Sexual assault experiences of university students and disclosure to health professionals and others

Melanie A Beres, Zoran Stojanov, Katie Graham, Gareth J Treharne

ABSTRACT

AIMS: The aim of this study was to investigate the number and correlates of sexual assault among students at a campus-based university in Aotearoa New Zealand and to determine how often students disclose such experiences to health professionals, other services and family/friends.

METHODS: An online survey based on the Administrator-Researcher Campus Climate Consortium tool was emailed to all students at the main campus of a large university in Aotearoa/New Zealand. It was completed by 1,540 students (8.1% of those emailed) of any gender in July–August 2019.

RESULTS: During their time at university to-date, 28% of the sample had experienced at least one form of sexual assault with 14.9% reporting experiences that meet a definition of rape. Sixty-six percent of victims in the sample and 53% of the reported perpetrators had been using alcohol at the time of the assault. Only 8% of those reporting sexual assault in the sample disclosed the assault to a health professional.

CONCLUSIONS: Considering the low number of university students disclosing sexual assaults to health professionals or support services, the results of this survey suggest more work is needed to facilitate greater disclosures to health professionals enabling victims to access the services they need regardless of alcohol use.

Health professionals have the potential to play a central role in receiving disclosures and providing care for physical or emotional trauma relating to sexual assault. Surprisingly little is known about how common it is for university students to experience sexual assault, particularly in Aotearoa New Zealand, and whether they disclose these experiences to health professionals or other support services. Experiences of sexual assault are one of the most distressing issues that a patient may disclose to a health professional[1–4] and it is therefore pertinent to understand how likely it is that health professionals will receive such disclosures from university students they provide care for. In this study we conducted a cross-sectional survey of experiences of sexual assault among students at a large campus of a university in Aotearoa New Zealand, with a particular focus on who people told about their experience from a range of groups including health professionals. This study adds new knowledge by providing a description of the scope of sexual assault at universities in Aotearoa New Zealand thus providing an indication of how health, counselling and other support services can work to support people who have experienced various forms of sexual assault. Reporting rates for sexual assault are typically low, but health professionals are one of the most common groups to receive disclosures. For example, in a survey in one US city including a subsample of university students about 50% of victims reported telling mental health professionals, 27% told physicians and 14% told rape crisis centres.[5]

The last published study of sexual assault among university students in Aotearoa New Zealand was released in 1991.[6] A convenience sample of students enrolled

in an introductory psychology paper at one university were asked to complete the Sexual Experiences Survey. The sample consisted of 347 female students of whom 51% reported that they had ever experienced some form of sexual victimisation, including 14% who reported ever experiencing rape. In a 2019 study of the general population in Aotearoa New Zealand, 34% of women and 12% of men reported experiencing sexual assault at some point in their lives.[7] Māori reported the highest rate of experiencing sexual assault with 29% having experienced sexual assault compared with 26% of New Zealand European/Pākehā, 19% of Pacific Islanders, 12% of Asian respondents and 18.25% of people with 'other' ethnicities. For assaults within the last 12 months, 66% were reported by respondents between the ages of 16 and 29.[8] International research specific to university campuses reports that between 19 and 27% of female students experience sexual assault over the course of one year.[9,10] Other research demonstrates that higher rates of sexual assault are also experienced by people of minority genders[11] and sexualities.[12]

At least half of all sexual assaults occur in the context of alcohol consumption where either the victim, the reported perpetrator or both were drinking.[13] People who experience sexual assault when intoxicated are less likely to recognise their experiences as sexual assault,[14] more likely to blame themselves,[15] and more likely to experience psychological distress.[16] Asking about alcohol consumption is often part of inappropriate victim-blaming approaches to receiving disclosures which are experienced as secondary victimisation. It is important to instead ascertain if anything differs between sexual victimisation when the victim or the reported perpetrator have been drinking in order have good insight into the types of context victims are likely to report without implying any element of blame. Survey research with university students in Aotearoa New Zealand has shown that 21% of female students and 12% of male students have experienced unwanted sexual advances due to someone else's drinking over a four-week window.[17]

Sexual assault results in a range of health impacts on victims. These include physical injuries, sexually transmitted infections (STIs) and pregnancy. Also victims experience a range of psychological consequences including the potential for post-traumatic stress disorder (PTSD) and difficulties with studies for university students.[18] Sexual assault has significant impact on communities and the economy in Aotearoa New Zealand. In 2012/2013 the Accident Compensation Corporation (ACC) spent approximately $45 million on sensitive claims related to sexual assault.[19] This number is likely much higher now considering that the overall rate of sensitive claims has risen to 21 claims per day in 2018 compared to 11 in 2013.[20]

The research questions addressed in this article are: 1) How common is sexual assault victimisation among current university students in Aotearoa New Zealand and how often does this occur in the context of alcohol consumption? 2) Does frequency of sexual assault victimisation among university students differ by age, gender, sexuality and ethnicity? 3) What is the gender of those who perpetrate reported sexual assaults? 4) To which health professionals and services do university students disclose experiences of sexual assault?

