce sanist and pathologizing labels (Poole et al, 2012). Discriminatory practices based on unequal power relations allows folx who are behaving 'differently' to be held

at the hospital ‘against their will’ justified by their intersecting identities such as, social location, gender, race, class and sexual orientation (Poole et al, 2012). This dehumanizing and violent practice can cause serious damage, preventing recovery “grounded in a focus on survivor rights, peer support and recovering from the oppressive effects of being a mental patient” (Poole 2011, p.15). This institutional violence is something that is upheld by what Procknow (2019) describes as sane supremacy. Procknow (2019) explains sane supremacy as, “…the sway that sane populations have over those with diagnosable mental disorders, singularly on the perceived psychic inferiority…” (p. 512). Therefore, survivors of SA who have been labelled as mentally unwell are not only responsible for their own recovery from a flawed system they are also forced to resist sane supremacy. In navigating this research and survivors’ stories, it was crucial that I engage with all these theories to interrogate whiteness, push back against psychiatry and the discriminatory colonial systems which hinder rather than help survivors of SA.

CHAPTER 4. METHODOLOGY

In this chapter, I turn my focus to methodology, or how I did my research for this MRP. Looking at all the studies cited thus far, I was particularly drawn to qualitative research approaches to inquiry. Qualitative research focuses on textual data to understand human behaviour as opposed to numerical data collection (Carter & Little, 2007), and those I reviewed often used interviews to collect the data. I want to note that the study most aligned with my research is by Starzynski et al (2017) where they began their data collection with a mailed survey which they followed up with in-depth interviews. The study used a phenomenological approach to examine the patterns of female SA survivors' experiences with mental health professionals (Starzynski et al, 2017). However, to address the silencing experienced by SA survivors who engage with the mental health system, I chose a narrative approach to my inquiry.

To honour survivors as the knowers of their stories and this subject area it was crucial that their narratives were at the centre of this research. My research question asked participants about their lived experiences accessing mental health post assault. It is their story told from their point of view. Specifically, I asked: 'Can you tell me about your story accessing mental health services post assault? What was your overall experience?' The question was purposefully open-ended to allow space for participants to share as much or as little as they wished in whatever way they felt best described their experiences. Originally, the questions I was curating were very leading and built on assumptions however, after engaging with both qualitative and narrative research literature I knew I needed to think differently and more openly, allowing participants to speak their own stories in their own ways and time.

What is Narrative Research?

Narrative Research most simply understood, is the collection of stories told from those who have lived through those experiences (Creswell, 2013). The lived experiences of individuals are imperative to narrative research because it is the key way in which we understand the human experience (Clandinin & Connelly, 2000). In narrative research individuals are viewed as embodiments of stories which they have lived through (Clandinin & Connelly, 2000). Narrative research is a collaborative approach between participants and researchers with the collection of participants' stories overtime (Clandinin & Connelly, 2000). It is the 'living', 'telling', 'reliving' and 'retelling' of individual stories which comprise their life experiences on personal and social levels (Clandinin & Connelly, 2000). The emphasis on storytelling is so important in narrative research because "…narratives help people to organize their experiences into meaningful episodes that call upon cultural modes of reasoning and representation" (Fraser, 2004, p. 180). This resonated with me as my own experiences with SA and engagement with the mental health system live in my own memory as mini episodes that make up a series of that chapter in my life.

The narration of our stories is a part of the human experience and represents the places, spaces and times in people's lives (Fraser, 2004). Clandinin & Connelly (2000) define these time periods through temporality which they feel is a central feature to narrative thinking. Temporality assumes that we see our experiences not as they are happening but something we see and understand over time (Clandinin & Connelly, 2000). As stories are collected, retold and restoried by the researcher there is an understanding that participants may communicate their narratives with temporality in mind as they navigate the past, present and future of their stories (Clandinin & Connelly, 2000). Narrative inquiry challenges traditional notions of research by

validating storytelling as a form of research (Fraser, 2004), which I feel is imperative to understanding experience. I view narrative research as a complete embodiment of human stories told from the humans who have lived through and own those stories.

The foundational place of narrative research is a combination of 'personal and social', 'past, present and future' and 'place' (Clandinin & Connelly, 2000, p. 50). The personal and social represent *interaction* and the past, present and future represent *continuity* where place represents the *situation* (Clandinin & Connelly, 2000). Each component creates what Clandinin & Connelly (2000) describe as a "…three-dimensional narrative inquiry space…" (p. 50). Thus, creating a place where stories live through time, context and multiple dimensions recognizing the countless layers in which stories exist. Furthermore, narrative research comprises various types which are autoethnography, biographical study and oral histories (Creswell, 2009). For this research, I have chosen to use oral histories in gathering participants' stories. Oral histories are a collection of individuals' personal stories, thoughts, reflections, and life events from the person who have lived through or is currently living through a particular experience (Creswell, 2009). The use of oral histories is paramount for SA and sanism survivors who are often silenced or not believed.

I believe narrative research situates itself perfectly with Anti-colonial, Anti-psychiatry and Mad Studies as it ultimately resists silence which is the center of my research. These theories too in their own ways, resist silence. They resist the standard way or status quo of viewing and perceiving things which I feel this research has done the same. It was my hope that no longer will silencing of survivors be the status quo but sharing our stories and hearing each other will be the new norm. When I embarked on my journey in doing this research my core philosophy was

to expose silenced narratives in the research and when I came across oral histories in narrative inquiry, I was hopeful I could begin to carry out this task.

Why Narrative Inquiry?

I choose the narrative approach to inquiry because of its focus on storytelling. Through my research with different approaches to inquiry I felt narrative research was the best way to capture individuals' experiences. In this research, it was important for me to *hear* the stories of survivors from *their* point of view. I felt that narrative research was the only approach I could take to this research in collecting survivors' stories. Capturing both the 'personal' and 'social' aspects of individuals' stories was important as Clandinin & Connelly (2000) believe one cannot exist without the other. This approach allowed the storytellers to be the owners of their stories and the experts in this area. For a change, survivors had full agency of their stories and were given the space to share in whatever way they felt was most meaningful to them. So many studies excluded the full narratives of survivors or had professionals speak for them. I wanted to do something different here which is why narrative inquiry was so important for this work. For once their experience would be valued as something important and crucial and not just a pain of the past but recognized as actual knowledge and expertise.

Ryerson Research Ethics Board Approval

The narrative research was approved by the Ryerson Research Ethics Board (REB). The process was a long and tedious one which required revisions and critical thinking. The process became increasingly challenging when COVID-19 shifted all our research to a digital format. This meant that our original REB proposals had to be amended to exclude in-person interviews and instead involve interviewing by phone or video call. It was during the REB process that I had to grieve the idea of in-person interviews. I had worked for months on curating an idea and

imagining the in-person interview- where it would be, what I would bring and how I would set up the space. A beautiful component of my original interviews was to involve painting together which we would later photograph and include in this MRP. Unfortunately, with the new digital format I would not be able to provide art supplies to participants. This was the most difficult part of the REB; realizing my original in-person interviews would not come to fruition. Although the process was long and difficult in the moment, it really allowed me to think through every possible ethical challenge and how I would mitigate any risks to participants. Looking back, the REB was a detailed road map of how I would conduct my research step by step in the utmost ethical manner. The process allowed me to view this research from a participant's lens which helped me to reflect on ways in which I would want to be treated in this process sharing my vulnerable story. As I reflect, the REB was the foundation of what was to come and how I would get there.

Recruitment

Once I received REB approval I moved into the next stage of recruitment. This was the stage I was most excited about as connecting with survivors made the whole process feel real. In recruiting folx I used the snowball sampling method which is an intentional process that selects individuals who are able to provide the information that is needed for a given study (Padgett, 2008). In attempting to recruit participants I sent my recruitment flyer to a few of my personal contacts and asked them to forward the flyer to their contacts and so on. This allowed my flyer to reach a broad audience in hopes of attracting respondents that fit the inclusion criteria. To be eligible to participate in the study I asked that participants were eighteen plus, identified as a SA survivor, had experiences accessing mental health post assault and were available for a phone interview. Since my research involved exploring trauma experiences, I was nervous that no one

would want to participate. This fear only increased when COVID-19 hit, and stresses were high and folx were stretched thin. However, I was pleasantly surprised to have three wonderful, brave survivors come forward to share their stories.

Data Collection Method

To collect the data for this research I used one-to-one in-depth phone interviews with SA survivors who have engaged with the mental health system post-assault. Using dialogue from participants through interviewing creates a space where hidden truths can be revealed (Fraser, 2004). This critical qualitative inquiry commits to the exposure of injustice and discrimination that occurs in day-to-day life (Fraser, 2004). I chose in-depth interviews as they are the most commonly used format of interviewing in qualitative research (Creswell, 2009) and they allow participants to focus on each detail of their story. I strategically curated an interview guide that consisted of open-ended questions, using probes where necessary (Creswell, 2009) to create space for survivors' stories to flow out in whatever way they saw fit. To prepare for the interviews I conducted what Creswell (2009) describes as a 'pilot test' where I engaged in a practice run on myself. I went through the entire interview process with myself from the verbal permission to participate, to each question where I regurgitated my own story and recorded it as well. This process really allowed me to prepare adequately and place myself in the participants shoes as well as tweak any questions or probes that did not work. It also allowed me to engage with my own trauma bringing it to the forefront and re-inspiring my reasons for doing this work.

Another aspect of the data collection process that was vital to this work was my re-working of the previously known 'consent form'. In preparing to do this research and writing my proposal to the REB it quickly became clear to me that the 'consent form' could be very triggering to the SA community. Oftentimes the word 'consent' is used to interrogate, berate and

harass the SA community as an act of sheer violence. Consent is also often assumed through clothing, silence, substance use or lack of an embodied response which is why I wanted to problematize the notion of consent and consent discourse. I felt that tilting any documents that the participants had to engage with the word 'consent' could be triggering and re-traumatizing which went completely against the purpose of this research. Additionally, the word 'form' can also be triggering and re-traumatizing for survivors of sanism who have been held on hospital forms. So, I made the radical decision to abolish the formerly known 'consent form' and re-term it to the *Research Relationship Agreement*. When obtaining participants' verbal 'consent' by phone I re-languaged the term to *verbal permission to participate*. This was not an easy pursuit and took three attempts for approval from the REB however, I did not back down as I felt this was crucial in creating a safe space for each survivor.

Data Analysis

To analyze the phone interview data from participants I began with listening to the interview once before transcribing the interviews word for word. Once the audio was transcribed, precisely, collecting each word spoken, I then left a period of reflection. After some time away, with a fresh mind I replayed the interview while following along the transcript to ensure every word transcribed was correct and exactly how I heard it. After confirming the transcription was adequality and correctly transcribed I destroyed the recordings as per REB protocol. I then sent the transcriptions to each survivor for their approval and to make any edits they wished to. This was a critical piece of the data analysis process as I wanted each survivor to be proud of how their story was represented and gave them the opportunity to remove any information they were not comfortable with. I felt that this was the ethical thing to do, especially since the regurgitation of trauma does not always come out linear, so the opportunity to edit their stories in a way that

made sense to them was important. I intentionally told each survivor to take as much time as they needed to not induce any pressure and because it was evident to me that revisiting their trauma via text would be heavy. Once I received each revised transcript, I read through each of them once again allowing for a space to really hear the words textually. The next stage I began reading through the transcripts again this time, circling key words and phrases which stood out (as per Poole, 2020). These highlighted sections became the direct quotes from the survivor's stories which you will see in the findings chapter. I then began organizing the stories into sectioned headings that would capture the stories in the most organized way. The headings I created to organize each story included: The Sexual Assault, The Medical Assault, Survival Method, Messages to Fellow Survivors and Recommendations for True Support.

Since storytelling was such a vital component to this research it was extremely important for me to take entire excerpts of participants' stories to include in this final research paper. My whole mission was to center silent narratives thus, I felt the best way to do so was to include large citations of participants' narratives right here in the research. I made the very intentional and radical decision not to over analyze survivors' stories in the writing up of the findings chapter. Despite what I am 'supposed' to do for this MRP, I strongly felt that adding in my analytical thoughts of survivor's stories between quotations would be an act of violence. For the next chapter, I wanted each survivor's story to speak for itself without my interpretation of what they have shared. The survivor's stories are strong enough on their own and do not require my opinion to get their profound messages across.

