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Understanding the pregnancy, birth, early motherhood and maternity care experiences of survivors of sexual violence in adulthood

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Understanding the pregnancy, birth, early motherhood and maternity care experiences of survivors of sexual violence in adulthood.

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Acknowledgements

Too many wonderful people have supported me with this work to thank them all here. But you know who you are, and I will find a way to thank you individually. I do want to say how deeply grateful I am to my three incredibly supportive supervisors, Dr Siân Oram, Dr Elsa Montgomery and Dr Angela Sweeney. I am in awe of your generosity, kindness and brilliance. Above all, thank you for listening to my views and valuing my perspective. That meant the world to me.

To every survivor I met during this research, thank you for trusting me with such an important and personal part of your life. This research would of course not be possible without you, and I hope I have done your experiences, your knowledge, and your strength justice. I wish to thank Susanna Alyce, Sophie Olson (The Flying Child) and Jo who took part in the public engagement workshops, as well all the other survivors who participated but did not wish to be named. The workshops would not have been possible without Jane Chevous from Survivors Voices – your authenticity and passion are truly inspirational. I hope we can continue to work together.

Finally, thank you to Tom, my partner, for your belief in me, your kindness and endless patience.

This thesis is dedicated to Ginger.

Abstract

Background:

Due to its profound and long-lasting health impacts, sexual violence is a global public health concern and UK healthcare priority. Sexual violence is prevalent among women yet shrouded in silence and poorly understood. Rooted in gender inequality, sexual violence includes sexual assault and rape as well as more subtle, hidden sexually coercive behaviours intended to exert power and control. Clinical and policy support for a trauma-informed, strengths-based approach to maternity care is increasing as research suggests that survivors can be re-traumatised by aspects of pregnancy, birth, early motherhood and maternity care. However, the evidence base currently focuses on vulnerability, overlooks systemic and structural issues, and lacks survivor involvement. To address these gaps in the literature, my survivor-led PhD used a trauma-informed lens and framed survivors as embodied, situated agents. From this position, my thesis explored: (1) sexual violence survivors' experiences of pregnancy, birth, motherhood and maternity care, and (2) experiences and needs among maternity care providers in relation to supporting survivors.

Methods:

This PhD is an example of survivor-led research: I conducted this research from an explicit standpoint of myself being a survivor of sexual violence and my work was guided by survivor research ethics and epistemology. As involvement and collaboration lie at the heart of trauma-informed approaches, I consulted and worked in partnership with survivors and maternity care providers throughout.

I completed three qualitative studies. In study one, I conducted a meta-ethnography and systematic review of 38 qualitative studies about healthcare experiences and expectations among female adulthood sexual violence survivors. In study two, I conducted a thematic

narrative analysis of 11 unstructured interviews with women survivors of sexual violence in adulthood. In study three, I conducted a reflexive thematic analysis of semi-structured interviews with 13 maternity care providers.

Findings:

In the systematic review meta-ethnography, I explore three themes describing how safety and trust can be built in healthcare. These were: (1) Acknowledgement: shifting shame and blame, (2) Being Seen: respect, validation and responsiveness and (3) Being Heard: choices, empowerment, and shared decision-making. A key finding was that reciprocity (providers trusting women and showing women they were trustworthy) was essential to building trust in healthcare.

In the narrative study with survivors, I present four themes that describe women survivors' experiences of pregnancy, birth, early motherhood, and maternity care. These were: (1) 'The most empowering moment of my life', (2) 'Something weird and wrong', (3) 'I was just a body' and (4) 'It's about so much more than just saying it'. Pregnancy, birth and motherhood created opportunities for women to heal from the impacts of sexual violence. However, dehumanising care disrupted the healing potential of this time. Providing women-centred care needed to foreground values of kindness, empathy and respect that helped survivors feel safe enough to connect with and communicate their needs and wishes.

In the qualitative study with maternity care providers, I consider three themes that describe maternity care providers' experiences and needs relating to supporting survivors. These were: (1) A window of opportunity for healing and harm, (2) creating safety in the face of uncertainty and (3) caught between women and the system. Providers in this study were deeply committed to supporting survivors but felt constrained by a system that prevented the delivery of trauma-informed, individualised and relational care.

Conclusions and implications:

Placing survivors’ priorities at the heart of research is critical to designing services that meet survivors’ needs. As the first survivor-led study about survivors’ experiences of pregnancy, birth, motherhood and maternity care, my research made a significant contribution to a field dominated by biomedical approaches and lacking survivor involvement. Existing research largely focuses on vulnerability, highlighting risks of survivors ‘re-experiencing’ trauma and largely overlooking opportunities for healing. Situating my study within feminist work on embodied subjectivity, my research highlighted the harms caused to survivors by a biomedically-dominated health system and how this could mirror the dehumanisation and silencing of sexual violence. Additionally, my research emphasised that, for some survivors, the perinatal period presented significant and unique opportunities to re-build embodied and relational safety after sexual violence. However, healing had to be supported by care that foregrounded trust, choice, empowerment and empathy. Maternity care providers in my research wanted to deliver care in alignment with trauma-informed values but felt constrained by a system predicated upon reductionism and standardisation. Sexual violence is prevalent among those using maternity and perinatal services, but providers lack of systemic support to deliver trauma-informed care, indicating a need to implement trauma-informed approaches in maternity care. Future research and policy must address the systemic factors that shape survivors’ experiences, and place survivors’ voices at the centre.

Glossary

Term	Definition
Alienation	As defined by Young (1984), alienation is when a person’s experience or action “is defined or controlled by a subject who does not share one's assumptions or goals” (p. 55).
Dualism	Dominant accounts assume that the self – or subjectivity – exists independent of a person’s social context (Brison, 1996/2022). Dualist accounts assume that the ‘thinking’ mind can be separated from the fleshy, material body (Brison, 1996/2022; Chadwick, 2018; Descartes, 1970).
Epistemically transformative experience	An experience that gives a person access to (experiential) knowledge they could not have gained through other means (Paul, 2014; Woollard, 2021).
Mainstream research	Mainstream research refers to research underpinned by positivist assumptions “which bases its claims for knowledge production on the belief that it is ‘value free’ and ‘objective’” (Rose, 2017, p. 784).
Medicalisation	I use Chadwick’s (2018) definition of medicalisation as an ontological framing and a way of thinking about pregnancy and birth “in which birthing bodies materialise as medical objects, birth becomes a

Term	Definition
	medical event, technology is valorised over embodied knowledge and the social and personal significance of birth is erased" (p. 27).
Minoritised	This term was coined by Gunaratnum (2003) to emphasise that people do not passively exist as a minority (as implied by terms like 'ethnic minorities') and to highlight that minoritisation is a social process shaped by power.
Objectification	Objectification is when "one is treating as an object what is really not an object, what is, in fact, a human being" (Nussbaum, 1999, p. 218).
Patriarchy	I use the following definition of patriarchy "a system in which male and female, masculine and feminine, and men and women are held in binary and hierarchical opposition with one another—where women are positioned as "other" and inferior to men" (Kelland, 2014, p. 2777; see also Kelland, 2011).
Re-traumatisation	Re-traumatisation means to become traumatised again "when something in a present experience is redolent of past trauma" (Sweeney et al., 2018, p. 322).
Reductionism	An assumption underpinning the biomedical model in which "parts are viewed as independent of the whole" and therefore "parts can

Term	**Definition**
	be disconnected from their context without affecting their identity" (Ashcroft & Van Katwyk, 2016, p. 144).
Sexual violence (SV)	The World Health Organisation (WHO) defines sexual violence as: "any sexual act, attempt to obtain a sexual act, unwanted sexual comments or advances, or acts to traffic, or otherwise directed, against a person's sexuality using coercion, by any person regardless of their relationship to the victim, in any setting, including but not limited to home and work" (Jewkes et al., 2002, p. 149).
Survivor research	Survivor research is conducted by survivors (of trauma and/or mental distress) from an explicit survivor perspective (Sweeney et al., 2009). It can be defined as "the methodical and disciplined exploration of phenomena important to survivors, based on shared experiences and perspectives, leading to new collective and transferable knowledge" (Slade & Sweeney, 2020, p. 389).
Trauma-informed approaches (TIA)	Trauma-informed approaches are an organisational change process, focused on preventing (re)traumatisation within services (Sweeney & Taggart, 2018). Trauma-informed approaches are distinct from trauma-specific services (e.g., trauma-focused cognitive behavioural therapy). Trauma-specific services may not necessarily be trauma-informed (Sweeney et al., 2016; Sweeney & Taggart, 2018).

Term	Definition
Women-centred care	The World Health Organisation recommends that all healthcare providers be trained in women-centred care as a form of first-line support (World Health Organisation, 2013). Women-centred care respects a woman's right to decide on her own pathway to safety and recognises that women need responses tailored to their level of acknowledgment of the violence, the type of violence, and the level of care they are accessing (García-Moreno et al., 2015a).

Abbreviations

ASA – Adulthood Sexual Violence and Abuse (adulthood defined in my thesis as age 16 or older)

CASP – Critical Appraisal Skills Programme

CSA – Childhood Sexual Abuse

DVA – Domestic Violence and Abuse

IPV – Intimate Partner Violence

IPSV – Intimate Partner Sexual Violence

MCoC - Midwifery Continuity of Carer Model

SV – Sexual Violence

TIA – Trauma-Informed Approaches

Chapter 1. Introduction

"Trauma matters. It shapes us. It happens all around us. It destroys some of us, and it is overcome by many of us. To ignore it is to ignore who we are in all our complexity."
(Filson, 2016, p. 20)

Guided by a trauma-informed perspective, my research explores experiences of pregnancy, birth, motherhood and maternity care among sexual violence survivors from a standpoint of myself being a survivor of sexual violence. This research has therefore been done not only *for* survivors, but *by* and *with* survivors (Sweeney et al., 2009). Sweeney and Taggart (2018) argued that researchers must "place survivor knowledge at the heart of the development and implementation of trauma-informed approaches" (p. 385). My thesis attempts to answer this call by foregrounding survivors' voices in my research. I also explore maternity care providers' experiences and needs with regards to supporting survivors because tackling systemic barriers and facilitators to delivering good care is critical to the implementation of trauma-informed care (Sweeney & Taggart, 2018).

My introductory chapter contains three main sections. I begin by locating my work within trauma-informed approaches and the survivor research movement. I then discuss how my explicit survivor standpoint shapes this thesis' contribution to knowledge. I make my survivor standpoint transparent early on because it is essential to understanding my approach, my findings and my contribution to knowledge. I end this chapter with defining key terms and justifying my language and terminology.

1.1 Situating the thesis within trauma-informed approaches and the survivor research movement

It is being increasingly recognised that survivors can experience harm when they use services (Oram, 2022). Interest in applying trauma-informed approaches to (TIA) maternity care is therefore increasing (e.g., Blackpool Better Start, 2021; Sperlich et al., 2017). TIA are designed to meet the needs of survivors of violence, trauma and abuse, regardless of whether trauma is disclosed (Sweeney et al., 2016). By “seeing through a trauma lens”, TIA represent a conceptual shift from asking ‘what’s wrong with you?’ to ‘what happened to you?’ (Elliott et al., 2005; Sweeney et al., 2018, p. 324). In TIA, the prevalence and impact of violence, trauma and abuse among both staff and service users is acknowledged, and, most importantly, survivors become partners in evaluating and designing services and research (Elliott et al., 2005; Sweeney et al., 2018). Although relationships are central to TIA, a focus on reductionism, standardisation and efficiency in health systems often leads to a failure to nurture relational aspects of care (Sweeney et al., 2018; van der Kolk et al., 2005). Implementing trauma-informed care therefore requires systems-level change to address the epistemic and power inequities that facilitate and perpetuate re-traumatising care practices (Elliott et al., 2005). To address these inequities, experiential knowledge held by survivors should be placed at the heart of all research about TIA (Sweeney & Taggart, 2018). My explicit survivor standpoint is therefore wholly consistent with TIA (Elliot et al., 2005; Filson, 2016; Sweeney et al., 2018).

In my work, I draw inspiration from survivor researchers who have challenged dominant norms about “who gets to study whom” and the hierarchies of knowledge that underpin this belief (Sweeney & Beresford, 2019, p. 1189). It is often overlooked that survivor activists and survivor researchers were fundamental to the development of TIA (Filson, 2016). Empirically, survivor researchers use their own and participants’ lived experience to highlight system harms caused by silencing, ‘power over’ approaches to care (Sweeney et al., 2009, 2019). Theoretical work by survivor researchers dismantles the dominant positivist assumptions that facilitate disempowering approaches to care and serve to exclude and devalue service users’ experiential knowledge (e.g., see Beresford, 2005, 2009; Rose, 2009,2017; Russo & Beresford, 2015). Acting as a “countervailing force to experts’ control and reproduction of knowledge” (Rogers & Pilgrim, 2003, p. 186), survivor-produced knowledge therefore tends to challenge normalised, hidden and invisible harms caused by services, as well as causes of harm, such as biomedical dominance (Brunner, 2019; Sweeney et al., 2009).

Before I discuss how the survivor research movement applies to my research on pregnancy, birth, early motherhood and maternity care, it is important to first outline my understanding of the meaning of the biomedical model and its impact on perinatal research and services. In the biomedical model, ‘illness’ is understood to exist independently of the person and thus can be identified as a biological pathology that, once identified, can be treated (Ashcroft & Van Katwyk, 2016; Faulkner, 2017). Reductionism therefore underpins the biomedical model, which is an assumption that “parts are viewed as independent of the whole” and therefore “parts can be disconnected from their context without affecting their identity” (Ashcroft & Van Katwyk, 2016, p. 144). Reductionism manifests in clinical practice primarily through the diagnostic model which is predicated on the assumption that everyone with the same diagnosis “has the same disease” (Faulkner, 2017, p. 502).

As I will discuss further in Chapter 3, in Western society, the dominance and acceptance of positivism means that reductionist (or ‘objective’) knowledge has significantly greater power than ‘subjective’ knowledge gained through lived experience (Faulkner, 2017). This cultural devaluing of experiential knowledge intersects with people’s social locations to devalue some people’s experiential knowledge more than others. In particular, when a person is labelled as ‘mentally ill’, their experiential knowledge is seen as holding even less value than those without this label, as in the biomedical model to be ‘mentally ill’ means to lack both insight and rationality (Slade & Sweeney, 2020). Building on the work of Foucault (1967), survivor researchers have therefore argued that consequently service users are seen as incapable of contributing to knowledge or producing their own knowledge (Sweeney et al., 2009), which has led to the systematic exclusion of survivors’ voices from knowledge production (Sweeney & Beresford, 2019; Wallcraft, 2009).

The biomedical paradigm is so pervasive and influential that clinicians, researchers and even service users take it as truth rather than seeing it as a social construction (Davis-Floyd & Sargent, 1997). For instance, Ashcroft and Van Katwyk (2016) state “the biomedical paradigm … is the current centrepiece of contemporary Western medicine … it has an enormous impact on how health is viewed and addressed” (p. 144). Assumptions that healthcare is a benevolent context (Shabot, 2021), that valid, credible knowledge must be ‘objective’ (Faulkner, 2017), and that people experiencing mental distress lack rationality and insight (Slade & Sweeney, 2020) intersect to devalue, dismiss and exclude service users’ voices. As a result of these ingrained cultural assumptions that prioritise reductionist, medical knowledge over experiential knowledge, mental health service users are silenced further and continue to be subjected to approaches to care that harm them (Sweeney et al., 2009).

Although my thesis is not about the mental health system (which is the focus of most survivor research), my explicit survivor standpoint and my aim to amplify survivors’ voices also serves to challenge positivist, reductionist and biomedical ideas that deem some types of knowledge more credible than others. Furthermore, I will discuss in Chapter 3 that pregnant and birthing people have also historically been treated as lacking rationality and credibility and that their voices have been devalued and overlooked as a result (Brison, 1996/2022). Although the level of dismissal is qualitatively different – a diagnosis of pregnancy does not, for instance, label someone as completely incapable of rational thought in the way a mental health diagnosis can (Wallcraft, 2009) – I do argue that there are important learnings from survivor research that can be applied to a perinatal context. Having this understanding also highlights that the intersection of mental distress and pregnancy/birth/motherhood may work to devalue a survivor’s voice in complex, overlapping ways.

Feminists have long argued that the medicalisation of pregnancy and birth in Western society turns a potentially empowering experience into an oppressive one (Davis-Floyd 1992; Kitzinger

1984, 2013; Martin 1987; Oakley 1980; Rothman 1982/1991). In my thesis, I consider medicalisation to be a process that devalues women and birthing people's voices through treating pregnancy and birth as if they are pathological events, reducing women to body parts to be monitored and checked, and prioritising clinician's assessments and convenience over women's own embodied knowledge (Simonds, 2002; Young, 1984). Everything that can make pregnancy, birth and motherhood an incredibly emotive, potentially empowering, and personally significant experience is thus lost when women become 'patients'. Like Garry (2001), I consider there to be important differences between medicalisation and medicine, and I agree with their assertion that "one can desire medicine without desiring medicalisation" (p. 262; see also Chadwick, 2018). Rather than seeing all medical intervention as oppressive, I use Chadwick's (2018) definition of medicalisation as a way of thinking about pregnancy and birth "in which birthing bodies materialise as medical objects, birth becomes a medical event, technology is valorised over embodied knowledge, and the social and personal significance of birth is erased" (p. 27).

In this thesis, I will argue that, for survivors of sexual violence, being reduced in this way can feel similar to the dehumanisation and objectification of sexual violence; particularly the uniquely harmful way that sexual violence "reduces the victim to flesh" (Brison, 1996/2022, p. 318). Through recognising and prioritising survivors' lived experience and critiquing the biomedical assumptions that dominate health research and maternity care, I argue that we can work towards designing systems and services that truly meet survivors' needs. Although I prioritise survivors' perspectives in this work, I also include maternity care providers' experiences, partially because in line with trauma-informed approaches system-wide transformation must target every level (Sweeney et al., 2018).

1.2 My explicit survivor standpoint and contribution of the thesis

Although attention to understanding survivors' experiences of maternity care is increasing (Montgomery, 2013; Sperlich et al., 2017), my thesis is, to my knowledge, the first explicitly survivor-led study examining sexual violence survivors' experiences of pregnancy, birth, early motherhood and maternity care. My survivor standpoint is critical to understanding my approach and findings, so it is important that I unpack this early on. Survivor-led research differs in several ways from mainstream (positivist) research[1], including qualitative research which can be just as harmful as biomedical research if "used in the 'wrong' way" (Faulkner, 2017, p. 507). In theory, both qualitative research and survivor research reject positivist assumptions that knowledge must be 'objective' to be valid (Braun & Clarke, 2019a, 2019b, 2020; Sweeney et al., 2009). However, due to its dominance, positivism can shape knowledge production even within qualitative research studies (Braun & Clarke, 2019a, 2019b; Faulkner, 2017). Consequently, researchers may collect qualitative data but analyse and interpret these data within positivist (biomedical) frameworks (Braun & Clarke, 2020). Therefore, although studies may deal with different types of data, they are shaped by the same positivist assumptions.