Method

Design and procedures

A cross-sectional, retrospective campus-wide survey approach was applied. The survey was reviewed and approved by the ethics committee from the host institution. An initial invitation to complete the online survey was emailed to all students registered as studying at the main campus of one of the universities in Aotearoa New Zealand including undergraduates and postgraduates. The invitation was sent in mid-July 2019 soon after the start of the second semester, and two successive reminders were sent at the end of July and in early August. Participants were entered into a draw to win one of two $200 travel vouchers. The survey was referred to as the Campus Climate Survey as per previous research in this area[21] and was advertised using posters around campus, social media posts and publicly visible screens around campus. The survey was closed at the end of August 2019.

Measures

The Administrator-Researcher Campus Climate Consortium (ARC3) survey tool[21] was used. The original survey, developed in 2017 in the US, contains 19 modules that assess a range of violations, including sexual harassment, dating violence, and sexual assault victimisation and perpetration. Results presented here are from the ARC3 sexual assault victimisation module. This module is adapted from the Sexual Experiences Survey (SES),[22,23] used for over three decades to measure sexual victimisation among university students. After conducting a pilot test of the instrument, the response patterns in the *Sexual victimisation* module, were changed from *0 times, 1 time, 2 times* and *3+ times* to *Never*, *Once or twice*, *Sometimes* and *Often*, based on the feedback from pilot participants. The piloting process confirmed that the ARC3 was culturally appropriate for use in Aotearoa New Zealand. Respondents were asked specifically about experiences of sexual assault that occurred while they attended their current university. The data on experiencing sexual assault was collected through a set of questions asking for their possible experience of: sexual contact; non-consensual oral, anal or vaginal sex; or attempted non-consensual sex. The levels of severity were measured using statements indicating coercion (*Telling lies, threatening to end the relationship, threatening to spread rumours about me, making promises I knew were untrue or continually verbally pressuring me after I said I didn't want to; showing displeasure, criticising my sexuality or attractiveness, getting angry but not using physical force, after I said I didn't want to*) or rape (*Taking advantage of me when I was too drunk or out of it to stop what was happening; threatening to physically harm me or someone close to me; using force, for example holding me down with their body weight, pinning my arms or having a weapon*).

Respondents who reported experiencing some form of sexual assault were asked a series of additional survey questions including whether or not they sought professional help following their experience(s) of sexual assault and, if so, where they went for such help.

Respondents who indicated they have experienced at least one incident of sexual assault were asked if they had told anyone about the incident from: flatmate; romantic partner; close friend other than flatmate; parent or guardian; other family member; the Proctor's office; campus security; the office of student conduct; disability support services; doctor/nurse; mental health team member at student health provider; off-campus counsellor, psychologist or therapist; local police; religious leader; university faculty or staff; hall of residence staff; Rape Crisis.

The people respondents disclosed to were merged into broader categories. The category Friends/family consists of: *flatmate, romantic partner, close friend other than flatmate, parent or guardian* and *other family member*. The category health professional consists of: *doctor/nurse* and *mental health team member at student health provider*.

Participants were also asked a series of demographic questions. Respondents were categorised as cisgender (non-transgender) women, cisgender men or gender diverse based on the answers they provided to two questions: 1) *What sex were you assigned at birth (as listed on your original birth certificate)*? (Options: *Female, Intersex* and *Male*); and 2) *How do you currently identify your gender?* (Options: *Man, Woman, Transmasculine, Transfeminine, Transgender, Genderfluid, Gender queer* and *I use a different term to identify my gender*). Participants were categorised as gender diverse if they responded *Intersex* to the first question or indicated a transgender history or other gender-diverse identity based on the terminology used by Statistics New Zealand Tatauranga Aotearoa. Analyses of specific subcategories within gender diverse are not reported due to the small number of respondents with such gender identities in this survey.

Participants' sexual orientation was requested using the question: *How do you currently identify your sexual identity/sexuality? Check all that apply.* (Options: *Asexual, Bisexual, Demisexual, Gay, Lesbian, Pansexual, Queer, Straight, Takatāpui*, and *I use a different term to identify my sexual identity/sexuality*). A binary categorisation was used due to a small number of respondents with specific queer identities in this survey. Participants who only checked the option *Straight* were categorised as 'straight' and those who provided another response/combination were categorised as 'queer' based on reclaimed terminology used by the local student association.

