ORANGA TAMARIKI
Ministry for Children

New Zealand Government

Understanding opportunities for government to support healing in Aotearoa

Acknowledgements

The Oranga Tamariki Evidence Centre works to build the evidence base that helps us better understand wellbeing and what works to improve outcomes for New Zealand's children, young people and their whānau.

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Foreword

Foreword

Te Aorerekura is the National Strategy to Eliminate Family Violence and Sexual Violence (FVSV). Te Aorerekura brings together nine government agencies to work in a more integrated and holistic way to strengthen community and whānau wellbeing, and prevent FVSV. The Strategy outlines a framework for collaborative government and community action to address FVSV. The development of the 25-year Strategy and the associated Action Plan were informed by extensive consultation with tangata whenua, the FVSV sector, and the community by Te Puna Aonui.

Consultation feedback identified six key shifts are needed to address FVSV in Aotearoa. These shifts are:

1: Towards strength-based wellbeing

2: Towards mobilising communities

3: Towards skilled, culturally capable, and sustainable workforces

4: Towards investment in primary prevention

5: Towards safe, accessible, and integrated responses

6: Towards increased capacity for healing

The shifts are being implemented under the Action Plan 1.0 which sets out 40 actions to realise the six shifts. Oranga Tamariki is the lead agency for Action 33: Undertake an analysis of healing services and responses to determine gaps and opportunities to support healing pathways and approaches across Aotearoa. This work was done alongside Actions 29 and 30, led by the Ministry of Social Development, to systematically identify and collectively address FVSV service gaps across Aotearoa.

FVSV can have a devasting impact on wellbeing, and it can leave whānau in states of extreme distress. The exposure to FVSV can be particularly detrimental for children and repetitive exposure can negatively impact their life trajectories. This is in addition to the significant harm caused by exposure to FVSV that can perpetuate a pattern of intergenerational violence. Opportunities for healing that promote intergenerational wellbeing are, therefore, essential to preventing future harm.

The emphasis on healing in Te Aorerekura reflects the engagement undertaken by Te Puna Aonui, and the recognition that te ao Māori worldviews, including mātauranga, kaupapa Māori approaches and Māori leadership are central to developing meaningful responses to addressing FVSV for Māori. Māori told us that appropriate healing practices and approaches have an important function in supporting whānau to heal from trauma and prevent the transmission from one generation to the next. Appropriate cultural mediation can be a transformative circuit

breaker to the intergenerational cycle of harm and recognises the impact colonisation has had on the Māori way of life.

Healing is one of the three dimensions of support of Te Tokotoru model[1]. Te Tokotoru is a systems approach to wellbeing and has been adopted by Te Aorerekura as the framework for the government to recognise the need for spaces and places that enable whānau to heal from past trauma and to invest in holistic prevention strategies.

Te Tokotoru encourages us to think beyond the limits of formal health and social services and programmes, and include in our focus activating or enhancing the existing ecology of wellbeing in the places where we live, learn, work and play. Te Tokotoru recognises that our communities often already have within them many of the things that we need to be well. The opportunity for government as we shift towards more centrally enabled and locally led approaches is how we can better organise ourselves (resources, policy, power, structures, funding) around enacting, enhancing, and enabling those ecologies of wellbeing.

Understanding and conceptualising healing

Oranga Tamariki partnered with *Allen + Clarke* to conduct a time-limited scan of the literature to understand how different communities conceptualise healing. This report is not a definitive consideration of conceptualisations of healing. Rather, it should be seen as the first, tentative step on a longer journey. The groups included in this report have been prioritised in Te Aorerekura Strategy to promote inclusion and equity as we work towards eliminating family violence and sexual violence. These groups are:

- Māori
- Pacific peoples
- Children and young people
- Disabled people
- Ethnic communities
- LGBTQIA+ communities
- Older people and Kaumatua
- People impacted by violence (including witnessing violence)
- People who use or have used violence.

[1] Hagen, P., Tangaere, A., Beaton, S., Hadrup, A., Taniwha-Paoo, R., Te Whiu, D. (2021). *Designing for equity and intergenerational wellbeing: Te Tokotoru.* The Auckland Co-design Lab. The Southern Initiative.

Examining conceptualisations of healing in relation to family violence and sexual violence: A literature scan

Summary

Healing is a journey or process that looks different across communities

- Healing is largely described as a process, or a journey, rather than an outcome or a goal.
- Indigenous and non-Western notions of healing are distinct from Western medicalised frameworks for health and healing. While Western frameworks tend to focus on 'restorative healing (e.g., restoring health as an outcome), Indigenous and non-Western notions are usually holistic, focusing on the interconnectedness of the mind, body, and soul and the ancestors and the environment.
- This is consistent across many practices within different cultures, including rongoā Māori, Islamic Faith healing, healing for Aboriginal and Torres Strait Islanders in Australia and First Nation's peoples in Canada.
- Health, wellbeing, and healing for Indigenous peoples, including Māori, are understood, and described in the context of colonisation and it's continuing and pervasive impacts on Indigenous communities.

Healing for Māori must be holistic, understand and address the ongoing impacts of colonisation and historical trauma, and be culturally safe

Healing for Māori requires acknowledgement and understanding of the damaging impacts of colonialism at both an individual and systemic level within Aotearoa. This often includes addressing different forms of trauma experienced by Māori such as land loss, language loss, and cultural alienation, as well as the intergenerational impacts inherent in these traumas. Addressing historical trauma is a difficult but important part of healing because it reinforces that Māori are not responsible for systemic fault.

- Approaches to healing for Māori are best when they are by Māori, for Māori, and as Māori as Kaupapa Māori and are holistic, collective, and whānau centred. Whakapapa and healthy relationships are particularly crucial for the connections they establish with land, whānau, hapū, iwi and culturally significant sites, all of which are integral for healing processes. Other examples include the use of waiata, group therapy, and safe community spaces to facilitate healing. Reconnecting with culture and pre-colonial/contact Māori gender and family structures support both healing at an individual and collective level for Māori.
- Culturally unsafe formal support for Māori experiencing FVSV is a key barrier to facilitating healing. This occurs both in the health system, and across other government agencies that may be involved with FVSV (e.g., Oranga Tamariki, Police). There is a high level of distrust of government agencies among Māori who have experienced FVSV.
- Practical facilitators such as financial stability, housing stability, and systematic acknowledgement and addressing of the ongoing impacts and process of colonisation are crucial for the conditions for healing to occur.

Incorporating Pacific social structures, knowledges, culture and spirituality into support for Pacific people helps with the healing journey

- Pacific populations are unique, and have different knowledges and culture, which leads to different approaches to FVSV and healing.
- There are some overarching barriers that apply generally to Pacific people and healing from FVSV. For example, Eurocentric views of family and community and the Western individualisation of FVSV does not generally fit into Pacific social structures.
- Western-style support programmes, therefore, do not necessarily work for Pacific people as successful healing in Pacific people tends to come from working holistically and with the wider family and community.
- Incorporating culture and spirituality can also be important for Pacific peoples in the pursuit of healing from FVSV, for both survivors, perpetrators, and others affected.

Other Indigenous communities share a need for holistic healing in the context of colonial violence and a need for reconnection with culture

- Indigenous communities such as First Nations people in Canada and Aboriginal and Torres Strait Islanders in Australia require healing approaches that are tailored to the unique identities, needs, experiences, and contexts of each Indigenous community, noting that all Indigenous communities are not homogenous.
- While specifics about healing vary across Indigenous cultures, they share common themes about holistic, collective healing, that acknowledge and address the ongoing process of colonisation. Similar to Māori, culturally unsafe formal supports are a key barrier to other Indigenous groups healing from FVSV.
- Healing approaches that have shown success include Indigenous storytelling, talking circles, and land-based healing activities and programmes.

Ethnic communities are diverse, and understanding the different cultural contexts is vital to supporting healing

- Experiences of FVSV in ethnic communities are diverse and generally underreported due to cultural attitudes around shame and honour. These are not often well understood by non-ethnic formal supports for FVSV. Culturally unsafe formal and informal support mechanisms are a key barrier to healing for ethnic communities.
- There is a key intersection between ethnic identity in Aotearoa and migrant status. The loss of agency, control, and relative isolation for survivor and perpetrator underpin many instances of FVSV for ethnic people who are migrants.
- Patriarchal views and family hierarchy create unique circumstances for abuse to occur in some ethnic families.

- While collective healing is necessary to end generational cycles of abuse, collective approaches are cautioned where they may create more harm for the individual experiencing violence.
- Skills training, technological support, group therapy, and educational programmes for women and school age children and young people have proven to facilitate healing for those that experience FVSV in ethnic communities, as well as support prevention for future generations.

Healing for tamariki and rangatahi is a complex and individual process, and specific tools for healing differ

- Tamariki relationships with their mothers (parents) and other support people are essential for healing. Therapeutic responses that work with both mother and child are beneficial, particularly for younger tamariki.
- Tamariki must be able to effectively express their emotions to heal, which may include speaking about their emotions, and feeling heard. Having their experiences and opinions taken seriously is essential but does not always happen.
- Barriers to recovery for tamariki include ongoing violence and a lack of support. Once tamariki and their family have left the abusive situation they can feel that there is an increased sense of safety and have a brighter outlook for their future.
- Indigenous tamariki and rangatahi experience violence at higher rates and need culturally specific approaches to healing. There are structural and institutional barriers to culturally safe services for young Māori (and other Indigenous communities), and social services must be improved to be multisectoral, culturally safe, and specialised for Māori rangatahi and whānau.
- Rangatahi from migrant communities of colour also experience disproportionately high levels of FVSV. They have specific barriers to healing, including lack of networks, social isolation, cultural beliefs, and structural barriers.
- There is little scientific research about men's specific needs for healing from childhood violence. The theme of control for male survivors is strong, and gaining a sense of control over their experiences later in life is an important element of healing from abuse.
- Tamariki who witness domestic violence also develop coping strategies, but not much is known about the long-term (adult) impacts of childhood witnessing. Healthy coping strategies are enhanced by the presence of a strong support person for tamariki who have witnessed abuse.

Disabled people are more likely to need to heal from FVSV and face additional physical and structural barriers to healing

- Disabled people are more likely to experience FVSV than those without disability.
- Disabled people also face additional challenges to help seeking and beginning their healing journey depending on their disability or disabilities.
- Barriers to healing include communication barriers for some survivors with intellectual disability and systemic barriers from a lifetime of being socialised to be passive, tolerant, and dependent.

- Disabled people often have to navigate ableist and/or paternalistic services; allowing for agency and self-determination is an important part of the healing process.
- Interpersonal relationships as a form of support plays a strong role for people with disabilities when navigating FVSV.

Healing from FVSV for members of LGBTQIA+ communities[2] must take into account the nuance of different gender identities, relationships, sexual orientation and expressions

- The LGBTQIA+ community face many structural and societal barriers to healing.
- Mainstream support services are not always inclusive of LGBTQIA+ relationships as many services are set up to respond to male violence in cisgender, heterosexual relationships, and professionals are not always well-equipped to work with people with different gender identities, sexual orientations, and sexual expressions.
- People in the LGBTQIA+ community sometimes avoid reporting abuse and beginning their healing journey because of concerns about being outed, not wanting to perpetuate negative stereotypes of their community, having negative interactions with support or legal services in the past, or not believing that their experiences are 'severe enough' to be considered FVSV.
- Peer support programs and seeking help from FVSV practitioners who are members of the LGBTQIA+ community, have positive responses from survivors and are reported to provide a greater level of understanding and empathy than mainstream services.
- Mainstream services that are adapted by/for the LGBTQIA+ community are also positively received by survivors.

Healing for older people from FVSV is not particularly visible

- FVSV in older people can be largely invisible. Older women are less likely to report abuse or may still be healing from historical abuse.
- Immediate support is also less accessible for older people facing FVSV; either due to their perception of immediate support services or because support services predominantly support younger survivors and may not have the appropriate facilities or staff to support older survivors.
- Key themes for healing in older people were the need for resolution, reframing the experience, and developing agency over the disclosure.
- As with many other groups, peer support and interpersonal connection have been found to positively support the healing process.

[2] This paper acknowledges that there are other terms used to describe this population group. LGBTQIA+ has been selected to ensure consistency with Te Puna Aonui. A definition of this term can be found in the Te Aorerekura summary engagement document LGBTQIA+-Analysis-Paper.pdf (tepunaaonui.govt.nz)

Background and context

It is acknowledged that healing is understood differently by different groups of people, therefore, demanding different responses, spaces, and services. Some work has already been done to define healing. Te Tokotoru model, adapted by Te Puna Aonui, from The Auckland Co-Design Lab and the Southern Initiative model[3], is a systems approach to wellbeing that focusses on strengthening, healing, and responding. Te Tokotoru is informed by practice-based evidence that includes whānau lived experience, mātauranga Māori, indigenous and western knowledge.

The literature scan draws on recent, white and grey literature, prioritising that from Aotearoa and from those jurisdictions with indigenous. The purpose of examining different conceptualisations of healing is to ensure a more comprehensive understanding of the construct. However, this approach becomes problematic when considering the intersectionality of identity[4]. The impact of intersectionality is, therefore, interwoven throughout this report.

Research questions and report outline

Six guiding research questions were provided to *Allen + Clarke* by Oranga Tamariki. These have been divided into two broader themes:

Cultural concepts of healing

1. How is healing described?
2. Is healing described as a process/journey or an outcome/result?
3. What does it mean to be healed?

Healing from family and sexual violence

4. What conditions are required for healing to take place? When/where is it occurring?
5. What are the barriers to healing?
6. What are the facilitators to healing?

This evidence brief does not attempt to gather all the available evidence on conceptualisations of healing from family violence and sexual violence. It should, however, provide an adequate overview and depth of coverage to inform discussion and decision-making.

[3] Hagen, P., Tangaere, A., Beaton, S., Hadrup, A., Taniwha-Paoo, R., Te Whiu, D. (2021). *Designing for equity and intergenerational wellbeing: Te Tokotoru.* The Auckland Co-design Lab. The Southern Initiative.

[4] A definition of 'intersectionality' is provided on page 9 of the document.

Definitions used in this report

Family violence and sexual violence

When referring to family and/or sexual violence, this report uses the definitions provided in *Te Aorerekura: National Strategy to Eliminate Family Violence and Sexual Violence*:

> "Family violence is a pattern of behaviour that coerces, controls or harms within the context of a close personal relationship (FVDRC 2016). Family violence includes intimate partner violence, elder abuse, child abuse, dating violence, stalking, and violence towards another family or whānau member including child-to-parent violence. It can be physical, sexual, psychological, emotional, spiritual, or involve economic abuse or exploitation." (Te Aorerekura, 2021, 10).
>
> "Sexual violence (also known as mahi tūkino, sexual abuse, sexual assault, or sexual harm) is any sexual behaviour towards another person without that person's freely given consent." (Te Aorerekura, 2021, 10).