CHAPTER 5. FINDINGS

The time has come for you to hear three unique stories of survival. With the survivors' support and input pseudonyms have been used to conceal their identity. Each name was chosen with care by the survivors themselves. River wanted a name that represented nature and had deep meaning. They chose the name River as a river is ever flowing and changing, which they felt represented them, their story, and their journey. The second survivor wanted two names and chose Melody Mars. When I asked why they were choosing those names specifically, they responded with such excitement, 'Well if I were ever a glam Rockstar my name would be Melody Mars!'. Vivian chose her name based on a character from her favourite film whom she felt represented a fearless, unapologetic, strong woman. Just as it was important for me to have the survivors choose their pseudonyms it was also essential that I gave space for their stories to be heard from their voices. I have made the radical decision not to over analyze their stories and layer in my voice in this chapter. I believe doing so would be an act of violence. I made a vow at the beginning of this paper that the survivors' stories would be the center of this research so that is exactly what I intend it to be. Too much of my voice would be counterproductive and violent. I am not the expert but instead a vehicle for these three survivors' stories to be heard and accepted as academic knowledge. Survivors often experience folx speaking for them in various scenarios as an act of sheer violence which I do not intend to repeat here. I also believe as a critical social worker it is crucial to interrogate white Eurocentric ways in 'analyzing' data. To make this section more accessible for those with comprehension issues like myself, I have bolded sections of survivor's stories for you to follow what I heard more easily. The stories you are about to read are directly from the survivors and speak for themselves.

Story 1: River

About River:

In the words of River, they self-identify as:

> *white Celtic dissent mostly. And gender identify as non-binary assigned female at birth (AFAB) trans masculine…I realize that's um… more trans masculine non-binary and they and them pronouns (River: 31-33).*

When asked why they wanted to participate in this research River stated:

> *okay yeah, I think because I've had such mixed experiences accessing healthcare services and I've had such an atrocious experience. The last time after having disclosed a sexual assault I just thought you know it would be nice if it could get captured, like maybe someone might read it and change their practises (laughs) as I laugh at that. Yeah that's my hope like to you know see some social justicy see stuff happen (River: 21-25).*

River Continued:

> *I wanted to participate just because I haven't seen a lot of research on Non-binary or trans folx experiences of sexual assault (River: 35-36).*

The Sexual Assault:

River began the sharing of their story with their most recent experience of SA, River shared:

> *I was sexually assaulted in **December 2018 and it was with somebody that I had met previously** they weren't a stranger and assigned male at birth, identified as male and we had had like pretty good meetings before (River: 58-60).*

They explained to a nurse practitioner:

> *Recently someone **removed a condom while we were having sex** (River: 131-132).*

River Continued:

> *And I was like no it wasn't consensual I **didn't agree to that** but that was not what we had discussed because usually I'm one of those people who likes to discuss what is going to happen.... you know because of my trauma history I like to be kind of clear with what I'm OK with and what I'm not. For me that's a practice that works. (River: 135-139).*

When speaking with a close friend River shared:

> *I went and talked to my friend that night and they were like* ***"what do you mean someone took off a condom while you were having sex and you didn't know"*** *and I was like well they took it off and I didn't know until after and they (the friend) were like* ***"that's sexual assault'".*** *And I was like what? My friend said, "how did she (the nurse practitioner) not catch that was sexual assault? You keep saying it was non-consensual and there's no such thing as un-consensual sex.* ***Un-consensual sex is rape and assault".*** *And I was like oh? So, it was kind of funny because I didn't even realize it was sexual assault (River: 141-148).*

When speaking of previous SA's River shared:

> *Not to blame myself but I think I was just…in like* ***other experiences I've had with sexual assault they have been like so blatantly a sexual assault*** *you know where you know from the get-go unlike people just doing stuff anyways…so I think* ***I just didn't have this awareness of something that changes in the middle is sexual assault****. Like if what you agreed to changes its sexual assault (River: 151-156).*

The Medical Assault:

When disclosing their experience of exploring their sexuality to the nurse practitioner River

shared:

> *I decided I would see what my sexual orientation was because it kind uhh was changing and I was like Okay I'll see how I feel about Cis-men and so I was kind of talking about that and the nurse practitioner asked me,* ***"why are you sleeping with so many people?"****. And I was kind of taken a back (River: 94-97).*

River continued:

> *I was explaining you know I'm navigating my body and relationships and this is confusing and I am kind of trying to figure out what I want and then she was like****, "oh well are these people paying you?"*** *(River: 102-105).*
>
> *It was such a strange question to me which* ***now I'm starting to*** **think it was because of the fact that I am trans***…. you know there's a lot of literature about trans folx engaging in sex work but at the time I didn't realize this is probably what she was thinking and then she (the nurse practitioner) asked if I was always using condoms while having sex. And I tried to explain to her that not all men have penises and not all women have vaginas (River: 108-115).*
>
> *She just kept having this assumption that sex equals pregnancy risk aside from the fact that it was really problematic that that's what she chose to focus on and didn't ask anything about the type of sex I was having. So, when she was asking me about*

*condoms, I was like no. She started screaming at me being like, **"why don't you use condoms that's so irresponsible of you, you're a public health hazard!**" (River: 121-126).*

When disclosing the SA where the condom was removed without Rivers permission, River shared:

*And she (the nurse practitioner) was like, **"how could you let them do that?! That's so negligent of you!"** And I was like I didn't know they did it. And she (the nurse practitioner) was like, **"how do you not know?! So clearly you let that happen!"** (River:132-135).*

***She was just screaming at me** and didn't take anything into consideration (River: 139-140).*

In receiving health care for the SA River explained:

*But the interesting thing was **nobody offered me any health care** at all no one was like we need to give you a blood test are you okay with having a pelvic exam. Like no one talked me through like do you wanna press charges do you want to look into any of these things (River: 173-176).*

*No supports like nothing and so I left, and it was in that space that **I felt such discrimination from the nurse** (River: 178-179).*

In navigating the denial of the SA from health care professionals, River shared:

*I was really surprised that **no one picked up like even my doctor didn't realize like that un-consensual sex is not consensual sex** (River: 182-184).*

***I put in an official complaint against the nurse** at one point, so I ended up having a meeting with one of the supervisors at the clinic and my doctor (River: 190-192).*

*I had concerns because **I had requested my records** at that point from my doctor's office and **it was all listed as consensual** (River: 219-220).*

***The nurse refused to change it** even after I was like I told you this was not consensual. And she was like, "Well that's not my understanding and I'm not changing it" (River: 223-225).*

***I ended up filing a human rights complaint against them** (River 228-229).*

In navigating continued support from the same health care professionals, River shared:

> *They seem to only be able to grasp heterosexual or homosexual and there was no space for all the different identities that exist even gender identities. What does it mean when someone says they're having sex with a man, but that man doesn't like have a penis? That wasn't even on their radar. I know I'm going into more than just an assault but* ***there's so many layers to my experience*** *(River: 539-543).*
>
> ***I just disclosed that I was dating again*** *and I'd hooked up with two people but that I been like doing everything that I felt was right for me regarding sexual health practises (River: 256-258).*
>
> *There was a lot of focus on heteronormative sex regarding pregnancy risk because even then she was like,* ***"you should go on birth control"*** *and I was like, anal sex has very low pregnancy risk (laughs) (River: 266-268)*
>
> *And* ***all their notes referred to me with she/ her pronouns*** *and even some of them would slip up the two of them when they were together talking about me and I think because they read me as female even though they know I identify as trans but because they saw me as female they didn't have the same understanding (River: 272-275).*
>
> *At one point* ***she asked me how many people I slept with*** *and I gave her the number of my entire life and* ***she recorded it as the sex I had in the last two weeks*** *(River: 292-294).*
>
> *And it wasn't till like after that I saw how things were being framed, their understanding of what was happening…* ***I started to dissociate*** *because I was like you're not understanding me and I think* ***I got triggered from a trauma perspective*** *clearly and I was like I've never dissociated with a health professional before ever. So, you know I said I was starting to dissociate. I need to put my feet on the ground I need you to distract me. I have a lot of energy and* ***it would be helpful if I could go for a walk*** *or something. And she was like, "no you need to sit down" she got really scared and later my doctor told me that she was really scared (the nurse). She said, "****no you need to sit down*** *I'm gonna go get your doctor I'll be right back" (River: 306-316).*
>
> ***She left the room for 40 minutes*** *(River: 318).*
>
> *Yeah and went to meet with my doctor and the psychiatrist who had been consulted twice and* ***ended up having a 40-minute meeting about me engaging in sex work… that's the way it ended up getting framed*** *and about me dissociating and left me alone in the room (River: 320-323).*
>
> *She came back and was like,* ***"I'm late for my meeting because of you!"*** *(River: 325-326).*

*I was just like what the fuck and then **the Doctor was like the nurse said, "You were pulling tricks".** And I was like what no…what are you talking about I'm not engaging in sex work and even if I was… there's different kinds of sex work and why is this a problem and she was like, "you're going to get pregnant". And I was like I'd have to have a particular type of sex to get pregnant (River: 354-358).*

And she was like, "There is no condom used" And I was like yeah because someone took it off and it was like not registering with her (River: 360-361).

***My doctor started yelling at me like, "You need an IUD!"** She ended up prescribing me an IUD even though I already told her numerous times that I didn't want one. My doctor was like, "you can't get pregnant!" (River: 349-352).*

River's thoughts on the mental health system from their experience explained:

*Our mental health care system isn't set up like that. It's very much like **let me diagnose you and give you pills** (River: 580-581).*

*Accessing healthcare at my doctor's office was like well just take these pills and they will help you and I was like nothing's wrong with me **I experienced trauma I disclosed the trauma and I experience more trauma now you're telling me it's my fault and I'm not acting right** (River: 586-589).*

***They were throwing around all these different labels** and telling me like maybe I have a personality disorder and I was like how? How do I have a personality disorder what from this tells you I have a personality disorder? (River: 592-595).*

*And so, it's not a normal circumstance I know why PTSD got put in the DSM it took a lot of advocacy and I understand why it's there and I think it can be useful but when you start saying someone has depression, like my reactions to things are like normal for what I experienced. Yes, they may not be healthy right now but stop telling me I'm depressed or I have a personality disorder or like whatever when **I'm doing what I need to, to survive and to figure out how to navigate a world that is dangerous in a way that I didn't know could be dangerous before** (River: 625-631).*

When asked how they would describe their experience in one-word River stated:

*Is **shit show** one word (laughs) (River: 639).*

*Can you hyphenate **shit show and cluster fuck** together? (Laughs) (River: 642-643).*

Survival Method:

When asked what was one thing or an artifact that got them through their experience River shared:

> *So, for me having **my chosen family, close friends, those few people who say no you're not crazy,** you are very good with relationships with your friends, you are not spontaneous like you're not perfect but it was … It was nice to have people to talk to and it was nice to have people to come to appointments with me and it was nice to have people who could say no these are structural issues this is not you these are people who don't understand trans identities, don't understand queer identities you are experiencing oppression (River: 782-788).*
>
> *Just like having people that were real with me and called me out on the stuff that maybe could've happened differently but for the most part supported me and went to appointments with me and helped me clarify that this is not how I am in the world at all and say, yes this is an assault, **yes the person in front of you is experiencing trauma now but this is them experiencing trauma it's not them in the world in general**. The nice thing that happened was a number of my friends had written me letters of support that they sent to the clinic saying what happened to this patient is not okay and you folx need to check your policies and you did not do stuff right. I had like six letters from people in a week (laughs) (River: 794-804).*
>
> *Having people who had an awareness that I **am a person who experiences things but I'm a person who experiences things within systems and systems have problems.** I think that was the thing that got me through. And having people who frame things in different perspectives and who let me make choices (River: 807-811).*

Story 2: Melody Mars

About Melody Mars:

In the words of Melody Mars, she self-identifies as:

> *I identify as a white settler of Irish and French descent and a cisgender, pansexual female (Melody Mars: 33-34).*

When asked why she wanted to participate in this interview Melody Mars shared:

> *Having more academic content of the lived experiences of survivors of sexual violence, and their experiences accessing the broad range of mental health supports that exist and that do not exist is important. Anything that can contribute legitimacy to the very common phenomenon of sexual assaults and secondary trauma stemming from our mental health services is important in developing a culture that can adequately address the needs of survivors and ultimately offer them tools for a faster recovery. It hopefully*

could provide incentives for the legal system to re-examine how it addresses sexual assault and survivors by demonstrating the severe and withstanding impact of sexual assault (Melody Mars: 23-30).