Due to its explicit survivor standpoint, survivor-led research also differentiates my research from reflexive, interpretive qualitative research. Because of their experiential knowledge and explicit social justice aim, survivor researchers may choose different topics, generate different data, and

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[1] In my thesis, mainstream research refers to research underpinned by positivist assumptions "which bases its claims for knowledge production on the belief that it is 'value free' and 'objective'" (Rose, 2017, p. 784).

produce different interpretations compared to other researchers (Sweeney, 2009). For instance, survivor researchers make their identity transparent to participants, and since narratives may be shaped by who is listening (Riessman, 2008), this may lead to different data. Survivor-led research may also lead to different interpretations, as survivor researchers may draw on their own experiential knowledge about violence, abuse, trauma and services to interpret data and enrich the findings (Sweeney, 2009). For instance, one study found that non-survivor researchers coded qualitative interview transcripts largely in terms of processes and procedures whereas survivor researchers who coded the same transcripts focused on interviewees' own feelings and experiences (Gillard et al., 2010). On a theoretical level, Rose (2009, 2017) has drawn on feminist standpoint theory (Harding, 2004) to argue that survivor researchers' dual identity may mean they are uniquely positioned to understand and explain other survivors' experiences on a broader and more nuanced level.

Survivor research therefore comes from an epistemological perspective that "flies in the face of traditional research" (Beresford, 2005, p. 4) and challenges "what we think we know" (Faulkner, 2017, p. 501). Because of these unique characteristics, survivor research leads to the production of a different kind of knowledge (Rose, 2017; Sweeney et al., 2009, 2019). My explicit survivor standpoint and survivor-led epistemological framework thus differentiates my research from existing research in this field. My survivor standpoint is therefore central to my unique contribution to knowledge and cannot be separated from the findings and interpretations that I present in this thesis. Having established how the survivor research movement relates to my work, and why my explicit survivor standpoint is central to understanding my unique contribution to knowledge, I will now provide an overview of definitions, language and terminology used in this thesis.

1.3 Definitions, language and terminology

1.3.1 Defining sexual violence

Although other definitions of sexual violence exist (e.g. see Basile & Smith, 2011), I will use the broad definition of sexual violence proposed by the World Health Organisation: "any sexual act, attempt to obtain a sexual act, unwanted sexual comments or advances, or acts to traffic, or otherwise directed, against a person's sexuality using coercion, by any person regardless of their relationship to the victim, in any setting, including but not limited to home and work" (Jewkes et al., 2002, p. 149). I chose this definition because it includes sexually coercive behaviours that are intended to intimidate and exert power and control but may not meet legal definitions of rape or sexual assault. Using this broad definition treats sexual violence as a tool to maintain or assert power, control and dominance, and locates instances of sexual violence within a wider culture of gender inequity (Burt, 1980; Johnson & Johnson, 2021; Lonsway & Fitzgerald, 1995). It is important to allow for this flexibility because as Herman (1997) argued, "the standard for what constitutes rape is set not at the level of women's experience of violation but just above the level of coercion acceptable to men" (p. 235). In line with trauma-informed and survivor-led approaches, this definition is therefore flexible enough to remain sensitive to survivors' own understandings about what sexual violence is (Sweeney et al., 2009, 2019).

1.3.2 Defining adulthood

This thesis focuses on survivors of adulthood sexual violence and/or abuse. I focus on adulthood sexual violence because the majority of the existing literature focuses on childhood sexual abuse, although even this literature is relatively small (Montgomery, 2013). Types of sexual violence experienced in adulthood may include rape or sexual assault from strangers, acquaintances, friends, family members and partners as well as forced prostitution, sex trafficking, sexual harassment and forced early marriage (Jewkes et al., 2002; Watts &

Zimmerman, 2002). Adulthood sexual violence has been defined differently across different settings, with existing literature using a variety of cut-offs to represent ‘adulthood’. In England and Wales, The Office for National Statistics uses age 16 (Office for National Statistics, 2021); in their international research the WHO uses age 15 (World Health Organisation, 2013, 2021), and some studies use age 18 (Tjaden, 2000). I use age 16 and older to indicate adulthood, as this is the legal age of consent in England where my research was conducted. However, although all the women who took part in my research had experienced adulthood sexual violence, most participants in both the systematic review (Chapter 5) and survivor study (Chapter 6) had been subjected to multiple, overlapping experiences of sexual violence, including childhood sexual abuse, as well as other types of abuse at different points in their lives, reflecting most survivors’ experiences (Sweeney et al., 2019).

1.3.3 Defining early motherhood

My thesis focuses on pregnancy, birth, early motherhood and maternity care. I define early motherhood as the first 6 weeks post-birth, because this is when women in the UK usually receive their post-natal check (National Health Service, 2022).

1.3.4 Avoiding pathologising language

My research is explicitly survivor-led and is located within a trauma-informed framework. This means that I use language that avoids pathologising mental distress (Sweeney et al., 2009), Instead, I take a strengths-based approach and I consider responses to violence and abuse to be adaptive (Herman, 1997; Sweeney et al., 2018). I also consider the biomedical model and associated diagnostic model to be socially constructed and predicated on assumptions that pathologise those experiencing distress (Faulkner, 2017; Sweeney et al., 2018). Recognising the harms that pathologisation can cause (Sweeney et al., 2009), I avoid language associated with the biomedical model where possible and instead use non-pathologising terms favoured by survivor researchers, including “survivor”, “mental distress” and “service user” (Beresford, 2002, p. 582; Plumb, 2012, p. 20; Tew, 2011, p. 5). If I need to speak about diagnoses or disorders, I use language that recognises that these labels are assigned to people and are socially constructed (Faulkner, 2017).

1.3.5 Using the term ‘survivor’

Naming is a political act because our language gives meaning to the experiences we describe (Kelly et al., 1996). I use the term ‘survivor’ interchangeably with ‘women’ in this PhD. I recognise that the label ‘survivor’ does not resonate with everyone, that people cannot be easily dichotomised into ‘victims’ or ‘survivors’, and people may move between these identities (Boyle & Rogers, 2020). Originating from the scholarship of Black feminist theologian Traci West (1999; see Jean-Charles, 2014), some have chosen to use the label ‘victim-survivor’ to allow for nuance, fluidity and holding multiple identities, thus addressing the individual limitations of each term (Jean-Charles, 2014). Some have also cautioned against using labels like ‘survivor’, arguing that “these words suggest a kind of person rather than an act or experience” (Khan et al., 2018, p. 453).

Overall, there is a lack of consensus in the literature on which terminology to use. I therefore make my reasoning clear below. Importantly, my use of ‘survivor’ is not intended to imply a hierarchy of recovery, strength or healing as others have argued (Khan et al., 2018), although I recognise that these associations are held in society (Papendick & Bohner, 2017). Within a trauma-informed framework, all responses to violence, abuse and trauma are seen as adaptive and valid ways to cope (Sweeney et al., 2018). Thus, in this account the term ‘survivor’ labels the violence that a person has been subjected to, not the way they have coped with this violence. Some survivors may use their experiences of violence as fuel for personal growth or collective action, but recognising this as an achievement *for that individual* does not and should not devalue other ways that people may choose – or be forced – to survive abuse. Similarly, in survivor research, the label ‘survivor’ is used to name, as violence, the often-invisible ways that services harm and re-traumatise service users, and the intersections between different systems of harm (e.g., institutions, social structures, discrimination; Brunner, 2019; Plumb, 1993). The label ‘survivor’ is therefore used in this field, and in my thesis, as an epistemic intervention (Chadwick, 2021b) to counteract the normalisation of coercive, dismissive and harmful treatment of service users within health systems and to name systemic harm.

The survivor research movement has largely focused on challenging and naming psychiatric harm (e.g., Sweeney et al., 2009). In this thesis, I focus on a different context – the maternity care system – but I have a similar aim. In my work, I aim to make visible the invisible harms caused by health systems to sexual violence survivors and highlight how these harms may mirror the harms of sexual violence. I also explore harms caused to providers and survivor-providers – a critical component of trauma-informed approaches (Sweeney et al., 2018). In my work, I aim to challenge assumptions that silence survivors, such as assumptions that healthcare is a benevolent context in which actions, behaviours and staff cannot be violent or abusive (e.g., Shabot, 2021). My use of ‘survivor’ therefore highlights both the multiple and overlapping harms caused to survivors by sexual violence and how these harms are perpetuated and re-created by people and systems who are meant to provide support. In many ways, my approach overlaps with literature on obstetric violence, as feminist scholars in this field also aim to explicitly name the normalised, hidden and invisible ways that birthing people are harmed by maternity systems as violence (Chadwick, 2021a). Lastly, I use the term ‘survivor’ to recognise that not everyone survives. I started this chapter with a quote by survivor and activist Beth Filson in which she states that “trauma… destroys some of us” (2016, p. 20). Sexual violence takes many survivors’ lives through homicide and suicide (Devries et al., 2011; Mazza et al., 2020). My use of ‘survivor’ therefore names the life-threatening and life-destroying nature of sexual violence as well as the way society responds to it.

1.4 Summary of Chapter 1

In this introductory chapter, I began by situating my thesis within trauma-informed approaches and the survivor research movement. I outlined how my explicit survivor standpoint shaped my unique contribution to this field. These links between my work, trauma-informed approaches and survivor research are critical to contextualising and understanding the thesis. I ended this chapter with an explanation and justification of the definitions, language and terminology that I use in this thesis, again locating my language within trauma-informed approaches and survivor research. The next chapter (Chapter 2 Background) summarises what is currently known about pregnancy, birth, motherhood and maternity care after sexual violence, provides policy context for this research and finishes by outlining my main aim and my objectives.

Chapter 2. Background

In this chapter I summarise existing knowledge relating to sexual violence, motherhood and maternity care, largely located within midwifery and public health research fields. I begin by framing sexual violence as a public health problem, before discussing what is currently known about experiences of pregnancy, birth, maternity care and motherhood among survivors of sexual violence. I contextualise existing research with survivors by discussing wider literature from traumatic birth and obstetric violence fields. I argue that research examining the health and maternity care needs of adulthood sexual violence survivors is scarce, as is research that explores maternity care providers' experiences and support needs. I also note that there is a low level of survivor involvement in this field, arguing that this has limited what we know thus far. This section concludes with my main PhD aim and my objectives which address these gaps in knowledge, particularly the absence of survivor-produced knowledge.

2.1 Sexual violence is a common but hidden and uniquely harmful form of gender-based violence

Sexual violence is a common, yet poorly understood experience among women (Jewkes et al., 2002). The World Health Organisation (WHO) defines sexual violence as: "any sexual act, attempt to obtain a sexual act, unwanted sexual comments or advances, or acts to traffic, or otherwise directed, against a person's sexuality using coercion, by any person regardless of their relationship to the victim, in any setting, including but not limited to home and work" (Jewkes et al., 2002, p. 149). Literature has tended to focus on the most extreme manifestations of rape and sexual assault (Basile & Smith, 2011). However, sexual violence and abuse often involves more subtle, manipulative and psychologically coercive behaviours, such as the use of threats or blackmail (Bagwell-Gray et al., 2015; Tarzia, 2020; Tarzia et al., 2019a). Furthermore, most survivors experience multiple, overlapping forms of abuse, including different types of sexual violence and abuse from different people and at different points in their lives (Sweeney, et al., 2019).

Sexual violence is highly prevalent among women and has remained stable despite substantial improvements in the understanding of sexual violence in the past 25 years and global social movements such as the #MeToo movement (McCauley et al., 2019). Globally, at least 30% of women have been subjected to partner or ex-partner physical and/or sexual violence and/or to non-partner sexual violence since age 15 (World Health Organisation, 2021). Looking specifically at sexual violence or abuse in adulthood in the UK, 23% of women have been exposed to sexual assault or rape since age 16 (Office for National Statistics, 2021).

Prevalence figures are likely to grossly under-represent the scale of sexual violence due to multiple and significant barriers to reporting. Sexual violence is shrouded in secrecy and shame, preventing women from feeling able to report experiences, even in anonymous surveys (Jewkes et al., 2002; Watts & Zimmerman, 2002; World Health Organisation, 2013, 2021). Furthermore, more than half of women exposed to sexual violence may not acknowledge or label their experiences as such (Wilson & Miller, 2015). Women rarely use the labels of ’rape’ and ’sexual assault’ to describe unwanted sexual experiences, and as a result when these labels are used in research and clinical settings, they are likely to contribute to significant under-reporting (Rousseau et al., 2020). This may be especially true for certain types of sexual violence, such as intimate partner sexual violence (IPSV) where links with psychological abuse and gendered expectations of women can prevent survivors from labelling their partner’s sexually coercive behaviours as violent (Tarzia & Hegarty, 2023). As a result of these multiple and significant barriers to reporting, prevalence statistics may be best understood to represent the minimum levels of violence that has occurred.

Sexual violence disproportionally affects women and is disproportionally perpetrated by men (Office for National Statistics,2021; Walby & Allen, 2004). Women also experience more frequent and more severe abuse compared to men: women are more likely to be injured; more often experience repeated violence by the same perpetrator; and are more likely to be sexually abused by someone they know and trust, most commonly a partner (Office for National Statistics, 2021; Tjaden, 2000; Walby & Allen, 2004). As Luce et al. (2010) argue: “sexual violence is an act of aggression by the powerful against the less powerful” (p. 489). Sexual violence is thus rooted in, and perpetuates, gender inequality (Burt, 1980; Heise, 1998; Kearns et al., 2020; Lonsway & Fitzgerald, 1995). Sexual violence is also considered a form of violence against women and girls (VAWG), which is defined as “any act of gender-based violence that results in, or is likely to result in, physical, sexual, or mental harm or suffering to women, including threats of such acts, coercion or arbitrary deprivation of liberty, whether occurring in public or in private life” (Menjívar, 2011, p.1).

Gender intersects with other inequalities to shape survivors’ lived experience (McCauley et al., 2019). Emerging from Black feminist scholarship, intersectionality theory highlights the limitations of focusing on only one oppressed identity, calling for research to acknowledge that multiple, overlapping systems of oppression intersect to shape women’s lived experience (Crewnshaw, 1990; McCall, 2005; Prins, 2006). For instance, racially minoritised[2] women, queer/trans people, autistic women, women with disabilities, and women in certain settings like prison or the armed forces are more likely to experience sexual violence and other forms of abuse (McCauley et al., 2019). Multiple identities may combine to produce unique social locations with meanings that cannot be explained or explored by examining one identity in

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[2] This term was coined by Yasmin Gunaratnum (2003) to emphasise that people do not passively exist as a minority (as implied by terms like ‘ethnic minorities’) and to highlight that minoritisation is a social process shaped by power.

isolation (Case, 2017). Importantly, intersectional approaches encourage researchers to examine invisible trauma and the historical context that shapes survivors' current lives, and this is also an important aspect of trauma-informed and survivor research approaches (Sweeney et al., 2009, 2018). For instance, the historical objectification of Black women's bodies provides important context for understanding and explaining systemic racism within maternity systems (Birthrights, 2022). It manifests in the normalisation of dismissive, disrespectful and abusive treatment of racially minoritised women reported in the obstetric violence literature (for example Chadwick, 2017). Ideas that devalue survivors' experiential knowledge also originate from historical, male-dominated individualistic thought about what constitutes valid, credible knowledge (Brison, 1996/2022; Sweeney et al., 2009).

All survivors of violence and abuse face stigma, shame and silencing, but research suggests that sexual violence is experienced as a particularly degrading and silencing form of violence. For instance, survivors of IPSV described IPSV as uniquely degrading and humiliating compared to other types of intimate partner violence and abuse (Tarzia, 2020b). For these women, the sexual element of intimate partner sexual violence was distinct from the other forms of violence and abuse that they experienced from their partners (Tarzia, 2020b). Societal perceptions of 'real rape' that justify sexual violence and blame women, and a cultural perception that talking about sex is 'taboo', are key to the silencing of survivors around sexual violence (Edwards et al., 2011; Tarzia, 2020a).

A common perception of 'real rape' is that rape can only be perpetrated by strangers in dark alleyways and must involve physical violence and a struggle (Tarzia, 2020a). However, most women experience sexual violence from someone they know (World Health Organisation, 2021), and even when women do experience stranger rape (a significant minority, e.g., see Office for National Statistics, 2021) they are blamed by people asking what she wore, or what she did to 'ask for' this violence, or to send 'mixed signals' (Edwards et al., 2011; McCauley et al., 2019). For survivors who experience rape from a partner, perceptions of ‘real rape’ can lead them to believe that their feelings of degradation and shame are irrational, reflecting a problem with *them*, and not their partner’s violence (Tarzia, 2020b). These stereotypes can and do stop women from ever speaking about their experiences of sexual violence, but they also enable societal and systemic silencing of women. As a result, if women disclose, they are all too often blamed for the sexual violence by those they turn to for support, compounding shame and preventing them from discussing their experiences further (Ahrens, 2002).

2.2 Sexual violence is a public health issue that requires a health system response

Exposure to sexual violence, whether in adulthood or in childhood, increases the likelihood of developing a range of health difficulties. Meta-analyses have found statistically significant associations between sexual abuse and mental distress, including suicide attempts and receiving a diagnosis of anxiety disorder, depression, eating disorders, post-traumatic stress disorder and sleep disorders (Chen et al., 2010; Dworkin, 2020). Diagnoses of depressive and post-traumatic stress disorders are especially prevalent following sexual violence (Dworkin, 2020). Survivors of sexual violence may also have additional physical healthcare needs. For instance, associations have been found between a history of sexual abuse and physical health problems such as a lifetime diagnosis of functional gastrointestinal disorders, nonspecific chronic pain, psychogenic seizures and chronic pelvic pain (Paras et al., 2009). Approximately a third of women seek healthcare as a direct result of sexual violence (European Union Agency for Fundamental Rights, 2014) and research suggests that IPSV may increase medical help-seeking (Wright et al., 2021). However, while evidence suggests many survivors will seek some form of healthcare for sexual violence, either directly or indirectly, research indicates disclosure rates remain low relative to estimates of prevalence (O’Doherty et al., 2015).