While many instances of family and sexual violence are influenced by patriarchal gender dynamics, not all family and sexual violence is gender-based violence, and gender-based violence includes other types of violence outside of family and sexual violence.

This review also does not include the abuse of children in state care. The authors note that the underlying societal context for family violence and abuse in state care, particularly for Māori, are inherently overlapping and do not exist in isolation of each other. However, abuse in state care in Aotearoa is being addressed through the Royal Commission of Inquiry into Abuse in Care; and learnings related to healing will need to be considered following the publication of the final report in March 2024.

Healing

The literature review and the basis of this report use the definition of healing as defined by the Tokotoru Prevention and Wellbeing model, which has been used to inform Te Aorerekura. This broadly describes healing as "a focus on supporting recovery, redress and restoration", or the "spaces and supports that enable healing, recovery and restoration for people, families, whānau, and communities, trauma and violence informed ways of working" (Te Aorerekura, 2021, 35).

Intersectionality

Intersectionality is a term first coined by Kimberle Crenshaw in the context of the compounding impacts of racial and gendered discrimination in the United States of America. It is a term used to describe "the converging effects of class, ethnicity, gender, sexuality, and characteristics that contribute to marginalisation, social identity and wellbeing", and is used to "examine the effects of multiple aspects of personal identity on health and wellbeing outcomes" (Roy et al., 2020, 10).

Cultural concepts of healing

This section responds to, and addresses, the following questions:

1. How is healing described?
2. Is healing described as a process/journey or an outcome/result?
3. What does it mean to be healed?

How the term 'healing' is defined and described

As stated earlier, this report draws on the definition of healing as provided by Te Tokotoru Prevention and Wellbeing model, which broadly sees healing as "a focus on supporting recovery, redress and restoration", or the "spaces and supports that enable healing, recovery and restoration for people, families, whānau, and communities, trauma and violence informed ways of working" (Te Puna Aonui, 2021, 35).

However, it is acknowledged at the inception of this review that the way people and different cultures conceptualise, understand, define, and describe healing vary.

Healing as a journey or outcome

Across the literature reviewed, healing is largely described as a journey, or a process, rather than an outcome. For example, healing is described as:

> "the personal experience of transcending suffering and transforming to a wholeness resulting in serenity, interconnectedness, and a new sense of meaning (McElligott, 2010 in Willis et al., 2014, 570).
>
> "a lifelong journey and process of bringing together aspects of oneself at deeper levels of harmony and inner knowing leading toward integration" (Dossey, 2008 in Willis et al., 2014, 570).

Popular definitions of healing in Australian literature are sourced from the Healing Foundation, as used by Carlson et al. and Morgan et al.:

> "The Healing Foundation (2018) describes healing as reconnecting with culture, strengthening identity, restoring safe and enduring relationships, and supporting communities to understand the impact that their experiences have had on their behaviour and create change." (Carlson et al. 2021, 9)
>
> "Healing refers to gaining and sustaining hope, a sense of identity and belonging, wellbeing, empowerment, control and renewal. Healing is a journey. Healing is not an outcome or a cure but a process: a process that is unique to everyone. It enables individuals, families and communities to gain control over the direction of their lives and reach their full potential. Healing continues throughout a person's lifetime and across generations. It can take many forms and is underpinned by a strong cultural and spiritual base (Healing Foundation, 2015)." (Morgan et al. 2022, 20)

Radu et al. reflect on the fact that healing is described as transformative and continuous, in the sense that the objective is not always to 'cure' a person biomedically, but to "empower them to make the right choices in life" (Radu et al, 2014, 92). Healing is described as a process of learning; of development; and as 'work' to understand past actions and behaviours, accept difficult realities and internalise this knowledge in a gradual, curative, and incremental way (Ibid). This 'work' implies not only individual responsibility, but community and collective action to develop supportive and safe conditions for individual healing in the context of social suffering caused by colonisation and systemic oppression (Ibid). Waldram delves into the definition of 'transformative healing':

> "…transformative healing involves a continuous, although not necessarily smooth, developmental process in which the patient undergoes changes in physical, behavioural, cognitive, emotional, social, spiritual, and/or existential functioning. In transformative healing, the goal may not always be clearly articulated, in part because it is not always clear when the transformation has started. However, as a central aspect of this healing, the patient emerges as 'new' in some way or is at least different from before the process began… the key is that the goal of healing is change." (Waldram, 2013, 193).

Waldram describes this notion of healing in the context of Indigenous peoples in Canada, and particularly as a response to distortions of 'restorative' healing caused by historic and ongoing colonial processes (2013). Waldram describes 'restorative healing' as working from an "implicit benchmark of the pre-sickness condition" (Waldram, 2013, 194). In restorative healing, there is a clear goal, or outcome to be achieved; the return from "liminal status inherent in sickness or disability to the psychological or physical state preceding the sickness" (Ibid, 194).

Western vs Traditional notions of healing

A common distinction found across the literature is that between Western, medicalised notions of health, disease and healing, and Traditional Medicines and systems of healing found in non-Western cultures. Traditional Medicines and systems of healing are generally holistic and consider the psychosocial and spiritual aspects of illness, as well as often encompassing the family and the community as a part of a healing process; simply healing the physical body is considered insufficient (Lichtenstein et al., 2017). Land, environment, and forces of nature are essential components of many of these systems (Ibid). Lichtenstein et al., (2017) describes a selection of these:

- In India, Traditional Medicine is called "Ayurveda". Illness is understood as a deficiency or a block in "physical, emotional, and spiritual harmony that may leave an opening for disease" (Ibid, 249).
- Traditional Chinese Medicine (TCM) conceptualises "meridians" or "paths" in the body, through with the blood and "qi" (lifeforce) circulates. Disease is understood to be caused by physical, exogenous atmospheric, and endogenous emotional factors. Similar to Ayurveda, disease occurs when these paths become blocked.
- In traditional Navajo Medicine, illness may come from contact with animals, ceremonies, ghosts of the deceased, or living or dead enemies. The spirit world plays a large role in causing disease, and so healing requires purification rituals

to ensure the mind, body and soul are cleansed, and that harmony with the universe is maintained.

- Many African traditions see sickness as caused by ancestral spirits, witchcraft, or sorcerers. Mental illness, in particular, is sometimes seen as a calling to be a healer and is sometimes embraced by society and used as a tool to heal (e.g., schizophrenic visions can be interpreted as communication with ancestors and the divine).
- In Mexico, traditional healing practices are called "Curanderismo". In Curanderismo, "susto" is an illness that refers to "soul loss", which is where the soul leaves the body after it experiences trauma (Ibid).

Contrary to this, Western medicine largely emphasises disease and organ focused specialities, and psychosocial and spiritual assessment is not usually a routine part of a person's treatment plan for healing from illness (Ibid). Lichtenstein et al (2017) discuss the fact that Western treatments often require patients to be extracted from familiar environments and moved into places like hospitals, where interactions with a patient's wider community are limited. They conclude that western medicine is "yet to tap deeply into the mind-body-spirit connection central to many other healing practices across cultures" (Ibid, p251).

In her chapter *Piki te ora healing: Autoethnography* in *He Rau Murimuri Aotearoa: Wāhine Māori insights into historical trauma and healing,* Vaeau references a definition of healing developed by Deleuze and Guatarri (1984) to further differentiate between Western and non-Western notions of healing:

> "…because people are relational, abstract, creative, irrational beings, their healing cannot merely be facilitated through 'rational' biomedical healing, underlining the importance of expressive forms of healing that draw on the many relations that make up the body. These relations are influenced by the socio-historical lens that shapes our experiences." (Vaeau, 2019, 80).

Rongoā Māori

Culturally appropriate healing

Rongoā is a holistic healing system, based on mātauranga Māori (Māori knowledge) accumulated by tupuna Māori (ancestors) and Māori cultural traditions. Mark, Boulton and Kerridge (2019) note that Rongoā Māori is often classed as Complementary and Alternative Medicine (CAM), but they argue that this categorisation minimises the right of Rongoā Māori to be respected as culturally appropriate healing treatment for Māori. Rongoā is a system that recognises the interconnected nature of the body, mind, emotions, spirit, energy, society, culture, relationships, and environment (Wikaire, 2020). Māori perceptions of health and wellbeing are "significantly different from Western health concepts and are significantly impacted by broader Māori realities and priorities" (Wikaire, 2020, 118). These perceptions align with health as conceptualised by other Indigenous communities internationally:

> "Māori concepts of health are holistic and align with other Indigenous health concepts through inclusion of spiritual influences on health; acknowledging close human connection with the natural environment; linking concepts of

past, present and future, between health and identity; and acknowledging the broad physical and metaphysical contexts within which we exist." (Ibid, 50).

Māori scholars note that Rongoā and the health and wellbeing of Māori people is inextricable from environment, and the role Māori have as kaitiaki (guardians) of the whenua (land) (Wikaire, 2020).

Furthermore, Rongoā is an example of Indigenous healing practices that are integral to a culturally appropriate way of life, rather than a specific set of universally applicable healing techniques (Mark et al, 2019).

Tapu and Noa

Health for Māori has historically been achieved through "staying within social bounds by obeying the lore of tapu (sacred) to remain in harmony with people and with the environment" (Mark et al., 2017, 78; Waikaire, 2020). Tapu and noa are Māori cultural concepts that are highly regarded within te ao Māori. There are two kinds of tapu as described by Brice (2020),

"Intrinsic tapu is within everyone from birth and stems from an innate connection to ancestors, whereas extrinsic tapu can be added to or removed from a person, place, or object and exists for the safety and wellbeing of people"

When trauma happens to someone, whether spiritually, physically, mentally or in the whānau space, the trauma they experience is conceptualised as extrinsic tapu. The addition of this tapu disrupts the wellbeing's natural state of balance. Noa is the restoration of that balance. The state of noa indicates that a balance has been reached, a crisis is over, health is restored, and life is normal (Mead, 2016). When added tapu disrupts the natural balance of someone's wellbeing it is important for the trauma to be addressed. Left unaddressed, the trauma or added tapu stunts the healing process and prevents noa, or the restoration of balance, from being achieved. Healing for Māori is generally focused on addressing and repairing trauma in order to achieve the restoration of balance, or noa.

Connectedness in Contemporary Māori Healing

Māori models of health view health and wellness as a broad, holistic concept that needs to be considered with a broad and holistic perspective. This contrasts with Western medicalised conceptions of health, where health and wellbeing are centred on the individual and have a focus on diseases and organ focused specialities (Lichtenstein et al, 2017).

A central feature of Rongoā Māori and mātauranga Māori is the role of relationships; whether this be with each other; with tupuna; or with whenua (Mark et al., 2017). Both physiological and psychological healing and benefits are derived from affirmative relationships. Relationships and connections are a distinguishing element in more contemporary Māori health and wellbeing models where they are more heavily emphasised. Wilson et al (2020) note that Māori health models such as the Kapakapa Manawa Framework, the Meihana Model, Te Hā o te Whānau, Te Kapunga Pūtohe, Te Whare Tapa Whā and Te Whetu are either grounded or heavily steeped in relationships and the notion of whanaungatanga or connectedness.

Whakawhanaungatanga (building relationships), is also foundational in Māori models of health and wellbeing. Vaeau describes how healing of the self is "relational in that it does not occur within the interior of an individualised body, but in the space between people" (2019, 84).

Land as a source of healing

The relationship Māori have with the land is an integral aspect of Māori identity. The significance of land moves far beyond a simple resource, leaning more towards a symbiotic or reciprocal relationship with the land as a site and source of healing for Māori, in the same way that kaitiakitanga and conservation are healing for the land. Mark et al. note that the relationship Māori have with the land "shape the ways in which the cultural, spiritual, emotional, physical and social wellbeing of people and communities is expressed" (2022, 2). Colonisation has had an insurmountable effect on Māori ability to have a relationship with the land. Land confiscation, deforestation, pasture conversion, wetland drainage and other land developments have transformed the land and disrupted its critical role in healing, health, and wellbeing for Māori (Barnes and McCreanor, 2019). Mark et al. (2022) iterate that where there was trauma on the land, this is evident in the people of that place; meaning that the health of the land and the people mirror each other; and so, one cannot be healed without healing the other.

The implications of this relationship are profound when considering the deeply destructive impacts of colonial violence on Māori people, culture, and land over the last few centuries; particularly when disconnection from local environment has been a devastating impact of colonisation for many Māori (Barnes and McCreanor, 2019). Land loss is more than a material damage for Māori, and this loss of connection includes affective impacts such as loss of identity, sadness, grief, anger, and cultural erosion (T Smith, 2019). Furthermore, in the late 1900s, urban migration shifted Māori from their rural communities into cities, further distancing Māori from their lands and their connections to it. The separation of Māori from their ancestral land removed place-based whānau, hapū and iwi from their richest source of healing. This interrupted long-established traditional knowledge and practices related to land use, resulting in dependence on colonial economic systems (Barnes and McCreanor, 2019; T Smith, 2019). Finally, in the author's analysis of the present and future of Rongoā, Wikaire sees Rongoā as holistic not only in all physical, emotional, and spiritual elements of Māori and their connection and responsibilities to the environment and land; but as pervasive in the social and political sphere that Māori today must navigate in order to heal:

> "…contemporary Rongoā is seen in the form of action, protest, research, and resistance against ongoing oppression. For example, occupation of ancestral land in resistance to land confiscation is rongoā; community action in spite of government inaction is Rongoā; and, calling out systems and businesses that seek to misappropriate our traditional Māori knowledge is also Rongoā" (Wikaire, 2020, 158).

Healing in other Indigenous cultures

Indigenous definitions of healing across Australia, Canada and the United States of America are generally consistent with those described in rongoā Māori. Radu et al.

describes Indigenous healing as “neither monolithic nor static but a contemporary expression of knowledge systems and values reflecting the rich cultural diversity of Canada’s First Nations, Métis and Inuit communities…it is a concept that is both diverse and multiple, reflecting particular conceptions of identity, place, culture, empowerment and responsibility” (Radu et al., 2014, 91).

Wirihana and Smith refer to Walker, et al’s (2013) description of indigenous wellbeing as a “simultaneously collective and individual inter-generational continuum that exists in the past, present and future”, and the disruptions to this continuum undermined their methods of sustaining wellbeing” (Wirihana and Smith, 2014, 199). Smith states that “bridging the chasm between Western health philosophies and Indigenous ancestral/contemporary wisdom is vital for urban Aboriginal peoples to prevent and/or heal from family violence for generations to come” (Smith, 2013, 317).