The Sexual Assault:

When beginning to share her history of SA and the most recent experience of SA, Melody Mars shared:

> *I'm taking a step back and going back in time. Because **I am a survivor of multiple sexual assaults including childhood sexual assault**. And that unfortunately contributes to the likelihood of a person experiencing assault again. Even though, it's not the fault of the survivor; that's just stats. If you've been sexually assaulted once, it's more likely to happen again. So, prior to the most recent assault, **I had been assaulted at age, 10, for a period of two years. Age 16, and age 18**. In the context of those experiences I've had highly traumatic experiences accessing mental health support (Melody Mars: 46-52).*
>
> *The most recent assault was more explicitly violent than what had happened before. So, in short, I had attended a staff party at the (LOCATION) for a restaurant that I worked at. I had two drinks and I was just a regular drinker at that point. I mean, I was a cook and frankly drinking goes hand in hand with the job, so two drinks was not enough alcohol to become intoxicated. I'm not saying that the amount of alcohol I consumed is legally relevant, but I found myself more intoxicated than I've ever felt in my life. **The last thing I remember** is going to try and sit down at the venue where the staff party was occurring, and then **waking up in a stranger's car**. The man who took me from the event wouldn't let me out of the car. He took me to an unknown location where there was another individual, where **they ended up physically abusing me and violently raped me**. And I mean rape and sexual assault are always violent, but this was absolutely cruel, brutal and intentionally so. And there was no attempt to feign that they thought I was 'giving' consent. They did not care whatsoever. In fact, I believe that **the lack of consent was a piece of what gave them pleasure** and enjoyment from the experience. Following assaulting me, from what I understand, **they made an attempt to traffic me**. During the experience, my community became aware that I was unsafe and missing due to me managing to send a text to a friend that read 'scared' before the perpetrator took my phone. My friend contacted my other friends, who then contacted the police. And due to this, I was able to eventually extract myself from the situation. To be clear, I have no love for law enforcement for a variety of reasons. Law enforcement is a violent institution, who rarely responds to the needs of survivors of violence in a manner that supports survivors or holds perpetrators accountable. However, in my case they literally saved my ass - which has been conflicting for me. Upon law enforcement learning that I was a white female who was missing, they were 'on it'. They triangulated my phone, and they basically followed me in the car with my perpetrator following them assaulting me. And when my perpetrators got wind, they were being followed they released me from the vehicle. It was pretty fucked up (Melody Mars: 56-81).*

Following me being released by the perpetrators, the police showed up to my house. This is the point at which I began to notice an absence of adequate mental health services, and the fact that police are in no way equipped to adequately respond to most things, in this case, sexual assault. For instance: A single male police officer with a gun followed up immediately following the perpetrators releasing me. For context, there were firearms involved in the assaults. ***My perpetrators, they held a gun to my head while sexually assaulting me****,* ***and taunted me that I was going to die****, and that if I survived I would wish that I was dead…I still struggle with this piece. So, when…when a male officer showed up to my house - with a firearm - immediately following this experience, to ask questions…it was confusing and immediately retraumatizing (Melody Mars: 83-92).*

I wasn't ready to report *because I was so acutely traumatized and was presumably still feeling the effects of whatever was put in my drink the night before (Melody Mars: 97-98).*

I also didn't know if I wanted to report because even before the assault, I was aware that the police and ***criminal justice system have chronically failed to support survivors of sexual violence*** *(Melody Mars: 101-102).*

The officer asked blunt and unnuanced questions *such as "Were you raped?", to which I responded "no" because a) I couldn't remember what had happened in detail and b) was unsure whether or not an affirmative response would qualify as an accusation/report and force me into a criminal process without me having the chance to think about it clearly (Melody Mars: 104-108).*

Following this question, I threw up on my floor. The officer immediately asked, "Are you drunk", which I was not. What this question did was immediately perk my awareness of the ***victim-blaming*** *nature of law enforcement (Melody Mars: 111-113).*

Out of ***fear of being roped into a criminal report without consent****, I denied my assault and lost out on the opportunity to obtain a toxicology report or DNA evidence of the assault I had experienced (Melody Mars: 132-134).*

*I spent the rest of the day taking care of my wounds -****My vagina and anus were torn and bleeding****- and lying on my couch dissociating, crying,* ***cleaning the cum stains off of my dress****. I wasn't thinking clearly and was definitely trying to cope with the fact that I had just been assaulted (Melody Mars: 135-138).*

I gathered my courage, called my brother, and then called my parents. ***They believed me****. They were kind. They were concerned and wanted me to come home (Melody Mars: 141-143).*

I went back to work. Which did not go well. Seeing as the assault happened at a staff party, ***work was triggering****. I couldn't focus. I was a zombie. I was crying in the walk-in freezer multiple times per shift.* ***I would look at the faces of my co-workers and be vividly transported back to that night.*** *I couldn't sleep. I couldn't eat. I was taking*

increasing doses of a (MEDICATION) I had been prescribed for anxiety. I was drinking more and more and smoking probably more marijuana than Cheech and Chong. All just to kill the feelings that were beginning to arise within me (Melody Mars: 145-151).

I informed the CEO of the company I worked for as to what had occurred, and we ***went to the event location to review the security footage*** *to try to identify the perpetrator. The security room is in the basement of this huge entertainment complex, and yet somehow,* ***the perpetrator*** *who apparently worked there* ***walked right into the security room while I was there****. I hardly recognized him cognitively, but within a few seconds, the mole on his face triggered my memory and I knew it was him. And then I vomited on the floor (Melody Mars: 154-159).*

I immediately quit my job, went to my apartment, packed my shit*, and got a friend to drive me back to my parent's town 3 hours away from Toronto. And fuck - I am so lucky to have had a home to go to, and parents who believed me. Had it not been for that, I would have been entirely homeless (Melody Mars: 161-164).*

I cycled between ***intensive rage, uncontrollable crying, and catatonic states****.* ***No sleeping. No eating. Impulsive substance use****. I went to a doctor to figure out what the fuck was going on with me (Melody Mars: 178-180).*

The Medical Assault:

When describing her experiences accessing mental health services post assault, Melody Mars shared:

Accessing mental health services to address previous sexual assaults were ***more traumatic*** *than accessing services for the most recent assault (Melody Mars: 52-54).*

My interactions with surviving sexual assault and mental health services could be defined as an ***absence of mental health services*** *- not just inadequate services, but often just no services whatsoever in moments when they would have been helpful (Melody Mars: 122-124).*

I went to see my family doctor. And from what they had heard of what I've been through the first thing I was told, and my parents were told was that ***she probably will never recover. She might be able to volunteer someday****… (Melody Mars: 180-182).*

What a gross, lack of understanding of what PTSD is and this was a doctor that I had dealt with before when I was trying to address an eating disorder that stemmed from previous sexual assault. This goes back to when I previously said that my earlier experiences contending with the mental health system were more explicitly harmful. By attempting to address my eating disorder, I was referred to a biomedical outpatient program with a local hospital. ***I was 18 or so at the time, 6 ft 1, and approximately 95 pounds*** *(Melody Mars: 184-189).*

My family physician looked at me and said I didn't appear anorexic. Again, I was 6 ft 1 and 95 lbs. What a dingus. So anyways, I went to the outpatient program. And my, my (three hour) intakes was conducted by a psychiatrist who had just been transferred from the women's prison, which just closed down in (LOCATION). ***He diagnosed me with everything from Anorexia to depression to anxiety to OCD****, which really messed up my sense of self via over pathologizing me and* ***reducing me to a bunch of labels*** *with no clear solution to the symptomology. But the most problematic was that* ***without my knowledge, he diagnosed me with Borderline Personality Disorder (BPD)****. He diagnosed me with everything else except for PTSD, which in my opinion was the only useful diagnosis he could have given me. A diagnosis of borderline personality disorder to a sexual assault victim is basically like handing an acquittal to the perpetrator (Melody Mars: 191-201).*

I was coming close to, like, attempting suicide for a second time. And I knew it would wreck my parents. Right. And so, and also like I didn't know what to do like I was screaming one moment for like hours and like punching holes in the walls. And the next moment I would be inconsolable. And ***then I would like sit for 12 hours at a time thinking about l how I would kill myself*** *because I just couldn't imagine how I would ever come back from this. So, I just didn't know what to do. I was talking to my therapist, and I said I need to….I need to go….I need to go to the hospital to be under observation. So, it was a voluntary forming, which was very….I think actually wise because had I attempted suicide….it would have been involuntary. Right…but I was there and* ***they were not kind*** *- it is hard to describe. There is* ***a coldness and cruelness that runs through the mental health system****, particularly the inpatient biomedical component of the mental health system. When they left me alone, it was fine, but when I had to interact with them - nurses, doctors, workers,* ***it was just fucking dehumanizing*** *(Melody Mars: 293-251).*

What it does is ***it isolates you and pathologizes a systemic issue****. The nature of trauma is that it leaves those who deal with it feeling alienated from society and the world at large.* ***To be alone in a hospital*** *due to the fact that some man decided to rape and abuse you* ***is traumatizing*** *- it sends the message that I was the problem, and how the fuck was it that I was the sick one when it was men who decided to rape me. And I had the best experience possible in the hospital - had I been Indigenous, Black, A Woman of Colour, Transgender or lacking in the language to self advocate I would have been left with a lot more baggage from the experience. But in the body that I occupy, it was just empty space for me to be in pain, when I couldn't breathe. I was there for about four days (Melody Mars: 254-262).*

When describing the pursuit to find a new female therapist, Melody Mars shared:

The woman who I saw is also a survivor of childhood assault but the way that she's, you know, worked through it is…maybe ***influencing her work a little bit more than it should*** *(Melody Mars: 270-272).*

> *So, she basically said to me like* ***you're not gonna heal from what's just happened to you*** *if you don't start from the beginning and talk through everything that's happened from age, 10 onward. And* ***don't talk to your family*** *because it'll just make things worse. If I had a toxic family situation, this would make sense, but I don't. I needed my family as a life line, a support system, and a witness to what I was living through. I would come home from every therapy session worse. I eventually told my parents what she had said and they were devastated.* ***Her approach*** *not only didn't help me, but it* ***put me in danger*** *because her advice cut me off from my only true support system at that time: my family (Melody Mars: 274-282).*

When describing the intersections of accessing mental health services and the pursuit of justice

Melody Mars Shared:

> *I was subpoenaed by the defense. And they filed for my medical files and to ask me about my sexual history. So, thank God I got my diagnosis changed before this all went down.* ***Accessing mental health services was terrifying in a court of law for sexual assault. Criminal court really hinders one's ability to access mental health services*** *in any capacity, even some things like Crown Attorneys will advise you to not to journal. Stay off of social media. Be careful what you put in emails.* ***I wasn't allowed to talk to any of my friends who were involved in that night*** *for over two years due to them having been subpoenaed- they were not even allowed to tell me that they had been subpoenaed which was hugely hurtful and confusing; I'm still repairing those relationships due to this process. It cut me off from a good portion of my community. So,* ***I think that the intersection between the legal pursuit of justice for sexual assault, and the pursuit of healing is inherently contradictory****. But ironically, I needed legal justice as a part of my healing even though it scared shit out of me. Knowing that the State had the capacity to say that what happened was illegal - and thank God they did. One of the perpetrators was found guilty (Melody Mars: 366-379).*
>
> ***That process*** *in and of itself* ***was traumatizing****, and it interfered with my ability to access support (Melody Mars: 392-393).*

When listening to this intersection of trauma I (the interviewer) pointed out to Melody Mars:

> *It sounds like you were experiencing a* ***three-tier trauma****- the* ***sexual assault trauma, the accessing mental health trauma, and then the pursuit of legal justice trauma*** *(Interviewer: 394-396).*

Melody Mars Responded:

> ***Nailed it!*** *Yeah, that's right (Melody Mars: 397).*

When sharing her thoughts on why she felt accessing mental health services post assault was so difficult Melody Mars explained:

> *Because individuating and* ***pathologizing the outcomes of assault is arguably the cultural gaslighting of survivors – 'it's not society that's the problem, it's YOU' -*** *is how it feels accessing services that lack a social justice component. So, while things have improved, during the initial phases of my recovery, I was on a cocktail of psychopharmaceuticals to quell the pain I was in. So many meds I couldn't think straight even if I wasn't traumatized. (LIST OF MEDICATIONS). But there was no amount of chemistry that could soothe or heal my central nervous system at that point. I was taking more and more pills, increasing my doses (Melody Mars: 309-316).*

When asked to describe her experience in one-word Melody Mars shared:

> ***Unbelievable yet ubiquitous****. It's just so traumatic but it's also not uncommon (Melody Mars: 442-443).*

Survival Method:

When asked what was one thing or an artifact that got her through her experience Melody Mars shared:

> *One thing that happened, that was wonderful is that I had a really strong community before this happened. And so, did my family. And so, when I was in bed just hanging on* ***community members sent me things*** *that ranged* ***from blankets to stones to cards to food****, and one community member who is a philanthropist who I've known since I was a kid,* ***offered to pay for my education*** *(Melody Mars: 505-509).*
>
> *Yeah it was because he wanted to give me something to hang on to and I mean my brain wasn't working. He knew that doctors were like 'oh she might be able to volunteer someday', and how undermining this was to my intellectual abilities, which I have always found pride and dignity in occupying. Really, being confronted with the potential of not being able to come close to my dreams ever again, such as getting a degree. So,* ***the collective response of small acts of care****, because I mean, frankly, some of those little stones or blankets that I got sent by community members mattered just as much as the dollars that were invested in my future (Melody Mars: 511-518).*
>
> ***Community member generosity- gifts from the community to inspire a will to live****. Well, that's one and the other one would be, and this is deeply personal and I don't talk about it very often: While the assault was happening, I'm not sure what it was, but I left my body in a way that wasn't like dissociation that I've ever experienced before.* ***I was watching myself from over overtop and being quite aware that I could probably die*** *(Melody Mars: 521-525).*

I was watching myself and it just became so clear. In that moment, I didn't do anything wrong. ***It became clear to me that I was good, that these people are into some really bad parts of being human****. It became profoundly clear to me that I am the tiniest little speck of matter in like a very, very large universe that spans across a long period of time. And that ultimately my life doesn't matter - I'm intricately connected to something bigger. But that doesn't mean that resistance and existence is futile. It means that while I'm on this planet, it's my job to be diligent in living according to what I believe in. And, you know, those questions of 'did I live a life that was worth it', and 'what do I really value?' were smacking me right in the face while I left my body. It probably only lasted like five seconds, but it felt like five years of contemplation (Melody Mars: 528-537).*

I would call it like pseudo spiritual or out of body or just my brain dissociating to the point where it was like, I'm just gonna go way over there into the spiritual realm to get you through this shit. So, there is ***the community generosity piece. And the spiritual piece*** *(Melody: 544-549).*

Story 3: Vivian

About Vivian:

In the words of Vivian, she self identifies as:

I self identify as a person of white European dissent and I am a cis-gendered woman (Vivian: 8).

When asked why she wanted to participate in this research, Vivian shared:

I want to participate in this interview because I think it's important work. I think that there's a silencing that has gone on with folx who engage with the mental health system after being sexually assaulted and I think there's some important stories to be heard here. And I think it's just really important that they're heard (Vivian: 3-6)

The Sexual Assault:

In beginning to share her story Vivian focused first on her SA experience where she shared what she described as a brief summary:

It's hard to know really where to start but ***when I was 18 I was sexually assaulted over a six-month period*** *by somebody my family had grown to know through work and I was heavily uhh groomed and coerced into certain situations um where I had been sexually assaulted repeatedly um sometimes several times a day for a six-month period. And* ***at the end of the six months I was actually taken by this person for three weeks*** *um Where I endured a lot of mental, emotional, and sexual abuse. And it definitely made anxieties grow in me and panic and worry and fear and at the end of those three weeks* ***I was found by my parents um they had been looking for me****, got in contact with me and found*

me. Um over that period of time…umm…they eventually did find me my dad specifically um came to where I was… they had gotten some information as to where I was and my dad came in and saw me and basically said a few things to me and my abuser was actually behind my dad um moving his hand across his neck and motioning like ***I'll kill you if you go*** *don't go and I just got up and I left with my dad. And we went home that night and I was very emotional and crying and just stricken with so much anxiety and when it came time to go to bed that night I could not go to sleep. Um Now looking back I think Nights were hard for me because I was taking at night (Vivian: 11-25).*

The Medical Assault:

Vivian shared three distinct experiences engaging with the mental health system where she was mis-treated. To make it easier for the reader I have categorized her three experiences into sections titled: 'The 1st Medical Assault', 'The 2nd Medical Assault' and 'The 3rd Medical Assault'. In beginning to engage with the mental health system Vivian was first brought to the hospital by her family and put on a 72-hour form where she experienced the '1st Medical Assault'. Vivian shared:

I got up and walked out of the room to the nurses' station and said I'm really anxious can you please give me something I feel like I may be like having a panic attack and I'm really anxious. And instead of giving me anything or talking to me or having a conversation with me the nurse just looked at another nurse and they said a few things to each other and she just said follow me um ***She put me in a room, locked me in the room****… It was a locked room for psychiatric patients in emerg and she handed me a gown because I think at that point I was in my own pyjamas.* ***So, she handed me a gown and said, "put this on"****. So, I did I was confused as to what was going on but I just put it on in this locked room and then* ***I looked up in the corner of the room and there was a camera and then I looked out to the nurses' station and there was two male nurses staring at the cameras in my room and I just stripped down naked into a hospital gown****. So, I started crying I was really upset and I was like kind of raising my voice a bit at the nurse and I was like how could you do this why would you do this to me you know I was just assaulted why would you make me change on camera? (Vivian: 37-50).*

Instead of like calming me down consoling me or anything like that ***the nurse just didn't wanna deal with me*** *you could tell she was just like annoyed and frustrated* ***so she called a code white and four male security guard showed up at this locked room.*** *It took me by the arms and* ***escorted me in a gown that wasn't even fully tied at the back*** *so basically my butt was hanging out. And walked me through emerg, through the hospital front entrance, through the whole hospital with my dad following in tow to the psychiatric unit (Vivian: 51-56).*

I was humiliated because I was pretty much naked from the back and I had these four security guards taking me by the arms when ***I just came from a very um male dominated, abusive situation*** *and so to have these four security guards take me like* ***not even fully clothed*** *to a place where* ***I didn't even know where I was going*** *and nobody was talking to me um…and I'm just hearing code white, code white, code white on the speaker system (Vivian: 57-61).*

The morning I knew I was going to meet my psychiatrist I got up early and went and shook her hand and said nice to meet you and she kind of looked stunned um…and then later on when my parents came to visit the doctor was meeting with them and me. She told my parents that I slept until 12 and then I wasn't cooperating. And I said actually you're lying because I was up at 9 o'clock and I walked to the nurse's station and I shook your hand and met you. And she was like oh, oh yeah maybe you did. And I just thought ***do they just make up stuff to tell people's families when they come in?*** *(Vivian: 85-91).*

Another thing that happened was ***my abuser found out I was in the hospital*** *and he knows people in the medical care system so* ***he got somebody to come in and speak to me*** *it was a nurse and she came in with these oxygen tanks and she came to my room and she was talking to me saying, "he doesn't want you to take the medication um he wants you to get out of here so that you guys can be back together um don't take the medication, don't listen to anybody in here, don't listen to your parents" blah blah blah. So then when my parents came to visit later, I told him this lady came in for (ABUSERS NAME). And my parents were like what?! They were so freaked out so they talked to the nurses and* ***the nurses didn't believe me****…****they told my parents that I was hearing voices*** *and my mom is the type of person where she doesn't back down and she's like my daughter is not lying so my mom basically got managers involved. And so, they checked the cameras and sure enough they saw that this woman came in and that I wasn't lying (Vivian: 101-111).*

So once ***things were confirmed through the cameras****, they actually had the police come (Vivian: 113-114).*

The police came *and so* ***they changed my file basically to like an alerted file*** *So only the people listed oh my file could come and visit (Vivian: 115-116).*

In continuing to share her story Vivian brought forth more details in a second experience which I have titled 'The 2nd Medical Assault'. Vivian continued:

So, then I was discharged after 18 days I spent Christmas in there. And ***I was given outpatient treatment with a psychiatrist*** *(Vivian: 152-153).*

I was on two different medications at the time. And I felt like a zombie I didn't feel like myself and I went to my doctor and my family doctor to get my prescription refilled and she basically read off a sheet of paper that the psychiatrist had faxed her saying ***you've been diagnosed with bipolar one, clinical depression, clinical anxiety, PTSD and***

> ***psychosis*** *and she was just listing all these diagnosis...they psychiatrist never said anything to me....aside from psychosis which they diagnosed me at the hospital* ***I was given all these diagnosis without my knowledge*** *(Vivian: 161-167).*
>
> *I started crying and I was like why does my psychiatrist… And it's even making me emotional right now (crying)… But* ***why didn't the psychiatrist not even say anything or have a conversation with me*** *about like hey this is what bipolar is this is what the symptoms do you feel that you feel this way? (Vivian: 171-174).*
>
> *I also* ***started to feel like I was going to have a seizure*** *because you know I had childhood epilepsy and had seizures in the past. And when I went to another psychiatry appointment I said I feel like I'm gonna have a seizure I don't feel well and they were like oh do you have a history of seizures and I was like yeah I had childhood epilepsy and they were like* ***this anti-depressant…people with a history of epilepsy should never be on this antidepressant*** *and I was sitting here thinking wow!! If you would've only had a conversation with me and treated me like a human and asked me questions like do you have childhood epilepsy or history of seizures this is the medication we want to put you on but these are the side effects.... If you have done your job properly I wouldn't even be in the situation. And at the time I was even driving because I was at college…* ***Can you imagine if I would've had a seizure while I was driving because somebody didn't do their job properly?*** *(Vivian: 184-195).*

In continuing to unravel her story Vivian shared some final details of a third experience which I have titled 'The 3rd Medical Assault'. Vivian continued:

> *So, I ended up having a bit of a psychosis again and because it is very easy for your brain to go back there once it's been there from what I've been told and so* ***I ended up in the hospital again*** *um in emerge then* ***they locked me in that room again.*** *This time I knew I was changing on camera, so* ***I did my best to try and cover myself while I changed on camera.*** *I felt so gross and violated (Vivian: 207-213).*
>
> *This time when they locked me in the room I was smart and* ***I kept my phone in my bra without them noticing*** *and so they locked me in this room and I was also on my period this time on a really heavy day. And I had to keep going to the washroom because um I'm use to using tampons and all they had were these thin pads and so that wasn't doing it for me and I needed to go to the washroom several times. So, I kept asking the nurse to go to the washroom because I couldn't just go by myself because I was in a locked room. And most of the time she would ignore me. And it got to a point where she was ignoring me so much that* ***blood was now running down my legs and now dripping on the floor*** *and I kept banging on the door saying please can I go to the washroom, Can I go to the washroom? And she would like say to me through the window, "you don't need to go again!* ***I'm not your personal assistant!****" (Vivian: 218-228).*
>
> *And when the blood was running down my legs and, on the floor, I was taking pictures with my phone and sending them to my mom...****Refused washroom, refused washroom,***

refused washroom. *So then eventually the nurse came to the door and she um saw the blood on my legs and on the floor and she was like,* ***"Stop acting like an animal!"*** *And I was like well maybe you should stop treating me like one. And she was like,* ***"I'm so sick of you!"*** *(Vivian: 230-235).*