In the perinatal period, sexual violence has been associated with a diagnosis of PTSD, a greater number of pregnancy-related physical difficulties, increased risk of C-section, hospitalisation, assisted vaginal delivery, longer labour and extreme fear during labour (Eberhard-Gran et al., 2008; Heimstad et al., 2006; Lev-Wiesel & Daphna-Tekoa, 2007; Lukasse et al., 2012; Nerum et al., 2010, 2013). Other studies have found no associations, for example, between sexual violence and C-sections or instrumental delivery and perinatal health outcomes (Lukasse et al., 2010; van der Hulst et al., 2006). However, many studies have methodological limitations, such as using retrospective reports and small clinical samples (Gisladottir et al., 2016; Nerum et al., 2010, 2013). Addressing these limitations, a registry study found that survivors of sexual violence presented with increased risks of maternal distress during labour and delivery, prolonged first stage of antepartum bleeding and emergency instrumental delivery (Gisladottir et al., 2016). An umbrella review of 16 reviews also identified current or previous exposure to different forms of abuse and violence as a key risk factor for a diagnosis of post-natal depression (Dadi et al., 2020). Therefore, current evidence suggests that there is a relationship between sexual violence and mental distress during the perinatal period, and that survivors may be more likely to experience events during birth that may be distressing or traumatic.

2.3 Healthcare can support healing after sexual violence

In addition to identifying harms of sexual violence, we must also recognise the impact of sexual violence on women’s ability to live whole, full lives, free from fear. Judith Herman argued that recovery after sexual violence involves three stages (1) establishing safety, (2) re-telling the story, and (3) reconnecting with others (Herman, 1997). Similarly, a meta-ethnography of healing after gender-based violence emphasised the importance of shifting self-blame and shame and connecting with others (Sinko et al., 2021). Research suggests that healthcare can offer an environment that supports these aspects of healing. For instance, research on intimate partner violence (IPV) has emphasised the role of health services and providers to build trust with women and validate women’s experiences (Feder et al., 2006; Tarzia et al., 2020). One review highlighted that survivors of IPV need individualised, non-directive responses from healthcare providers that validate their experiences, and survivors want providers that are "loving and kind" (Tarzia et al., 2020, p. 20). Similarly, healthcare contexts can compound feelings of shame and isolation. As Courtois and Riley (1992) argue, if healthcare providers dismiss women's experiences of sexual violence, they "become another betrayal in the betrayal that surrounds abuse" (p, 222). As a social issue rooted in gender and power inequality, every person has a responsibility to counteract the cultural silencing of sexual violence survivors. In this thesis I will argue that this is especially important for professionals who are in a position of power and trust and to whom survivors may turn to for care and support, such as healthcare providers (Herman, 1997). Furthermore, I will argue that the responsibility of providers to bear witness (Herman, 1997) may be even greater in maternity care settings as providers may see more survivors of sexual violence than other health settings (Shen et al., 2021). Becoming a mother is deeply embodied and emotional experience that may create important opportunities for healing but is also a time when survivors may experience harm (Montgomery, 2013).

2.4 Responding to sexual violence in health and maternity care settings

Due to the profound impacts of sexual violence on women's health, the World Health Organisation (WHO) have identified violence against women and girls as an urgent public health issue and called for a comprehensive health systems response (García-Moreno et al., 2015a, 2015b). Using an ecological model, García-Moreno et al. (2015) argue that healthcare responses to sexual violence must be systemic and nurture every part of the system – including providers. A Health systems response must therefore recognise that healthcare providers are part of a society that has historically overlooked violence against women and girls and blames and shames women for the sexual violence they have been subjected to, shaping the care they provide on both a structural and individual level (García-Moreno, et al., 2015a, 2015b). However, despite this call to action and despite the #MeToo movement raising awareness about the pervasiveness of sexual violence in women's lives, evidence on how to address sexual violence in health settings is sparse (Hegarty & Tarzia, 2019). Hegarty and Tarzia (2019) call for more health and social care research on identifying and responding specifically to sexual violence, as most current research focuses on IPV.

2.5 Sexual violence is particularly significant to maternity care

Maternity care services are likely to see more survivors than other health settings. Sexual violence is highly prevalent among women (Jewkes et al., 2002; World Health Organisation, 2021). Trans men and non-binary people (who are at an even greater risk of experiencing sexual violence than cisgender women; Martin-Storey et al., 2018) may also become pregnant and give birth (Alvarez, 2022). Reflecting these high prevalence rates among people who might use perinatal services, a systematic review examining exposure to sexual violence among pregnant women found that globally almost one in three (31%) pregnant women has experienced lifetime sexual violence (Shen et al., 2021). Research therefore indicates that many users of maternity care services will be survivors of sexual violence.

Research has also identified important links between pregnancy, intimate partner violence (IPV) and sexual violence. The risk for IPV – which may include intimate partner sexual violence (IPSV) – may also increase during pregnancy. As many as 20% of women report having been exposed to IPV during pregnancy (Drexler et al., 2022). IPV can also start or escalate during pregnancy (Cook & Bewley, 2008). For instance, in one study, approximately 50% of women reported that the first instance of IPV occurred during pregnancy (García-Moreno et al., 2005; see also Drexler et al., 2022). Another study found that women who experienced IPV during pregnancy were more likely to have been subjected to intimate partner sexual violence, more severe forms of physical IPV, and more frequent violence compared to those who were not exposed to IPV during pregnancy (Brownridge et al., 2011).

The perinatal period may also be a particularly significant time to intervene. Judith Herman (1997, 1998) argued that life transitions such as having a child can cause unprocessed trauma to emerge, presenting women with an opportunity to acknowledge the trauma and begin a process of mourning and remembrance. Empirical evidence supports this assertion. In their qualitative systematic review, Chamberlain et al. (2019) argue that the perinatal period represents a “lifecourse opportunity” (p. 1). They note that the perinatal period offers a window of opportunity for intervention because it is a time where parents can begin to face, process and heal past trauma and the first time that most people will have frequent and regular healthcare appointments as an adult (Chamberlain et al., 2019). A meta-ethnography on healing following gender-based violence also identified becoming a mother as an important reason for survivors to acknowledge and process trauma and thus begin a journey of recovery and healing (Sinko et al., 2021).

2.6 Maternity care offers an ideal environment in which to implement trauma-informed care

The WHO identified that healthcare responses must understand sexual violence as a human rights violation rooted in power inequality and that the individual needs of survivors must be prioritised through women-centred care (García-Moreno et al., 2015). Maternity care offers an ideal environment in which to deliver women-centred, individualised, and trauma-informed care. Regular healthcare provision over an extended period of time (Chamberlain et al., 2019) may provide opportunities to build the trust and relationships central to trauma-informed approaches (TIA). Furthermore, the philosophy and values underpinning midwifery align with those of TIA, particularly the focus on collaborative, empathic relationships and being ‘with woman’ (Sperlich et al., 2017). A theory synthesis found trust to be foundational to the practice and values of midwifery, and that trust was built through women-centred care; active listening; creating emotional safety; facilitating choices and continuity of care; being reliable and dependable; and communicating with empathy (Peters et al., 2020). However, although midwifery values align with those of TIA, midwives practice within a society in which a biomedical model – with a focus on physical health and 'scientific' knowledge – prevails (Neiterman, 2013; Rice & Warland, 2013). Furthermore, for maternity care to be trauma-informed, interactions between *all* staff and women must be women-centred – not just those between women and midwives (Elliott et al., 2005).

2.7 Birth and maternity care may be traumatic for any person

Before I discuss literature that examines sexual violence survivors' experiences of pregnancy, birth, motherhood and maternity care, it is important to provide context about wider traumatic and difficult experiences of birth and maternity care. Traumatic experiences of birth are prevalent, with approximately 30% of women in the UK reporting their birth experience as traumatic (Ayers, 2014; Simpson & Catling, 2016). Traumatic birth experiences are also poorly understood (Greenfield et al., 2016), although more recently Leinweber et al. (2020) created a definition of traumatic birth with input from researchers, clinicians and women:

> A traumatic childbirth experience refers to a woman's experience of interactions and/or events directly related to childbirth that caused overwhelming distressing emotions and reactions, leading to short and/ or long-term negative impacts on a woman's health and wellbeing (p. 691).

Although sexual violence has been identified as a risk factor for traumatic birth (O'Donovan et al., 2014; Verreault et al., 2012), disempowering and dismissive interactions with maternity care providers appear to be most important factor, irrespective of previous experiences of violence (Leinweber et al., 2020; Reed et al., 2017; Simpson & Catling, 2016). For instance, Leinweber et al. (2020) called the quality of provider interaction a "a key causal factor" in traumatic birth experiences (p. 691). Noting that in their review of the literature women who experienced their birth as traumatic reported “a limited or total lack of caring, personalised, and humanising interactions” [which resulted in] being or feeling as though they were ‘at the lowest level of the hierarchy’ … ‘desolated’ … ‘disempowered’ … ‘suppressed’ … or ‘raped’ …. *Many also felt their most basic human rights were not respected*” (p. 691, my emphasis). To emphasise that traumatic birth experiences are often shaped by provider interactions, Leinweber et al. (2020) purposefully placed “interactions” before “events” in the definition. This decision was driven by lived experience perspectives from the users they consulted.

Women’s perspectives reported in the traumatic birth literature highlight two key points that are important to understanding sexual violence survivors’ experiences. First, it is often disrespectful, dismissive treatment of women and birthing people that lies at the heart of traumatic birth and maternity care experiences. Second, such treatment results in women and birthing people feeling silenced, devalued and degraded. The importance of dehumanising, disempowering and disrespectful provider interactions to traumatic birth experiences, highlights the important overlaps between the traumatic birth literature and the conceptual framework of obstetric violence.

Obstetric violence is a form of gendered violence and a term first proposed by activists in Latin America in the 2000s to name harm experienced by pregnant and birthing people within maternity care (Chadwick, 2021a, 2021; Shabot, 2016; Van der Waal et al., 2022). Obstetric violence includes, but is not limited to:

> Physical, verbal, sexual, structural, and epistemological forms of violence, such as non-consensual procedures, neglect, gaslighting, surrogate decision-making, shaming, and discrimination (Van der Waal et al., 2022, p. 1).

Based on this definition, it is clear that experiences reported by women in the traumatic birth literature, such as behaviours that violate or overlook consent, or instances of dismissive, disrespectful interactions between women and providers, can also be understood as obstetric violence. Indeed, the literature on traumatic birth contains many similar themes to that of obstetric violence (Chadwick, 2022). Yet, the two literatures appear to be geographically separate as research on traumatic birth tends to focus on the global north (primarily the UK), and research on obstetric violence on the global south (Chadwick, 2022). Chadwick (2021a) notes that using the term obstetric violence is stigmatised, potentially leading to counteraccusations of violence and harm. Chadwick (2021a) also argues that individualist assumptions, for instance, that 'violence' can only refer to direct physical violence, prevents obstetric violence from being used as a framework to interpret more subtle, often hidden and invisible modes of harm in maternity systems.

Using the term 'obstetric violence' is distinct from more neutral terms such as traumatic birth. It is important to recognise that women and birthing people may not have access to the language needed to name experiences as violent or even traumatic, as providers' (mis)treatment of women is widely normalised and accepted, and healthcare presumed to be a benign context free of violence (Shabot, 2021; Chadwick, 2021b). The term obstetric violence can therefore be seen as an "epistemic intervention" because it names, *as violence,* normalised, hidden and invisible modes of harm (Chadwick, 2021b, p. 2). Significantly, international recognition of obstetric violence as a global issue and a form of gendered violence is growing (Chadwick, 2022). In 2014, a consensus statement released by the World Health Organization (WHO) recognised mistreatment and abuse during childbirth as a violation of human rights (World Health Organisation, 2014a). Furthermore, in 2019, the United Nations (UN) Special Rapporteur on Violence against Women (VAW) used the term 'obstetric violence' in their report on violence in reproductive healthcare services (United Nations, 2019).

Although both traumatic birth and obstetric violence fields shed light on difficult experiences of birth (or care during birth), there are key epistemic and conceptual differences between them.

This aim of the obstetric violence literature to name, challenge and dismantle invisible systemic harm therefore aligns more closely with the aims of both survivor research and trauma-informed approaches (e.g., see Sweeney et al., 2009, 2018). While traumatic birth literature focuses on individual behaviours, experiences and impacts (see Leinweber et al., 2022), obstetric violence is conceptualised as a structural issue rooted in the biomedical, racialised, gendered and classed relations of power that excuse, minimise and facilitate disrespectful and violent care practices (Chadwick 2021a, 2021b). When comparing the two literatures, the individualistic focus in the traumatic birth literature may risk obscuring the beliefs, systems and structures that devalue women and birthing people and normalise violence towards them. Although some have argued that the concept of obstetric violence causes violence to providers and even to birthing people (e.g., see Lappeman & Swartz, 2021), those researching obstetric violence have focused on systemic and structural failings rather than blaming individual people (Sadler et al., 2016).

Naming systemic violence places maternity care in the context of wider structures of power and oppression. It raises important implications for women and birthing people who already experience discrimination due to, for instance, their race, gender, class, sexuality or a combination of these identities. For instance, Chadwick (2021a) argues that obstetric violence is "a mode of discipline that is inextricably intertangled with multiple axes of social marginalisation" (Chadwick, 2017, p. 493). Therefore, minoritised and marginalised birthing people who defy middle-class norms of 'good mothers', 'good women' and 'good birthing bodies' are more likely to be subjected to dismissive, disrespectful treatment and obstetric violence (Chadwick, 2017; Dixon, 2015; Smith-Oka, 2015). In particular, racialised and class-based stereotypes increase the likelihood that some women and birthing people will experience violence, for instance, research has found that poor, Black, and/or adolescent mothers are more likely to be subjected to micro-aggression (Smith-Oka, 2015). The obstetric violence literature therefore highlights that women and birthing people's experiences of care cannot be separated from the system and wider society within which they are experienced, and this perspective aligns most closely with the approach taken in my PhD.

2.8 Maternity care can be re-traumatising for sexual violence survivors

A small, but growing body of research, mostly focused on survivors of childhood sexual abuse has found that aspects of pregnancy, birth, motherhood and maternity care can be re-traumatising for survivors of sexual violence (Halvorsen et al., 2013; LoGiudice, 2016; LoGiudice & Beck, 2016; Montgomery, 2013; Sobel et al., 2018). Survivors can re-live sexual violence during the perinatal period through experiences trauma-related responses such as flashbacks and dissociation, regardless of whether sexual violence is disclosed or even acknowledged by the woman herself (Montgomery, 2012, 2013a). When we look at the words used to describe traumatic experiences of birth, such as likening the experience to rape (Kitzinger, 2013), these links are not surprising, although existing literature in this field rarely contextualises survivors' experiences by drawing on traumatic birth or obstetric violence literatures.

Overall, existing research exploring survivors' experiences of pregnancy, birth, early motherhood and maternity care, finds that survivors may be re-traumatised by loss of control, as this may mirror the loss of power and control characteristic of sexual violence. Findings are similar across research on childhood sexual violence (Byrne et al., 2017; Leeners et al., 2016; LoGiudice & Beck, 2016; Montgomery et al., 2015a, 2015b) and adulthood or lifetime sexual violence (Halvorsen et al., 2013; Sobel et al., 2018). For example, lack of control was highlighted as a key factor underpinning re-traumatising experiences of maternity care in a qualitative synthesis of eight studies focusing on childhood sexual abuse survivors (Montgomery, 2013). Similarly, in a systematic literature review, Logiudice (2016) concluded: "the physical changes associated with pregnancy and a feeling of lack of control during labour and birth may be catalysts for trauma from past abuse(s) to permeate the childbearing experience" (p. 585).

Healing experiences remain scarce in the literature. The small number of existing studies find that the perinatal period may be time where survivors can re-build trust in their bodies, feel a sense of meaning, connection and accomplishment, and acknowledge and process their experiences of violence (for individual studies see Lasiuk, 2007; Palmer, 2004; Parratt, 1994; Rhodes & Hutchinson, 1994; Seng et al., 2002, and for reviews see Montgomery, 2013; Chamberlain et al., 2019; Sinko et al., 2021). In particular, research indicates that becoming a mother may provide an important turning point in survivors' healing (Chamberlain, 2019, p. 1; see also Sinko, 2021 and Lasiuk, 2007) as motherhood may present a new beginning for some survivors. Feeling safe, heard and valued in care may also help survivors re-build safety with other people (Montgomery, 2013).

The literature tends to focus on negative experiences, and when healing is explored it is rarely a main theme. For instance, 'Healing' was the smallest theme in the synthesis conducted by Montgomery (2013) and was heavily influenced by the findings from just one study (Lasiuk 2007). Focusing on negative, individual experiences of re-experiencing trauma means that, at present, the literature as a whole portrays survivors as vulnerable and traumatised rather exploring the full range of experiences that survivors may have. Extant research usually advocates for choice and control to be prioritised in maternity care (Montgomery, 2013). Chadwick (2018) challenges this focus on 'choice' and 'control' in perinatal literature, however. They argue that true 'choice' and 'control' may not be a reality for some women – especially marginalised women – and are goals shaped by privileged, middle-class ideals of 'good' births (Chadwick, 2018).

Research that focuses on individuals' negative experiences alone may overlook ways that care practices and interactions with providers can cause re-traumatisation. For instance, Sobel (2018) interviewed both sexual violence survivors and non-survivors to compare maternity care needs, reporting that unlike non-survivors the survivor participants re-lived abuse through "negative verbal trauma cues" (p. 1465). Sobel et al. (2018) referred to an example where a maternity care provider threatened a woman with force if she moved during a vaginal examination to illustrate what they meant by a negative trauma cue, failing to acknowledge that threatening to use force on women is in itself abusive and violent (Chadwick & Mavuso, 2021). Any person may feel distressed and traumatised by this treatment, irrespective of previous experiences of abuse, especially during a procedure where they may already feel especially exposed and vulnerable (Reed et al., 2017). Although instances obstetric violence may indeed remind survivors of previous abuse, to focus on this alone obscures the potential role of re-traumatising *environments* in explaining distress.