Similar to Wikaire’s (2020) description of contemporary rongoā, Radu et al. describe Indigenous healing as a “social movement in response to social suffering caused by colonisation and land loss, which aims to strengthen and renew social relations as well as reconstitute and reaffirm contemporary Cree identity” (Radu et al., 2014, 93).

Islamic faith healing

Embedded in Islam is a code of ethics that requires adherence to a holistic, healthy lifestyle as an aspect of religious identity (Haque and Keshavarzi, 2014). In the case of psychological disorders and mental ill health, Muslim communities may typically attribute these to demonic possession known as ‘Jinn’ or ‘Zar’ (Ibid). This possession can come as a consequence for past sins; a curse by the evil eye; or because of one’s distance from Allah (God).

Haque and Keshavarzi note that Muslim scholars have written about mental ill health as spiritual ailments since as early as 866 CE, and so methods of healing for mental ill health in Muslim communities are intrinsic within the religion of Islam:

> “Cognitive coping mechanisms that are inherent in the religion of Islam and delivered through a medium of religious instruction are necessary for positive mental health… the mind is created for positive feelings like love, compassion, patience and so on, and called it ‘nafs-us-subhanior’ - the mind that is immersed with Allah-consciousness - as opposed to ‘nafs-us-shaytani’ - a negative mind that leads to all kinds of psychological disturbances.” (Ibid, 301).

As with many other non-western traditional healing frameworks described, Islamic faith healing focuses on the mind-body-spirit relationship and finding harmony between all four aspects of the human soul; nafs (ego), agl (mind), and galb/ruh (heart/spirit – these are often used interchangeably) (Haque and Keshavarzi, 2014). Psycho-spiritual interventions are intended to rid dissonance between the ‘current self’ and the ‘ideal self’. This is done by healing the spirit/ruh; correcting behavioural inclinations; and restoring healthy cognitions (Ibid).

How survivors heal from family and sexual violence

This section responds to the questions:

4. What conditions are required for healing to take place? When/where is it occurring?
5. What are the barriers to healing?
6. What are the facilitators to healing?

Healing for Māori

Pre-colonial violence and healing in Māori communities

Within traditional Māori society, whānau is considered the basic social unit, and the primary source of support in terms of wellbeing (Pihama et al, 2019). Healthy relationships, tikanga Māori, and whakapapa all play a role in the arrangement of Māori society and its values, bringing forth collective obligations and responsibilities for each other in the wider sense of wellbeing. As described by Pihama et al., "traditionally whānau, hapū and iwi lived collectively on their ancestral lands in contexts where people knew each other and their connections to each other, enabling tikanga to be enacted as a mechanism for collective wellbeing" (Ibid.). In *He Ara Uru Ora: Traditional Māori understandings of trauma and wellbeing,* Smith et al. describe how strategies of healing for violence have long been a part of Māori culture and society; and violence, particularly random violence, is understood as deeply at odds with Māori cultural practices and values:

> "It is clear that acts of whānau violence were not accepted by our ancestors. They are not, and never have been, a part of what it means to be Māori (Balzer et al., 1997). The violence we see within our homes and communities is behaviour that has become a part of the contemporary experience of many whānau; however, it does not originate from our tikanga. In fact, it is antithetical to how our tūpuna viewed the role and place of women and children in our society." (Pihama et al., 2019, 11).

Random and violent behaviour was associated with Tāwhirimātea, an atua who attempted to kill his brothers for separating Ranginui and Papatūānuku. Violent offending in times of war was identified with 'riri', meaning anger, or warfare (Smith et al, 2019). The term 'ngākau riri' then refers to the interior of the house being closed off and isolated; used to represent a person's internal system (Ibid). In times of war, warriors would divorce their human, caring and nurturing side, or 'te ira tangata', in order to participate in warfare (Ibid). Integration and restoration back into the community following battle required strategies for healing that focused on reconnecting the individual with te ira tangata (Ibid).

In Māori cosmogony, the female presence was "all-encompassing', and Māori women traditionally held roles of immense social power, such as Wāhine Rangatira (Māori women chiefs), Tohunga (wise women/experts), and Ariki (high priests/chiefs) (Pihama et al., 2019). Furthermore, it is well established in historical documentation that Māori women had and have central leadership roles stemming from both whakapapa and their actions. This is reflected in Māori women signing Te Tiriti o Waitangi on behalf of their hapū or iwi, and in the various names of hapū, iwi and

wharenui named after them. Research by Dhunna et al. outlines the rarity of violence against women in pre-colonial Māori society due to this status and respect for women and their mana; and the collective nature of responses to violence against women "in which the law of rangatiratanga (self-determination) obliged whānau (extended family) to work together to determine appropriate reparations for the survivor" (2021, 193).

Accounts from colonial missionaries describe how violent offenders were not tolerated in Māori society, and it is reported in one instance that a man who assaulted a woman was banished for a year (Pihama et al., 2019).

The impact of colonisation on whānau structures and Māori healing systems

For Māori, as with many other indigenous communities, FVSV is a direct consequence of the historical and intergenerational trauma of colonial violence. In *He Rau Murimuri Aroha: Wāhine Māori insights into historical trauma and healing*, Smith and Tinirau (2019) provide examples of the damage colonisation caused in relation to Māori and whānau relationships:

> "Changes to the structure of interpersonal and family relationships also had a damaging effect on the Māori community. The adoption of colonial views towards women as inferior to men had a further subjugating effect on Māori women (Jenkins & Mathews, 1998). A study conducted by Poananga (2011) identified that prior to colonial contact, Māori children were nurtured and protected within intergenerational extended family environments (Poananga, 2011). Early observations of Māori children and child-rearing practices evidenced an approach of "loving care (aroha) and indulgence", which became fragmented by colonial practices of physical abuse to reinforce discipline" (Smith and Tinirau, 2019, 5).

Colonisation destabilised Māori gender relations, and stories were rewritten with a patriarchal lens to undermine the mana of Māori women in order to fit into the colonial, patriarchal system (Pihama et al., 2019). Wirihana and Smith describe how this rupturing of the "sacredness of relationships between men and women" and the destruction of "the nurturing protective environments required for child rearing" have created a contemporary reality for Māori where they disproportionately suffer from high rates of exposure to physical, sexual, and psychological abuse (Wirihana and Smith, 2014, 201).

Pihama et al. describe how sexual violence is "not only about being a crime against the individual person but is an attack on the persons entire being and mana" and is therefore a simultaneous violation of past and future generations (2016, 9).

In addition to this, colonisation destabilised traditional whānau structures. In a colonial Pākehā 'nuclear family' structure, living situations accommodate only immediate family; this is incompatible with Māori and other non-Western traditional notions of the family structure, where the support and knowledge that comes with grandparent generations and wider whānau being present daily is welcomed and valued (Pihama et al., 2016). Furthermore, the impact of colonisation on whānau structure resulted in significant disconnection of wairua from lands, environments,

spiritually significant sites, food sovereignty and other natural resources that maintained the structure of collective living, and therefore, disconnected Māori from their primary systems of wellbeing and sources of healing (Pihama et al, 2019). The authors describe how this 'privatisation' of the whānau home has served to undermine the collective accountability and responsibility embedded into traditional Māori whānau structures, further reinforcing environments where violence and abuse is hidden, and healing on both the individual and collective plains remain inaccessible (Pihama et al., 2016).

Smith et al. describe how colonisation has resulted in a breakdown of traditional healing systems, and how colonial land loss has disconnected contemporary Māori communities from sacred sites of healing (2019). Futhermore, the concept of "disenfranchised grief," relates to grief that is unresolved, denied and unacknowledged (Pihama et al, 2016). For indigenous peoples, this denial of cultural grief continues to manifest and impact subsequent generations. This coupled with the layered effects of disconnection has left generations of Māori with unresolved trauma due to the colonial violence experienced by their ancestors. Pihama et al. discuss a framework for healing that is based on "the notion that colonisation has distorted Māori notions of whakapapa, tikanga, wairua, tapu, mauri and mana, and in doing so any view of whānau violence must locate colonisation as central", and refer to the Māori Family Violence in Aotearoa report (Balzer et al., 1997) that shows that there are "links between the suppression of Māori knowledge and tikanga; colonisation and the imposition of Western beliefs and practices; and acts of violence in Māori whānau, hapū and iwi" (Pihama et al., 2019, 17). Healing from FVSV is thus inherently and deeply linked to collective healing from the trauma of colonisation (Pihama et al., 2019). Māori face structural and systemic barriers to healing.

Pihama et al. describe Western reductionist modalities and wider societal denial of the impact of colonisation and historical trauma on Māori as a critical barrier to healing trauma that has served to further marginalise Kaupapa Māori healing pathways (2019).

In a study of young Māori mothers who had experienced intimate partner violence, Dhunna et al. found that participants generally held feelings of fear and distrust of government agencies like Child, Youth and Family (CYFS)[5] due to experiences of victim-blaming, racism, and stress around the capacity of CYFS to label them an 'unfit mother' and take away their tamaiti/tamariki:

> "…there is a lack of trust, and a concomitant presence of fear, toward social services and institutions that are operated by the New Zealand government, although this is not always true for Māori community and health services. This is illustrative of how a systemic normalization of racism, sexism, and other forms of discrimination within state welfare institutions has led to culturally unsafe practices that are not appropriately supporting, and therefore harming, young Māori mothers experiencing intimate partner violence" (Dhunna et al., 2021, 210).

Early colonial documentation represented Māori men as "violent savages," a representation that has continued to influence contemporary perceptions (Hamley and Le Grice, 2021). The perpetuation of this stereotype creates a context in which FVSV committed by Māori men against their children, partners and other Māori is considered 'normailised dysfunction,' and therefore an inherent trait of Māori masculinity (Ibid). This ideology further sways how Māori men are treated in the health and mental health systems. For example, research demonstrates that non-Māori health practitioners perceive Māori as non-compliant in relation to their health, blaming Māori for their own health inequities (Ibid.) Dhunna et al. reported further that despite being overrepresented as perpetrators of intimate partner violence, there was a distinct lack of mental health support for Māori men, even when showing clear evidence of mental illness or issues with anger management (Dhunna et al., 2021). One participant in the study explained how she was forced by CYFS to break up with her abusive partner to retain custody of her child; but despite displaying behaviour that could have benefitted from support, service providers did not offer any (Ibid).

As stated by Wilson:

> "While much attention is paid to wāhine and what they are doing to keep their mokopuna safe, those using the violence (often their male partners) have been rendered invisible. The Family Violence Death Review Committee (2016) has stressed the need for the focus to shift onto those using violence and stopping their use of violence. Because of the entangled nature of whānau violence, protecting and keeping mothers safe will also assist in keeping their children safe." (Wilson, 2016, 39).

In order to facilitate healing from FVSV in Māori communities, men must be provided with support and intervention outside of the justice system in order to support not only the healing of their mental health, but the health of the collective.

[5] Oranga Tamariki – formerly Child Youth and Family Services (CYFS), Ministry for Social Development.

Healing for Māori requires culturally safe support and reconnection with cultural identity

Cultural safety is defined as an "environment that is spiritually, socially, emotionally and physically safe for people; where cultural identity is recognized and valued through shared respect, meaning, knowledge and the experience of learning together" (Klingspohn, 2018).

Wikaire found that mental health services in New Zealand are generally unsafe and inappropriate for Māori, and that Māori are "unnecessarily medicated, labelled and incarcerated; whilst Māori experiences in wairua spaces are denied rather than validated" (2020, 156). Wilson states that healing for Māori and whānau requires culturally safe and informed services that can:

- strengthen the cultural identity and connectedness of Māori seeking to heal from FVSV.
- understand the historical and contemporary contexts for Māori, as services that understand people's life context and distress are better equipped to provide support that works (Wilson, 2016).

Cultural understandings and expanded definitions of whānau and sexual violence are integral to facilitate counselling and healing for Māori who experience FVSV and access support outside of Māori specific service providers (Pihama et al., 2016). Wirihana and Smith describe Māori-centred approaches such as Paiheretia (Māori-centred relational therapy), which "aims to improve Māori wellbeing by enhancing identity, reconnecting with cultural heritage and balancing relationships within families and wider tribal networks" (Wirihana and Smith, 2014, 202).

Waiata (song, chant, psalm) is cited by many Māori scholars as a traditional form of healing with a long history of efficiency in maintaining wellbeing for Māori (Smith and Tinirau, 2019; Wirihana and Smith, 2014; Wilson, 2016).

According to Smith and Tinirau, waiata "form a strong body of oral literatures within which our [Māori] resistances are captured", and "become historical markers of the assertion of our tino rangatiratanga and represent a particularly efficient and resilient method of knowledge transmission from mother to child" (Ibid, 26).

Similarly, Wirihana and Smith describe how traditional oral narratives such as waiata (songs), karakia (ritual chant, prayer), and pūrākau (storytelling) can be used by Māori as methods to express joy, anger, grief, loss, and sadness (Wirihana and Smith, 2014). Pūrākau is an important part of healing for Māori, as it facilitates the transmission of ideas and creates shared meaning and identity (Stansfield, 2020). This includes the restoration of whakapapa knowledge, language, and ways of being.

Building relationships and strong whānau centered networks further support healing

In the article *Transforming the normalisation and intergenerational whānau (family) violence,* Wilson describes how many young parents need support to develop alternative ways of interacting as parents; and that promoting healthy adult and adult-child relationships occurs across all types of whānau functioning (Wilson, 2016). Wilson states that it is not enough to put people in safe spaces; rather work should focus on restoring the mana (prestige, control, authority) of those involved in FVSV, as well as "understanding whānau whakapapa, how violence became a part of it, healing work, and where whānau want to go into the future" (Wilson, 2016, 38). Vaeau found that group courses for people with lived experience of FVSV were often transformative for those that attended, not necessarily for the content and skills learned, but because of the relationships built between people with shared experiences of trauma (2019).

Dhunna et al. found that motherhood was often transformative for young Māori women; in that they were able to reify their mana and rebuild themselves and their whānau after generations of colonial based family fragmentation (2021). In addition to this, the author found that young Māori mothers found extensive support among other teen mothers who they have developed relationships within local community spaces (Dhunna et al., 2021). This suggests that community and schooling spaces are, and can be, further supported and developed to be significant sites of healing for Māori who are otherwise disconnected from positive whānau or social relationships (Ibid).