I kept documenting this all on my phone and then my mom came in the morning and actually I had called a few people and left voicemails that night on my phone. Um because I don't know ***I just felt like I'd be forgotten in that room*** *and of course my parents were going to forget me, but I just felt like really afraid. And um so One of the messages I left was for my aunt so she actually came and she brought me a bagel from Tim Hortons because* ***they hadn't fed me*** *and um so like they just didn't want to deal with me so they didn't bring me breakfast or anything. So, um she brought me breakfast and she saw the room and she couldn't believe it. Like there was blood on the floor like even that morning* ***nobody came to ask if I needed to go to the washroom*** *nobody came to give me like anything to wipe my legs. I tried to wipe as much as I could with tissue paper the last time I was in the washroom (Vivian: 242-251).*

So my mom came in the morning I hadn't heard from her like over text or anything and then I saw her sitting in the nurses station with the social worker that I knew from the first time I was at the hospital who is really nice the only person who was nice and the doctor…the emerg doctor. And then later the social worker (NAME) um told me the conversation that was had with my mom, the social worker and the doctor. The doctor was like oh ***"she's paranoid she thinks there's cameras in the room".*** *And (SOCIAL WORKERS NAME) said there is look at that monitor right there. So,* ***the doctor was not even aware there's cameras in these rooms for psychiatric patients. Like how disconnected are you?*** *(Vivian: 262-269).*

(SOCIAL WORKERS NAME) said I can't believe it but the doctor the night before wrote in the notes that ***you were manic because your nails are all different colours*** *(Vivian: 271-273).*

(SOCIAL WORKERS NAME) said yeah, ***I am really disgusted with how they treated you*** *down there (Vivian: 280-281).*

The emerge doctor had me on a very low-dose of medication actually the lowest dose possible which was 50 mg and the psychiatrist in the psych unit was like "I've never had someone in such a little medication so ***I wanna up your medication I also want to add a mood stabilizer****" and I said no I don't want any of that I'm fine with this one I slept great last night it's good. And she said well I've never had anyone on such a low dose, and I said I guess I'm your miracle patient and she just kind of stared at me. And I refused to go on more medication. And she like extended my form and so I think at that time I was in the hospital for like close to two weeks, like just under two weeks maybe like 12 or 13 days (Vivian: 297-305).*

Vivian continued to share her story by offering up her thoughts on how she felt she was treated while entering the mental health system. Vivian shared:

> *Those experiences with the mental health system um we're* ***extremely traumatizing*** *um you would think after coming out of such a traumatic experience that you'd be met with support and not with* ***more trauma*** *(Vivian: 360-365).*
>
> *It has been hard um I just felt too that I had seen so many psychiatrists so many doctor's um and* ***everyone had their own opinion and had their own diagnosis they wanted to throw into the mix****. And I just felt like it was really hard to navigate and like for my family as well we, we never had to deal with mental health in our family and we were leaning on these professionals for expertise and support but instead of getting expertise and support* ***I was being traumatized and treated like shit*** *(Vivian: 365-370).*
>
> ***I felt broken, I felt Messed up… I felt like a fucked-up person****, I felt like nobody would understand. I just felt disposable. I felt like trash I just felt like garbage. Um I just thought that I wasn't deserving of anything good, that I was just kind of like used, washed up garbage… Like I didn't feel worthy at all (Vivian: 400-404).*
>
> *I just felt like really depressed by it really debilitated by it. And for a while actually* ***I was suicidal*** *to the point where I was waking up every day where* ***I would say a good two years*** *where every day I was waking up and was feeling like* ***today would be a good day to die*** *(Vivian: 405-408).*
>
> *I didn't even tell my friends I didn't tell anyone till years later.* ***Because I didn't want another diagnosis I didn't want to be formed again*** *(Vivian: 413-415).*

When asked to describe her experience in one word, Vivian shared:

> *That's really hard. Tragic, mentally fucked, dangerous, detrimental, destroyed, ruined. But I think if I had to pick one word tragic. Maybe two* ***Truly Tragic*** *(Vivian: 425-426).*

Survival Method:

When asked what was one thing or an artifact that got her through her experience Vivian shared:

> ***This song*** *and music video by an artist Lady Gaga called* ***Mary The Night*** *(Vivian: 452).*
>
> *I felt like* ***there was somebody that went through what I went through*** *and (crying) so I would watch that video over and over and over again. And (crying) I felt like it was my new beginning (crying) and sorry (crying) I'm getting emotional again…my new beginning for my second chance (deep sigh) and so* ***I just did what Gaga did I just decided to do it all over again*** *(crying). And I asked the universe for a sign for a new*

name because I had written down all the qualities of the person, I wanted to become which was confident, fearless, un-apologetic and strong. And I started to become that person, ***so I asked the universe to send me a sign for a new name to call this new person that has emerged from within me****. And I was sitting in a college class one day and this girl sat beside me and she said I'm gonna call you (NAME) (Vivian: 467-476).*

I was like boom there it is that's my new name and so ***I just started having my friends call me this new name*** *when I would introduce myself to new people I would introduce myself with this name.* ***I got the name tattooed on my ribs*** *and I really felt like* ***that song freed me from the chains of all the shame that I had*** *(Vivian: 478-481).*

Messages to Fellow Survivors:

In closing this chapter as someone who felt very alone in my recovery of SA and the Medical Assault, it was important to me that I asked these courageous survivors what messages they had for fellow survivors. I wanted you, the reader and possible fellow survivor, to have something to hang onto in your own healing journey.

River Shared:

I think you will know what you need and even if it doesn't feel like that right now, even if you don't feel like you remotely know what you need right now, ***trust yourself and trust that you will start to know what feels right for you*** *and it's okay if what feels right for you isn't what other people say it is and it's okay if you don't want to do things the quote on quote traditional way because I think you will know. A lot of things that helped me heal or get through this situation weren't necessarily the traditional western way of dealing with things I think listening to myself and starting to be able to say this is what's right for me and this isn't what's right for me let me take back some of that power and autonomy and really feel okay within myself and in the world (River: 826-835).*

Melody Mars Shared:

Well as much as ***what happened to you is not your fault****, the outcomes of the assault are your responsibility to heal from. It was never your fault. But unfortunately, it's now yours.* ***You're dealing with the by-product of a very sick society*** *and legal justice doesn't equal healing or truth. But if legal recourse is what you need go get 'em! (LAUGHS) (Melody Mars: 559-562).*

Vivian Shared:

So what I would like other survivors to hear is that you're not alone, you're not disposable, you're not washed up or used up, your life is not over, you're not finished

> *you're not ruined.* ***You're actually whatever you choose to be next****. And take as much time as you need to grieve the old you, to sit with the old you, sit with your pain, your worry, your fear. Trust yourself, take time with yourself and then* ***when you're ready, let go, step forward and be whatever you dreamed of being*** *and* ***if nobody's rooting for you, just know that I am*** *(Vivian: 496-502).*

It is my hope that these words hug you tight and allow you to feel not alone in your pain and survival journey.

CHAPTER 6. DISCUSSION & IMPLICATIONS

Implicating Whiteness:

First, I would like to address that all three participants have identified as white. I thought deeply about this and who feels safe in these research spaces to share. I want to acknowledge that racialized voices are missing in these narratives which is a disservice to racialized communities and survivors alike. Racialized communities have experienced exploitation, objectification, oppression, and discrimination through research studies (Chadderton, 2012). Since racialized communities are so heavily researched, I believe these spaces have become unsafe and violent for racialized folx. I believe racialized folx bring a unique perspective to this conversation, one that unfortunately was not captured here. Both historically and presently racialized folx have experienced white voices speaking for them, contributing to further marginalization and discrimination (Chadderton, 2012). Thus, it is my hope that this research is the opening to many more works like it, led by racialized researchers who will bring a unique perspective and create safe spaces for other racialized folx to share their stories and be heard.

I'd also like to take this opportunity to implicate myself as a white researcher in this work. It was and is essential that I am not complacent in my whiteness throughout this process and instead name it and implicate it in the work. The subject position of the *white researcher* allows for a lot of power as the *knower*. Hunter (2002) acknowledges whites as the dominant group whose epistemologies are authenticated as the knowers. Thus, my knowledge production will be validated by my whiteness and the whiteness of participants. Simply because of the colour of our skin and the privilege our whiteness holds, our experiences will be accepted as true authentic knowledge. This powerful role as the white researcher perpetuates more whiteness in the research and survivor advocacy as it only represents and reproduces white voices. This

subject position excludes my ability to provide an intersectional experience of SA or sanism entangled with race. I acknowledge that my experience with sanism and SA is a very privileged one as a white, cisgender woman. This status excludes me from understanding or knowing the lived experience of racialized folx who navigate through the same systems. Melody Mar's highlighted this privilege in her own story when she shared:

> *And I had the best experience possible in the hospital - **had I been Indigenous, Black, A Woman of Colour, Transgendered or lacking in the language** to self advocate I would have been left with **a lot more baggage from the experience**. But in the body that I occupy, it was just empty space for me to be in pain, when I couldn't breathe (Melody Mars: 258-262).*

Hunter (2002) explained black researchers were more successful in researching their own communities as they avoided perpetuating further racism and eliminated white researchers' ability to pathologize black folx. Although racialized voices are not heard in this work, I also strongly believe white folx researching racialized individuals is problematic. No matter how critical I am or anti-oppressive, I cannot escape my whiteness in such a dominant role. Therefore, I feel those with an intersectional racial identity would be the best to conduct similar works with racialized folx.

Surprises & Implications:

The three unique stories of survival that were shared brought forth such important knowledge on the medical assault or re-victimization experienced by SA survivors who engage with mental health services post assault as well as some surprises. All three survivors had *negative* experiences accessing mental health services post-assault and were all pathologized with mental health disorders that they themselves did not associate with. I was specifically surprised that folx experienced diagnoses they did not associate with as well as experiencing being diagnosed without their knowledge. Since I felt so alone in these experiences, I wasn't sure

if I would have others divulge similar experiences. In using narrative research, it was my intent to expose silent narratives and educate interdisciplinary professionals on best practices in interacting with SA survivors. Although this is limited with, the guidelines of smaller samples sizes for this paper I hope at the very least I have started a conversation to a larger issue. Through narrative research social workers are able to explore social phenomena to find deeper understandings (Fraser, 2004) a goal I hope I accomplished here. The most profound and surprising finding that I have chosen to detail here is that each survivor stated that they felt the medical assault was more traumatic than the SA. I thought I was alone in this feeling however, I learned it is a common experience.

River stated:

> ***My sexual assault didn't feel that bad compared to like accessing the healthcare*** *I received and at one point I even said* ***I would rather be raped another 50 times than ever go through what I did with the healthcare providers*** *that were supposed to help me because I know how to navigate a sexual assault I don't know how to navigate healthcare providers who are ridiculous (laughs) (River: 764-769).*

Melody Mars stated:

> *I've had* ***highly traumatic experiences accessing mental health*** *support, probably* ***more traumatic than the most recent assault*** *(Melody Mars: 51-53).*

Vivian stated:

> *I often said to my mom and friends that um* ***I would rather experience the sexual assault experience again then go through the experience I had accessing mental health*** *after the assault because* ***that was way more traumatic than the sexual assault itself****. I think that in life as a woman and a female growing up you kind of live in a world where you know…you fear being raped or sexually assaulted because it's just so ramped I mean for all genders and all races and all places in the world but I can only speak for my gender identity as a cis-gendered women it's just this idea of like…it's kind of instilled in you to be afraid of it happening. And I think because you're so afraid and weary of that growing up even as a little girl that* ***sometimes bad guys come and take a little girls for bad things****…****I think that in some kind of weird way you mentally prepare yourself*** *but I was never mentally prepared to access healthcare and be traumatized like that…that was never even on my radar (Vivian: 351-360).*

> *I felt messed up from the sexual assault and being taken and emotionally and mentally abused, but* ***I felt even more messed up from the trauma I endured with healthcare providers*** *(Vivian: 397-399).*

Another surprising finding was survivors' experiences being diagnosed with mental health disorders without their knowledge or input. Again, I thought I was alone in this experience.