Participants' ethnicity was requested using the question: *What term/s do you use to describe your ethnicity?* Responses were coded according to the Ministry of Education Ethnic Group Codes.[25]

Sample

A total of 1,623 students responded to the survey, which equates to a response rate of 8.1% of the approximately 20,000 students (with the exact number unknown as ethical requirements meant the email invitations were sent by central computing services). Initial data cleaning found and removed blank records (0% of questions completed) for 82 respondents (5.1%). The final sample of 1,540 consists of 1,165 (76.3%) cisgender women, 355 (23.1%) cisgender men, and 20 (1.3%) gender diverse people. Participants ranged in age from 18 to 72 with a mean age of 22.23 years (SD 5.71). Seventy-nine percent of the sample was between the ages of 18 and 23. Of the 1,540 participants, 1,127 (73.2%) identified exclusively as straight or heterosexual, with the other 413 (26.8%) identifying with at least one term associated with lesbian, gay, bisexual, pansexual or queer. The sample consisted of 1,000 (65.6%) participants of only New Zealand European/Pākehā descent; 165 (10.8%) participants of Māori descent, 53 (3.5%) participants of Pacific Island descent, 244 (16.0%) participants of Asian descent, and 62 (4.1) participants of other ethnicities. The sample breakdown and the comparison with the total university student population is presented in Table 1.

Table 1: Sample structure compared to the total university population.

Characteristic	Survey sample	University population
Gender		
Cis-women	1,165 (76.3)	12,588 (59.6%)
Cis-men	355 (23.1)	8,519 (40.3%)
Gender diverse	20 (1.3)	1 (.1%)
Total	1540	21078
Ethnicity*		
Pākehā	1,000 (65.6)	14,099 (71.4)
Māori	165 (10.8)	1,955 (9.9)
Pacific	53 (3.5)	928 (4.7)
Asian	244 (16.0)	4,048 (20.5)
Other	62 (4.1)	1,441 (7.3)
Total	1524	22471
Sexual orientation		
Straight	1127 (73.2)	No info
Queer	413 (26.8)	No info
Total	1540	N/A
Year of study		
1st	358 (23.5%)	4,023 (20.4%)
Bachelor excl. 1st	856 (56.2%)	10,654 (54.0%)
Post-grad	190 (12.5%)	3,670 (18.6%)
PhD	120 (7.9%)	1,399 (7.1%)
Total	1524	19,746

*Students who reported more than one ethnic group in the total university population category are counted once in each group reported. This means that the total number of responses for all ethnic groups can be greater than the total number of students who stated their ethnicities. Therefore, totals may be greater than 100%.

Data coding and analysis

Consistent with the recommended coding of the Sexual Experiences Survey (SES), reported experiences of sexual assault were categorised into six categories: non-victim, non-consensual sexual contact, attempted coercion, coercion, attempted rape and rape. The difference between the coercion and rape categories relies on the tactics used by the reported perpetrator. Coercion was non-consensual oral, anal, vaginal sex achieved by the reported perpetrator by telling lies, threatening to end the relationship, threatening to spread rumours about the victim, making promises the victim knew were untrue, by continually verbally pressuring the victim, showing displeasure, criticising the victim's sexuality or attractiveness or getting angry but not using physical force. Rape was defined as taking advantage of the victim when she/he was too drunk to stop what was happening, threatening to physically harm the victim or someone close to the victim, using force or having a weapon. Using the types of sexual assault outlined above a variable was created to assign participants to groups based on their most severe experience of sexual assault.

Data are reported as number and percentages within this sample. Inferential analyses testing differences in frequency of the categories of sexual assault experienced were conducted using chi square test of independence.

Results

Table 2 presents the number and percentage of respondents who reported each type of sexual assault. Almost 28% of respondents reported experiencing some form of sexual assault while at university. Almost one third of cisgender female respondents reported experiencing at least one form of sexual assault. Queer cisgender females were more likely to report experiencing sexual assault compared with straight cisgendered females ($X^2(2, N=1,165)=6.04$, $p<.05$). Sexual assault was twice as frequent among queer cisgender male respondents (over 1 in 5) compared to straight cisgender male respondents (around 1 in 10) ($X^2(2, N=355)=9.96$, $p<.01$). In addition, queer respondents were more likely to have experienced attempted rape or rape compared to the straight respondents ($X^2(5, N=1,540)=15.35$, $p<.01$).

Table 2: Reported cases of sexual victimisation among respondents by gender and sexual orientation.