Conditions for healing rest in structural and systemic support and change

Dhunna et al. described practical and material facilitators to healing such as housing and financial security (2021). The author iterated that Māori women and young Māori mothers in particular were not "passive receptacles" of abuse; these women exercised agency in reaching out to state authorities, creatively used their environments to evade violence (e.g., school), and found healing in the safety that housing security could provide (Ibid).

A key barrier to healing for Māori survivors of FVSV is attempting to heal within a societal context in which colonisation is a continuous and inherently damaging process that forms the basis of, and continues to influence, many of the key systems of authority in Aotearoa to this day. As described by Dhunna et al:

> "Importantly, decolonization is often antithetical to neoliberal economic restructuring, whose ethos of individualism contradicts Māori principles…neoliberalism, as an extension of colonialism in certain ways, seeks to further destabilize *whānau* and communities through individualizing and privatizing key social structures suggests that it also stands in opposition to the flourishing of Māori women. This manifests more concretely, as shown in the *E Hine* stories, through the racism, sexism, and classism faced by Māori mothers at the frontlines of state services which themselves are governed through increasingly neoliberal economic models.

> In other words, restoring the *mana* of Māori women necessarily involves a transformative restructuring of Aotearoa/New Zealand's socioeconomic fabric, not simply through piecemeal reform in frontline service provision" (2021, 213).

The literature states that FVSV experienced in Māori communities is directly linked to, and caused by, the historic and pervasive influence of colonisation in Aotearoa; and that healing from one cannot be wholly complete without healing from the other.

Given this context, conditions for Māori who experience FVSV to heal require a transcendence of both the individual and the collective and occur at a systematic level in order for long lasting and meaningful healing and change.

Healing for Pacific people

Pacific communities are not homogenous and have unique experiences with family and domestic violence, as well as unique approaches to recovery and healing. The research available for some groups of Pacific peoples in relation to FVSV is limited. For example, Mitaera et al., were faced with a scarcity of Cook Islands literature when commencing a literature search to identify Cook Islands cultural concepts to inform the development of Cook Islands FVSV interventions and practices (Mitaera et al., 2018). Havea et al., stated, "[t]he lack of substantive literature on Pacific-indigenous faith-based approaches to FVSV intervention was the catalyst for this article" (Havea et al., 2021).

There is not one specific model that will work best for Pacific people as 'Pacific' is not a homogenous group (Fa'alau & Wilson, 2020). There are learnings that can be taken from various Pacific knowledges and culture that can be applied to supporting the healing process.

Pacific populations in Aotearoa New Zealand have significant rates of FVSV as both victims and perpetrators (Fa'alau & Wilson, 2020). Pacific people are more likely to commit a serious offence against a family member than other ethnic groups (Havea et al., 2021).

Eurocentric interventions do not work with Pacific social structures

The social structures of Pacific communities are varied, but generally do not fit into Eurocentric views of family or community. For example, Tongan culture contains complex gender roles where men and women hold differing roles subject to their cultural role and rank. Everyday family roles transcend the nuclear family and therefore programmes developed for an individualized model of practice within a nuclear family are problematic from a Tongan perspective (Havea et al., 2021).

Western ideologies of the gendered division of labour does not fit with the traditional status of Pacific women, which has disrupted pre-colonial understandings of gender and gender relationships in Pacific cultures (Fa'alau & Wilson, 2020).

For Pacific people, violence is conceptualised as a disruption to the relational space between people that can fracture relationships with others. There are multiple

systemic factors which have disrupted these relationships in Pacific families, such as colonisation, migration, acculturation, and globalisation (Fa'alau & Wilson, 2020).

On a micro level, a lack of cultural consideration in FVSV support services can lead to non-engagement and a client feeling unheard, misunderstood, or unable to emotionally connect (Fa'alau & Wilson, 2020).

Successful healing is not an individualistic pursuit

The Duluth model of power and control that is used for screening for and addressing domestic violence cases in Aotearoa New Zealand includes individualist assumptions that both survivors and perpetrators of FVSV are devoid of broader family structures (Havea et al., 2021).

Working holistically with Pacific families is fundamental in achieving effective outcomes, which often requires working with the whole family as a unit (Fa'alau & Wilson, 2020).

Incorporating culture can assist with the healing process

The participants for the Pacific Champions of Change Fono 2010 found that culture must be the basis for constructing solutions for FVSV (Mitaera et al., 2018). For example, the *Tūranga Māori* framework was developed, from Cook Islands Māori cultural knowledge, for practitioners working with survivors, perpetrators, their families, and their communities. Critical elements to the *Tūranga Māori* framework are:

- Akono'anga Māori (Cook Islands Māori culture). Akono'anga Māori is informed by papa'anga (genealogy/kinship) and to be expressed it requires the following four elements: turanga: (one's position/standing), piri'anga (relationships), akaue'anga (duties and responsibilities) and ngakau aro'a (generosity to self and others).
- No teia tuatau (being relevant and realistic to the environment and context within which people live today). The notions of komakoma marie (gradual conversation) and kia maru to korua komakoma'anga (calm and peaceful conversation) are cited as ways to have relevance in engagement.
- Ta'anga'anga'ia refers to the use of knowledge and tools, and argues that cultural concepts and tools are only useful when they are put into practice. (Mitaera et al., 2018)

Tongan cultural core values of *faka'apa'apa* (respect), *angafakatokilalo* (humility), *tauhi va* (cultivating healthy relationships), and *mamahi'i me'a* (loyalty/passion) (The Tongan Working Group, 2012 in Havea et al., 2021) have been identified by faith leaders as important to apply in efforts to heal families (Havea et al., 2021).

The spiritual dimension can be important for healing in Pacific communities

Interventions for Pacific families require time and space to hold *talanoa* toward healing the relational space between family members (Fa'alau & Wilson, 2020). Havea and Alefaio-Tugia explored the use of talanoa for the Kainga Tu'umalie programme for the prevention and restoration from FVSV within Tongan churches. In

this programme, the key role of spiritual faith in the healing and restoration processes was presented (Havea & Alefaio-Tugia, 2018).

As some Pacific cultures (for example, Tongan culture) and Christian faith have evolved together, the two have become intertwined as part of modern cultural life (Havea et al., 2021).

Some research has shown that increased participation in faith-based communities provides strength, resilience, healing and whole-ness (Ellison et al., 2007; Nason-Clark, 2009 in Havea et al., 2021). It should be noted that other research has shown that while faith-based organisations can be a source of emotional and practical support, they may perpetuate silence or may not have the capability or capacity to respond to FVSV (Nason-Clark, 2004; Pyles, 2007; Zust et al., 2018 in Havea et al., 2021).

Healing for other Indigenous communities

Majority of the literature in this space acknowledges that healing from FVSV for Indigenous people is complex. In a research report by Australia's National Research Organisation (ANROWS), Morgan et al. found Aboriginal and Torres Strait Island children and young people suffer "significant and often lifelong consequences; are exposed to the ongoing cycle of child removal and intergenerational trauma, further embedding disadvantage in these children's and young people's lives; are likely to be at high risk of further violence in institutions; are more likely (without appropriate intervention) to perpetrate and/or experience violence in their own future intimate relationships; and experience early entry into the youth justice system" (Morgan et al., 2022, 10).

Morgan et al. discuss how although there is extensive literature outlining the impact of intergenerational trauma on Aboriginal and Torres Strait Islander children and young people, there is far less evidence available on how to support healing for these groups (2022).

Safety was described as "the centrepiece of healing" for Aboriginal and Torres Strait Islander children; and that safety for these children has a number of dimensions, including physical, emotional, social, cultural and spiritual (Ibid). Morgan et al. describe a set of eight values providing by Aboriginal and Torres Strait Islander community leaders that are central to supporting children and young people to heal from FVSV: "safety, respect, empathy, reciprocity, unconditional positive regard for children, truth, empowerment and hope" (Ibid, 20).

Literature reviewing healing for Aboriginal and Torres Strait Islanders in Australia and Indigenous and First Nations peoples in Canada mirrors the messaging of many other Indigenous cultures reviewed thus far; holistic approaches to support social and emotional wellbeing that connect body, mind, emotions, family and kind, community, culture, land, spirituality, and ancestors, are crucial to success (Mark et al., 2022; Redvers, 2022).

Morgan et al. express a consistent theme from Indigenous literature – that FVSV is not a part of Aboriginal and Torres Strait Islander cultures (2022).

Culturally safe service provision is key to facilitating healing in Indigenous communities

Cultural safety in health and social service encounters is extensively described as a condition for healing to occur for Indigenous peoples who have experienced FVSV (Allice et al., 2022; Redvers, 2020; Morgan et al., 2022; Carlson et al., 2021; Smith, 2013). In order for healing to occur in health and social service spaces, the literature iterated a need to centre Indigenous peoples and perspectives; recognise and reduce current barriers to culturally safe care; acknowledge where harm has occurred; build trust; and cultivate unhired, non-judgemental relationships (Allice et al., 2022; Morgan et al., 2022; Carlson et al., 2021; Smith, 2013). Allice et al. found that studies were consistent in that Indigenous clients accessing services for support for FVSV "felt safer to engage in disclosure and healing when they felt listened to and could see themselves centred and reflected in the resource, service or organisation they accessed" (Allice et al., 2022, 8; also see Smith, 2013).

Morgan et al. discuss the emerging evidence on the need to provide healing for Indigenous men and boys as central to addressing and facilitating broader collective healing from FVSV in Aboriginal and Torres Strait Islander communities (Morgan et al., 2022). This requires men's leadership of healing; positive father-figure role-modelling for boys; teaching of lessons that once occurred through traditional ceremony; connecting boys to core cultural practices to create change in relationships; and combining culture and western therapeutic practices (Ibid, 21). Evidence also notes that men's healing work must centre the safety of women and children, and accountability for perpetration of violence (Ibid).

In particular, Allice et al. acknowledged that non-Indigenous providers and perspectives in FVSV are often aimed primarily on helping people leave situations of FVSV; but that this is often a much more complex process in non-Western cultures, due to differing notions of how people and communities operate (Ibid).

Instead, interventions to support healing from FVSV rarely focused solely on individual safety, but rather on holistic healing both at the individual and community level, including "a deepening of connections to self, community, and culture, and restoration of Indigenous identity and wellbeing" (Allice et al., 2022, 11).

Approaches to and understanding of healing must be decolonised

In their review, Allice et al. discussed how healing approaches detailed across Indigenous literature included focus on "disentangling the influence of Western colonial practices and values on Indigenous communities, while reclaiming important aspects of pre-contact Indigenous culture, including, for example, matriarchal community structures and peaceful relationality among family, kin, and community" (Allice et al., 2022, 11). The review found examples where men were supported to talk about the role of colonisation and Western culture in FVSV patterns, which in turn supported recognition of how destructive and patriarchal gender roles that underpin FVSV trends are not inherent in Indigenous communities (Ibid).

Challenging these notions can encourage Indigenous peoples to see their values and traditional roles as potential sites of healing, rather than causes of violence

(Morgan et al). This emphasised themes consistent with the section on Māori experiences with FVSV:

> "Counter to Western theories of family violence within many of the studies, family violence was described by Indigenous participants as a complex social and historical phenomenon, enveloping whole families and their communities through multiple generations, and as a product of cultural dispossession, historical violence, and specific colonial and mainstream racist policies that sought to separate and weaken Indigenous families" (Allice et al., 2022, 8).

Healing as related to reclaiming Indigenous identity was often cited as a key facilitator to healing from FVSV in Indigenous communities (Allice et al., 2022, Morgan et al., 2022). This was often cited to involve "strengthening connections to family, community, culture, and land and restoring spirituality and traditional practices" (Ibid, 11). Morgan et al. also found that core elements of healing for Aboriginal and Torres Strait Islander people include a "need to reconnect with their culture, restore social networks, strengthen their identity and support the community through understanding and behaviour change" (Morgan et al., 2022, 20).

This was reiterated by Carlson et al., who found that attempting to treat the symptoms of abuse that occurs in FVSV settings without addressing the underlying causes, such as colonialism and historic and intergenerational trauma, can result in people disengaging with services and becoming further traumatised by violence (Carlson et al., 2021). Thus, collective healing – "a culturally based group approach which views the individual in the context of their family, community, culture and country" – is integral to facilitating healing for Indigenous peoples (Ibid, 10). Carlson et al. reference the 'Collective Healing Tree model' to conceptualise this, where (Ibid):

- the trunk of the tree is intended to represent programs, projects and activities that support collective healing
- the root system of the tree represents the nutrient that support and sustain these activities, including values, resources and foundational activities
- the branches and leaves that grow fruit show how individuals, families, communities and broader society can grow and flourish when collective healing is supported and invested in for Indigenous communities.

However, several articles suggested caution regarding a 'blanket involvement' of Indigenous family and Elders in FVSV responses and healing processes, as there are often complex community power dynamics related to colonisation, where power is held in communities, and the fact that some Elders may have used violence against family members themselves (Morgan et al., 2022).

There is also the risk of limited confidentiality in these approaches when disclosing violence to Indigenous providers in small communities, meaning that mainstream services could sometimes be preferred by some Indigenous peoples (Ibid).

It was suggested that engagement with community and culture in healing from FVSV should be driven by the survivor accessing support in accordance with their own needs and preferences and understood and supported by both Indigenous and non-Indigenous service providers alike (Ibid).

Indigenous storytelling as an approach to healing

Smith discusses Aboriginal story telling as a philosophical approach to bridging the gap between ancestral wisdom and present-day healing practices to support wider healing from FVSV (Smith, 2013). Smith describes how talking circles can provide a safe and respectful space where members/survivors can share their voices without fear of criticism or judgement (Ibid). Talking circles are intended to treat everyone as equals; and facilitators are encouraged to share their stories as well so that participants can related to them. More than spoken knowledge is shared in these circles; rather a transfer of cultural understanding, energy and strength, that forms within and between tellers and listeners; and in the context of FVSV, a healing energy as well (Smith, 2013). Smith articulates those programmes involving storytelling work because of their "emphasis on tradition, honesty, holism, humility and spirituality" (Ibid, 320).

Similarly, Klingspohn describes the integration of spiritual practices and ceremonies into family group counselling for Indigenous peoples in Canada, such as smudging (purifying/cleansing the soul through ritual), the talking/healing circle (a form of group therapy) and sweat lodges (purification ritual using heated huts) in order to facilitate healing from FVSV (2018). Healing circles, a form of group therapy, were reported to make women who had experienced FVSV feel empowered; safe; and comfortable (Ibid). The Indigenous knowledge shared in healing circles provided 'personal meaning' for the women, which helped them strengthen their connection to the Indigenous identity and healing methods (Ibid).