Melody Mars shared:

> *He diagnosed me with everything from Anorexia to depression to anxiety to OCD, which really messed up my sense of self via over pathologizing me and reducing me to a bunch of labels with no clear solution to the symptomatology. But the most problematic was that* ***without my knowledge, he diagnosed me with Borderline Personality Disorder (BPD)****. He diagnosed me with everything else except for PTSD, which in my opinion was the only useful diagnosis he could have given me. A diagnosis of borderline personality disorder to a sexual assault victim is basically like handing an acquittal to the perpetrator (Melody Mars: 195-201).*

Similarly, Vivian shared:

> *I was on two different medications at the time. And I felt like a zombie I didn't feel like myself and I went to my doctor… my family doctor to get my prescription refilled and she basically read off a sheet of paper that the psychiatrist had faxed her saying* ***you've been diagnosed with bipolar one, clinical depression, clinical anxiety, PTSD and psychosis*** *and she was just listing all these diagnosis...the psychiatrist never said anything to me....aside from psychosis which they diagnosed me at the hospital* ***I was given all these diagnosis without my knowledge*** *(Vivian: 161-167).*

Carrying Stories & 'Breaking Open the Bone':

These narratives have the potential to broaden the understanding of SA survivors' experiences in medical systems. Although limited in sample size and diversity it is my hope that this research is a small beginning to many more works of its kind. This research really allows the public, and the reader, to access an insider perspective on what it is like to navigate the trauma of SA through systems which are intended to provide support, however, instead induce further trauma. This is a process which activist and poet Eli Clare coined 'breaking open the bone' (cited in Poole & Ward, 2013). Poole et al (2013) describe, "when we break open the bone and let the

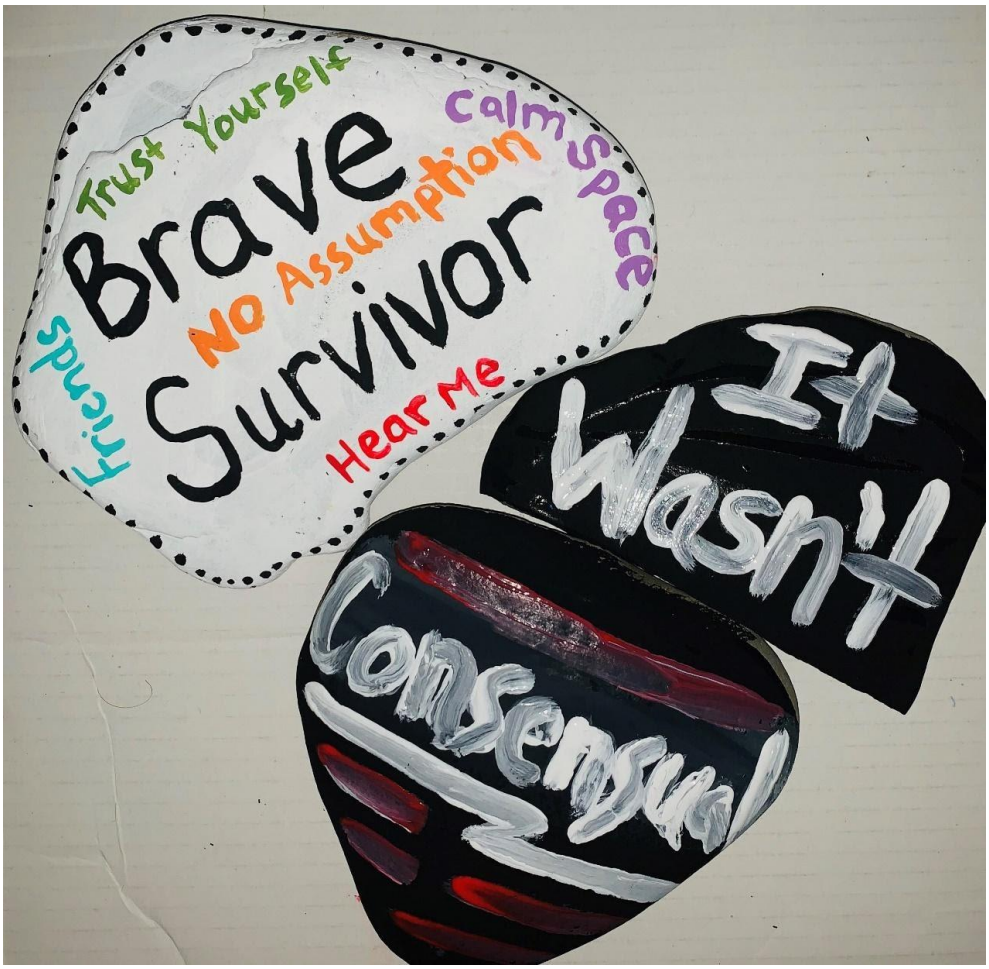
stories slip/spew/trip/rage from our lips, we make it possible for others to break out too" (p. 102). This statement spoke to my gut and what I feel to be the core of this research. I felt that if I could create a space in this work for survivors to 'break open the bone' then perhaps it could inspire or create space for others to as well. Perhaps it would inspire other survivors to look deep into their own stories and find healing or maybe inspire them to take on similar works that attempt to resist the discriminatory treatment experienced by survivors alike. Breaking open the bone is a risk-taking act which involves going deep down in your story (Poole & Ward, 2013) a brave decision each survivor took on in sharing their story.

It was quite clear to me that the survivors were making such a courageous brave stance in sharing their stories; however, I too was also taking a risk in carrying their stories. Would I do their stories justice? Would the survivors feel proud of the representation of their stories? Would they feel their stories were safe with me? How would I feel sitting with their stories inside of me? These were all questions I asked myself throughout the entire process of this work even before the recruitment phase. I was pleasantly surprised that I was so trusted with their stories and encouraged by each survivor and even thanked for taking on this work. They were so raw in their story sharing, so real and authentic which affirmed to me that they felt the space was safe. Not only is it important to 'break open the bone' but it is also imperative that you show the rawness in one's story which allows us to be more vulnerable (Poole & Ward, 2013). Vulnerable is exactly how I felt in listening to each participant's story and listening to the recordings. So much of their trauma responses, re-traumatization and survival methods spoke to my own story, making things very raw, real and vulnerable. I had to space out my interviews and give myself time between the interview and listening to the recordings to give myself room to process the survivor's stories. I even found myself mentally in 2009 the year I was assaulted, rolling around

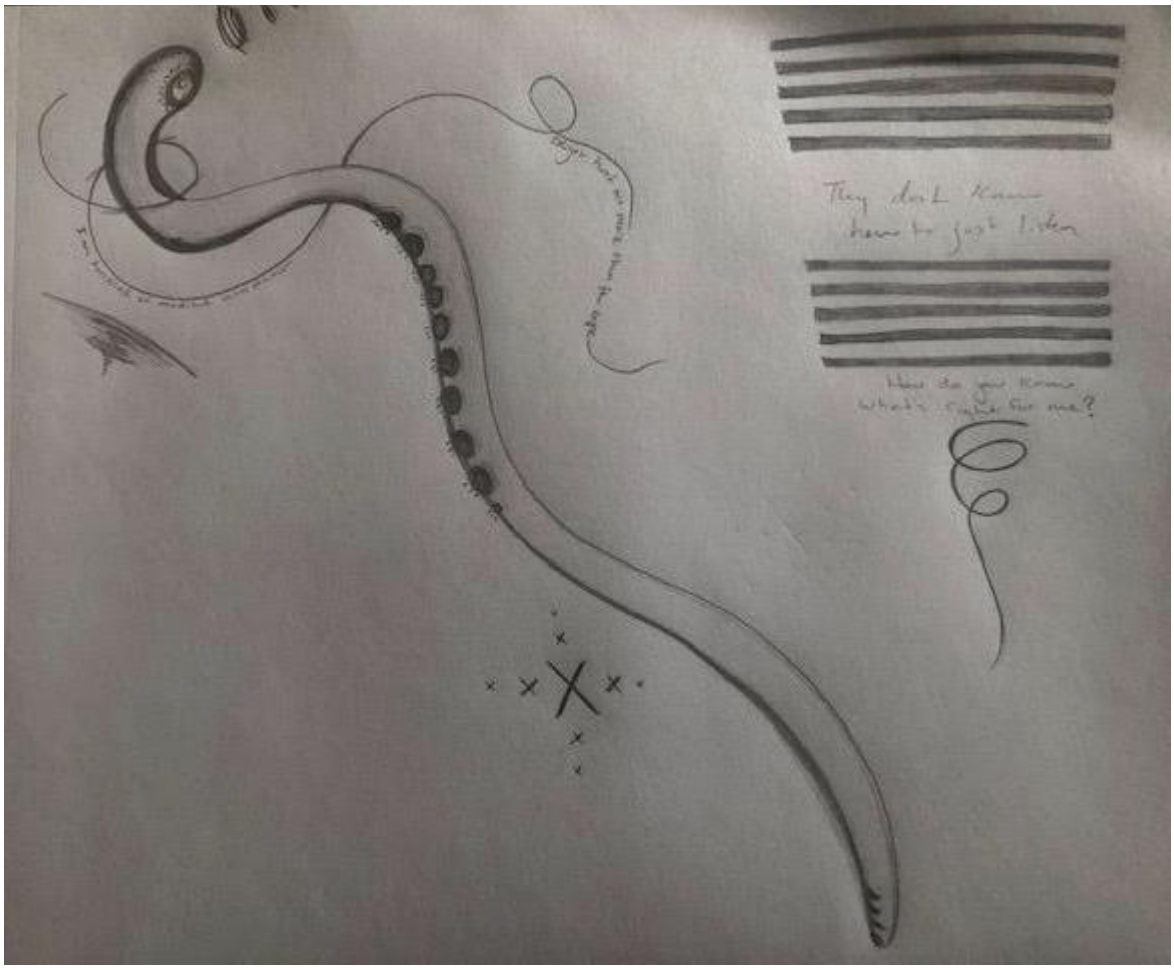
in my own story because the truth is, their stories hit a core to my own experiences. Their realness and rawness ‘broke open the bone’ to my own story, one that I keep tucked away on a shelf that I don’t often visit.

My response during and after hearing these stories was embodied but also an arts-based one. With a nod to my original project design, one which included an arts-based piece, I crafted painted rocks with words from the stories-heavy, tactile rocks that will live on longer than an MRP. Two of the story tellers crafted too, and these are included below. Importantly, I share them here not for analysis, but to demonstrate their impact and the weighty responsibility I have as a researcher to these words and storytellers.

River:



These are the rocks I painted during River's Interview. The white rock was painted at the end of the interview when River was describing what got them through the experience and what true support would have looked like for them. In River's story the nurse refused to change her notes from consensual to non-consensual even after River reiterated the experience wasn't consensual. So, I specifically wanted River's words 'It Wasn't Consensual' to live here in *our* notes.



This is the doodle River created during their Interview.

The writing on the right reads:

"They don't know how to just listen" and "How do you know what's right for me?".