It is therefore important to differentiate between different ways that survivors may lose control. There is a difference between unavoidable loss of control caused by aspects of pregnancy, birth or motherhood that are outside of providers' control (e.g., pain, physical changes to the body), and avoidable, and unacceptable, events during maternity care that may mirror abuse, such as environments that impede full, informed consent, interactions that dismiss women's needs or consent violations (Montgomery 2013, 2015a, 2015b). Although physical aspects of care, such as the crossing of body boundaries, can remind women of the sexual violence they were subjected to, it is often the way in which touch, examinations and medical procedures are approached that is most important to women's feelings of safety and control (Montgomery, 2013). For example, women can experience their bodies becoming 'public property' during maternity care, with their bodies and babies becoming the property of the system once they enter it (Garratt, 2011). Therefore, the crossing of body boundaries may be experienced not as a necessary aspect of 'care' but as a one-directional, disempowering violation in which women have no choice (Kelly et al., 2018). Furthermore, women report that feeling frightened, disrespected and silenced in maternity care can be just as, if not more, important to their feelings of safety (Montgomery, 2013).

To summarise, re-traumatising experiences of maternity care reported by sexual violence survivors are similar to the traumatic and violent experiences of care reported in traumatic birth and obstetric violence literatures (Chadwick, 2017; Leinweber et al., 2022; Reed & Sharman, 2017). Therefore, although survivors may indeed face unique challenges during the perinatal period that are outside of providers' control (Montgomery et al., 2015b), the behaviours, experience and events that re-traumatise, and sometimes re-victimise, survivors are often avoidable (Kitzinger, 2013; Montgomery, 2013; Reed et al., 2017). This highlights the fundamental importance of research to place survivors' experiences within their wider systemic context, to situate their findings within wider literature on traumatic birth and obstetric violence, and to portray a range of (healing and harmful) experiences.

2.9 Survivor partnerships are essential to implementing trauma-informed care in the perinatal period

Trauma-informed approaches (TIA) are system-wide transformations (Harris & Fallot, 2001; Sweeney et al., 2018) of which collaboration and partnership working are core principles (e.g., Elliot et al., 2005; Sweeney et al., 2018). This means that involving survivors in shaping services, decisions and research evidence is key to implementing TIA (Sweeney et al., 2018; Sweeney & Taggart, 2018). Survivors should have opportunities to provide meaningful input into both the services offered to them and the research that guides practice and policy decisions. Yet, survivor involvement is poorly reported and/or often lacking in research on violence and abuse (Kennedy et al., 2022). Although survivor-led research is an important way to ensure services and policies reflect survivor's priorities, (Chevous et al., 2019), to my knowledge, no research study exploring experiences of pregnancy, birth, motherhood and maternity care among sexual violence survivors has been led by survivors.

Existing guidance on implementing trauma-informed care in the perinatal period also rarely addresses the full meaning of the principle of 'collaboration', i.e., that survivors should be meaningfully involved at every level of the system (e.g., Elliott et a., 2005). A recent NHS-commissioned report by Blackpool Better Start (2021) which focused on providing practical guidance to practitioners is an exception as it stated that services should be co-designed with survivors. However, peer-reviewed literature on TIA in maternity care focuses on strengthening collaborative relationships between women and maternity care providers (e.g., through shared decision-making); improving partnership working between different professions working within maternity services (e.g. improving communication between doctors and midwives), and strengthening connections between maternity care services and trauma-specific services (Long et al., 2022; Nagle-Yang et al., 2022 and Sperlich et al., 2017). This could reflect wider misconceptions that TIA are implemented by individual practitioners rather than systems (Sweeney & Taggart, 2018).

Although collaborative woman-provider and provider-provider relationships are essential to trauma-informed care, focusing on these relationships alone excludes survivors from shaping their care at higher levels of the system. For system-wide change to be possible survivors must be actively involved in the design and evaluation of services and must shape the research evidence that underpins practice and policy decisions (Elliot et al., 2005; Oram et al., 2022; Sweeney et al., 2018). As Sweeney and Taggart (2018) argued, “moving forward, there is a need to place survivor knowledge at the heart of the development and implementation of trauma-informed approaches” (p. 385). This tendency to overlook the importance of partnership working with survivors within literature on trauma-informed maternity care highlights an urgent need for research and guidance that is co-designed with or produced by survivors. To summarise, while maternity care may be an ideal environment in which to implement trauma-informed care, current approaches and systems can dehumanise women and re-traumatise survivors. Current knowledge and understanding about trauma-informed approaches in maternity care is limited by low levels of survivor involvement as well as narrow conceptualisations of survivor involvement relevant literature.

2.10 Maternity care providers can feel unprepared or unsupported to respond to sexual violence

Despite its high prevalence and well-established links between sexual violence and perinatal health, little research addresses how maternity care providers approach supporting survivors. Existing research suggests that maternity care providers can feel unprepared and unsupported to respond appropriately to sexual violence, indicating a need for education and training on sexual violence. Most of the existing research has focused on responding to domestic violence in health settings more broadly – both in relation to survivors and men who use violence – and focused largely on responses to disclosure (Hegarty et al., 2016; Hudspeth et al., 2022; McLindon et al., 2019, 2021; Tarzia et al., 2019b).

Research has reported that midwives see themselves as ‘active protectors’ of women in their care, but that they may feel cautious and sceptical about addressing violence against women and girls in their work (Siller et al., 2022). One study examined midwives’ attitudes to disclosures of sexual abuse through analysing open-ended survey questions and found that midwives felt unprepared and that they lacked training (Jackson & Fraser, 2009). Focus groups with maternity care providers about supporting childhood sexual abuse survivors indicated that, although survivors rarely disclosed, midwives could sense that some women may have had additional unaddressed needs but often did not know how to respond (Montgomery, 2012). Others have also argued that maternity care providers may feel confused at observing trauma responses such as dissociation in the absence of disclosure (Montgomery et al., 2021). Importantly, a meta-synthesis on providers’ personal readiness to address domestic violence found that having a commitment to addressing gender-based violence and adopting an advocacy approach were central to personal readiness (as well as system support; Hegarty et al., 2020).

Overall, there is a need for increased education and training to help maternity care providers build confidence and knowledge to respond appropriately to sexual violence, but this education most conceptualise sexual violence as a social justice issue. Furthermore, in line with trauma-informed approaches (Sweeney et al., 2018), survivors must be integral to designing provider education and training resources and delivery as well as general guidance on trauma-informed care.

2.11 Maternity care providers may also be survivors

Due to the prevalence of sexual violence and other forms of trauma in the general population, a substantial proportion of maternity care providers will be survivors of trauma. However, evidence suggests that violence prevalence may also be higher among healthcare providers than the general population, providing support for a ‘wounded healer’ theory (Cavell Nurses’ Trust, 2016; McLindon et al., 2022). Most studies to date have focused on domestic violence and abuse (DVA) or intimate partner violence (IPV). Evidence on sexual violence suggests that prevalence is high among female healthcare providers. In a cross-sectional survey of 471 female health professionals in a maternity hospital, 12.1% reported having been raped by a partner since the age of 16 (McLindon et al., 2018). A more recent study by the same authors found that 22% of women carers, nurses and midwives had experienced sexual assault or rape from a partner (McLindon et al., 2022). In another cross-sectional study, 49% of maternity care providers disclosed a sexual violence history (de Klerk et al., 2022).

Hernandez et al. (2016) conducted a review of physicians’ and medical students’ experiences of IPV and found relatively low prevalence among physicians across studies. Addressing limitations in Hernandez’ review (i.e., it focused on physicians who had experienced IPV and did not use meta-analysis), Dheensa et al. (2022) conducted a meta-analysis of DVA prevalence and a systematic review of risk markers and consequences among different types of HCPs. Although the majority of included studies focused on physicians and nurses, their review also included data on psychologists, physicians, health technicians, healthcare operators, management, midwives, healthcare assistants, paramedics, healthcare workers, allied healthcare professionals and mental health professionals. Dheensa et al. (2022) found that the pooled lifetime prevalence of domestic violence and abuse (DVA) victimisation for HCPs from 38 studies was 31% and the past-year prevalence of DVA victimisation for HCPs from 11 studies was 10%. The lifetime prevalence significantly differed between male (14.8%) and female (41.8%) HCPs. This gender difference has also been noted in other studies (Cavell Nurses' Trust, 2016; Hernandez et al., 2016). Lifetime prevalence also differed significantly by profession, especially between nurses (35.4%) and physicians (12.1%). Being female, a nurse, or from a low- or middle-income country were important risk factors for experiencing violence, and ethnicity was also significant although no specific pattern was found.

Lived experience may be an important source of empathy and knowledge for survivor providers, although most research has focused on domestic violence and broader healthcare settings (Candib et al., 2012; Hegarty et al., 2020; McLindon et al., 2018, 2019, 2021, 2022). Qualitative research looking at the work experiences of midwives who had been sexually abused as a child found that midwives saw their lived experience as fuel for them to advocate for survivors and that their lived experience made them especially able to provide trauma-informed care (Garratt, 2011). Similarly, a cross-sectional study found that midwives who had experienced sexual violence were more likely to have sought further training, estimate prevalence rates accurately and feel more confident to identify and respond to sexual violence when supporting women (de Klerk et al., 2022). Similarly, in a review on readiness to respond to domestic violence and abuse, Hegarty et al. (2020) found that lived experience increased providers' commitment and motivation to address violence in their work as well as increasing the quality of care they provided. However, research suggests that survivor providers may face additional stigma which may prevent disclosure (Dheensa et al., 2022; Hernandez et al., 2016). Therefore, although research suggests that lived experience may be a largely untapped source of the motivation, commitment and knowledge needed to deliver women-centred, trauma-informed care, providers may not have opportunities to use their lived experience in their work and may face additional shame and silencing due to their profession (Dheensa et al., 2022).

2.12 Systemic and structural factors create barriers to identification and response

Providers face systemic and structural barriers to identifying and responding to sexual violence, even if they feel confident and knowledgeable. One study examining in-depth maternity care providers' needs and experiences in relation to supporting survivors of sexual violence (focusing on childhood sexual abuse) found providers could sense through a 'gut feeling' that a woman was struggling, but they were afraid to invite a disclosure or response from women that they did not have the time, knowledge or skills to address (Montgomery, 2012). Providers found working with survivors of childhood sexual violence emotionally challenging and in order to function within the system they had to protect themselves and unintentionally silence women (Montgomery, 2012). Garratt (2011) explored how, despite feeling better equipped to deliver trauma-informed care, survivor midwives also felt that the hospital environment made it difficult to provide this kind of care. Similarly, other authors have found that healthcare providers that understood trauma and wanted to deliver trauma-informed care could feel constrained and frustrated by the system within which they worked (O'Dwyer et al., 2019).

2.13 Policy context

Trauma-informed and women-centred healthcare must be underpinned by trauma-informed an women-centred policies (García-Moreno et al., 2015a). Several recent events indicate an ideal social, cultural and political climate in the UK for research on responding to sexual violence in maternity care. In February 2021, a good practice guide for implementing trauma-informed care during the perinatal period was released (Blackpool Better Start, 2021). This identified important aspects of trauma-informed care but did not focus on sexual violence specifically. The first ever Women's Health Strategy for England was published in July 2022 (Department of Health and Social Care, 2022a) and identified two priority areas that are directly relevant to sexual violence. First, 'The Health Impacts of Violence Against Women and Girls' was identified as a priority area (and the 8th most selected topic for inclusion as a priority area), and second, addressing trauma was identified as an important consideration under the heading 'Mental Health' (which was in the top five most popular topics for inclusion as a priority area). At the same time, the Sexual Violence Priority Setting Partnership[3] identified ten urgent research priorities related to the health and social care needs of survivors (James Lind Alliance, 2022). Two urgent research priority areas that have direct relevance to this PhD include: 'What support is most helpful to and valued by survivors of sexual violence / abuse themselves?' and 'How can mental health services and physical healthcare services that are likely to come into contact with survivors of sexual violence / abuse become more 'trauma-informed' to best support survivors and prevent re-traumatisation?'. Similarly, a survivor-led research priorities consultation emphasised that research must unpack the harms that are caused by the different systems that survivors encounter (Robotham et al., 2019). These recent events indicate survivor, clinician, policy research support for trauma-informed research with high survivor involvement (and/or which is survivor-led) and which prioritises survivors' perspectives on their health and maternity care needs, as well as exploring harms caused by systems.

Although these changes are encouraging and welcome, it is important to highlight the current high-risk environment created by short staffing levels in the UK and its significant implications

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[3] Priority Setting Partnerships (PSPs) involve a collaboration between clinicians and service users to identify and prioritise evidence gaps in healthcare research.

for sexual violence survivors (Department of Health and Social Care, 2022b). The Ockenden review was conducted after years of sustained campaigning by bereaved and harmed parents (Birth Trauma Association, 2022) and found patterns of repeated poor care and substantial failures in maternity care governance and leadership resulting in "psychological trauma" for women and partners (Department of Health and Social Care, 2022b, p. 107). Several findings are significant to sexual violence survivors. The report noted a pervasive culture of fear, lack of compassion, and dismissing women's needs as well as reports of excessive, repeated, unnecessary and painful vaginal examinations. The report included shocking accounts of dismissive and abusive treatment of women by maternity care providers, including being accused of being lazy in labour and casual insensitive statements that disregarded the impact of events on women and partners, such as maternity care providers saying they "don't hold out much hope for the baby" (Department of Health and Social Care, 2022b, p. 106). These instances of dehumanising and degrading treatment may cause significant harm to any person, but for sexual violence survivors, such experiences may compound the dehumanisation, degradation, dismissal, and silencing of sexual violence.

The Ockenden review recommended that the Midwifery Continuity of Carer Model (McoC) be suspended as short staffing levels created an unsafe environment. The review recommended against reinstating the McoC until "robust evidence is available to support its reintroduction" (p. 149) and questioned if the McoC model "is a model fit for the future" (Department of Health and Social Care, 2022b, p. 3). This recommendation has significant implications for survivors of interpersonal trauma, violence and abuse as having continuity of carer is critical to creating emotional safety and building trust (Birthrights & Birth Companions, 2019). For survivors of sexual violence, research consistently finds that relationships and trust-building are critical to creating safety in maternity care, and that fragmented, inconsistent care can re-traumatise and silence survivors (for example see Montgomery et al., 2013). This raises an implication that future rates of re-traumatisation and harm to survivors may increase if the McoC is permanently suspended as the Ockenden report recommends. Although the Ockenden report focuses on immediate and short-term risks to physical safety, arguing that the suspension of the McoC model will preserve the safety of pregnant women and families, survivors may live with the impact of re-traumatising experiences of care for the rest of their lives.

2.14 Summary of background

Sexual violence is a common, but hidden, experience that is rooted in gender inequality and occurs against a backdrop of gendered social, cultural and political expectations of women. Sexual violence can have profound and long-lasting impacts on women's mental and physical health and can prevent women from being able to live whole lives. Healthcare providers, services and systems are a vital part of the community response to sexual violence, and the World Health Organisation have recognised this by calling for a strengthening of the health system response to gender-based violence (García-Moreno, Hegarty, et al., 2015a). Maternity care providers and services are uniquely placed answer this call, but research shows that systemic and structural barriers to appropriate responses lead survivors to be re-traumatised by maternity care. Existing research (largely located in midwifery and public health literature) has done important work to shed light on previously hidden and silenced experiences, but a focus on negative and individual impacts limits the current body of knowledge. Although trauma-informed approaches in perinatal settings have gained popularity in recent years, existing literature lacks the survivor involvement fundamental to implementing them. There is therefore an urgent need for trauma-informed, survivor-led research to explore the full range of experiences that survivors can have as well as the wider systems and structures that affect survivors' experiences of pregnancy, birth, early motherhood, and maternity care.

2.15 Aim and objectives of this PhD

Trauma-informed health services need to be informed by trauma-informed research; research that amplifies the voices of survivors and represents survivors' perspectives (Sweeney & Taggart, 2018). Currently, little is known about maternity care needs among women who have experienced sexual violence and abuse in adulthood, although there is a small body of research looking at maternity care needs of survivors of childhood sexual abuse. Trauma-informed approaches centre the voices and perspectives of survivors, but no research study in this field has been survivor-led and existing guidance on trauma-informed maternity care mostly fails to address the importance of survivor involvement at higher levels of the system. Research suggests that structural issues associated with 'trauma-uninformed' systems can interfere with committed and empathic healthcare providers' ability to deliver trauma-informed care. However, few studies have explored experiences and perspectives of maternity care providers. To address gaps in the current literature, my thesis aims to produce findings that are meaningful, understandable, and helpful to survivors and which highlight systemic and structural sources of harm. This research was located within a trauma-informed framework and was explicitly survivor-led to meet its primary aim of amplifying survivors' voices.

This thesis had the following objectives:

(1) To identify and synthesise existing qualitative research on healthcare experiences and expectations among survivors of sexual violence in adulthood.
(2) To understand pregnancy, birth, early motherhood (up to 6 weeks post-birth) and maternity care experiences among survivors of sexual violence in adulthood.
(3) To understand maternity care providers' experiences and needs in relation to supporting survivors.

2.16 Chapter structure

The next chapter, Chapter 3, details my theoretical and conceptual framework. Chapters 4 and 5 detail how I conducted the research; the former focuses on epistemology and methods and the latter focuses on ethics and reflexivity. In Chapter 6, I describe the findings of a systematic review and meta-ethnography that examines healthcare experiences and expectations among survivors of sexual violence in adulthood. The systematic review focuses on healthcare generally due a paucity of research examining maternity care needs among adulthood sexual violence survivors. Chapter 7 describes the findings of the second study – a qualitative interview study with adulthood sexual violence survivors about their maternity care needs. Chapter 8 describes a qualitative interview study with maternity care providers about their experiences of supporting survivors and their support needs. Finally, in Chapter 9, I discuss the overall findings of my thesis, situate them within wider literature and theory, and make recommendations for policy and practice.

Chapter 3. Theoretical and Conceptual Framework

> *Trauma … not only shatters one's fundamental assumptions about the world and one's safety in it, but it also severs the sustaining connection between the self and the rest of humanity (Brison, 1999, p. 40).*

In this chapter I discuss the theoretical and conceptual framework that guided my approach. I start by outlining my underlying assumptions and considering how my trauma-informed lens guided my theoretical framework. I then discuss theories relating to the embodied self and consider how this theoretical lens may explain sexual violence survivors' experiences of pregnancy, birth, motherhood and maternity care.

All the survivors who participated in this research identified as cisgender women. I therefore refer to experiences of pregnancy and birth and the first 6 weeks post-birth henceforth as 'motherhood' unless I am referring to a specific aspect of this experience. I also apply the theories and concepts discussed in this framework to cisgender women.

3.1 Underlying assumptions

I make a number of assumptions in my work, drawing on concepts of embodiment, trauma, knowledge and power. I will explore these concepts in further detail in the rest of this chapter, but it is important to briefly outline my assumptions here. This awareness forms a critical part of reflexivity and transparency which is a central part of survivor-led research and wholly consistent with trauma-informed approaches (Faulkner, 2004; Sweeney et al., 2009).