Land-based healing

Redvers describes land as a central dimension of wellness that is "embedded in Indigenous knowledge and is a necessary foundation for culturally responsive mental health care in Indigenous communities" (Redvers, 2020, 92). The author reports that land-based programs have been proven to increase resilience and wellness for young Indigenous people by improving self-esteem, interpersonal relationships, and cultural pride (Ibid).

Land based healing was described in literature on Aboriginal Torres Strait Islander healing and Indigenous and First Nations people in Canada alike. In *Land, life and knowledge in Chisasibi: Intergenerational healing in the bush,* Radu et al. outline a land-based healing program developed for Indigenous Cree communities in Canada (Radu et al., 2014). The program manual has since been used by Canadian courts as a sentencing alternative for Chisasibi offenders, as well as local social services (Ibid). This model aligns with Aboriginal storytelling approaches described by Smith (2013); Radu et al. describe the use of storytelling to discuss bravery, survival, respect and forgiveness to "provide a foundation from which participants can draw strength and make sense of their particular personal contexts" (Ibid, 93).

The author explains that the model "recognizes the healing power of nature and the 'return to the land' as a way of connecting individuals to Cree culture and language; as promoting intergenerational knowledge transfer; and offering a safe space in which individuals can share personal experiences and detoxify (when necessary)" (Ibid, 93). The model was developed by Eddie Pashagumskum, a Cree elder, and has generally provided services to young male community members that were either

self-referred or referred by the Cisasibi Justice Committee as a diversion option (Ibid). The program aims to "improve the mental health of individuals so they can effectively participate in the life of their family and community" and is primarily delivered through teaching Indoh-hoh (Cree bush skills), the values embedded in them, and in the Cree language (Ibid, 88).

The intersection of Indigeneity and LGBTQIA+ identities creates unique experiences of FVSV

There is little published evidence on the intersection of Aboriginal and Torres Strait Islander LGBTQIA+ identity and their experiences of healing from FVSV. Carlson et al. emphasise the interconnected nature of these identities along with the limited awareness and understanding of sexuality and gender diversity within Aboriginal and Torres Strait Islander communities and note the compounding impacts of racial discrimination on these people outside of Indigenous circles (Carlson et al., 2021). Soldatic et al. highlight the importance of understanding further how colonial violence not only impacted traditional gender norms within Indigenous communities; but how the influence of heteronormative Christian values has shaped negative attitudes towards gender and sexuality diversity within Indigenous communities, and how these have become conflated with 'traditional' Indigenous culture (Soldatic et al., 2023).

Soldatic et al., presents a unique analysis of FVSV experienced by Indigenous LGBTQIA+ people in which they may experience FVSV within traditional family and cultural environments, but also at the hands of a 'chosen family' when entering into rainbow community spaces (Soldatic et al., 2023). Soldatic et al. report that Indigenous LGBTQIA+ people often seek rainbow spaces to escape discrimination from Indigenous families and communities, but often experience racism in the form of microaggressions, discrimination and explicit verbal and physical abuse within non-Indigenous rainbow spaces, leading to increased feelings of isolation and exclusion (Ibid).

A young queer nonbinary transperson who participated in the study reported that 'white settler' violence was far worse than what they had experienced within Indigenous spaces, and that "queer Aboriginal spaces" were the only places they did not experience discrimination (Ibid).

While there is little literature reviewing the facilitators and conditions for healing for Indigenous LGBTQIA+ individuals and communities, literature to date iterates the importance of understanding intersectionality across service provision and safe spaces for these people. Safe spaces where people with similar identities and experiences can build relationships and support one another present possible sites for healing for these people, and future research could explore this further.

Healing for ethnic communities

According to Te Tari Mātāwaka, Ministry for Ethnic Communities (2022), ethnic communities represent almost 20 percent of Aotearoa New Zealand's total population. The term 'ethnic communities' in Aotearoa includes "people who identify their ethnicity as African, Asian, Continental European, Latin American or Middle

Eastern. They include former refugees, asylum seekers, new and temporary migrants, long-term settlers and multi-generational New Zealanders" (Ibid, p26).

Simon-Kumar (2019) acknowledges that the term "ethnic" or "ethnic community" encompasses at least 200 distinct ethnic groups and a large diversity of language, cultural and religious beliefs and practices. In Aotearoa, the largest ethnic communities' population groups are Chinese, at 4.9 percent; Indian, at 4.7 percent; and Filipino, at 1.5 percent (Te Tari Mātāwaka, Ministry for ethnic Communities, 2022). In recent years, the Muslim community has become increasingly recognised as a marginalised minority community; currently, around one percent of the Aotearoa population identify as Muslim (Simon-Kumar, 2019). They come from regions such as South Asia, Eastern Europe, Africa, the Pacific and the Middle East; however, those of Islamic faith are found in Māori communities as well (Ibid). Much of the literature returned for this search focuses on the experiences of South Asian migrant women. The term South Asian refers to people from the Indian subcontinent, for example, India, Pakistan, Bangladesh, Nepal, Bhutan, Sri Lanka, Afghanistan, and Maldives (Sultana et al., 2022).

Risk factors for violence against ethnic peoples are different to the general population; they encompass individual factors, such as language barriers, and isolation; household factors, such as migration, employment conditions; community factors, such as gender norms and patriarchal values; and systemic factors, such as racism, colonisation, and capitalism (Joshi, 2019; Simon-Kumar, 2019; Sultana et al., 2022). Simon-Kumar (2019), Joshi (2019) and Sultana et al. (2022), found that reporting and help-seeking behaviours in ethnic communities are relatively infrequent, and that this may reflect shame and fear of stigma, as well as limited formal and informal avenues available to safely disclose their experience.

According to Te Puna Aonui, under-reporting and a lack of specificity around ethnicity and immigration status in data has led to "a lack of evidence and knowledge about the profile of family and sexual violence in different ethnic, migrant and former refugee communities, particularly for those in smaller population groups (2022a, 3).

It is important to ensure that review and analysis of violence in ethnic communities does not service to cast a racist gaze towards ethnic cultures (Joshi, 2019). Rather than being a feature of ethnic cultures, the oppressive social relations that cause violence are often reinforced by western societies (Ibid). Simon-Kumar states that "explanations of violence against minority women as something about 'their' culture perpetuate colonial views that keep women in their unsafe circumstances" (Simon-Kumar, 2019, 13).

Patriarchy, family hierarchy, honour, and shame

In a technical report for Shakti Community Council on developing an intimate partner violence intervention service for youth from migrant communities of colour, 27 women between the ages of 16-28 who self-identified their ethnicities as Indian; Fijian-Indian; Chinese; Korean; Chinese/Indian; Pakistani; Afghani; Iranian and Sri Lankan participated in a survey and small group discussions on their perspectives and experiences with intimate partner violence as young migrants of colour (2015).

Multiple participants in the Shakti Community Council study from Pakistani and Fijian-Indian ethnic backgrounds explained that FVSV is an inherently patriarchal, learned, behaviour, passed down through generations within ethnic families:

> "Pakistani participant A: I think it is generational as well. Men learn it from their fathers, that it is okay to do whatever they want. In our culture, a female has been taught her whole life that, "This is what you are supposed to do. You are supposed to grow up and get ready for marriage, and after that you are supposed to do everything to make your husband happy" men are never satisfied, especially in our culture, because they want more power, they want more control." (Mayeda and Vijaykumar, 2015, 32)
>
> "Fijian Indian Participant: If you interview a group of women who have come from other countries or migrated here, and you get them in a room and ask them, 'Is your husband hitting you, is it a normal thing, is it acceptable?' A lot of women would say, 'yeah, this is just part of being married, suck it up. It is part of being a woman.' A lot of older women think that's just what it is. It's just in our culture" (Ibid, 32).

The author writes that "in short, children learn from early ages to assign girls and women with secondary status tied to domesticity and subservience" (Ibid, 2015, p32). The author further clarifies that although patriarchal beliefs and practices exist in many cultures, including Western culture, they can be more pervasive within migrant communities who look for ways to retain their culture in societies with dominant cultures that encourage assimilation (Ibid). In the qualitative study by Joshi (2019) a service provider described violence as a 'language' that was understood in the South Asian social sphere, and that South Asian men tend to be skills deficit in healthy communication, leading them to resort to violence as something that is understood and culturally sanctioned.

While family and sexual violence in ethnic communities is largely perpetrated by men, a key difference within this key group from others is that patriarchal and hierarchical family structures that place particular members of the family into positions of power also results in women being abused by other family members, such as in-laws, or other extended family members (Aujla, 2021). In a study on South Asian migrant women's experiences of domestic violence in Canada, the author noted that all seven women who participated reported violence occurring outside of the typical gender binary framework (Aujla, 2021).

As described by Simon-Kumar:

> "While intimate partner violence is the dominant form of family violence against women in Anglo-European/white groups, in many ethnic communities, particularly of Asian origin where multiple families may cohabitate in one household, it is not uncommon that the violence is expressed through members of the family rather than only the spouse or partner; these might include parents and in-laws, brothers and sisters-in-laws, siblings especially brothers, and uncles etc." (2019, 7)

In addition to this, honour and shame are key concepts to understanding FVSV within ethnic communities. Joshi (2019) explains that honour, or *izzat*, which is "closely related to family's reputation in wider community and is critical to social status and prestige"; and shame, or *sharam*, which is the consequence of an individual's or family's honour is compromised.

> "The institution of family, including marital bonds and relationships with extended family members is deeply rooted into the socio-cultural fabric of South Asian countries such as India and Pakistan, and forms a core source of influence for individuals within the family. Decisions of educational pursuits, career prospects as well as selecting a marriage partner are made with consideration for the maintenance of family harmony and cooperation. In other words, the needs and interests of the collective family supersede those of the individual" (Joshi, 2019).

Sharam is used as a silencing force for South Asians who experience violence, as disclosure could bring shame not only to themselves, but their families as well; and as explained by Joshi (2019) above, the needs and interests of the collective family supersede the need for these experiences to be addressed and for the women to heal.

South Asian women who experience violence are thus frightened to disclose their experience, because disclosing that their honour has been compromised may also compromise financial security, stability, and in the case of migration, legal status in the country where their family resides (Ibid). Research suggests that ethnic women are less likely to be concerned about future risk of violence for themselves, rather more concerned about what the best decision would be for the benefit of their children and the stability of their family (Simon-Kumar, 2019).

Mayeda and Vijaykumar use a description of traditional honour in Asian and Middle Eastern migrant communities as occurring across three planes;

1. male control of female behaviour
2. male shame when control is lost
3. level of participation by the larger community in controlling the shame (2015, p10).

In this characterisation of honour and shame, Mayeda and Vijaykumar describe how women from Asian and Middle Eastern communities become upholders not only of their family's reputation, but carriers and bearers of the community's ethnic identity in wider society (2015).

Young women in these communities are often socialised to be unaware of their rights, while men are socialised with the belief that they have the right to dominate women; leading to a strong focus on policing female youth due to the belief that their 'misbehaviour' will reflect not only on the immediate family, but on the ethnic identity of the community (Ibid).

When women in these communities experience abuse or violence, internalised notions of shame prevent them from help-seeking in order to protect the reputation of their immediate family, and their wider community, which presents a deep-rooted barrier to these women being able to heal themselves or access support to heal from the violence and abuse they have experienced.

Intersection of ethnic identity with migration

There are significant overlaps between the terms 'migrant' and 'ethnic'. It is estimated that 76 percent of Aotearoa's ethnic people were born overseas; and so not all ethnic people in Aotearoa are migrants; and not all migrants to Aotearoa are ethnic peoples (Simon-Kumar, 2019). However, the term migrant is strongly associated as an ethnic identifier for those from Asian, African, and Middle Eastern backgrounds, as opposed to Anglo-European/white migrants (Ibid).

Joshi (2019) notes that South Asian women who have migrated to Canada bear the major burden of settlement and integration when their families move to a Western context, and this further situates familial violence within the migration context for these women. Often for ethnic migrant women, their legal status is tied to their spouse, who are often the ones abusing them, or sanctioning their abuse from another family member (Joshi, 2019). For perpetrators, migration can bring a perceived loss of authority, status and self-esteem, control over life, and unemployment (Simon-Kumar, 2019).

On the other hand, those experiencing violence in ethnic communities, migration can result in isolation, loss of social capital and social networks, language barriers, and increased dependence on their spouse (Ibid).

Simon-Kumar (2019) highlighted the fact that the intersection of ethnic communities who experience FVSV with various immigration and legal statuses in the countries they reside in mean that loss of legal status and deportation are real fears, and present huge barriers to those in ethnic communities experiencing violence in seeking help and beginning a journey of healing.

The intersection of ethnic identity and migration is prevalent even for younger generations, who were born in their host country. As discussed by Mayeda and Vijaykumar, the gendered patterns of family migration experiences have a generational impact on familial cultural dynamics on all family members, irrespective of whether the family member themselves has immigrated (2015).

Young people in ethnic families can risk becoming alienated from or abandoned by their communities and families if they challenge normative cultural beliefs and practices (Simon-Kumar, 2019). This means that 'migratory influences' are still significant for youth within migrant ethnic communities and make it more difficult for these youth to seek help and heal from FVSV.

According to one participant in the study by Joshi (2019), the tensions and stress that develop due to generational difference in ideas, values, preferences, and lifestyles can serve not only as a barrier to healing, but as a cause of FVSV in and of itself.

Culturally unsafe formal and informal support mechanisms are crucial barriers to healing for women in Ethnic communities

Mayeda and Vijaykumar and Simon-Kumar found that that mainstream organisations in Aotearoa are not currently equipped to address FVSV with youth from Asian and Middle Eastern ethnic backgrounds (2015, 2019). Inman and Rao (2018) found that it often takes multiple consultations for ethnic women to disclose FVSV to a service provider, as the women need to experience non-judgemental, safe spaces for venting and disclosure, and time for service providers to encourage women to see themselves as survivors, rather than victims (Ibid).

A lack of culturally safe support mechanisms, counselling and therapy options is a large barrier for those that have experienced violence from Ethnic communities (Simon-Kumar, 2019). For Pākehā women, “leaving” a relationship often symbolises the beginning of a healing process and is a common strategy to remove oneself from a situation of family or sexual violence (Ibid). However, given the collectivist nature of many Ethnic communities, the role of honour and shame in these communities and the intersection of migration and ethnicity, this strategy is more complex and much less fit for purpose for ethnic women.

Many of the seven women interviewed in a study by Aujla (2021) reported issues with accessing both mainstream and South Asian specific support services. The women found that mainstream service providers often did not understand the cultural context and particularly the collective nature of South Asian family structures, and found themselves having to explain, educate their providers about their culture, or defend aspects of their culture that were not familiar to the providers (Ibid). Language barriers were also cited as an issue with mainstream services (Ibid). Participants in a hui on preventing sexual violence in Aotearoa ethnic communities considered that mainstream services would benefit from a ‘national cultural safety training approach’ and a register of ethnic based counselling and professional services for survivors of sexual violence from ethnic communities in Aotearoa (Shama Hamilton Ethnic Women’s Centre Trust, 2019).