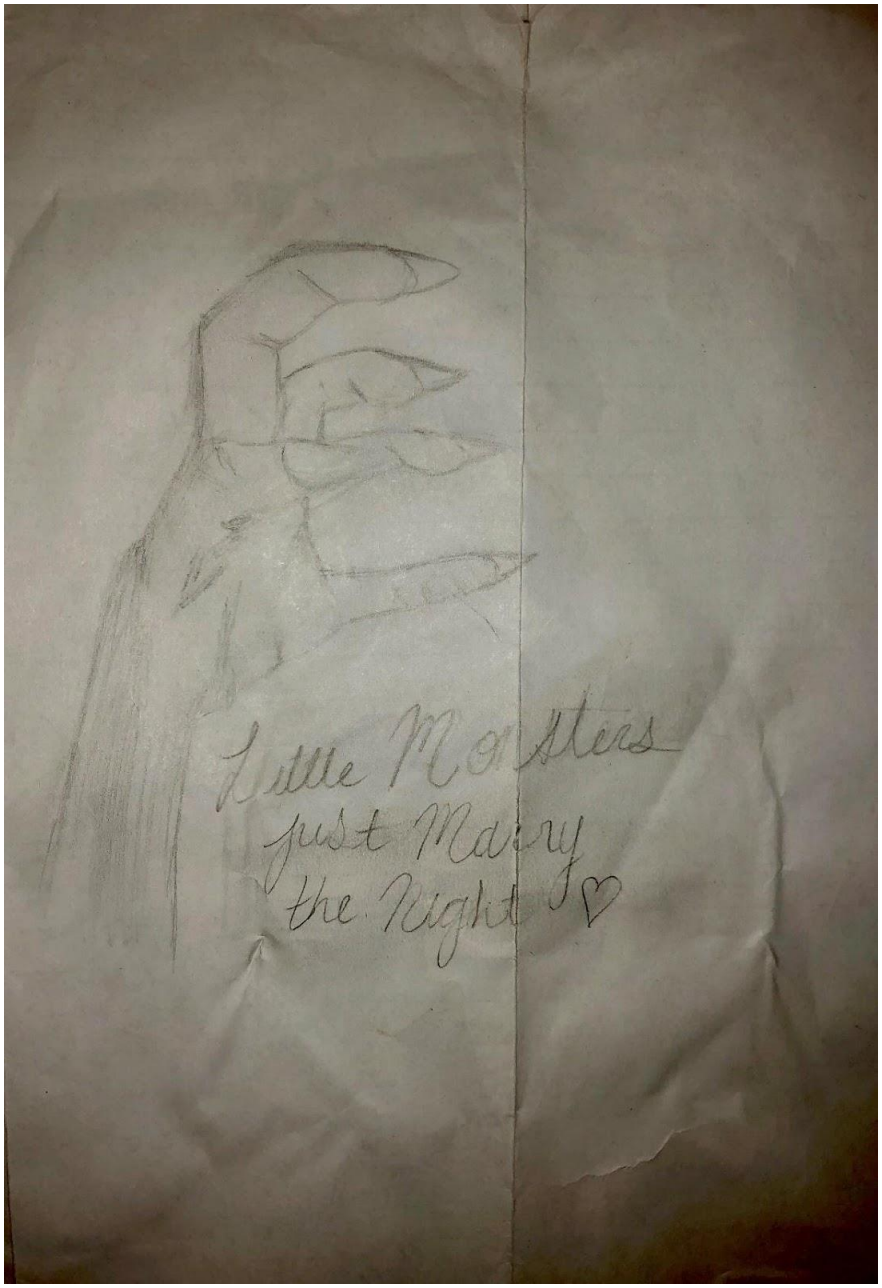
Melody Mars:

These are the rocks I painted during Melody Mars' Interview. I chose her words: "They held a gun to my head" because I thought it was so brave to share and for me captured Melody Mars' whole presence in the interview which was her ability to really go there. She confronted such dark parts of her trauma with such calmness & grace, so I wanted to confront them with her too. I chose brighter colouring for two of the rocks as her story started out with such darkness but ended with such brightness, victory and hope.

Melody Mars decided not to doodle or include any personal artwork which I fully supported.

Vivian:

These are the rocks I painted during Vivian's interview. I chose to focus one rock on the trauma that Vivian shared in being taken for three weeks. For that rock, I used dark colouring in the background to represent the darkness of the abuse she experienced and glitter to represent the glimmers of hope she shared in her survival. I painted the white rock to represent the song that helped her through her trauma and the pink rock inspired by her message to other survivors.



Vivian chose not to doodle during the interview and instead asked to include some art she created during her recovery journey.

The sketch reads: “Little Monster Just Marry the Night”.

Implications & Theory:

The findings of this research were primarily guided by Anti-colonial theory in hopes of resisting the continuous colonial project. As I have mentioned previously, we cannot begin to resist colonialism (an act of anti-colonialism) until we have acknowledged what has happened. Therefore, it was important that I focussed solely on the survivors' stories and their experiences of what Singh (2018) describes as the *after* period of abuse. With the in-depth exploration of survivor's stories, we were able to acknowledge their silenced narratives which brought us to a space to resist. In writing up the findings I made a point to resist dominant academic, colonial practices by deciding not to over analyze or layer my voice in survivors' stories. I did this to avoid perpetuating further violence to these courageous survivors, an act of sheer resistance. However, I believe the real resistance begins now in having survivors' stories accepted as academic knowledge and with you the reader that will take this work to your own professions as you too resist oppressive discriminatory practices. As my second reader made clear, this is already the focus of the Missing and Murdered Indigenous Women and Girls Report (2019) where thousands of depositions were made to teach, un-learn and make change and resistance. What that report makes clear is that assault, or rape is always used as a genocidal tool. The personal experiences of Indigenous women and girls can never be disconnected from colonial violence and its goal of destruction, extraction and capital accumulation. This reminds me of how an anti-colonial lens takes up the personal and the political simultaneously, and how I could have worked more deeply from an anti-colonial stance.

A theory that I discovered throughout this process that did not fit after learning the survivor's stories was Mad studies. My intent in including Mad studies as a theory was to provide an understanding of survivor's stories through societal contexts without reducing them to

systems. In theory, Mad studies does provide a foundation of compassion and understanding. However, this is problematic when survivors themselves do not identify as mad. All three survivors did not identify with their psychiatric diagnosis' or the notion of being Mad but instead felt their experiences and behaviour were simply a trauma response. Although all survivors identified as white, River identified as trans masculine and non-binary. This had me think about who is safe to identify as Mad and who those spaces are really set up for. In reflecting, I have come to understand Mad studies is a framework that emerged to provide counter discourses, however, fails to acknowledge an intersectional lens.

Anti-psychiatry however, fits perfectly with survivors' stories as the theory rejects the notion of psychiatry altogether, a view that was echoed in all three stories. The implications of this theory were affirmed in each survivor's rejection to the damaging and discriminatory psychiatric treatment that they experienced post assault. This anti-psychiatry lens allowed space for new perspectives to emerge as it rejected traditional ideas of psychiatry, creating a safe space for some truth to be revealed. This framework also allowed for the focus on psychiatric survivorship which Joseph (2015) described as surviving something endured or imposed. All three survivors survived some form of psychiatry that was imposed, such as the diagnosis they were not consulted on. I believe this theory, along with Anti-colonialism created a beautiful space of resistance through the exposure of these very real and unfortunately common silent narratives.

Implications to Social Work Practice:

With these survival stories and representations there are various implications to social work practice. One prominent implication is the inability to recognize a SA or the denial of a SA.

For River, they explained:

> *I hadn't realized what had happened was sexual assault (River: 62-63).*

They continued:

> *I went and talked to my friend that night and they were like "what do you mean someone took off a condom while you were having sex and you didn't know" and I was like well they took it off and I didn't know until after and they were like "that's sexual assault'" (River: 141-144).*

I believe River's experience is a very common one among survivors of violence. Our society has become so susceptible to violence that we cannot always recognize it at first glance. Since sexual violence can become a routine experience there is often a struggle in viewing it as a violation (Benoit, Shumka, Philips, Kennedy and Belle-Isle, 2015). This is crucial information not only for social work but for all interdisciplinary professionals. It is our job to recognize these violent acts and identify them especially when survivors themselves are challenged with seeing them as a violation. River should have never had to experience their doctors lack of ability to acknowledge the SA or the later denial of the SA all together. This itself was an act of violence.

Additionally, Melody Mars experienced the denial of their SA because one she didn't want to admit to herself that she had been assaulted *again* and two she could not remember everything clearly.

Melody Mars shared:

> *I did not want to accept that I had just been assaulted again (Melody Mars: 139-140).*

She continued:

> *I couldn't recall what happened to me - I only remembered the finite details years later (Melody Mars: 103-104).*

Impairment issues create barriers to survivors reporting sexual violence (Benoit et al, 2015). This speaks to Melody Mars' initial experience in having apprehension of reporting her SA. This is

vital information for social workers as it underscores the importance of not only believing survivors but allowing their stories to come out in non-linear ways. Trauma does not make sense; therefore, survivors' stories may be hard to follow and confusing however, our job is to sit with their stories and create space for their stories to exist, be heard and believed.

In terms of intersectionality River's story brought forth such an important lesson in transphobia and the lack of training or understanding from professionals. This was highlighted when River shared:

> *I was explaining you know I'm navigating my body and relationships and this is confusing and I am kind of trying to figure out what I want and then she (the nurse) was like, "oh well are these people paying you?" (River: 102-105).*

It is clear here that this comment was made because River self-identifies as trans masculine and non-binary. Trans folx are targeted by transphobia through systemic discrimination, harassment and violence based on the grounds of ignorance, fear or discrimination of those who sit outside the societal binary (Raj, 2007). This implicates inter-disciplinary professionals who lack the training and understanding of various identities and social locations. Had the nurse in this case been properly educated on trans identities and issues that affect trans folx, River's experience could have been completely different. As humans are ever growing and ever evolving with different identities emerging, it is our responsibility as social workers to engage in a continuous journey of education about people's different issues and intersecting identities. Without this commitment, we *will* cause further damage and harm.

Another implication to social work is the navigation of additional trauma that survivors have experienced through the medical assault. We have come to a place where we *must* assume that each survivor we meet may have experienced a medical assault through healthcare or even

by a fellow social worker. How will we navigate this? How will we navigate these power relations? When speaking of the second time she was formed at the hospital Vivian shared:

> *So, I decided that night that even though I wasn't feeling well that I was not going to sleep. I was going to stay awake because I did not want um these nurses and doctors to make up lies about me um so if I was awake I would know what was going on and I didn't want to be in a situation like when I was in the psych unit and the doctors and nurses would be like, "oh she's not cooperating" (Vivian: 213-217).*

Treatment within the medical model continuously places authority roles with professionals who hold the power to make decisions for patients who are by default in a passive role (LeFrançois, 2008) with little to no agency of their treatment plans. In Vivian's above statement you can hear the fear in her trauma response in not wanting the same mistreatment she experienced previously. She was in a place of powerlessness with all the authority in the hands of professionals who could do as they please with her story. There is something to be learned here of the deep sense of power which we as social workers hold in assisting service users in navigating their stories. We must ask ourselves if the power we are holding is assisting in the solution or causing further harm? How will you carry and hold survivors' stories?

By now it is clear that this research has captured critical information which contributes to the literature on the survivor's re-victimization experiences. It was my intent to not only name survivors' experiences as negative but to dive deep into each story to reveal the harrowing details in an attempt to expose these silent narratives. I hope I've done these stories justice and I hope that whomever these stories reach that they provide an element of understanding and compassion to this community and trauma survivors alike. I hope when you engage with SA survivors that you remember these stories and lead with gentleness and kindness.

CHAPTER 7. CONCLUSION

When thinking of concluding this work I felt that I could not write a conclusion at all. Simply because this work could not be concluded- there is so much more to be done. So instead, I offer you not a conclusion but rather a beginning to hopefully more research of this kind. And with that hope, I will leave you with some recommendations or *next steps* in what true support should entail for SA survivors. From the experts themselves, each survivor expressed their ideas of true support which I will share with you here. When asked what true support would look like for them…

River shared:

> *It would involve just being listened to. It would be* ***actually being listened to, people not making assumptions like people if they're not clear on something ask for clarification*** *or like if they are having feelings towards clients and their statements pay attention to what's going on in their bodies not that it's my responsibility to deal with it but just be aware when you're listening to someone's story be aware of what's happening in your body and how you're reacting to it and figure out how you are going to address this because I think what happened in my situation was people were having their own experiences to my story and I ended up having to deal with their experiences as opposed to them being able to be there for me (River: 667-676).*
>
> ***Let the person guide what's happening*** *I think I felt so much of my power and autonomy had been taken away through the assault and then it just continued to be taken away through my interactions with healthcare providers. If they had just actually listened to me and let me make decisions and be okay with what I'm deciding for myself I feel like it would have been a very different experience. And* ***don't pathologize me as if I've done something wrong.*** *Question where your assumptions are coming from and* ***understand that people experience the world very differently*** *than you and that there could be a lot of cultures or subcultures that you're not aware of and that things are normalized that you might not understand or agree with (River: 680-689).*

Melody Mars Shared:

> *It would have looked like a* ***trauma informed police response****. It would have looked like, access to* ***economic support from the state*** *such as ODSP without 'testing'; the process of applying for ODSP forces one to put themselves into a box of being 'permanently disabled', which is contradictory when you're trying to heal, while also needing to feed yourself. It would have looked like services that are economically accessible, and that understand trauma from a* ***non-biomedical perspective****, or from a…. I would loosely say*

> ***holistic perspective****. Because I think there is a neurological and physiological component to trauma, it damages the central nervous system. But there's also just something that happens in your soul. And the soul-pieces require a tender and yet fiercely committed community. It requires people not being afraid to reach out and talk to you and let you know that they're there. The state requires economic support, so you don't have to be afraid of being homeless. It requires a lot. It requires support in feeling safe in your body and being able to see your body not as your betrayer but as just as part of you - a gift that you are the keeper of. I think it requires* ***education about the ubiquity of sexual assault*** *so that survivors are not living in a vacuum of individuated pathology. And a legal system that doesn't treat violence survivors as criminals. Those are a few things (Melody Mars: 480-494).*

Vivian shared:

> *So, I think true support would be* ***hearing me, being with me, listening and then the fundamental first thing they teach you in social work...start where the clients at****.... that just start where I'm at if I'm anxious and can't breathe then just breathe with me that's all I needed in that moment I didn't need to be locked in a room (crying). So, I think just be with me hear me sit with me don't shut me out don't throw me away don't push me away don't lock me up instead be with me hear me listen to me and just start with where I'm at that would be true support for me (Vivian: 442-448).*

It is with these thoughtful words that we all have the ability to make a change- how will you be a part of this change? As critical social workers, I believe it is crucial in the service delivery process that we centre survivors' stories through creating space where we limit social work analysis while survivors are 'sharing' and acknowledge that a mental health referral could be the worse intervention to provide a SA survivor post-assault. Instead it is clear that we must re-think care, re-think discourses around consent and re-think discourses around spoken practices. I hope you carry these stories and this knowledge to your interdisciplinary practices and that this is not the last work of this kind. We now know more so we must do more.