I start from the premise that sexual violence, pregnancy and birth are gendered and embodied experiences. This position is necessary to explain not only women's experiences of sexual violence, motherhood and maternity care in the context of gender inequality but also to understand how the embodied experiences of pregnancy and birth may interact with the embodied experience of trauma. I also consider that the gendered and embodied nature of sexual violence makes it a uniquely harmful and dehumanising type of violence, and that these unique harms can be re-created in care, and particularly in maternity care which is a medically complex health setting (Kingma, 2021). This understanding is key to interpreting how maternity care may re-create and re-enforce harms specific to sexual violence, but also to identifying how healing can be supported during this time.

My other assumptions relate to knowledge and power. I consider sexual violence, pregnancy and birth to be epistemically transformative experiences that give people access to knowledge that they could not otherwise have gained (see Carel & Kidd, 2020; Paul, 2014; Woollard, 2021). Seeing these experiences as epistemically transformative aligns with an essential premise of trauma-informed approaches: that the experiential knowledge held by service users and survivors is a valuable and powerful source of knowledge (Sweeney et al., 2018). I will argue that experiential knowledge has been historically devalued and remains devalued in Western approaches to healthcare. I will draw on theories of embodied subjectivity to explain why, and to consider the impact of on survivors. Finally, I consider childbirth to be a “sociocultural, discursive, and political event in which multiple forms of power coalesce” (Chadwick, 2017, p. 489). This position explains how and why I consider maternity care to be a distinctive form of healthcare. It also recognises that survivors may find aspects of pregnancy, birth and motherhood empowering, but they may also be uniquely disempowered and silenced by maternity care providers and within maternity care systems.

3.2 How my trauma-informed approach guided my theoretical framework

My trauma-informed lens guides the concepts and theories that I draw upon in this thesis (see Elliott et al., 2005; Sweeney et al., 2016, 2018, 2019; Sweeney & Taggart, 2018), I will therefore begin by briefly outlining the relevance of trauma-informed approaches to my theoretical framework – particularly their focus on system-wide change.

Trauma-informed approaches (TIA) originated in mental health to address the biomedical model’s failure to address relationships between trauma and mental distress and to challenge the use of behaviours that re-traumatised survivors, such as the use of coercion and restraint (Elliott et al., 2005; Sweeney et al., 2018). It is important to outline that the theoretical underpinnings of trauma-informed approaches are heavily influenced by the survivor research movement (Filson, 2016). Survivor researchers have applied Foucault’s (1967) work to highlight the systemic devaluing and dismissal of service users’ experiential knowledge (in favour of medical and professional knowledge) and resulting silencing of service users (Sweeney et al., 2009). Filson (2016) explains that “what I learned about madness is this: whoever has the power determines what it means” (p. 21). This systemic silencing due to biomedical dominance may mirror the cultural silencing of sexual violence; a silence “demanded and coerced by perpetrators, and sanctioned by families, communities and society” (Sweeney et al., 2019, p. 598). Respecting, valuing and genuinely listening to lived experience perspectives therefore lies at the heart of both survivor research and TIA. My theoretical framework and wider thesis reflect this core principle by focusing on lived experience throughout and situating women’s experiences within historical and cultural ideas about valid and credible knowledge.

Despite misconceptions that trauma-informed approaches are merely a “theorised call for practitioners to ‘be nicer’” (Sweeney & Taggart, 2018, p. 383), to implement TIAs requires intentional and consistent action at the whole system level. Informed by trauma theory and systems theory, TIA recognise the impacts of trauma on individuals – both staff and service users – and take steps *at every level of the system* to actively prevent re-traumatisation and promote healing (Bloom, 2006; Elliot et al., 2005; Sweeney et al., 2018; Sweeney & Taggart, 2018). Providers must therefore have support on a systemic level for sustainable change to be possible (Sweeney et al., 2018). As no one is able to face trauma alone (Herman, 1997), trauma-informed individuals working within “trauma-uninformed” systems (Sweeney et al., 2018, p. 322) become exhausted and disempowered and may turn to distancing as coping mechanisms to avoid helplessness (Sweeney et al., 2016). If trauma-informed principles are not embedded at a system level, interactions with exhausted, emotionally distant providers may therefore represent “another betrayal in the betrayal that surrounds abuse” (Courtois & Riley, 1992, p. 222). This critical importance of understanding providers’ working conditions and the systemic root of harm is why I include the perspectives of providers in my research.

The TIA framework is needed to move away from a focus on individual agents and towards examining ways that systems harm both survivors and staff. TIAs therefore offer an important system-based framework as well as terminology and concepts that allow me to place my work within a wider systemic context. In particular, vicarious trauma, moral injury and burnout are important concepts to highlight here. Vicarious trauma is when, in the absence of appropriate support and supervision, those working with survivors of trauma become traumatised themselves (Dunkley & Whelan, 2007). Moral injury is present when there has been a betrayal of what is morally right by someone who holds authority in a high-stakes situation (Shay, 2010). In a healthcare context, that means bearing witness to human suffering and feeling a responsibility to address it, but feeling one has not done enough, or that one has actively participated in delivering harmful care (Čartolovni et al., 2021). In line with TIA, Dean and colleagues argue for a shift in focus from burnout, which focuses on individuals not being able to ‘cope’ with the job, to 'moral injury, where the root of the problem is a broken system that cares more about efficiency than compassion (Dean et al., 2019). In other words, burnout blames the individual rather than what is being asked of them. A trauma-informed approach urges a move away from blaming individuals to acknowledging and labelling system harm.

An ecological model (Bronfenbrenner, 1979, 1986, 1996) Is highly relevant to the trauma-informed lens that guides my thesis because TIA are whole-systems approaches (Sweeney & Taggart, 2018). Bronfenbrenner (1979, 1986, 1996) argued that in addition to being impacted by individual factors (such as their biology), individuals are affected by multiple levels of the social ecology. These levels are interconnected which means that changes at any one level of the social ecology will affect other levels. Ecological models have been influential in literature on trauma-informed approaches and in health and violence research fields. For instance, they have been applied to implementing trauma-informed care (Mahon, 2022), evaluating trauma-focused interventions (Gultekin et al., 2019), identifying levels of the system response to gender-based violence (García-Moreno et al., 2015a), and explaining the causes, harms, risks and protective factors for both sexual violence (Campbell et al., 2009; Tarzia, 2020a) and intimate partner violence (Heise, 1998).

In alignment with ecological systems models and trauma-informed approaches, in my theoretical framework, I consider ways that women’s experiences may be shaped by the social and historical context of sexual violence, motherhood and maternity care. My theoretical framework addresses the following areas: (1) the individual level which captures the individual factors (e.g., embodiment), (2) the microsystem/mesosystem/exosystem which includes factors at the maternity system level (e.g., culture of disregarding consent), and (3) the macrosystem/chronosystem, which included cultural assumptions, beliefs and values their historical context (e.g., what counts as credible knowledge). I will return to these levels at the end of my thesis when making recommendations for policy and practice (Chapter 9).

To summarise, trauma-informed approaches recognise the prevalence and impact of violence on individuals, value the experiential knowledge of service users, and place both experiences of violence and services within their social and historical context. They are also system-wide approaches, and my theoretical framework reflects this by examining theories at several levels of social influence.

3.3 Theoretical and conceptual framework

In this section I will outline the theories and theorists that I draw on in my work. Because embodiment is central to both sexual violence and motherhood, I situate my work within feminist theory on embodied subjectivity that sees the self as embodied and relational. I will therefore begin by outlining the theoretical basis of embodied subjectivity.

3.3.1 The embodiment of trauma

As discussed in Chapter 2 a consistent finding in existing literature is that traumatic memories may re-emerge during pregnancy, birth, motherhood and maternity care (Montgomery, 2013). Authors in this field often find that aspects of maternity care, such as vaginal examinations, or uncontrollable aspects of pregnancy or birth, such as feeling the baby move or experiencing pain during labour, may remind women of the sensations or feelings they experienced during sexual violence (Montgomery, 2013, 2015a, 2015b). Some women report suddenly remembering and re-experiencing the trauma at a time when they already feel very vulnerable, for instance during birth (Montgomery, 2012).

Neurobiological theories of trauma (e.g., Porges, 2009; van der Kolk, 2014) offer one explanation as to how and why this happens. On a neurobiological level, memories of a traumatic event behave differently to non-traumatic memories and re-emerge, often without warning, when the brain is reminded of the original trauma (van der Kolk, 2014). As van der Kolk states: “long after the actual event has passed, the brain may keep sending signals to the body to escape a threat that no longer exists.” (van der Kolk, p. 53). Traumatic memories may be ‘triggered’ by any stimulus that the brain associates with the original trauma, leading the survivor to re-live and re-experience the sensations and feelings felt during the original trauma (van der Kolk, 2014). Consequently, the body becomes both the site of violence and the source of remembering it, and survivors may feel very unsafe in a body that is “constantly bombarded by visceral warning signs” (van der Kolk, 2014, p.97).

A neurobiological lens therefore offers one explanation as to why “without a voice our body finds other ways to speak for us” (Etherington, 2003, p.9). However, this model is limited by, and has been critiqued for, its individualistic nature (e.g., see Wasco, 2003). Assumptions that “traumatised people have a tendency to superimpose their trauma on everything around them” (van der Kolk, 2014, p. 17) risk rendering experiences of systemic harm or oppression invisible. Feminists have long argued that, due to the pervasiveness of sexual objectification in women’s lives, the threat of sexual violence remains constant for women (Cahill, 2001; Kelland, 2011). Although healthcare is widely presumed to be a benign context (Shabot, 2021), the experiences reported in the obstetric violence literature tell a very different story (Chadwick, 2017). Indeed, Simonds (2022) critiques “the widespread belief” (p. 559) that increased awareness about women-centered approaches (such as midwifery), the presence of women in obstetrics, and feminist activism in recent years have meaningfully changed power dynamics between women and medical authority. Assumptions that survivors see danger where there is none may therefore become problematic when examining survivors’ experiences of maternity care. To understand the specific and complex harms caused by sexual violence and how these harms may be shaped by a person’s social and cultural location, it is necessary to look beyond neurobiological explanations.

Several theorists have advocated for a narrative model of recovery from sexual violence, arguing that the key to healing is for survivors to acknowledge what happened to them and place their experiences within a wider narrative within a safe environment (Brison, 1996/2022; Herman, 1997; Kelland 2012a, 2012b; van der Kolk, 2014). While van der Kolk (2014) focuses on embodied processing to address the embodied harms of trauma, others emphasise the importance of relational healing and collective remembrance, mourning and truth-telling to address the relational harms and silenced nature of sexual violence (Brison, 1996/2022; Herman, 1997). In this relational perspective, the cultural silencing that shrouds sexual violence becomes an important context that shapes survivors' experiences, as healing is prevented at a societal level. Brison (2002), a philosopher and a survivor of rape, echoed this argument, stating that to be able to tell the story of trauma others need both to want to hear it and to truly understand what it means. For instance, she argued that "we need not only the words with which to tell our stories, but also an audience able and willing to hear us and to understand our words as we intend them" (Brison, 2002, p. 51).

When trauma remains unacknowledged and untold this therefore does not mean that survivors' voices are lacking or even silent. Herman (1997) acknowledges that the horror and unspeakable nature of sexual violence does not merely keep memories hidden from an individual's consciousness; women's experiences are further denied by others' unwillingness to hear it. Without the language or the encouragement to express what they have been through, women's bodies carry the burden; the trauma is expressed, at least eventually, perhaps not through words but through physical illness or mental distress (Herman, 1997). This is important when considering survivors' experiences of motherhood, as society may prevent women from speaking about sexual violence before the physical and social transformation of motherhood potentially brings additional challenges.

To summarise, the experience of sexual violence is deeply embodied but also silenced. While the neurobiology of trauma offers a partial insight into an individual's experience of trauma and why certain sensations, environments or contexts may remind a person of that trauma, it does not explain the specific, gendered and uniquely silenced context of sexual violence. Although trauma theory (e.g., Herman, 1997) highlights ways that the cultural silencing of sexual violence may shape survivors' experiences and ability to begin healing, it is necessary to look wider in order to capture specific ways that sexual violence may intersect with motherhood and maternity care. In the following sections, I will explore this unique context further, starting with a discussion of theoretical understandings of the embodied self.

3.3.2 The embodied self

Sexual violence is experienced, re-lived and sometimes expressed through the body (Herman, 1997; van der Kolk, 2014) and because of this it can profoundly impact a person's sense of self. For instance, Brison (1996/2022) notes, "survivors of trauma frequently remark that they are not the same people they were before they were traumatised" (p. 313). Herman (1997) argued that survivors of prolonged, repeated violence may "feel they have lost themselves" (p. 157) and van der Kolk (2014) argued that to escape re-occurring traumatic memories "survivors learn to hide from their selves" (p. 97). Sexual violence may impact a person's experience of their body and their self through dissociation – a "defence against annihilation of the self" (Brison, 1996/2022, p. 318) which can be experienced as the self splitting from the body in order to mentally escape the violence (Herman, 1997; Kelland, 2011, 2014; van der Kolk, 2014).

An examination of the self as embodied is also important to my research because pregnancy, birth and motherhood are also deeply embodied experiences (e.g., Young, 1984). However, dominant accounts of the self consider a person's sense of self – or their subjectivity – to exist independent of their social context (Brison, 1996/2022). Influenced by Cartesian mind-body dualism - *I think, therefore I am* - one's ability to think, reason, and to have self-awareness is considered to be the defining feature of humanity (Brison, 1996/2022; Descartes, 1970). In dualist accounts like this, the 'thinking' mind can be separated from the fleshy, material body (Chadwick, 2018). This historical "tendency to value the cerebral over the corporeal" has led to the rejection of the body in theories of the self – especially the female body (Brison, 1996/2022). However, existential phenomenologists Sartre (1956), Merleau-Ponty (2004) and de Beauvoir (1949/2011) argued that the self cannot be separated from the material body as the body provides the means through which we live and experience ourselves, others, and our lives (see also Kelland, 2011). In other words, we cannot separate our thinking, reasoning, rational self from our fleshy, physical and material bodies and the social and historical context within which we our bodies are situated. We *are* our bodies.

Seeing the self as embodied recognises that our body is both a source of agency and oppression, and that our sense of self is profoundly shaped by this tension or ambiguity. Our body is a source of agency because it is through our bodies that we express ourselves, turn intention into action and move around in the world (Kelland, 2011; Sartre, 1956). For instance, pregnancy, birth, and aspects of motherhood, such as breastfeeding are possible because of the physical body (Woollard, 2019; Young, 1984). However, due to their material nature, our bodies also limit us. Our bodies physically limit us, by limiting our choices (e.g., the ability to become pregnant). Furthermore, critical to understanding mothers' and sexual violence survivors' experiences is that our bodies are also in a constant relationship with a world "which imbues them with meanings that we do not choose." (Kelland, 2011, p. 170). Summarising arguments by Sartre (1956), Merleau-Ponty (2004) and de Beauvoir (1949/2011), Kelland (2012a) writes that this constant tension between our materiality and the relationship our bodies have with the world profoundly shapes our lived experience:

> As embodied agents, then, we live and experience our bodies as this structural relationship—as both the instrument through which we express ourselves in the world, and as the site for meanings which the world assigns to our bodies given the prevalent ideologies and social practices of the time (p. 23).

Our embodiment therefore shapes our lived experience of ourselves and the world through our body's relationship with other people. In this account, our sense of self is seen as "formed in relation to others and sustained in a social context" (Brison, 1996/2022, p. 314).

Through our embodiment, therefore, we are actively engaged in a relationship with other individuals, each with their own ideologies, beliefs and values. This relationship limits us because it presents us with other people's ideas of our bodies and thus others' ideas of ourselves (Kelland, 2011). These ideas are not chosen by us. Rather, they are assigned to us, presenting us to ourselves "as objects in the world of another—under the gaze of another subjectivity" (Kelland, 2011, p. 171). The result of this process is alienation, which means to be presented with another's idea of us that we do not recognise as part of us (Sartre, 1956).

Although all people live with this ambiguity created by living through a material, socially situated body (Sartre, 1956), feminists have argued that, under patriarchy, women face a unique layer of ambiguity (De Beauvoir, 1949/2011; Kelland, 2011; Moi, 1994; Moi 2000). I use the following definition of patriarchy: "a system in which male and female, masculine and feminine, and men and women are held in binary and hierarchical opposition with one another—where women are positioned as "other" and inferior to men" (Kelland, 2014, p. 2777; see also Kelland, 2011). I agree with Kelland's positioning of patriarchy as hegemonic, i.e., that socially constructed gender norms become internalised by both men and women and are presumed to be 'natural' rather than socially constructed (Kelland, 2011). This means that, under patriarchy, "the subjectivity of women is objectified by the subjectivity of men" (Kelland, 2011, p. 172). One way that this male gaze manifests in women's lives is through the pervasive, accepted and normalised sexual objectification of women's bodies. As Young (2005) noted:

> "An essential part of the situation of being a woman is that of living *the ever-present possibility that one will be gazed upon as a mere body*, as shape and flesh that presents itself as the potential object of another subject's intentions and manipulations, rather than as a living manifestation of action and intention" (p. 44, my emphasis).

As this sexual objectification is so pervasive that it is seen as the normal and natural way of being, living under this perpetual male gaze leads women to become alienated from their sexually objectified bodies (Kelland, 2011). Due to being in this constant tension between freedom and alienation, women's subjectivity – their sense of self – is inextricably linked to their situation under patriarchy (Kelland, 2011; Moi 1994). As Moi (1994) argued, the impact of pervasive sexual objectification of women is that women are "subjects painfully torn between freedom and alienation, transcendence and immanence, subject being and object being. *This fundamental contradiction is specific to women under patriarchy*" (p. 155, my emphasis). Understanding women's subjectivity as shaped by patriarchy is, therefore, essential to understanding how women are harmed by sexual violence, as I will explore next.

3.3.3 Women are harmed by sexual violence in ways that are unique to their situation under patriarchy

To understand how the harm of sexual violence may be re-created – or indeed counteracted – in maternity care, it is important to first unpack how women are harmed by sexual violence. This section will focus on explicating the unique harms of sexual violence caused to women and forms the foundation for exploring, later in this chapter, how these harms may be re-created in maternity care.