In the case of issues with South Asian specific services, while some women noted feeling better for not having to explain their cultural context, others experienced revictimization when service providers upheld views around honour and shame and encouraged women to stay in their abusive families or relationships (Ibid).

The insular nature of some South Asian communities posed risks to the women where service providers were known by the women and their families already; some women reported the service providers refused support or went as far as to make the family aware of the disclosure (Ibid). While ethnic women seeking help for FVSV prefer support from those of the same ethnicity or religion, they may deliberately avoid interactions with people from their own community out of fear of revictimization.

Simon-Kumar (2019) warns of the balance between developing family-oriented approaches to address cultural safety, and the risk that these may compel ethnic women to deprioritise their own wellbeing and continue in abusive relationships or familial structures. This presents a significant barrier to survivors of FVSV healing from their experiences:

> "…the use of community-led solutions may not be the best path for every community/population cohort or sub-cohort, as intrinsic cultural violence is socially sanctioned by some community leaders. This can effectively prevent victim-survivors from reaching out, or services from reaching in. Where service providers are located within the community, they are best placed to be the bridge between the victim-survivor and intervention" (Te Puna Aonui, 2022a).

Simon-Kumar (2019) noted that intersectionality of identity is a large issue with the cultural safety of support services; ethnic women who have disabilities are more likely to seek support for family and sexual violence from disability support organisations as FVSV support is often unable to provide culturally safe support for disability. However, disability support services are often not equipped to deal with people who are experiencing family and sexual violence (Ibid). Simon-Kumar (2019) references intersectionality again with ethnic people who are also LGBTQIA+; lesbian ethnic women may not seek help due to heterosexism and racism-based shame:

> "…for many of them, being a lesbian meant being ostracised from their families and communities. To acknowledge violence would then be seen as losing face in front of others. Again, this speaks to the barriers of navigating multiple socially stigmatised or minority status identities" (Ibid).

Facilitating healing through skill training, technology, religion, and reclaiming of domestic spaces

Inman and Rao reported evidence that healing for ethnic women often combines mental health support as well as development support, such as skill training (2018). The authors found that providing women the space to create strong interpersonal networks, feel safe to disclose personal details and experiences, and support each other to cope and heal from experiences were just as important as the skills the women were learning (Ibid).

In a systematic review of barriers and facilitators of help-seeking behaviours of South Asian women when experiencing FVSV in high-income countries, Sultana et al. (2022) found that women emphasised the importance of technological education and support to facilitate healing. Access to computers, mobile phones, and the internet provided women with access to information and education through websites and online prevention programmes; and facilitated help-seeking through new opportunities for communication such as email, video call and social media (Ibid).

Joshi (2019) found evidence that some women who have experienced FVSV build resiliency through religion, with prayer offering a sense of hope. Similarly, Inman and Rao cited power and faith as important sites of resilience for Asian Indian women, stating that “ritualistic behaviours based in religious practices and meditation have been noted to be important to coping and linked to positive outcomes for women in the diaspora” (2018, p92). Inman and Rao noted despite evidence that faith-based resilience held a strong role in healing for many survivors of FVSV, it was not well researched (2018).

Joshi (2019) found that in some cases, ‘reclaiming’ domestic acts such as cooking and other communal activities allowed survivors of FVSV to build feelings of autonomy and empowerment. The author described how cooking can help survivors maintain their intrapersonal connection to their homeland, and where support mechanisms are centred around cooking classes or child rearing, it can serve as a catalyst for survivors to build rapport, trust and agency among people with similar experiences (Ibid). This is supported by Simon-Kumar (2019), who found that the healing is supported by strong social networks that in instances of FVSV can be built around “life skills” classes such as cooking or parenting programmes.

Educational interventions to support collective healing

Healing at a community level in ethnic communities is vital to break the cycle of intergenerational FVSV and gendered violence. In a discussion paper reporting on a series of hui on sexual violence prevention produced by Shama Hamilton Ethnic Women’s Centre Trust and the Shakti Community Council study, the community noted the taboo of many topics related to sexuality, and they were described as ‘off limits’ for discussion with parents or older family members (2015, 2019).

Mayeda and Vijaykumar described how families are silent on topics such as dating, romance and sex, other than to convey that such behaviours were unacceptable for girls and women prior to marriage (2015).

While boys and men in ethnic communities are reported to receive little guidance on such issues, girls and women received far greater and stricter regulations and surveillance (Ibid). Participants in the Shakti Community Council study described how dating, sexual intimacy and sexual violence are confusing topics for youth and adults alike from a range of ethnic backgrounds and iterated that they had not learnt about intimate partner violence from family or school health courses alike (Ibid).

Mayeda and Vijayakumar suggest that programming could be implemented in schools as part of larger health curricula to teach youth from an early age. The authors iterated that this education should be provided to youth across the gender spectrum, especially male youth, to ensure FVSV and intimate partner violence, in particular, are not perceived as a ‘women’s issue’ (2015).

It would be important for these programmes to be presented by personnel who are Asian and Middle Eastern, so that they may connect on a cultural level, as well as serve as positive role models for youth from these communities (Ibid).

It was suggested that to support youth from Asian and Middle Easter ethnic communities, programmes that address FVSV should:

- define and identify FVSV within specific cultural contexts
- explain the consequences arising from FVSV
- critique mainstream and ethnic media
- critique cultural, patriarchal tendencies that justify many forms of violence
- encourage and nurture perspectives from the younger generation that connect high female aspirations and gender equity to cultural pride (Mayeda and Vijakumar, 2015, p3).

Shama Hamilton Ethnic Women's Trust again highlighted education as a key facilitator to healing from FVSV at both the community and individual level (2019). Participants considered that community education focusing on recognising power dynamics between perpetrators and victims; guidelines for how to stop religious and cultural practices perpetrating this behaviour; and encouraging ethnic families with school age children to allow them to attend classes at school on sexual education and healthy relationships would support healing from FVSV at a community level (Ibid).

The needs of ethnic men who both experience and perpetrate violence are under researched and complex

While the vast majority of this literature focuses on the experiences and healing journeys of ethnic women who experience FVSV, there is very little literature focused on the healing journeys of men from ethnic communities who perpetrate violence. This is likely compounded by patriarchal and culturally sanctioned nature of FVSV in many ethnic communities.

However, across much of the literature in this space, it is acknowledged that in order for healing to occur at the individual level, it is imperative ethnic communities heal at a community level (Mayeda and Vijyakumar, 2015; Simon-Kumar 2019; Shama Hamilton Ethnic Women's Centre Trust, 2019).

Due to the intergenerational and cyclical nature of FVSV, majority of participants in qualitative studies reviewed reported that they and/or their partners had a childhood of trauma and violence (Alghamdi et al., 2021; Mayeda and Vijaykumar, 2015; Nair, 2017). In a qualitative study on the experiences of intimate partner violence among Canadian Muslim women, all participants provided some detail about their partners surviving childhood abuse and trauma, which included "loss and abandonment, neglect, physical and verbal abuse, living in a war zone, teen migration, poverty, illiteracy, and child labour and imprisonment" (Alghamdi et al., 2021, p64). Alghamdi et al. further reported on direct links from childhood trauma to perpetrating intimate partner violence from one participant interview:

> "One day when we were together arguing, he pressed my hand, and I said you are breaking my hand, and he said 'So? My dad broke my mom's hand, and you are not better than my mom'." (2021, p62).

Thus, healing for ethnic men from their own experiences of FVSV and trauma are integral to supporting wider healing within ethnic communities.

Healing for children and young people

The United Nations (UN) defines a child as a person below the age of 18 (United Nations, 1989). A young person is generally defined in the research as anyone aged between 15 and up to 25 years of age. The UN Convention on the Rights of the Child recognises that children have a universal right to live free from all forms of violence (Ibid, Article 19). Aotearoa is a signatory to this Convention.

Although there is no single data source that gives an exact understanding of harm to children in Aotearoa, the level of harm is suspected to be significant (Oranga Tamariki, 2020).

Although the exact numbers are not clear, the impacts of violence on children are. Violence and trauma in childhood, and during the transition to adulthood, can have important impacts on the formation of identity, physical and mental health, cognitive function and learning capacity, wellbeing and independence, and lead to long-term detrimental consequences (Robinson et al., 2022; and English, Edleson & Herrick, 2005 in Swanston et al., 2014). Therefore, it is important to study and identify healing approaches, barriers and facilitators for children who have experienced violence.

Healing from childhood abuse is a complex and individual process, and specific tools for healing differ. More research is needed into what leads to resilience in children (Campo, 2015). Research that does exist shows that some children draw on a number of coping strategies, and show resilience, while others do not have any negative outcomes at all (Ibid).

Strategies include:

- strong relationships with friends, being able to participate in school and social activities, and being able to escape the home (Campo, 2015)
- finding some way to make sense of the abuse (Graham et al., 2022)
- talking with others may be important but is not the only way to heal (Ibid)
- developing alternative accounts of trauma in relation to healing may also be helpful for some people (Ibid)
- actively involving children in the healing journey (Campo, 2015).

Trauma-informed care is usually recommended in therapeutic responses to children, particularly for Indigenous children who may be exposed to multiple forms of violence or abuse (Campo, 2015). Service responses for children should be child-centred and trauma-informed (Robinson et al., 2022; Campo, 2015).

A child-centred approach seeks to “expand our focus on children and young people, in or outside of their families, and the development of policies and practices which support this” (Winkworth & McArthur, 2006 in Robinson et al., 2022).

According to Powell et al. (2020) and Winkworth and McArthur (2006) (both in Robinson et al., 2022), a child-centred approach:

- recognises critical time frames in childhood and adolescence, including the importance of intervening early in children's lives as well as early in the life of problems
- takes developmental needs of children and young people into account in practice contexts
- provides children and young people with opportunities to participate in decisions about things that affect them
- promotes a collaborative approach to influencing the multiple environments that children and young people engage with, and interactions between these domains.

Callaghan et al., (2015) noted that there should be a move away from passive framing of children as 'witness' to something more complex, that sees them as victims and active beings, to enable them to deal with and recover (heal) from domestic violence. Children have rights to be respected as individuals who live with, experience and are affected by the violence, just as much as adult victims are.

Ragavan & Miller (2022) noted that paediatric healthcare settings can provide healing-centred care through healthcare provider training and direct support for survivors of violence. Healing-centred engagement is a strengths-based approach which focuses on connecting survivors with supports that help them meet unique needs.

Oranga Tamariki has previously published an evidence brief specifically on "*Support for child victims of sexual crimes"* (Oranga Tamariki Evidence Centre, 2021a) which discusses key support services for child victims of sexual crimes including through the court system, and culturally appropriate services.

Relationships with their mothers and other support people are essential for healing

It is clear from the research that relationships children hold with their mothers and other support people are essential (Anderson & van Ee, 2018 in Hooker et al., 2022; Lieberman et al., 2015 in Hooker et al., 2022; Katz, 2015; Schon et al., 2019; Topor et al., 2011; Tew et al., 2012, all in Katz, 2015; Swanston et al., 2014). Although there is little research examining the best responses to children exposed to FVSV, it seems that therapeutic responses that work with both mother and child are beneficial (Campo, 2015). For younger children in particular, the most important thing for resilience is a strong parent-child attachment (Campo, 2015), therefore responses to children experiencing domestic violence should focus on strengthening the relationship between parent and child (although note that a lot of the literature refers to 'mother').

There is a growing body of research assessing how partial recovery can take place at the social level through a person's relationships, and that in particular, children and mothers with past experiences of domestic violence may play key roles in promoting each other's recoveries (Schon et al., 2019; Topor et al., 2011; Tew et al., 2012, all in Katz, 2015).

Katz's (2015) study of 30 participants (15 children and young people and 15 mothers) in the United Kingdom showed that mothers and children often require professional help to begin recovery, but that recovery also occurred via successful techniques that mothers and children used to promote each other's long-term recoveries and well-being, including:

- reassuring one another about the past, present, and future
- rebuilding each other's confidence and self-esteem
- assisting one another to understand the past and overcome its emotional/behavioural impacts.

The study showed that the resilience of children can be better if they have strong emotional regulation and experience good parenting from their mother (Ibid).

Katz (2015) explored three key aspects of participants' recoveries:

1. decrease in abuse or creating conditions needed for recovery
2. formal supports from professionals – to recover, many participants needed professional support to limit barriers to recover, particularly ongoing post-separation abuse
3. mothers and children promoting one another's recovery within their lives.

Child-parent psychotherapy is an evidence-based intervention initially designed for young children and their mothers affected by intimate partner violence to strengthen their relationship and positively impact on their mental health (Lieberman et al., 2015 in Hooker et al., 2022). Hooker et al. (2022) conducted a study on eighteen pairs of mothers and their young children (<5 years old) undertaking child-parent psychotherapy, and found that two important outcome measures changed significantly: parental warmth, and improved child emotions and behaviours (Hooker et al., 2022).

The research shows that mothers tend to give their children longer-term supports, while children focus on lifting their mother's mood in the short term, including building confidence through praise (Katz, 2015). It is often necessary for mothers and children to have professional support to be able to play these positive roles for each other (Ibid).

If the mother is unable to support the child themselves, due to their own experiences, it's important to have others (e.g., family, friends, services) to help. Once mothers have left the domestic violence and received support for their own emotional wellbeing, they are better able to support their child's emotional needs (Swanston et al., 2014).

Children must be able to effectively express their emotions to heal

Speaking about their emotions, and feeling heard, plays a key role in how children cope with difficult feelings and heal from the impact of violence (Swanston et al., 2014). While professional services (e.g., psychotherapy, counselling) can help children to heal, they need to feel that they are being listened to. Having their opinion taken seriously is essential, but often doesn't happen.

Barriers to recovery for children include ongoing violence and a lack of support

In Katz's 2015 study, identified barriers to recovery in the first one-two years of separation from the perpetrator included:

1. post-separation violence, stalking, harassment etc.
2. contact visits between children and perpetrators
3. no safe and settled place to live.

Similar themes have been identified in other studies – children in Swanston et al.'s 2014 study talked about seeing a "brighter outlook for their future" after leaving the domestic violence, due to an increased sense of safety for them and their family.

As above, not feeling listened to, or not being taken seriously by professionals or other support people was also identified as a barrier to healing (Swanston et al., 2014).