APPENDIX A – RECRUITMENT POSTER

Are You:

A sexual assault survivor between the ages of 18-40 who has had experience accessing mental health services post- assault?

Has your experience with sexual assault been within one-five years?

If you answered yes to the above questions you may volunteer in this study. The study intends to research the lived experiences of sexual assault survivors who engage with mental health services and professionals following their assault.

You will be asked to participate in a one time in phone interview, up to 2 hours from the comfort of your own home. I am seeking 3 participants who meet the above criteria.

In appreciation of your time, you will receive a $25.00 Honorarium for your knowledge, sharing of your experiences.

This study is being conducted in partial fulfillment of my Master's in Social Work Degree which is being supervised by Jennifer Poole Director of the Masters in Social Work program.

If you are interested in participating in this study, or would like more information, please contact:

Ryerson MSW Student as part of my Studies centered

sarah.catani@ryerson.ca

Your participation is voluntary and you can withdraw at any stage of the process.

This study has also been reviewed and approved by the Ryerson REB 2020. Their contact information is:

If you have any questions about your rights or treatment as a research participant in this study, please contact the Ryerson University Research Ethics Board at rebchair@ryerson.ca (416) 979-5042

The Ryerson Reference ID (REB 2020-037).

APPENDIX B – EMAIL SCRIPT TO PARTICIPANTS

Dear Person,

Ryerson REB has approved my research proposal to interview up to a maximum of 3 folx with negative experiences accessing mental health services one-five years post assault. I am attaching my recruitment poster in the hopes you will share with your networks. My email is on the poster for potential participants to contact me at their own convenience. Please email me if you have questions. Thank you in advance.

Warmly,

Sarah Catani

If you are interested in more information about the study or would like to volunteer, please reply to this email sarah.catani@ryerson.ca.

If you have any questions about your rights or treatment as a research participant in this study, please contact the Ryerson University Research Ethics Board at rebchair@ryerson.ca (416) 979-5042

The Ryerson Reference ID (REB 2020-037).

APPENDIX C – INTERVIEW GUIDE

Interview Guide:

1. a) Why did you want to participate in this interview?

   b) How do you self-identify based on race, ethnicity and gender?

2. Can you tell me about your story accessing mental health services post assault? What was your overall experience like?
3. Some individuals had said engaging with mental health services has been hard, does that resonate with you and if so how?
4. If you could imagine true support post assault, what would that look like for you?
5. Is there anything else I should know about your story?

APPENDIX D – RESEARCH RELATIONSHIP AGREEMENT

RYERSON UNIVERSITY

Research Participation Agreement to Participate in Research

Title of Research

Survivor's Silenced Narratives

INTRODUCTION AND PURPOSE

My name is Sarah Catani. I am a Graduate Student at Ryerson University working with my faculty supervisor, Professor Jennifer Poole in the School/Department of Social Work. As a part of the fulfilment of my masters in social work I would like to invite you to take part in my research study, which concerns sexual assault survivors' experiences accessing mental health services post assault.

WHAT YOU ARE BEING ASKED TO DO

You are being asked to voluntarily complete an phone interview. It involves questions about your personal experiences and should take about 1-1.5 hours to complete.

Sample Questions:

1. How do you self-identify based on gender and ethnicity?
2. Why are you here today? Why did you want to participate in this research?
3. Can you tell me about your story?
4. What was your experience engaging with mental health services post assault?
5. Some individuals have said engaging with mental health services has been hard, does that resonate with you and if so how?
6. If you could imagine true support post assault what would that look like for you?

POTENTIAL BENEFITS

There is no direct benefit to you for taking part in this study other than potential relief in sharing your story. It is hoped that the research will inform interdisciplinary professionals on best practices when engaging with sexual assault survivors

WHAT ARE THE POTENTIAL RISKS TO YOU

During the interview, there is a risk that the participants (you) may experience psychological discomfort while disclosing experiences of sexual assault and the lived experiences accessing and engaging with the mental health system post assault.

To mitigate this discomfort prior the phone interview participants will be reminded that they can skip questions, take a break, or discontinue the interview permanently as well as withdraw from the study at any time. They will also be made aware of resources they can access in order to receive psychological supports. After the interview, the researcher will again check-in with the participant and offer information about how to access support services. The researcher will also advise the participant that the participant can contact the researcher at any time for information about accessing support services.

YOUR IDENTITY WILL BE

Kept confidential from the public. The only person who will know your identity is the researcher who will be interviewing you and corresponding with you to set up an interview and approve data collected from you. Beyond this point participants will cease to be anonymous as their identities will be kept confidential.

Please note that I have a duty to report any intent to harm oneself or others, including children under the age of 18.

HOW YOUR INFORMATION WILL BE PROTECTED AND STORED

Signed research relationship agreements, audio recorded interviews, interview transcriptions, and contact information (names, email or phone number) will be collected and digitized. All digital data will be stored electronically on Ryerson's secure Google Drive. The audio files will only be kept until the transcripts are complete, and then those files will be deleted. The transcripts will be accessible to both myself and my supervisor Jennifer Poole until findings are drafted. All files will be deleted once I have completed my MRP.

DATA DISSEMINATION

The MRP will be accessible to all participants via Ryerson's Digital Repository. Should you wish to have a copy of the findings/final MRP, please go to Ryerson Library Digital Repository | Ryerson University Library.

DUTY TO REPORT

There are some specific cases in which your confidentiality cannot be protected: (a) If you intend to harm yourself; (b) If you intend to harm someone else; (c) If there is reasonable suspicion that a child up to the age of 16 years old is at risk of neglect, abuse, or witnessing parental violence (we are required by law to report this to child protective agencies immediately); or (d) If a regulated healthcare professional has engaged in inappropriate sexual behaviour toward you and you provide us with the name of this individual.

INCENTIVE FOR PARTICIPATION

You will not be paid for taking part in this study but will receive a 25.00 honorarium for your time and knowledge. This honorarium will be given at the start of the interview.

YOUR RIGHTS AS A RESEARCH PARTICIPANT

Participation in research is completely voluntary and you can withdraw your participation at **any point** in the research process this includes during the interview and after the interview.

QUESTIONS

If you have any questions about this research, please feel free to contact the researcher.

Researcher: Sarah Catani

Sarah.catani@ryerson.ca

Supervisor:
Jennifer Poole
Phone Number: 416-979-5000, ext. 6253
Email: jpoole@ryerson.ca

If you have any questions about your rights or treatment as a research participant in this study, please contact the Ryerson University Research Ethics Board at rebchair@ryerson.ca (416) 979-5042

Participation Agreement Signature: _____

Permission to audio record interview _____

APPENDIX E – RESOURCE LIST

Resource Referrals for Research Participants:

Legend:

Colour:	**Heading:**
Highlight	***Main Headings***
Red	***Emergency Services***
Blue	***Peel Region***
Green	***Toronto Region***
Orange	***Halton Region***
Purple	***Support Services***

Sexual Assault *Services:*

Name of Program	Location	Description	Contact Number
Peel			
Chantel's Place	Mississauga	Sexual Assault & Domestic Violence Services (Regional Program)	905.848.7580 ext. 2548.
Victim Services	Mississauga	Assists Victims of violence including sexual violence	905.568.1068
Toronto			
Hassle Free Clinic	Down Town	Sexual Health Clinic serving the Trans community	416.922.0566
SASSL (Sexual Assault Survivors' Support Line)	North York	Offers support to survivors and their families	Crisis line: 416.650.8056 Office: 416.730.2100 ext. 40345
Sexual Assault Care Centre - The Scarborough Hospital	Scarborough	Medical and emotional care for victims of sexual assaults 12 years and older, male & female	416.495.2555 TTY: 416.498.6739
Halton			
Sexual Health Clinics	Operator will search by city	Health Clinics in your area	905.825.6000 ext. 6065
SAVIS (Sexual Assault & Violence	Oakville	Provides, Education, Counselling, Practical Support &	905.825.3622 TTY:905.825.3743

Intervention Services)		Senior Sharing Circles	
Nina's Place (Joseph Brant Memorial Hospital) (Sexual Assault Care Centre)	Hamilton	Provides care to those who have been sexually assaulted	905.632.3737 ext. 5708

Main *Crisis Lines:*

Name of Line	Description	Contact Number
Peel		
Interim Place South	For those in crisis- needing shelter, referral or counselling	905.403.0864
Interim Place North	For those in crisis- needing shelter, referral or counselling	905. 676. 8515
Distress Centre Peel	For persons in distress or crisis	905.278.7208
Toronto		
Distress Centre	For persons in distress or crisis	416.408.4357
Halton		
COAST	For residents of Halton 16yrs & up with mental health and/ or in crisis	1.877.825.9011
SAVIS (Sexual Assault & Violence Intervention Services of Halton)	24-hour Help Line for Victims of Sexual Assault	905-875-1555
Oakville Distress Centre	For residents in distress or crisis (24 hrs.)	905-849-4541
North Halton Distress and Info Centre	For residents in distress or crisis (24 hrs.)	905-877-1211
Mental Health Helpline	For those with Mental Health Diagnoses	1-866-531-2600

Counselling *Services:*

Program Name	Location	Description	Contact Number
Peel			
Catholic Family Services	Mississauga	Counselling Services	905.897.1644
Tangerine	Mississauga- Several locations (visit website)	Walk-In Counselling **free of charge** for children and youth-18 yrs., + their parents, + caregivers/adult supporters. **Only available to** residents of the Region of Peel.	905.795.3530
Catholic Family Services	Brampton	Counselling Services	905.450.1608
Family Services of Peel	Mississauga	Counselling Services	905.270.2250
Family Services of Peel	Brampton	Counselling Services	905.453.7890
Toronto			
Family Service Toronto	Downtown Toronto, Scarborough, North York, South Etobicoke, and Rexdale.	Counselling Services	416.595.9618
Catholic Family Services of Toronto	Central	Counseling Services	416.921.1163
David Kelly Program (provided by: Family Services Toronto)	Down Town	Counselling Services & Groups for LGBTQ persons	416.595.9230
Sheena's Place	Down Town	Group Therapy Support- Eating disorders	416.927.8900
Halton			
Burlington Counselling and Family Services	Burlington	Counselling Services	1.866.457.0234
Family Services of Peel	Bolton	Counselling Services	905.857.1554
Positive Space Network (LGBTQ youth groups)	Burlington	Offers groups for LGBTQ youth	905-634-2347 ext. 408

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