Feminists have argued that women are harmed by sexual violence in ways that are unique to their situation under patriarchy (Kelland, 2011, 2014). For instance, Kelland (2014) argues that, for women, sexual violence is not only an attack on subjectivity, as is the case in other forms of violence, but to experience sexual violence as a woman is "to have one's personhood threatened *in virtue of one's sex*" (p. 2783, my emphasis). Although the claim that women live with a constant threat of rape was made before this (e.g., Cahill, 2001), Kelland (2011) conceptually situates the harms of rape within the continual threat of rape created by the pervasive sexual objectification of women's bodies. Due to the pervasiveness of sexual objectification in women's lives, sexually violent acts like rape may therefore be better understood not only a threat in and of itself, but as “a threat fulfilled” (Cahill 2001, pp. 162-164; Kelland, 2011).

Locating the lived experience of sexual violence within a wider culture of sexual objectification challenges ideas that rape is simply sex-minus-consent (or non-consensual sex; Archard, 2007; Brison, 1996/2022; Maung, 2021; Woollard, 2019). I will briefly critique this conceptualisation of sexual violence as sex-minus-consent because it is relevant to understanding the impact of unconsented touch and examinations on sexual violence survivors; a topic I will discuss in detail later. Archard (2007) noted a pervasive assumption in society that “normal sex is sex plus consent, whereas rape is sex minus consent” (p. 384). The problem with this is that both consensual sex and rape are presumed to involve the same activity i.e., sex (Woollard, 2019). In no other crime do we make this assumption, as eloquently argued by Brison (2002):

> We don’t think of theft as ‘gift-giving minus consent.’ We don’t think of murder as ‘assisted-suicide minus consent.’ . . . In the cases of both theft and murder, the notion of violation seems built into our conceptions of the physical acts constituting the crimes, so it is inconceivable that one could consent to the act in question. (pp. 6-7).

Therefore, to equate the experience of rape to the physical acts involved is flawed. Put simply: rape does not involve sex. As argued by Woollard (2019), “lack of consent does not just change the permissibility of the activity. *Lack of consent changes what is being done*. (p. 143, my emphasis).

Feminists in the 70’s fought to conceptualise rape as an act of violence rather than sex (Brownmiller, 1977; see also Herman, 1997). Although it is important that sexual violence be considered a form of violence, not sex, it is nevertheless sexual (Maung, 2021). It is the sexual element of sexual violence that makes it an “especially serious kind of wrong” and makes it so deeply dehumanising and degrading (Maung, 2021, p 2; see also Cahill, 2001; Gavey, 2005;

McPhail, 2015). Brison, herself a survivor of rape, argues that “victims of human-inflicted trauma are *reduced to mere objects by their tormenters”*. (Brison, 1996/2022, p. 40, my emphasis). The uniquely dehumanising, degrading and violating experience of being reduced to a sexual object by another human being is difficult to put into words, but Cahill explains it as such:

> One cannot rape an inanimate object, nor does rape turn a victim into an inanimate object. She remains, painfully, an embodied being, vulnerable to harm, yes, but a subject nevertheless… Yes, her subjectivity is (temporarily) eclipsed, but in some ways that is the point: she must have a subjectivity that can be eclipsed, she must occupy the role of “person” or “subject” in order for her assailant to feel the thrill of violence (Cahill, 2011, p. 136; see also Cahill, 2009).

Objectification therefore plays a central role in both women’s situation under patriarchy (e.g., alienation) and the lived experience of, and meaning attached to, sexual violence (Kelland, 2011). By definition, to be objectified means to be reduced, dehumanised and treated as a thing, not a person (Kelland, 2011; Nussbaum, 1999). When one is objectified, one is therefore devalued, dehumanised and silenced. As objectification is also fundamental to the reductionism of medicalisation (Ashcroft & Van Katwyk, 2016), I will unpack the concept of objectification later in this chapter when discussing how the harms of sexual violence can be re-created in maternity care.

3.3.4 The embodiment of motherhood

I have argued that embodiment is central to our sense of self and that women’s embodiment is key to understanding the specific context of dehumanisation, objectification and silencing within which women experience sexual violence. Embodiment is also central to experiences of pregnancy, birth and motherhood, and so I will explore links between the embodied experience of becoming a mother and women's sense of self next.

Becoming a mother may have a significant impact on a woman's sense of self through changing her experience of the boundaries of her own body (Woollard, 2021; Young, 1984). For instance, Woollard (2021) notes, "pregnancy involves rapid changes to one's body while growing what will become another person growing inside one's body, blurring one's bodily boundaries and perhaps changing one's very conception of one's self" (p. 161). Similarly, Young notes the unique impacts of pregnancy on her sense of self, as "in pregnancy, I literally do not have a firm sense of where my body ends and the world begins" (Young, 1984, p. 49). Both sexual violence and becoming a mother are therefore deeply embodied experiences that may change a person's sense of their own self (Brison, 1996/2022; Herman, 1997; van der Kolk, 2014).

The importance of embodiment to both sexual violence and motherhood may explain why some survivors experience distress during this time (e.g., see Montgomery, 2013). Indeed, Simone de Beauvoir in The Second Sex (1949/2011) noted that the uniquely embodied experience of pregnancy may feel like an unwelcome physical invasion that diminishes her subjectivity. For instance, she stated that "the foetus is part of her body and it is a parasite exploiting her; she possesses it and is possessed by it; it encapsulates the whole future and in carrying it, she feels as vast as the world; but this very richness annihilates her, she has the impression of not being anything else". (p. 612) Similarly, Little (1999) described pregnancy as being inhabited: "To be pregnant is to be inhabited. It is to be occupied. … the foetus shifts and alters the very physical boundaries of the woman's self" (p. 301). In these accounts, pregnancy is described as a parasite that may strip a woman of her autonomy, individuality and subjectivity, and it is therefore unsurprising that for some women, aspects of becoming a mother may mirror aspects of the harms of sexual violence.

The embodiment of pregnancy and birth may also create significant opportunities for healing the impacts of sexual violence. Iris Marion Young (1984) argued that if the pregnancy is chosen the embodied experience of pregnancy and birth can bring women *closer* to their bodies. For instance, when examining her own experience of pregnancy, Young (1984) wondered whether the desexualisation of the pregnant body increased opportunities for self-love. She states: “I gaze in the mirror for long minutes, without stealth or vanity. I do not appraise myself, ask if I look good enough for others, but like a child take pleasure in discovering new things in my body” (p. 53). In contrast to de Beauvoir (1949/2011), Young (1984) considered pregnancy to be a temporal liberation from the sexually objectifying gaze which “alienates and instrumentalises” women when not pregnant (p. 53). In this account, Young suggests that pregnancy may offer a time-limited escape from the sexual objectification that pervades women’s lives and the alienation of women from their bodies. However, Young (1984) also notes that medicalisation can disrupt this process and alienate women from their bodies yet again. These aspects of maternity care will be discussed later in the chapter, but for now it is important to state the links between embodiment, alienation and medicalisation.

Young’s proposition that the physical, embodied experience of pregnancy and birth can help women to feel more connected to their bodies, counteract alienation, and facilitate self-love indicates that the perinatal period may present important opportunities for re-building the embodied safety that was shattered by sexual violence (e.g., see an der Kolk, 2014). Indeed, the social significance of motherhood and the opportunity to develop a new relationship with their baby may also support relational healing as proposed by Herman (1997). Brison (1996/2022) reflects on how her son represented the very embodiment of her new life after rape, helping her to re-build her sense of self through symbolising the trust and safety she had felt before rape:

> One remakes oneself by finding meaning in a life of caring and being sustained by others. While I used to have to will myself out of bed each day, I now wake gladly to feed my infant son whose birth gives me reason not to have died. *He is the embodiment of my life's new narrative*, and I am more autonomous by virtue of being so intermingled with him. (p. 325 – 326, my emphasis).

Pregnancy and motherhood, like sexual violence, can therefore profoundly impact a woman's sense of herself. Additionally, the changes and transformation that pregnancy involves may create both opportunities for healing and for distress. Pregnancy may provide a welcome retreat from sexual objectification but at the same time may replace a woman's sole purpose from sexually servicing men to nurturing her unborn child. The embodied changes involved in pregnancy may offer a window of opportunity for women to become closer to their bodies and to counteract the alienation women may feel due to sexual violence. Clearly, the meaning that a woman attaches to aspects of pregnancy, birth and motherhood is very individual and may be shaped by wider narratives about what it means to become a mother. In the following sections, I will examine meanings attached to women, pregnancy, birth and motherhood to contextualise the individual experiences discussed in this section.

3.3.5 Women are expected to be nurturing, irrational and passive

Seeing the self as embodied indicates that the meanings that others place on our bodies significantly impact our sense of ourselves and of the world (de Beauvoir, 1949/2011; Kelland, 2011; Merleau-Ponty; 2004; Sartre, 1956). I have argued that the meanings assigned to women's bodies are fundamentally shaped by patriarchy (Kelland, 2011), and thus far I have focused on sexual violence. I will now explore these meanings in greater detail and apply them to pregnancy, birth, motherhood and maternity care in order to illuminate intersections between these experiences.

Haslanger (1993) summarises three key meanings that are placed on women's bodies; that women are nurturers (or mothers), emotional (or irrational) and cooperative (or passive, like an object, see Kelland, 2011). These traits are the opposite of masculine traits of independence, rationality and assertiveness:

> "In the traditional privileged Western scenario, to be good at being a man (that is, to be masculine), one should be strong, active, independent, rational… to be good at being a woman, one should be nurturing, emotional, cooperative." (Haslanger, 1993, p. 89).

As Haslanger (1993) argues, under patriarchy, to be considered a *good* woman, women (and their bodies), *should* possess these qualities. It could be argued, then, that if women or their bodies do not fulfil expectations of being nurturing (or carers), emotional (or irrational) and cooperative (or passive or object-like) they are considered defective or deviant and are thus shamed. As shame is also fundamental to the lived experience of sexual violence and is often a response to being silenced (Herman, 1997), these expectations and how they link to shame are important to examine. I will do this next.

3.3.6 The 'good mother' ideal re-enforces the shame of sexual violence

These expectations of women take on a special significance in motherhood. Pressure to meet expectations of being a 'good' nurturing, emotional and cooperative woman permeates (primarily western, middle class, white) discourses around motherhood, manifesting as "a culture of pervasive guilt and continuous self-sacrifice that undermines women's emotional wellbeing" (Woollard, 2016, p. 126; see also Chadwick & Foster, 2013). For instance, bottle feeding by choice is considered a failure of maternal duty (Woollard & Porter, 2017). Others have referred to this culture of pervasive guilt as the ideology of exclusive motherhood (Blum, 1999) or the ideology of essential motherhood (DiQuinzio, 1999). The 'rules' that mothers must follow can be contradictory and confusing. For instance, breastfeeding is seen as an essential duty of mothers, yet mothers who choose to breastfeed beyond 6 months are considered "weird" (Newman & Williamson, 2018, p. 232).

These expectations about what it means to be a 'good' mother shame and silence women whose wishes, experiences, expectations or bodies do not comply. As Kingma (2020) stated, "there are only perfect mothers, and dreadful ones" (p. 462). The shame may be especially great for anyone for whom pregnancy, birth or motherhood are not 'easy', as women are not fulfilling their role as 'nurturer'. Johnson (2010) powerfully illustrates this below when reflecting on why she had not felt able to tell her friends about her experience of birth:

> I could hardly bear to have been such a failure at having a baby, an event in human life we know to be both ordinary and extraordinary but which we mostly take to be commonplace. An emergency temporary colostomy as a result of giving birth does not feature anywhere in our romanticised imagery of new mothers and babies triumphantly awash in flowers, breast milk and champagne" (p. xi)

The cultural silencing that shrouds difficult or distressing experiences of pregnancy, birth or motherhood provides important context for understanding survivor mothers' experiences. Research consistently shows that trauma may create additional challenges for survivors during pregnancy, birth or motherhood (e.g., see reviews by LoGiudice, 2016; Montgomery, 2013). For some women, aspects of pregnancy, birth and motherhood may mirror the disempowerment, violation and dehumanisation of sexual violence (de Beauvoir, 1949/2011; Little, 1999). Shame felt by mothers who are not "triumphantly awash in flowers, breast milk and champagne" (Johnson, 2010, p. xi) may therefore intersect with and be compounded by shame due to sexual violence. Feeling (re)traumatised by maternity care (Montgomery, 2013) may also have long-term impacts on a woman's well-being. In the following section, I will discuss another aspect of this shaming, silencing and potential source of re-traumatisation for survivors: the silencing of women in maternity care through devaluing embodied knowledge.

3.3.7 Devaluing embodied knowledge re-creates the silencing of sexual violence

Historical ideas that our subjectivity, our sense of self, comes from the rational and ‘objective’ mind, not the material, fleshy, physical body, are intrinsically tied to our ideas of knowledge. For instance, Plato praised philosophers for “despising the body and avoiding it,” and urged that “if we are ever to have pure knowledge of anything, we must get rid of the body and contemplate things by themselves with the soul by itself” (Plato, 2002, 65c–67d). Ruddick (1989) noted that knowledge, or reason, is therefore seen as coming from masculine, ‘objective’ thought, not the feminine, subjective body, stating that “philosophers have tended to associate, explicitly or metaphorically, passion, affection, and the body with femininity and the mind with masculinity” (p. 194). Ruddick (1989) argued that, in these accounts, the lack of intellectual control over female bodily functions such as menstruation, pregnancy and birth, set the female body even more against reason than the male body. Consequently, the female body is considered to be even “more bodily” than other bodies (Brison, 1996/2022, p. 315), with female bodily functions such as pregnancy and birth representing the “the antithesis to reason” (Brison, 1996/2022, p. 315).

In Western society, valid, trustworthy or credible knowledge must still meet masculine traits of rationality, objectivity and impartiality (Rose, 2017; Sweeney et al., 2009). We see this, for example, in the hierarchy of knowledge in evidence-based medicine where experiential (so-called anecdotal) knowledge has the least credibility and systematic reviews of randomised controlled trials have the most credibility (Faulkner & Thomas, 2002, Faulkner, 2017). As ‘objective’ medical knowledge is valued above all other sources of knowledge it can silence other kinds of knowledge, most notably the embodied and experiential knowledge held by the woman herself (Davis-Floyd & Sargent, 1997). For example, Davis-Floyd and Sargent (1997) write, “medical knowledge supersedes and delegitimises other potentially relevant sources of knowledge such as the woman's prior experience and the knowledge she has of the state of her body… Nonmedical knowledge is devalued by all participants" (p. 61).

This historical devaluing of intuitive, emotional or experiential knowledge, especially when the knowledge comes from a person's embodied experience, may explain why women's needs or voices are too often unheard in maternity care and why women may not even have the language to identify aspects of care as violent or traumatic (Chadwick, 2021b). The idea that the pregnant or birthing body represents the "antithesis to reason" (Brison, 1996/2022, p. 317) therefore has important implications for the person whose body that is, the value that is placed on their embodied, experiential knowledge, and the way other people, such as maternity care providers, may treat them. Pregnancy intersects with other characteristics that devalue a survivor's voice. Colonial ideas that painted Black women as 'uncivilised' and animal-like were used to justify sexual exploitation, abuse, and neglect of Black female bodies (Chadwick, 2018; Holmes, 2016), and have fatal consequences for Black pregnant and birthing women today (Birthrights, 2022; Knight et al., 2021). Survivor researchers have also challenged the devaluing of service user knowledge by providers who are taught to see them as "by definition incapable of rational thought" (Wallcraft, 2009, p. 133). Pregnant and birthing survivors who are racially minoritised and/or experience serious mental distress are therefore even more likely to be dismissed, as they may be seen to lack rationality, insight and reasoning in multiple domains. These are important intersections to highlight, as Black women continue to experience disproportionate rates of sexual violence (Holmes, 2016; McCauley et al., 2019) and there are well-established and bi-directional links between experiences of interpersonal violence and mental distress (Khalifeh et al., 2016; Trevillion et al., 2012).

Filson (2016) reflected on these links between power and knowledge in relation to mental distress, stating, "what I learned about madness is this: whoever has the power determines what it means" (p. 21). Importantly, Davis-Floyd and Sargent (1997) also point out that "the power of authoritative knowledge is not that it is correct *but that it counts*" (p. 58, my emphasis). In other words, because it seen to be objective and impartial, medical knowledge has significant power to define what is meant by illness and therefore how best to treat it.

These power imbalances between healthcare providers and service users may be further amplified in maternity care when contextualised by the long history of seeing the 'uncontrollable' pregnant or birthing body as irrational, uncontrollable and unpredictable (Brison, 1996/2022; Ruddick, 1989). To make the links between patriarchy and medicalisation clear, it is important to state that the practice of obstetrics was historically dominated by men (Simonds, 2002). In the 18th century, most births in the United States were attended by female midwives and occurred at home (Leavitt, 1986; Simonds, 2002). From the 19th century onwards, male obstetricians gained status by perpetuating the idea that obstetrician-led births were safer than midwife-attended home births (even though their interventionist methods were more likely to lead to infection at that time; Leavitt, 1986; Simonds, 2002). As a result, male obstetricians took over in a field which had not previously been defined as medical (Young, 1984), and did so "by recasting birth as a pathological event and by vilifying midwives" (Simonds, 2002, p. 561; see also Rothman, 1982/1991). Therefore, while midwifery is dominated by women (Pendleton, 2019), the medicalisation of pregnancy and birth that permeates Western maternity systems today is inherently masculine (Simonds, 2022). In the next section, I will explore the impact of medicalisation further by examining the concept of objectification.

3.3.8 The reductionism of the biomedical model mirrors the dehumanisation of sexual violence

Objectification is central to the lived experience of sexual violence. To experience sexual violence is to be reduced to an object (Brison, 1996/2022) and women experience this dehumanisation within a culture of pervasive sexual objectification that creates a constant “threat” of sexual violence (Kelland, 2011). I will unpack the concept of objectification and how it applies to both sexual violence and maternity care further below.

Drawing on work by Nussbaum (1999) and synthesising this with developments from Langton (1995), Cahill (2009) and Bartky (1990), Kelland (2011) argues that sexual objectification satisfies the following features of objectification: instrumentality (being seen as a tool); fungibility (being seen as interchangeable); denial of subjectivity (having one’s experience or feelings dismissed); representing the part as the whole (being reduced to a part or parts). Kelland (2011) argues that, by satisfying these features of objectification, sexual objectification creates an “atmospheric threat” (p. 177) of rape. This threat is created because “to be treated as nothing other than a generic, sexual object whose experience and feelings need not be taken into account … threatens further degradation” (Kelland, 2011, p. 177). In other words, if someone thinks it is acceptable to treat a person as an object in one way then it is likely that they may also feel entitled to treat that person as an object in other ways.