Indigenous children and young people experience violence at higher rates, and need culturally specific approaches to healing

This section should be read bearing in mind the context of the section above, "*Healing for Māori*" of pre-colonial violence and the impact of colonisation.

A study by Dhunna et al. (2021) analysed six narrative interviews with young Māori mothers (aged 14 to 19) to understand their lived realities in experiencing intimate partner violence. According to their research, there is a clear illustration of disproportionately higher rates of intimate partner violence among Māori, particularly young women. Compared with pākehā women, Māori women between the ages of 15 and 24 are seven times more likely to be hospitalised due to assault (Kruger et al., in Dhunna et al., 2021).

The authors noted that young (defined as teenage or adolescent) Māori mothers are particularly vulnerable to intimate partner violence (Dhunna et al., 2021). Young women may have less relationship experience and therefore perceive certain forms of abuse as 'normal'. In addition, intimate partner violence is higher during unplanned pregnancies, which may occur more often in relationships between young people. The issue is not just the greater risk of abuse, but the pathways out of that abuse (i.e., towards healing), which are disproportionately unavailable to young Māori mothers.

The study found that there are structural and institutional barriers to culturally safe service responsiveness for young Māori women, including racism at the frontlines of government agencies, pervasive victim-blaming, and a lack of genuine decolonial structural change at the institutional level.

The authors concluded that social services must be multisectoral, culturally safe, and specialised for rangatahi Māori and whānau to support Māori mothers experiencing violence.

Dhunna et al. (2021) noted the importance of Māori culture in the process of relationship-building, healing, and self-reconstruction for rangatahi Māori. Young women in the research experienced healing from the trauma of assault through living with whānau, who provide significant avenues for emotional, material, and spiritual support.

Whānau can be a source of healing, for example by gaining physical and emotional support and safety. Young Māori mothers found that youth and community service, particularly those using Māori modes of engagement, were important in enabling them to meet supportive figures (Dhunna et al., 2021). Similarly, having a Māori counsellor improved the quality of counselling for the participants. State resources must be directed towards whānau strengthening, as this is where Māori women derive their support and safety. The response to violence must involve strengthening existing whānau and community relationships.

In the research conducted by Robinson et al., 2022 (discussed in more detail below), children with disability who were Aboriginal and/or from regional and remote areas were even further over-represented in exposure to FVSV compared to children without disability.

Young people from migrant communities of colour experience violence at higher rates

This section should be read bearing in mind the context of the section above, "*Healing for non-Indigenous ethnic communities*".

Likewise, while research addressing violence in migrant communities is limited, it shows that migrant women of colour living in Western communities are disproportionately impacted by intimate partner violence (Mayeda & Vijaykumar, 2015). Asian constructs of family do not align with western 'empowerment' notions of feminism, which means it's difficult for them to use mainstream services and risk breakup of their families (a key element of healing for Western mothers and children).

Mayeda & Vijaykumar (2015) conducted research with 27 young women and girls from Auckland, who provided views on how intimate partner violence is understood in migrant Asian and Middle Eastern communities. Participants in this study noted

Barriers to healing for migrant young people include (Mayeda & Vijaykumar, 2015):

- a lack of friend and family networks
- other social isolation due to language barriers
- cultural beliefs that stress not expressing issues beyond the family.

Migrant women of colour therefore experience a lot of factors which make leaving relationships very challenging (Mayeda & Vijaykumar, 2015). Migratory influences are highly significant for young people from migrant communities, even if they were born in Aotearoa. Feelings of shame make it difficult for women and girls to report violence and/or remove themselves from violent situations/environments.

Study participants noted that solutions should begin with younger generations, both young women and young men, to change perspectives (Mayeda & Vijaykumar, 2015). Participants also noted that it would be useful to have school counsellors from ethnic backgrounds that better reflected diverse students (Mayeda & Vijaykumar, 2015).

Young people can be taught what it means to be 'strong' in different contexts, moving out of a framework that defines strength as only physical. The researchers noted that girls and boys should be taught to have strong personal identities (Mayeda & Vijaykumar, 2015) to assist in the healing process.

Men have specific needs for healing from childhood violence

There is little scientific research on men's healing from childhood violence (Willis et al., 2014), particularly on the barriers to healing. However, there are some studies that have sought to describe and interpret male healing, and barriers to healing for men after childhood violence (Willis et al.,2014; Patterson et al., 2022; Rapsey et al., 2017).

Healing for male survivors of childhood maltreatment has been defined as "liberating of the self from preoccupation with abuse, which permits the discovery, cultivation, and sustenance of the authentic self-capable of experiencing and maintaining a sense of peace and wellbeing." (Willis et al., 2014 p571).

Before healing, male survivors felt that they were trapped in the past – the felt that they were "Dwelling in Suffering" personally, relationally, and social-environmentally. Life patterns of those early in the healing process included physical, emotional, psychological and sexual distress (Draucker et al., 2012 in Willis et al., 2014).

Male survivors report that healing is facilitated by:

- making sense of their lives within the context of abuse (Willis et al., 2014)
- sharing their abuse experiences, particularly with fellow male survivors (Willis et al., 2014)
- helping others (Willis et al., 2014) and gaining a sense of belonging (Rapsey et al., 2017) or meaning (Patterson et al., 2022)
- incorporating spirituality into their daily lives (Willis et al., 2014)
- engagement in safe and healing relationships (Draucker et al., 2009; Easton, 2013; Willis, Rhones, et al., 2015 in Rapsey et al., 2017), and learning safe ways to manage those relationships (Kia-Keating et al., 2010 in Rapsey et al., 2017)
- receiving treatment (Easton et al., 2013 in Rapsey et al., 2017).

For male survivors, the theme of 'control' was strong – as they gained a sense of control over their experiences later in life, they changed their perception of the abuse and gained meaning from their experiences (Patterson et al., 2022). However, participants in Patterson et al.'s study (2022) also reported using avoidance tactics as a coping mechanism rather than working through the abuse. Using avoidance was described as a way to control the ongoing impacts of the abuse. Some participants in the study described using distractions (e.g. alcohol or drugs) to avoid dealing with the abuse (Patterson et al., 2022).

Male survivors report very different barriers to healing than other populations. The experience and impact of sexual abuse on boys clashes with Western constructs of masculinity. This clash is often a substantial barrier to disclosure and treatment engagement (Patterson et al., 2022; Rapsey et al., 2017).

Western constructs of masculinity can heighten the feelings of responsibility, shame and blame for male victims, making it hard to cope with abuse effectively, and delaying healing.

An important element of healing from the effects of abuse is therefore the capacity to reappraise the meaning of masculine norms and associated implications of sexual abuse (Rapsey et al., 2017).

Other barriers to seeking treatment and therefore healing, which relate to Western concepts of masculinity, include (Rapsey et al., 2017):

- stigma – fear of judgement or ridicule for seeking help
- identification of the parallel between the power differential in an abusive relationship and that of a professional and their client in a therapy relationship
- cost and complexity of access to treatment
- difficulty establishing a positive relationship with the treatment provider
- negative experiences with a treatment provider in the past.

Disclosure at the time of the abuse for men (e.g. as te tamaiti) often led to a negative response with little to no support or guidance, which also delayed healing (Patterson et al., 2022).

Children who witness domestic violence also develop coping strategies

Witnessing domestic violence may damage long-term emotional and social wellbeing of a child (O'Brien et al., 2013). However, not much is known about the long-term (adult) impacts of childhood witnessing (O'Brien et al., 2013). It's been noted that the potential threat to te tamaiti witness's immediate and long-term wellbeing can be mediated through the development of a range of adaptive coping strategies (O'Brien et al., 2013).

For young children, the main coping strategy is often to remove themselves from the immediately violent situation and hide somewhere safe to try block out the abuse (O'Brien et al., 2013). Some children or young people tried to intervene in the violence, but when that didn't work, they removed themselves for longer periods of time and actively sought out a safe haven (grandparents' house, friend's house etc.) (O'Brien et al., 2013).

Later in life, abuse of alcohol and drugs was a non-productive coping strategy (O'Brien et al., 2013)

Young people realised they needed to take control of their own life in order to move out. Establishing a safe supportive place of retreat enabled them to (O'Brien et al., 2013):

- develop more effective ways of coping than those modelled by their parents
- move on from their childhood traumatic experiences of witnessing domestic violence
- develop a different sense of self from that of their parents.

As above, coping strategies were enhanced by the presence of a strong support person e.g., grandparent or friend (O'Brien et al., 2013). "Buffering" by a support person is an integral part of the resilience process as it helps facilitate positive functioning and resourcefulness during adversity (O'Brien et al., 2013).

It has been noted that resilience is a process of accessing necessary protective resources rather than a personal trait (Luther et al., 2000 in O'Brien et al., 2013).

Healing for Disabled people

Within Disabled communities, there is a high prevalence of FVSV. Women with disabilities are two – five times more likely to experience intimate partner violence during their life (Sasseville et al., 2022) and disabled adults and children are significantly more likely to equally likely, compared to those without a disability, to experience FVSV (Saleme et al., 2023).

For those who are intellectual disabled, it can be challenging to understand what the impact of FVSV is and what is required to begin the healing process.

For example, a disability practitioner said "I don't have too many [clients] that are able to verbalise what they want. And for me that's hard to find out from my direct clients' perspective or what they need or the impacts of the [domestic violence] around them and how it's impacting them, other than through engaging behaviours of concern to express their emotions." (Robinson et al., 2022).

There is also a focus in the literature on intervention and prevention of family and domestic violence for disabled women (Jordan, 2022); which tends to evaluate strategies for navigating FVSV rather than healing from it.

The socialisation of Disabled women to be passive can be internalised when Disabled women seek help

There is also evidence that Disabled women are socialised to be tolerant and complacent (Lee, 2007; Teaster et al., 2006 in Sasseville et al., 2022), which therefore restricts their ability to establish appropriate boundaries around violence (Sasseville et al., 2022). Literature often notes that Disabled women are generally constructed as passive, helpless, dependent, and non-autonomous beings (Coffman-Rosen, 2014; Women with Disabilities Australia, 2007 in Jordan, 2022) which can be internalised by Disabled women when seeking help (Jordan, 2022).

This creates risk in help seeking if there is a reliance on the perpetrator for care and assistance, a fear of retaliation from the perpetrator, emotional abuse related to the disability, or the exacerbation of secondary physical and mental health consequences of the abuse (Saleme et al., 2023).

Other interactions with disability support systems will influence the perception of FVSV services

Disabled women often have experience with disability support services throughout their lives, and how they perceive that experience will likely impact their expectations for domestic violence services.

As many of those experiences are negative (Women with Disabilities Australia 2007 in Jordan, 2022), Disabled women are unlikely to believe that domestic violence services would be responsive to their needs (Jordan, 2022).

The initial response that is received when help-seeking will determine whether they will engage further help-seeking efforts (Bui & Morash, 2007 in Jordan, 2022).

Intellectual disabilities can impact on the ability to express people's needs for healing

Intellectually disabled people may find it difficult to express their perspectives and have their priorities heard, which can be particularly evident for people with high and complex support needs, who do not use conventional speech (Robinson et al., 2022). It has been found, however, that intellectually disabled women have agency and can be self-determining in their decision-making around FVSV (Pestka & Wendt, 2014 in Jordan, 2022).

There are also a range of other complexities that disabled survivors of FVSV face; there are sometimes physical barriers to domestic and FVSV services, as well as ableism in places where help is being sort (such as medical professionals or legal services) (Jordan, 2022).

Interpersonal relationships provide effective support system for Disabled people healing from FVSV

Effective support systems are beneficial for Disabled people in terms of safety and mental wellbeing. Utilising close friends as sources of support can play an immediate role in the initial navigation of domestic or FVSV and the beginning of the healing process (Jordan, 2022). Disabled children and young people whose families experienced FVSV reported that feeling safe and happy was achieved through interpersonal relationships and interactions (Robinson et al., 2022).

Disabled children and young people have specific needs and barriers to healing

There are important gaps in policy and knowledge for Disabled children and young people, who experience FVSV. They are known to experience it at rates significantly higher than children and young people without disabilities (Jones et al., 2012 in Robinson et al., 2022).

Robinson et al. (2022) conducted research to provide new knowledge on how Disabled children and young people experience domestic and FVSV, applying intersectionality theory and approaches to children rights and disability rights.

The research found that Disabled children had double the exposure to FVSV (eight percent) compared to children without disability (four percent) (Robinson et al., 2022).

Participants in the research identified many barriers in receiving reliable, consistent support for FVSV and disability (Robinson et al., 2022). Disability is "interwoven with trauma" for children and young people with significant support needs, and therapeutic responses from skilled practitioners need to be a priority to help them begin to recover from FVSV.

The research shows that healing for Disabled children and young people is not "immediate enough". Children often receive support through family focused services, but this can present issues where the response is tailored towards the healing process of the adults involved (Robinson et al., 2022). This can mean that adult women may begin to process their trauma, while children are not prioritised, and their trauma wounds continue to 'fester' (Ibid). It's noted that the woman (mother) notices the effects of this trauma in her children later down the track, once she has begun to do her own healing. The children then have well-established maladaptive coping mechanisms, and must heal not only from the trauma, but from the responses to the trauma (Ibid).

Healing for members of LGBTQIA+ communities

While LGBTQIA+ or 'rainbow community' is used to encompass a range of gender identities, sexual orientations, and sexual expressions, much of the literature breaks the evidence down into more discrete groups/communities, as the experiences of intimate partner violence and sexual violence can be different.

The term 'intimate partner violence' is generally used in the literature in lieu of 'family violence' or 'domestic violence' to allow for recognition that LGBTQIA+ relationships are not necessarily "domestic" or fit within the traditional interpretation of "family" (Ay et al., 2020).

While the types of FVSV experienced within LGBTQIA+ communities have similarities to the types experienced by other FVSV victim-survivors, there are some important differences including:

- household members may not be recognised as family and yet have the same complex dynamics as other families
- discrimination and stigma can mean the additional tactics used by people who use violence have particular power
- coming out and transitioning can be times of high vulnerability for LGBTQIA+ people, particularly young people
- people breaking sexuality and gender norms are often targeted with violence, including sexual violence

- families and whānau are not always safe for LGBTQIA+ people and often chosen families; for example, friends and community, and other LGBTQIA+ people play a more central role in their life
- FVSV may include threats to reveal a person's sex, sexual orientation, gender identity or intersex status to friends, peers, work colleagues, family or others
- FVSV may also include, for transgender and nonbinary people, threatening to withhold or actually withholding, access to hormones, medical treatment or other support (Te Puna Aonui, 2021)

Mainstream FVSV support services are not always inclusive of LGBTQIA+ relationships

Many members of the LGBTQIA+ community face unique barriers to healing from FVSV as specialist FVSV services are generally set up to respond to men's violence within a binary sex/gender framework (Dickson, 2016), professionals who work with people in the LGBTQIA+ community often need education to understand the nuances of queer relationships (Bloemen et al., 2019) and survivors noted that a common barrier to seeking help is concerns about homophobia, biphobia, and transphobia and other concerns that they would be "outed" if they sought help (Dickson, 2016). A lack of trust in mainstream services can result in a barrier to seeking help (McNair & Bush, 2016; McNair et al., 2017; Turell Herrmann, Hollan & Galletly, 2012 in Ay et al., 2020).