	Cisgender women			**Cisgender men**			**Gender diverse**	**Total (%)**
	Straight (%)	**Queer (%)**	**Total (%)**	**Straight (%)**	**Queer (%)**	**Total (%)**	**Total**	
No victimisation	593 (69.8)	196 (62.2)	789 (67.7)	245 (89.7)	63 (76.8)	308 (86.8)	12	1,109 (72)
Non-consensual sexual contact	45 (5.3)	22 (7)	67 (5.8)	7 (2.6)	2 (2.4)	9 (2.5)	0	76 (4.9)
Attempted coercion	15 (1.8)	6 (1.9)	21 (1.8)	1 (0.4)	1 (1.2)	2 (0.6)	1	24 (1.6)
Coercion	21 (2.5)	5 (1.6)	26 (2.2)	0 (0)	1 (1.2)	1 (0.3)	2	29 (1.9)
Attempted rape	39 (4.6)	21 (6.7)	60 (5.2)	7 (2.6)	4 (4.9)	11 (3.1)	2	73 (4.7)
Rape	137 (16.1)	65 (20.6)	202 (17.3)	13 (4.8)	11 (13.4)	24 (6.8)	3	229 (14.9)
Total	850 (100)	315 (100)	1,165 (100)	273 (100)	82 (100)	355 (100)	20	1,540 (100)

Table 3: Most severe form of sexual victimisation among respondents by ethnicity.

	European descent (%)	Māori (%)	Pacific Island (%)	Asian (%)	Other (%)	Total (%)
No victimisation	700 (69.3)	115 (69.3)	39 (72.2)	201 (81.4)	48 (85.7)	1,103 (72)
Non-consensual sexual contact	55 (5.5)	8 (4.8)	2 (3.7)	9 (3.6)	2 (3.6)	76 (5.0)
Attempted coercion	14 (1.4)	3 (1.8)	2 (3.7)	3 (1.2)	2 (3.6)	24 (1.6)
Coercion	19 (1.9)	3 (1.8)	1 (1.9)	5 (2.0)	0 (0)	28 (1.8)
Attempted rape	51 (5.1)	10 (6.0)	2 (3.7)	7 (2.8)	3 (5.4)	73 (4.8)
Rape	171 (16.9)	27 (16.3)	8 (14.8)	22 (8.9)	1 (1.8)	229 (15.0)
Total	1,010 (100)	166 (100)	54 (100)	247 (100)	56 (100)	1,533 (100)

The associations between type of sexual assault and gender was significant (X^2(4, N=1,540)=51.59, p<.01). Cisgender male respondents were less likely to have experienced rape compared to the cisgender female respondents and less likely to have experienced coercion than the cisgender female and gender diverse respondents (Table 2).

The number of sexual assaults reported by Māori and New Zealand European/Pākehā respondents was equivalent, with 31% of each group reporting some form of sexual assault. 28% of Pacific Island respondents, 19% for Asian respondents and 14% for the respondents of other non-White/non-Polynesian ethnicities also reported some form of sexual assault (see Table 3).

In addition, respondents of Asian or other non-White/non-Polynesian ethnicities were less likely to have reported rape specifically compared to the respondents of New Zealand European/Pākehā, Māori or Pacific ethnicities (X^2(8, N=1,533)=23.80, p<.01). No other differences related to ethnicity were found.

A majority of respondents (88.6%) who reported sexual assault indicated that the assaults were committed by male perpetrators. Male perpetrators were reported in 98.2% for female victims, 22.2% for male victims and 6/8 of gender diverse victims. Of the queer respondents who reported victimisation 97.6% of queer female victims and 12/21 of queer male victims reported male perpetrators. Over 60% of perpetrators and 72.1% of those reporting victimisation were under the influence of alcohol or drugs at the time of the assault (see Table 4).

Table 4: Use of alcohol or drugs by the reported perpetrator or the victim.

Use of alcohol or drugs	**Perpetrator (%)**	**Victim (%)**
Had been using alcohol	279 (62.1)	322 (71.7)
Had been using drugs	44 (9.8)	24 (5.3)
Had been using both alcohol and drugs	40 (8.9)	22 (4.9)
Had not been using either alcohol or drugs	74 (16.5)	125 (27.8)
Not known	92 (20.5)	N/a
Total	449 (100)	449 (100)

Out of 431 participants who reported experiencing any type of sexual assault, 178 (41.3%) told no one about their experience, 179 (41.5%) told one supporter, 74 (17.2%) told two or more supporters. Type of supporter that victims disclosed to is presented in Table 5.