3.3.9 The reductionism of medicalisation re-creates silencing

If we take objectification to mean that “one is treating as an object what is really not an object, what is, in fact, a human being” (Nussbaum, 1999, p. 218), understanding the cultural positioning of women’s bodies as objects is highly relevant to understanding survivors’ experiences of maternity care. First, both Bartky (1990) and Kelland (2011) argue that representing a part as the whole is a critical aspect of sexual objectification. Similarly, the biomedical model relies on a reductionist assumption that separating of a person’s parts from the whole is the only way to gain true, unbiased knowledge about their condition (Ashcroft & Van Katwyk, 2016). In addition, medicalisation satisfies several other features of objectification. Instrumentality (being treated as a tool) and fungibility (being interchangeable) can be seen in instances where women report feeling reduced to a ‘birthing machine’ (e.g., Halvorsen et al., 2013; see also Leinweber et al., 2022 for a review).

The denial of subjectivity, which is to treat a person as if their experiences and feelings need not be taken into account, is commonly reported by women who experience their birth as traumatic (e.g., Leinweber et al., 2022, Reed et al., 2017) and is a recurring theme in the obstetric violence literature (Chadwick, 2017, 2021a, 2021b, 2022). In the biomedical model, subjective experiences and feelings are not only deemed useless but are considered harmful as they may impede and disrupt the providers' ability to gain objective biomedical knowledge (Ashcroft & Van Katwyk, 2016; Sweeney et al., 2009, 2019). When the biomedical dominates and the 'subject' is erased, it becomes medicalisation. Young (1984) noted that a key aspect of medicalisation is the devaluing of women's voices and women's own knowledge in favour of clinician's assessments. Similar to the threat created by sexual objectification, the environment created by medicalisation, where women are reduced to parts and their subjectivity denied, may therefore create the 'threat' of further degradation i.e., obstetric violence. Having previously experienced the "threat" of sexual objectification fulfilled (Cahill, 2001, p. 162; Kelland, 2011), sexual violence survivors may understandably feel unsafe in an environment that objectifies them again. Such an environment can be experienced as inherently violent and threatening.

3.3.10 Medicalisation facilitates an environment in which women's autonomy may be violated

I have argued that medicalisation shares features with sexual objectification. The reductionism (objectification) characteristic of medicalisation may therefore create a threat of violence (Kelland, 2011). Building on Kelland (2011), I have argued that this threatening environment created by medicalisation may be especially harmful to survivors of sexual violence. I will now explore commonalities between sexual violence and direct instances of violence and abuse experienced within maternity care.

Unlike most areas of medicine, maternity care involves sensitive body parts for which consent is socially significant beyond the medical encounter and for which the violation of consent has a much greater meaning i.e., as in instances of sexual assault or rape (Kingma, 2020). Although there are overlaps with other types of healthcare, such as sexual health, maternity care is medically unique because it may involve harming one person (the mother) to benefit a different person (the baby; Kingma, 2020). However, paradoxically, while ethically these conditions create a significantly *greater* need to prioritise autonomy and consent in maternity care compared to other areas of medicine, consent and autonomy are particularly at risk of being disregarded in this setting (Kingma, 2020).

Before considering why, I will briefly return to the concept of objectification and consider how consent and autonomy violations in maternity care relate to this. Kelland (2011) argued that to be objectified in one way threatens further degradation (see also Nussbaum, 1999). Further degradation may include (taken from Kelland, 2011, p. 175 – 177 but see also Nussbaum, 1999, p. 218):

1. *Violability.* The objectifier treats the object as lacking boundary integrity, as something that is permissible to break up, smash or break into.
2. *Ownership.* The objectifier treats the object as something that is owned by another, can be bought or sold, etc.
3. *Denial of Autonomy.*
    a. Non-attribution of autonomy: the objectifier treats the object as lacking in autonomy and self-determination; or
    b. Violation of autonomy: the objectifier attributes autonomy to the ‘object’ and violates this autonomy through their behaviour towards the ‘object’.

Understanding autonomy to be actively violated rather than merely not attributed (as originally proposed by Nussbaum, 1999) is critical to understanding the *relational* harm of sexual violence

(Kelland, 2011, Langton, 1995; Stoljar, 2011) and thus how this relational harm may be re-created in maternity care. In practice, violation of autonomy may manifest in care as, for instance, consent violations.

The crossing of women's body boundaries without consent (the result of violability) is a common theme in traumatic birth and obstetric violence literatures as well as research on maternity care experiences of sexual violence survivors (Chadwick, 2017, 2021a, 2021b, 2022; Leinweber et al., 2022; Montgomery, 2013; Reed et al., 2017). Some have also noted that women become the property of the maternity care system once they enter it (Garratt, 2011) i.e., the result of ownership. Maternity care providers certainly have powers to take rights away. For instance, despite women legally having the right to decline or refuse care (Kingma, 2020), women who do this risk being accused of "medical neglect" and having their parental rights removed through safeguarding referrals and social services involvement (Shorey et al., 2023, p. 28). As Davis-Floyd and Sargent (1997) argue, this accusation reveals and re-enforces assumptions that medical knowledge is more credible or more valid than women's own embodied, intuitive or experiential knowledge. As Davis-Floyd and Sargent (1997) also note, medical knowledge can then be legally enforced in maternity settings, stating that "in the rare case that she does not acquiesce and decides to actively resist, we get, as we have seen, the phenomenon of the court-ordered caesarean section – that is, *the legal enforcement of one particular kind of knowledge*" (p. 61, my emphasis). In the next section I will explore in greater detail the mechanisms that underpin consent violations in maternity care.

Expectations of women (that women should be passive, irrational and self-sacrificing) may explain why consent and autonomy violations may be particularly normalised in maternity care settings. Ideas about what makes a 'good woman', 'good patient', 'good birthing body', and 'good mother', are critical to understanding the complex context in which survivors use maternity care and the reasons why women experience dismissive or violent treatment

(Chadwick, 2017). For instance, Kingma (2020) considers that systematic dehumanisation of women and how this permeates maternity care systems; that women are expected to be passive and to serve others (even if that means harming themselves); that women are considered to be irrational (and therefore their knowledge not credible); and that women's bodies are already considered more object-like, and therefore violating them may be seen as more permissible (see also Kukla et al., 2009; Langton, 2009; Manne, 2017; Villarmea & Kelly, 2020). In other words, as Kelland (2014) argued in relation to sexual objectification, it is acceptable and normalised to treat women as objects; "women qua women are the kinds of creatures that it is permissible to treat as instrumental, fungible, inert, and violable" (Kelland, 2014, p. 2783). This is consistent with conceptualisations of obstetric violence as a form of gendered (racialised and classed) violence (Chadwick, 2017).

When trying to understand sexual violence survivors' experiences It is therefore critical that consent and autonomy violations in maternity care are not merely considered to be care-minus-consent, similar to my previous assertion that sexual violence is not merely sex-minus-consent (Archard, 2007; Brison, 1996/2022; Maung, 2021; Woollard, 2019). These actions have a much deeper meaning and are shaped by historical ideas about the value of women's bodies and voices.

3.4 Summary: Pregnancy, birth, motherhood and maternity care may replicate the silencing and dehumanisation of sexual violence

To summarise, I have argued that women's embodiment is both a source of power and of oppression. Pregnancy, birth and aspects of motherhood such as breastfeeding are made possible by the body. In addition, these are potentially empowering and transformative physical experiences that may positively impact a woman's sense of self-worth, personal strength and sense of agency in unique ways. Yet, pregnancy, birth or motherhood may also be experienced as oppressive. The blurring of one's body boundaries and changing sense of self may feel like an unwelcome or unexpected invasion. Furthermore, a woman’s autonomy may be violated, her choices judged, her body shamed, and her knowledge devalued in unique ways *because* she is pregnant, birthing or has become a mother. Aspects of pregnancy, birth, motherhood and maternity care may therefore replicate the violation, shaming and silencing of sexual violence in unique and complex ways.

3.5 Summary of Chapter 3

I have argued in this chapter that being pregnant, giving birth and becoming a mother lead to labels and assumptions that strip women of their humanity and silence them, and that this dehumanisation and silencing can look and feel similar to the experience - and aftermath - of sexual violence. Bringing together theoretical perspectives from trauma theory, survivor research and feminist scholarship I have argued that biomedical dominance facilitates the dehumanising and silencing treatment of women as well as consent and autonomy violations. It does this through prioritising professional knowledge over women’s experiential and embodied knowledge and reducing women to their body parts. I also highlighted that the experience of pregnancy, birth, early motherhood and maternity care are shaped by a patriarchal society that expects women to be passive, irrational and self-sacrificing nurturers. In my thesis, I use this understanding to situate, explain and understand women’s and providers’ experiences.

Chapter 4. Epistemology and Methods

This chapter details the methods used in three studies: a systematic review and meta-ethnography and two qualitative interview studies – one with survivors of sexual violence and another with maternity care providers. This chapter focuses on the methods used and provides context for Chapter 5 which focuses on ethics and reflexivity.

4.1 Overview of studies

To begin this chapter, Table 1 outlines each study's overarching research question and the methods of data collection and analysis used. A key goal of each study was to produce findings that could be understood and actioned by key stakeholders such as clinicians, survivors and policy makers (Tripp-Reimer & Doebbeling, 2004; Woolf, 2008). Qualitative translational health services research such as this PhD foregrounds the needs and experiences of both users and providers of healthcare (Tripp-Reimer & Doebbeling, 2004). Consequently, each study takes an "empathic", experiential approach that aims to understand and honour participants' experiences (Braun & Clarke, 2013, p. 54)

Table 1. Overarching research question and methods for each study in this thesis.

	Study 1 **Systematic Review**	**Study 2** **Survivor Study**	**Study 3** **Provider Study**
Data collection dates	July 2019 (searches conducted)	January 2020 – March 2020 (pre-COVID)[4] March 2021 – June 2021 (post-COVID)	September 2020 - February 2021
Overarching research question	What are women's experiences and expectations of healthcare after experiencing sexual violence in adulthood?	How do women experience pregnancy, birth, early motherhood, and maternity care after experiencing sexual violence in adulthood?	What are maternity care providers' experiences, expectations and needs regarding supporting survivors of sexual violence?
Data collection methods	Systematic review	In-person and online unstructured interviews	Online semi-structured interviews
Data analysis	Meta-ethnography	Thematic narrative analysis	Reflexive thematic analysis

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[4] Data collection was disrupted due to the COVID-19 pandemic. The study was paused for a period after which data collection and recruitment continued online.

4.2 Using a qualitative, interpretive paradigm

A qualitative, interpretive paradigm[5] underpinned each study in this PhD. Research conducted within a qualitative paradigm acknowledges, celebrates and nurtures researcher subjectivity, treating it as an analytic resource, not a weakness (Braun & Clarke, 2013). A qualitative paradigm assumes that research is not conducted in a vacuum, and therefore, knowledge produced through research can never be separated from the context within which it was produced (Braun & Clarke, 2013). This includes both the context in which the data were generated (such as interviews) and the broader social, cultural and political context of the research (Braun & Clarke, 2013; Miller & Glassner, 2011). Research that uses a qualitative paradigm therefore differs from positivist approaches that assume research provides mirror reflection of the social world (Braun & Clarke, 2013; Miller & Glassner, 2011). As a result of this difference, whilst quantitative research tries to minimize 'bias', the qualitative paradigm rejects the notion of an objective or unbiased researcher, instead acknowledging and celebrating subjectivity (Braun & Clarke, 2013; Silverman, 2000). In other words, positivist approaches treat the researcher as "an archaeologist, whereas qualitative research sees the researcher as a sculptor, actively *shaping* and *generating* both the process and result (Braun & Clarke, 2013). Therefore, importantly, research conducted within a qualitative paradigm assumes that analytic themes are actively generated by researchers rather than passively 'emerging' from the data (Braun & Clarke, 2013, 2019a; Charmaz & Bryant, 2011).

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[5] Paradigm refers to "the beliefs, assumptions, values and practices shared by a research community" (Braun & Clarke, 2013, p. 4).

4.3 Ontology and epistemology

My assumptions about ontology and epistemology are shaped by both the qualitative paradigm and survivor research. I focus on the qualitative paradigm in this section and discuss the more specific (but complementary) epistemological assumptions of survivor research, and their interrelation, in section 4.4.

The methods chosen in this PhD can be used with a variety of ontological (what is real) and epistemological (what is meaningful knowledge) positions that are compatible with a qualitative paradigm, so it is important that I outline my approach here (e.g., see Braun & Clarke 2020 for reflexive thematic analysis; Riessman, 2011, 2008 for narrative analysis; Toye et al., 2014 for meta-ethnography). To give a brief overview, realist ontology assumes there is one ultimate *truth* (even if we can never fully access it) whereas a relativist ontology assumes there are multiple constructed *realities,* each equally valid and true in their own way (Braun & Clarke, 2013). Critical realism sits between these two positions and "assumes an ultimate reality but claims that the way reality is experienced and interpreted is shaped by culture, language and political interests" (Braun & Clarke, 2013, p. 329). In this perspective, knowledge is viewed as socially influenced but not wholly socially constructed; there is "a knowable world that sits behind the subjective and socially located knowledge a researcher can access" (Braun & Clarke, 2013, p. 27; Madill et al., 2000; Miller & Glassner, 2011).

Some have argued that a critical realist perspective must underpin any research with applied or knowledge translation aims (Braun & Clarke, 2013; Miller & Glassner, 2011). Researchers must assume that their data reflects some version of reality or 'truth' to make any claims about the findings being useful for policy and practice (Braun & Clarke, 2013; Madill et al., 2000; Miller& Glassner, 2011). As Miller and Glassner (2011) argued:

> “For those of us who hope to learn about the social world, and in particular, hope to contribute knowledge that can be beneficial in expanding understanding and useful for fostering social change, the proposition that our interviews are meaningless beyond the context in which they occur is a daunting one” (p. 132).

Due to its qualitative paradigm, in this PhD, knowledge was treated as inextricably linked to the research context and actively generated *by* me*,* the researcher. As I wanted the knowledge that I produced to be translational, I treated language as a situated and socially influenced reflection of an external reality (i.e., lived experience), rather than seeing language as a way of constructing multiple realities.

4.4 Survivor research: background, history and epistemology

This thesis is also an example of survivor-led research (Sweeney et al., 2009). Survivor research can be defined as “the methodical and disciplined exploration of phenomena important to survivors, based on shared experiences and perspectives, leading to new collective and transferable knowledge” (Slade & Sweeney, 2020, p. 389). Survivor research has its own epistemological underpinnings (e.g., Armes, 2009; Beresford, 2005; Brunner, 2019; Rose, 2009, 2017, 2018) that complement and expand those of the qualitative paradigm (but survivor research is not tied to qualitative methods; Sweeney et al., 2009). Although I focus on epistemology - the theory of knowledge - in this section, I weave examples of reflexivity throughout this thesis as reflexivity is a central tenet of survivor research (Faulkner, 2004; Sweeney, 2009). For instance, see the ‘Underlying assumptions’ section in Chapter 3 and the ‘Reflexivity and positionality’ section in Chapter 5

My research was survivor-led in several ways. Importantly, I conducted this research from an explicit survivor standpoint with a primary aim to amplify survivors’ voices. I was transparent with participants about my survivor identity (Sweeney, 2009; Chevous et al., 2019). Through engaging in an active process of reflexivity (Sweeney & Beresford, 2020), my own experiences of violence and abuse actively informed all parts of this research, including choosing the research questions and methods, guiding ethical and analytical decisions, shaping my analysis and interpretation of data, and influencing how I approached involvement and engagement activities (see the section on ‘Reflexivity and positionality’ in Chapter 5 for more information). In addition to my lived experience, one of my PhD supervisors, Dr Angela Sweeney, is a survivor researcher and survivor of multiple forms of trauma in childhood and adulthood and has experienced three births, two of which were traumatic.

In the following sections, I consider how survivor-produced knowledge differs from mainstream research (Sweeney et al., 2009; Rose, 2017). Mainstream research refers to positivist research “which bases its claims for knowledge production on the belief that it is ‘value free’ and ‘objective’” (Rose, 2017, p. 784). In this section I will examine a specific theory of knowledge and knowledge production that underpins my approach as a *survivor researcher*, going beyond general ideas about ‘what is true’ and ‘what can we know’ to asking questions like: ‘what type(s) of truth does *a survivor standpoint* uncover?’ and ‘what type(s) of (situated) knowledge do *survivor researchers* have access to’ (Sweeney et al., 2009; Rose, 2017, 2018). The purpose of this section is to discuss the theoretical (i.e., epistemological) underpinnings of survivor research and what this means for the knowledge produced. I will begin by outlining a brief history of survivor research before describing what it is (and what it is not), considering the central importance of reflexivity in this approach.

Survivor research began in the late 1960’s and early 1970’s around the same time as other identity-based liberation movements (Brunner, 2019). Survivor research was formed to produce knowledge that better represents users’ experiences and own interpretations, as service users found that mainstream research reflected neither their experiences of distress nor views of services (Sweeney, 2019). Lying the heart of survivor research, therefore, is a challenge to the dominant ways of thinking about illness, distress or trauma, or “what we think we know” (Faulkner, 2017, p. 501). Survivor researchers argue that there are two related reasons why research does not represent users’ own views, experiences and priorities. Dominant, mainstream, positivist research devalues experiential knowledge because they assume that researchers must be dispassionate, unbiased and value-free to be credible (Beresford, 2016). As a result of the dominance of positivism, existing knowledge is biased in favour of biomedical ideas about distress that pathologise people (Sweeney et al., 2009).

Survivor research may increase the ecological validity of research findings (Faulkner & Thomas, 2002). For example, drawing on feminist standpoint theory, Rose (2009, 2017) notes that survivor researchers may hold situated, experiential knowledge, not available to mainstream researchers, that may help them better understand survivors’ experiences. Concurrently, survivor researchers have access to experiential knowledge, ‘professional’ research identities and, potentially, clinical knowledge. Holding multiple identities places survivor researchers in a unique position to produce knowledge that may therefore be more meaningful to survivors and more likely to represent of survivors’ perspectives. Similarly, in Chapter 3 I argued that sexual violence is an epistemically transformative experience that gives people access to experiential knowledge that they could not otherwise have gained (Carel & Kidd, 2020; Paul, 2014; Woollard, 2021). In one study that compared qualitative data analysis codes between survivor and non-survivor researchers, authors found that survivor researchers’ codes focused on interviewees’ experiences and feelings, whereas non-survivor researchers coded the same transcripts largely in terms of processes and procedures (Gillard et al., 2010). The knowledge produced by survivor researchers is therefore fundamentally different to knowledge produced by mainstream researchers, because it comes from different epistemological underpinnings (Sweeney, 2009).