Some survivor spaces can be unsafe if they are not designed to support the LQBTQIA+ community. For example, many shelters and support groups are designed to provide support for women who have been abused in opposite-gender relationships and are not used to having to screen out female perpetrators who have been violent in female same-sex relationships (Harden et al., 2022).

In a survey of transgender and intersex people in New Zealand, over a third of respondents reported that organisations where they sought help with FVSV were not helpful at all to them. Only 11.1% indicated that they were "very helpful" (Gender Minorities Aotearoa, 2023).

Heteronormative perceptions of intimate partner violence are prevalent

Generally intimate partner violence is seen as heteronormative crime (cisgender male perpetrators and female victims within heterosexual relationships) by mainstream organisations. The way that FVSV services are presented invites members of the LGBTQIA+ community to believe that they would not 'fit' into those services (Ay et al., 2020). Concerns about heteronormativity prevent some survivors from seeking help (Bloemen et al., 2019; Dickson, 2016). For example, Harden et al., focuses specifically on the experience of intimate partner violence within female same-gender relationships, noting that intimate partner violence is often thought of as a heteronormative crime and that women are not thought of as perpetrators of intimate partner violence (Harden et al., 2022).

Some survivors feel like they are not an "appropriate client" for intimate partner violence programs as their "experience wasn't severe enough" (Ay et al., 2020). In a

survey of 407 members of the LGBTQIA+ community in Aotearoa New Zealand, 130 respondents did not seek help because they considered their experience minor, despite serious impacts being reported earlier in the survey (Dickson, 2016).

Some LQBTQIA+ people find it difficult to identify FVSV, because many assume that is means overt physical and/or sexual violence, rather than non-physical abusive tactics used to coerce, control, or cause fear (Soldatic et al., 2023).

Members of the community want to avoid perpetuating negative stereotypes

Another barrier to help-seeking, and therefore to healing, is a fear of contributing to negative views of the LGBQTIA+ community by reporting intimate partner violence (Ay et al., 2020; Harden et al., 2022).

There are concerns that reporting violence or abuse will contribute to existing harmful stereotypes, such as trans women being abusers (Dickson, 2016). The likelihood of help-seeking can also be impacted by a concern that they will have a negative experience due to their gender identity or sexuality, particularly if the abuse were related to their LGBTQIA+ status (Bloemen et al., 2019).

Queer and trans people are less likely to report an abuser who is also a member of the LGBTQIA+ community, as there is a fear that reporting an abuser will reflect badly on the community as a whole (Chen, Dulani, and Piepzna-Samarasinha 2011 in Shultz, 2020).

The community has negative interactions with the legal system

The LQBTQIA+ community have a fraught relationship with the criminal and legal systems (Ay et al., 2020) and there is a reported lack of positive interaction between the community and law enforcement (Harden et al., 2022). In New Zealand, members of the LGBTQIA+ community reported that police were more likely to be not helpful or supportive than asking for help from friends, whānau, queer community groups, or counsellors (Dickson, 2016).

For example, trans people who are survivors of intimate partner violence often avoid police altogether (Stanley and Smith 2011; Stern 2011 in Shultz, 2020) as transantagonistic violence in the legal system (in the United States) is well documented (Grant et al., 2011; Stanley and Smith 2011; Stern 2011 in Shultz, 2020).

Mainstream services work better when adapted for/by the LQBTQIA+ community

Healing and support services for the LQBTQIA+ community require a different approach to the ‘traditional’ services for intimate partner violence, which are generally only appropriate for cisgender heterosexual couples (Dickson, 2016).

The required support for members of the LGBTQIA+ community is often different to the support that is provided for survivors of family and domestic violence within cisgender heterosexual couples. Specific programmes that have been tailored to remove content that is heteronormative or misgendering have been found to be beneficial for LGBTQIA+ survivors (Ay et al., 2020).

Many survivors also referenced the ability to openly talk about their experiences to allow them to feel validated and supported (Harden et al., 2022).

Peer support provides a greater level of understanding and empathy

Following an assessment of a peer support group for transmasculine survivors of intimate partner violence, Shultz found that there was a heightened sense of trust within support spaces that promotes sharing and that there are intimate understandings reached, and shared, in spaces that exclusively cater to transmasculine survivors (Shultz, 2020).

It has been found that for many trans survivors, the ability to find support with empathy and innate understanding provides a useful tool in recovery (Rymer and Cartei 2019 in (Shultz, 2020). More broadly, FVSV practitioners who are also members of the LGBTQIA+ community feel it is better for both survivors and perpetrators to be treated by other members of the community due to the greater awareness and empathy (Ay et al., 2020).

In Aotearoa New Zealand, members of the LQBTQIA+ community reported that friends and counsellors were the most likely to be ‘very supportive and helpful’, as opposed to domestic violence agencies (Dickson, 2016).

Healing for Older people

Intimate partner violence and sexual violence continues to occur in older adults. This abuse, and the needs and aspirations of Older people, are largely invisible (Te Puna Aonui, 2022). Older people may also be continuing with their healing from earlier abuse (Graham et al., 2022).

Older women are less likely to report abuse

Sexual assaults against older adults are significantly less frequently reported than sexual assaults committed against younger victims (US Bureau of Justice Statistics 2014; UK Office for National Statistics, 2016 in Crockett et al., 2018). In Europe, though 28 percent of women aged over 60 reported experiencing some form of abuse in the previous twelve months, the majority of survivors did not disclose or seek help (Luoma et al., 2001 in Crockett et al., 2018).

Immediate support is less accessible for Older people

Older adults who are trying to access support for current abusive situations face unique barriers. Domestic violence service providers like shelters predominantly support younger victims and may not have the appropriate facilities and/or the staff did not have the appropriate training for older victims (Bloemen et al., 2019).

Some survivors may think that they are ineligible for services because intimate partner violence and sexual assault programmes because they appear to only service younger women and children (Crockett et al., 2018).

Saint Arnault and O'Halloran examined the healing journeys of 21 women, between the ages of 34 – 65, receiving domestic violence services in rural Ireland. More than half of these women did not seek help because it was inconvenient, unavailable, or they were prevented by external barriers (like transportation issues or getting time off work).

Over two-thirds of the women said that they faced structural barriers such as lack of information, financial barriers, and dissatisfaction with the care available. (Saint Arnault & O'Halloran, 2016)

Older women's healing from childhood sexual abuse carries specific generational considerations

Some people undergo healing from childhood abuse much later in life. Graham et al. (2022) explored older (60+) women's reflections on healing related to their childhood sexual abuse, and showed that some form of resolution was needed for the women to recover and move on from their experiences.

Agency over their disclosure was an important part of the healing process, with the women developing agency over if, and how they talked to people about their experience. Positive responses to disclosure were also an important part in the healing process (Graham et al., 2022). The study found that while participants did not need to disclose what had happened to them in order to heal, what was important was having agency over the decision of whether to disclose. Graham et al. (2022) established three main themes of healing through their research.

- Need for resolution - this could be through justice, or alternative routes to resolution.
- Thinking about the abuse differently - key strategies were reframing the experience and drawing upon positive life philosophies.
- Developing agency over disclosure - agency developed with time, and whether to disclose became a well-thought-out decision.

A significant barrier to healing for Older women was not being able to make sense of the experience. This led to continued influence of the negative feelings and memories (Graham et al., 2022).

Poor coping strategies that lead to worse longer-term outcomes included (Graham et al., 2022):

- withdrawing from people
- using alcohol and drugs
- engaging in dangerous sexual practices.

Respect for adults in their family, fear of the perpetrators, and uncertainty of the consequences meant that a lot of the participants did not disclose as children (Graham et al., 2022). Some of them also wanted to protect others, either physically

or from an emotional burden. In addition, many of the participants grew up in a "swept under the carpet" cultural era, and disclosed later in life, rather than at the time of the abuse.

Peer support benefits the healing process

Community-based programmes, and models where Older women can connect with their peers, have proven to be successful (Mears and Sargent, 2002; Mears, 2015 in Crockett et al., 2018). Loneliness and isolation may undermine the healing process, and peer support groups with other older people who have been through similar experiences creates a space for survivors to share their experiences in an affirmative and empowering way (Mears and Sargent, 2002 in Crockett et al., 2018).

Conclusion

Healing is understood differently by different groups of people, and this demands different responses, spaces, and services when facilitating and supporting healing for survivors, and perpetrators, of FVSV. The literature scan provided insights into this across a range of key groups in Aotearoa New Zealand. The key and overarching themes and areas for future research are summarised below.

Healing is a journey, not an outcome, and each journey has a unique cultural context

Across the literature reviewed, healing is regularly cited as a journey, not an outcome. This journey may begin with disclosure of violence, before help-seeking behaviours, and moving to immediate and short-term support. Healing in the context of FVSV continues further with a process of 'coming to terms' and reframing the experience, before seeking and potentially finding resolution – whether this be through forgiveness; the justice system; or other means.

A journey of healing for both survivors and perpetrators of FVSV is likely to look different depending on the cultural context from which the individual is coming from. Western notions of healing are yet to fully adapt and incorporate more holistic notions of health and wellbeing, which provide greater support for people from different cultures.

Healing is sourced from empowerment and agency

FVSV centres around patterns of behaviour that coerces, controls, or harms, within the context of a close personal relationship. Regaining control is a key part of healing.

Many groups that are traditionally viewed as vulnerable, or face paternalistic treatment in wider society, such as children, people with disabilities, and migrant women, identified having agency over decisions and the feeling of empowerment as a key element of regaining control over their lives.

Creating space for survivors of FVSV to regain agency and self-determination is beneficial for disclosure, help-seeking, and finding a sense of 'resolution' for survivors.

Connections to people, culture and culturally safe services support healing across all groups

Mainstream FVSV services tend to incorporate a Western concept of family and community, which is generally focused on the individual/s directly involved (rather than the wider family structure or community) and based on the assumption that FVSV occurs with a male perpetrator in cisgender heterosexual relationships. This concept of family further alienates cultures with extended family units where simply 'leaving' an abusive relationship is often not a viable option as it may include leaving an entire community as well.

A key theme across all groups is the importance of interpersonal relationships for healing from FVSV. This is particularly pertinent for those with experiences that differ from the mainstream or traditional view of FVSV, such as relationships within particular LGBTQIA+ communities, people with disabilities, or people who live within non-Western concepts of family and community. The empathy and understanding that can be gained from those connections appears to be invaluable to holistic healing.

The literature has consistently revealed that where people experience intersection of identity, the less likely their healing journey is to be well facilitated by supports available to them. Services that were created (or adapted) specifically for a particular group of people or community were generally found to better support healing. Approaches to healing such as group therapy, 'life skills' courses, talking circles and storytelling were effective in that they provided safe spaces for disclosure and healing; opportunities to reconnect to people and culture; and facilitated the building of networks to sustain ongoing support and healing.

There are structural and systemic barriers to healing for all groups

While healing from FVSV can be well facilitated with many of the above approaches and considerations, literature across this review cited structure and systemic barriers to healing for each identified key group.

Colonisation has and continues to play an immense role in preventing healing within non-Western communities. The patriarchal and white supremacist ideals packaged within colonial ideas and systems have, and continue to support, a wide range of structural and systemic barriers to healing from FVSV; whether that be through internalised shame and stigma stopping survivors from disclosing violence; to a distrust in and a lack of safe and appropriate immediate and medium-term support from government agencies; to preventing long term and generational healing from occurring due a lack of acknowledgement and action to provide redress for historical trauma and violence.

For healing to occur at the individual and collective level, systematic and structural change is vital.

More research is required on healing for key groups, particularly where the journey is stalled at help-seeking or reporting

Much of the literature reviewed acknowledged that healing from FVSV is a relatively under researched field; and while consistent evidence is emerging in some areas, more research is required to fully understand what healing looks like for different groups in the specific context of FVSV. Some suggestions for future research from the literature, and the authors include:

- the healing journeys of men who have experienced FVSV as children, particularly those from ethnic and Indigenous communities.
- healing journeys of perpetrators of violence outside of incarceration.
- healing journeys for ethnic women who have experienced violence, particularly in overcoming shame and stigma.
- healing journeys for Māori men who have experienced and/or perpetrated violence.
- healing for Pacific peoples from FVSV that is specific to the knowledge and culture of the particular ethnic group.
- healing journeys of children who have witnessed FVSV.

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Methodology

Following discussions with Oranga Tamariki, our team undertook a scan and analysis of relevant literature across academic and general research platforms, based on agreed search terms (see Table 1 below).
The data range for this brief was evidence and literature from 2013 onwards.

Table 1: Search terms

Search term 1	Search term 2	Search term 3	Search term 4
Family violence	Māori	People impacted by violence	Aotearoa New Zealand
Sexual violence	Children	People who use or have used violence	Australia
Healing	Young people/rangatahi		Canada
	Ethnic communities		Ireland
	LGBTQIA+		Scandinavian countries (e.g., Sweden, Finland)
	Older people/kaumatua		The Netherlands
	Pacific peoples		The United Kingdom
	Disabled People		The United States of America

The title and abstracts of initial returns were reviewed for relevance to the key research areas. A total of 63 documents – including research articles, government reports, and reports from relevant non-governmental organisations working in the FVSV space – were reviewed, forming the basis of this report.

Limitations

This review is a time-constrained examination that draws on a limited research base. The review is based on a search of literature available through the internet and library services. The most recent and relevant sources were reviewed, synthesised, and discussed. The review is primarily limited to English language documents. Documents in te reo Māori on the topic are limited. This review acknowledges that mātauranga Māori and tikanga (Māori knowledge and practices) are broadly held and not always available or easily accessible in written form. For this reason, further targeted evidence searches, and research is recommended.

Further, literature specific to cultural conceptualisations in the context of FVSV, was limited. For this reason, literature focused on culturally specific experiences of FVSV, and cultural conceptualisations of healing not necessarily limited to the FVSV context, have both been included to create a fulsome picture. This may mean that some of the descriptions of healing, while still informative and useful, have not all been developed with the context of FVSV in mind.