Respondents who reported victimisation were asked who they told about the incident, and were able to report more than one response. The numbers in Table 5 refer to the number of disclosures reported, not the number of respondents reporting victimisation. Respondents reporting victimisation were most likely to disclose their experience to friends and/or family members (45.3%). If victims told more than one person about their experience family and/or friends followed by health professionals were most likely to receive the disclosure. Health professionals, other services within the university, and off-campus services were less likely to receive disclosures (42, 39 and 36 respondents respectively) while nine respondents disclosed their experience to the university's sexual violence support service.

Discussion

This study replicates and expands on a study from 1991 [6] that surveyed sexual assault victimisation and perpetration at university in Aotearoa New Zealand. The results suggest that 28% of respondents have experienced some form of sexual assault during their time at university. Women, and sexual minority respondents were over-represented as victims and men were identified as the majority of perpetrators. In our sample, New Zealand European/Pākehā and Māori participants reported the highest rates of sexual assault. Few respondents reported seeking medical or health support, including mental health support. These results are consistent with international literature on sexual assault at universities.[9,21]

Considering the high number of reports to family and friends there is potential for medical professionals to provide 'secondary support' to those who have received disclosures from others. This pattern of non-disclosure is likely to relate to feelings of shame, uncertainty about how the disclosure will be handled, and concerns about secondary traumatisation.[26] Future research could explore these reasons for non-disclosure in depth with university students. Increasing training for health professionals about how to open up conversations around sexual assault may facilitate increased disclosures to health professionals.

Of note, the number of cases where it was reported that alcohol had been consumed by the victim and the perpetrator at the time of the reported sexual assaults is high but is consistent with other research in university settings.[13] Those who experience sexual assault while intoxicated are more likely to be distressed and blame themselves,[14,15] which may inhibit disclosure to a health professional and needs to be handled in a way that avoids victim-blaming when disclosure does occur. Increased training in the dynamics of alcohol facilitated sexual assault could also improve medical professional's response to sexual assault disclosure and encourage increased disclosure.

Table 5: Number of disclosures to different types of supporters.

Supporter category	Total number (%)	Number who disclosed to a health professional (%)
Friend/family	252 (45.3)	41 (9.1)
Health professional	42 (7.6)	N/a
Other university service*	39 (7.0)	20 (4.6)
Off campus service	36 (6.5)	18 (4.2)
University sexual violence support service	9 (1.6)	6 (1.4)
Nobody	178 (32.0)	N/a

*Other than the university sexual violence support service.

Strengths and limitations

The intention was to conduct a representative cross-sectional survey to better understand the sexual assault experiences of students. This was not fully achieved due to the low response rate, which resulted in a self-selected sample. While the study was advertised extensively through emails directly to students and posters around campus the response rate is still low. The percentages reported in this study cannot be read as prevalence statistics for the whole student population. However, the results presented here do provide contemporary information that is highly relevant to understanding the scope of the problem of sexual assault on campus and the results are consistent with studies on other campuses using the same methodology,[21] suggesting that the problem of sexual assault on campuses in Aotearoa New Zealand is similar to the problem in other countries. In addition, the survey method was limited by being cross-sectional and retrospective in nature. Future surveys could use oversampling approaches for subgroups such as gender-diverse people or ethnic groups to provide better representation of the total student population, and apply targeted sampling methods to attempt to achieve a more representative sample.

Conclusions

Understanding sexual assault victimisation and perpetration is important in order to better support the needs of those impacted by sexual assault as part of an overall approach to preventing the occurrence and impact of sexual violence.[27] Considering the low number of victims accessing support services, including health services, the results of this survey suggest more work is needed to assist clinicians and other support providers to recognise potential warning signals around sexual assault and to open up conversations that may facilitate disclosures from university students and others who have experienced sexual assault. Simultaneously, it would be helpful to work with the student community in making them more aware of relevant health services who can support victims of sexual assault.

Competing interests:
Nil.

Author information:
Melanie A Beres, Associate Professor, Te Whare Tāwharau, University of Otago, Dunedin; Zoran Stojanov, Assistant Research Fellow, Te Whare Tāwharau, University of Otago, Dunedin; Katie Graham, Assistant Research Fellow, Te Whare Tāwharau, University of Otago, Dunedin, Gareth J Treharne, Associate Professor, Department of Psychology, University of Otago, Dunedin.

Corresponding author:
Dr Melanie A Beres, Associate Professor, Te Whare Tāwharau, University of Otago, Dunedin.
melanie.beres@otago.ac.nz

URL:
www.nzma.org.nz/journal-articles/sexual-assault-experiences-of-university-students-and-disclosure-to-health-professionals-and-others

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