Placing a high value on situated, experiential knowledge is not widely accepted. For example, in their critique of positionality statements, Savolainen et al. (2023) argue that knowledge only improves through scholarly debate with “intellectual adversaries” (p. 5) and reflexivity has no place in science. Although reflexivity requires ongoing, active and critical engagement (Braun & Clarke, 2019b; Mauthner & Doucet, 2003; Sweeney & Beresford, 2019), Savolainen et al. (2023) position reflexivity as a passive, unavoidable process stating that “humans are naturally self-aware beings with a tendency to reflect on their situation as a matter of everyday routine” (p. 2). These beliefs - that reflexivity and positionality do not belong in science - exclude survivors. In mental health-related and violence research, “intellectual adversaries” (p. 5) may be patients, survivors or service users who are rarely academic, clinical or research peers (Sweeney & Beresford, 2019). Only experiential knowledge can challenge the positivist knowledge that dominates health research (Faulkner, 2017), yet it is exactly the type of situated, subjective knowledge that Savolainen et al. (2013) argue does not belong in science. Wallcraft (2009) summarises this contradiction below:

> Mental health service users have traditionally been excluded from creating the knowledge that is used to treat us, and many of us have suffered from the misunderstanding of our needs by people who have been taught to see us as by definition incapable of rational thought. (p. 133)

As I discussed earlier in this chapter (see section 4.2), the qualitative paradigm rejects positivist assumptions of impartiality and objectivity. However, as outlined in Chapter 1, the biomedical model is so dominant and influential (Ashcroft & Van Katwyk, 2016) that even qualitative methods “used in the wrong way” can re-enforce and re-produce biomedical ways of thinking (Faulkner, 2017, p. 507). Braun and Clarke (2019a, 2019b, 2020) highlight a tendency for positivism to shape even qualitative research in the health and psychological sciences. Referring to Kidder and Fine’s (1987) concept of ‘small q’ (positivist) qualitative research, Braun and

Clarke (2020) introduce the term ‘confused q’ to describe research studies that “unknowingly, unreflexively and incoherently combine elements of qualitative positivism with the values and assumptions of a qualitative paradigm” (p. 329). Lacking the reflexivity central to the qualitative paradigm (Braun & Clarke, 2020) or to survivor research (Sweeney et al., 2009), small q and confused q qualitative research risks re-framing survivors’ words to fit researchers’ and clinician’ agendas (Faulkner, 2017; see also Dyson & Brown, 2005). This may re-enforce the very same harmful stereotypes and assumptions that perpetuates systemic harm and produce a form of collective silencing of survivor perspectives.

It may be helpful to briefly examine an example. In their book, Dyson and Brown (2005) provide a powerful example of how this collective silencing can occur:

> One of us obtained for research purposes a few years ago some transcripts of interviews with mental health service users about their treatment. What was even more interesting than their responses were the interventions of the transcriber. For example, one client described her consultant psychiatrist as a ‘paid poisoner’ yet the potentially interesting comments which ensued were editorialised as ‘rambles on endlessly with largely delusional content’. This rather prim comment discloses which side the transcriber is on. … Rather than being seen as a pithily expressed lay version of the professional concerns about the side effects of drugs … the respondent’s comment was used to discount what she subsequently had to say (p. 166).

Dyson and Brown rightfully note that this woman’s account was discounted as ‘delusional’ and subsequently and purposefully omitted from the transcript. However, Dyson and Brown’s (2005) critique reveals an assumption of their own.

A lay person, according to the Cambridge Dictionary, is “someone who is not an expert in or does not have a detailed knowledge of a particular subject” (Cambridge Dictionary, 2023). Their conceptualisation of this woman's perspective as a 'lay' version of the 'professional' concern about the side effects of drugs therefore positions her experiential knowledge as secondary to that of 'professional' or 'medical' knowledge. Her experience is reduced to a less sophisticated version of what, according to Dyson and Brown, professionals are already worried about. However, any meaningful critique of psychiatry itself is impossible if we see her words through the views of the profession that she is critiquing. In adopting a survivor perspective, her words are not interpreted in light of dominant ways of understanding them. Instead, experiential knowledge is held as valuable in its own right. As survivor researchers, we may use our own lived experiences of using services to help us understand more deeply what she might mean. We might note her use of the word 'poison*er*', indicating that she may have intended to critique her psychiatrist rather than the medication they prescribed. Survivor researchers' reflexive engagement with their own situated, experiential knowledge is what sets survivor research apart – and why it is important.

4.5 Determining number of participants included in a qualitative paradigm

Researchers often refer to the concept of 'saturation' to justify the number of participants included in their research (Braun & Clarke, 2013, 2019a). Saturation refers to the idea that data collection should stop when more data collection is no longer leading to new information and therefore it assumes an end point to the theoretical and analytical insights possible (Braun & Clarke, 2013, 2019a). This is a positivist assumption and thus incompatible with a qualitative paradigm i.e., if researchers collect enough data, they will gain access to a complete and truthful picture of what they aim to study (Braun & Clarke, 2019; Low, 2019). When we see the researcher themselves as a critical analytic tool, new theoretical insights are always possible as long they continue to collect and analyse data (Low, 2019). Therefore, instead of saturation, a more appropriate concept may be 'information power' which suggests that the sample size needed is shaped by (a) the aim of the study, (b) sample specificity, (c) use of established theory, (d) quality of dialogue, and (e) analysis strategy (Malterud et al., 2016). As Patton (2002) explains:

> There are no rules for sample size in qualitative inquiry. Sample size depends on what you want to know, the purpose of the inquiry, what's at stake, what will be useful, what will have credibility, and what can be done with available time and resources. (pp. 242-243).

In this PhD, for the two qualitative studies (Studies 2 and 3), I continued to collect data until I believed I had enough information to answer my research questions. The number of participants I interviewed was also guided pragmatically by my PhD timeline and how many people contacted me about the study. Braun and Clarke (2013) recommend that 10-20 interviews will usually be enough for one study in a large project such as PhD, and I found that this was accurate for my qualitative studies.

4.6 Ensuring trustworthiness in a qualitative paradigm

Although subjectivity is celebrated within a qualitative paradigm, the findings produced must still be grounded in the data (Braun & Clarke, 2013). Trustworthiness is therefore a critically important component of qualitative research (Connelly, 2016; Lincoln & Guba, 1985). Trustworthiness was supported through discussion and reflection with supervisors and peers, engaging in a process of reflexivity, keeping careful and detailed records of reflections, insights and decisions and discussing preliminary findings with survivors. Due to the length of the PhD, I had period of being 'embedded' in the data and times where I stepped back to reflect on my assumptions. I wrote field notes after each interview in both studies, noting personal reflections, my observations from during the interview, and thoughts about potential themes. I also kept a research diary from the start of my research which created a record of how my thoughts developed as I progressed through my PhD. For each study, I discussed themes with my supervisors as I reviewed and refined them, and I reflected on my responses to the data in monthly group reflective supervision led by a clinician that was organized by my research team. Having these spaces for discussion and reflection increased the likelihood of the themes being a true representation of the data and provided a space for reflexivity that allowed me to examine how my experiences and beliefs influenced this stage of the research (Guillemin & Gillam, 2004). I describe the process of reflexivity in detail in Chapter 5.

Another important part of trustworthiness, especially for research that aims to understand and honour experiences for marginalised and silenced groups, is to discuss findings with the people that your research affects (Tracy, 2010). To address this, I held public engagement workshops where I discussed preliminary findings with a group of sexual violence survivors who had experienced maternity care, some of whom had participated in the research. These workshops shaped the final findings and served as a form of "member reflection" (Tracy, 2010, p. 844). These public engagement workshops are described in detail in Chapter 5.

4.7 Summary of epistemology

Each study in this PhD is grounded in a qualitative paradigm that acknowledges and celebrates researcher subjectivity and addresses it through a process of reflexivity. The research in this PhD also aims to understand and honour lived experiences and to produce applied knowledge that could be useful for policy and practice. In line with these aims, each study is underpinned by an assumption that language allows researchers access to an external reality (i.e., lived experience) but that the knowledge produced is tied to context and researcher positionality. The sections that follow will detail the methods used in three studies included in this PhD.

4.8 Systematic Review and meta-ethnography

This section describes the methods used to conduct a systematic review and meta-ethnography examining healthcare experiences and expectations among female survivors of sexual violence and/or abuse in adulthood.

4.8.1 Review questions

Overarching review question: What are women's experiences and expectations of healthcare after experiencing sexual violence in adulthood?

Additional review questions:

1) What are women's experiences of accessing and using healthcare services after experiencing sexual violence in adulthood?
2) How do women experience being asked about, and disclosing, adulthood sexual violence within healthcare services?
3) What do women survivors of adulthood sexual violence find helpful and unhelpful about their interactions with healthcare workers?

Review aim: To develop a unique understanding of healthcare experiences and expectations after adulthood sexual violence and to work towards a conceptual model, grounded in survivor perspectives, that could guide policy and practice.

4.8.2 Ethical approval

As I only used published research, I did not need to seek ethical approval for this study. However, I considered and addressed several ethical issues that I discuss in Chapter 5.

4.8.3 Search strategy and processes

Comprehensive searches were conducted to identify all available qualitative studies that met the inclusion criteria. A comprehensive (rather than a purposeful) search was conducted due to the current paucity of research examining adulthood sexual violence survivors' healthcare experiences and expectations. Search terms were tested and refined in Ovid and then adapted for other databases. Each category included medical subject headings (MeSH) and keywords using trunctation (*) within title or abstract fields. Boolean terms "OR" and "AND" were used to combine searches within and between categories. See appendix A for the Ovid search strategy.

I conducted a systematic search of fourteen electronic databases on 22nd of July 2019 with no lower time limit: CINAHL, EMBASE, HMIC, BNID, ASSIA, IBSS, SSCI, MEDLINE, PsycINFO, MIDIRS, OATD, NDLTD, OpenGrey and SCIE Online. Additionally, forward citation tracking in Web of Science and Google Scholar and reference list screening complemented database searches. The review was registered on the 14th of January 2019 on PROSPERO, an international prospective register of systematic reviews (registration number CRD42019120101).

4.8.4 Selecting primary studies

All abstracts identified were imported into Cadima software (Kohl et al., 2018). After duplicates were removed, abstracts were screened using the following inclusion criteria:

1) Report primary qualitative research or mixed methods research where qualitative findings can be separately extracted.

2) Conducted with female survivors of adult sexual violence (age ⩾ 16[6]).
3) Published in peer-reviewed or grey literature, including postgraduate research theses/dissertations, book chapters or reports.
4) Investigated experiences/expectations of healthcare provision or healthcare workers, and/or being asked about or disclosing adulthood sexual violence in a healthcare setting.
5) Reported the research in the English or Dutch language.

This review excluded all other study designs. Healthcare was broadly defined to reflect the broad range of people and settings survivors may come into contact with when they seek healthcare. Studies that include a mixed sample of violence survivors (e.g., experiences of sexual violence in childhood and/or in adulthood) were included if data could be separately extracted for female survivors with experiences of adulthood sexual violence. Corresponding authors were contacted for assistance if this was not clear. Survivor-led research was eligible for inclusion if it met the inclusion criteria. If two reports were from the same study and the findings were similar (e.g., research appearing in a PhD thesis and a journal article), the most detailed report was included in the synthesis. If two reports from the same study reported different findings, both reports were included.

A sample of 250 abstracts were independently screened by another PhD student (GS). Agreement was high between GS and I (90%). We resolved disagreements through discussion, eventually reaching 100% agreement. I screened all full-text articles, of which 25 were reviewed independently by GS. Agreement was approximately 80% and again we resolved disagreements

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[6] This age cut-off was chosen because of the legal age of consent in the UK.

through discussion. A third researcher (AK) and I conducted forwards and backwards citation tracking for reports that met the inclusion criteria.

4.8.5 Meta-ethnography

Why choose meta-ethnography?

Meta-ethnography is the most frequently used approach to qualitative evidence synthesis in health research (France et al., 2019b; Ring et al., 2011). It is a theory-based approach to synthesising qualitative studies (France et al., 2019b; Noblit & Hare, 1988). It draws on Geertz's concept of 'thick description' (Geertz, 1973) and Turner's (Turner, 1980) theory of sociological understanding as 'translation' - that "all explanation is essentially comparative and takes the form of translation" (Noblit & Hare, 1988, p. 25). Meta-ethnography is interpretive rather than aggregative approach to synthesis; it aims to generate a new interpretation of the original studies instead of summarizing or aggregating findings (France et al., 2019b; Noblit & Hare, 1988). A key strength is that meta-ethnography considers the unique research contexts of the primary research studies in producing this new interpretation (France, et al., 2019b; Noblit & Hare, 1988).

Meta-ethnography was chosen to align with the qualitative, interpretive paradigm that underpins this PhD and meet the aim of this review to produce a new understanding that could be useful for policy and practice (France et al., 2019b; Toye et al., 2014).

4.8.6 Meta-ethnography reporting guidelines

Reporting of this systematic review and meta-ethnography follows eMERGe reporting guidelines for meta-ethnographies (France et al., 2019a). Appendix B details each eMERGe reporting criteria and the section numbers where information for each criterion can be found in this thesis.

4.8.7 Approach to analysis

The approach taken was adapted from the steps suggested by Noblit and Hare (1988) and guided by several worked examples (Atkins et al., 2008; Britten et al., 2002; Campbell et al., 2003, 2011; Malpass et al., 2009; Sattar et al., 2021) including specific guidance on the complex synthesis and translation phases (France et al., 2019b).

Familiarisation and data extraction

I read each report in full several times. Each report was assigned a unique study ID. The following study information was extracted during familiarisation: publication year, participant characteristics, contextual information such as policy context, aims and ideology of the research, approach to analysis, key themes, participant quotes and author interpretations. GS extracted data for 5 studies and disagreements were resolved through discussion. All study information extracted was imported into NVivo.

Deciding what to extract

In this review, I extracted and analysed both participant quotes (first order constructs) and author interpretations (second order constructs). Many meta-ethnographies in health research include both participant quotes and author interpretations in their analysis (Britten et al., 2002; France et al., 2019b; Malpass et al., 2009). Authors have drawn on Schütz's concept of first and second order constructs to differentiate between the different levels of interpretation and data relevant to meta-ethnography (Schutz, 1962). Table 2 summarises definitions of first order, second order and third order constructs as used in this review (adapted from Malpass et al., 2009 and see also Britten, 2002). However, Noblit and Hare posited that the aim of meta-ethnography is to produce new interpretations from the interpretations that authors present in the original reports and did not analyse participant quotes in their seminal text (France et al., 2019b; Noblit & Hare, 1988; Toye et al., 2014). They argued: "each account to be synthesised is already an interpretation of interpretations. The translation of accounts raises this to another level: interpretations of interpretations of interpretations” (Noblit & Hare, 1988, p.35).

Table 2. First, second and third order constructs. Adapted from Malpass et al. (2009) with examples from Halvorsen et al. (2013) and my systematic review findings (Chapter 6).

Construct	Definition	Interpretation level	Example
First order constructs	Survivors’ views, accounts and interpretations of their experiences and expectations of healthcare.	Interpretations of experience	“I did not want to be on my back with my legs up, but they held my legs. … For me, it led to just giving up, they could do whatever they wanted” (p. 185)
Second order constructs	Authors’ views and interpretations (expressed through themes and concepts) of survivors’ experiences and expectations of healthcare.	Interpretations of interpretations of experience	Theme called ‘Surrender’: “Through the unintended unfortunate interaction with the birth attendants, in which they tried in vain to resist, the women gradually allowed themselves to be dominated and finally surrendered.” (p. 185).

Construct	Definition	Interpretation level	Example
Third order constructs	The views and interpretations of the reviewer(s) (expressed in terms of themes and concepts).	Interpretations of interpretations of interpretations of experience	Sub-theme called ‘Healthcare mirroring abuse’: “Healthcare could mirror the coercion and silencing of sexual violence through unconsented touch and examinations and/or dismissing or ignoring women's needs” (Chapter 6, section 6.3).

To stay true to meta-ethnography, I did not analyse quotes (first order constructs) and author interpretations (second order constructs) separately. Instead, I extracted and analysed them together, preserving the order in which they appeared in the original report. I did this to recognise that research is a curated process - quotes are chosen by the author(s) as exemplars of their interpretations (Toye et al., 2014). My approach therefore follows recommendations from France et al. (2019b) who argue that: “first order constructs can be analysed and synthesised along with their corresponding second order constructs but not in isolation” (p. 7).

Assessing the quality of included studies

The Critical Appraisal Skills Programme tool for Qualitative Research (CASP, 2018) and the COREQ statement (Booth et al., 2014) were completed for each study. GS conducted quality assessment for 4 reports and disagreements were resolved through discussion. Both were completed because the CASP tool provides a brief overview how studies compared against quality criteria whereas the COREQ statement allows researchers to capture detail about what was reported (e.g., experience and credentials of interviewers, details about theoretical and methodological approach etc.). I added three additional quality criteria to collect information on indicators of quality that were not addressed by generic quality assessments: (1) Do the authors report ethical considerations specific to research with survivors that go beyond standard ethical considerations? (2) Do the authors report survivor involvement in the research? (3) Do the researchers address power imbalances? For the CASP and the additional quality criteria added, studies were awarded ‘Yes’, ‘No’ or ‘Unsure’ for each checklist item. For the COREQ, each checklist item was answered with information contained within the study or, if the information could not be found, with ‘Not Reported’. A second version of the COREQ was produced that provided a quick overview of whether information was reported or not reported for each checklist item.

Quality assessment in qualitative synthesis is a contested area (Carroll & Booth, 2015). Since the concept originates from syntheses of quantitative literature and is grounded in a realist epistemology, there are problems with applying quality assessment to qualitative and interpretative approaches (Toye et al., 2013, 2014). Furthermore, published qualitative research often contains limited detail on methodology due to word limits imposed upon authors by journals and therefore a low score on quality assessment does not mean the findings are unreliable (Saini & Shlonsky, 2012; Toye et al., 2013). Quality assessment is therefore particularly problematic in qualitative syntheses if studies are excluded on the basis of quality assessment (Braun & Clarke, 2019a). As highlighted by Toye at al. (2014) decisions to include more ‘realist’ methods like quality appraisal are sometimes made to ensure the synthesis findings are not dismissed by the wider research and clinical community. Health research takes place within a scientific research community where positivist and realist approaches dominate, and where quality appraisal is an expectation of rigour (Toye et al., 2014). As a result, qualitative researchers in healthcare can find themselves between “a rock (medical research culture) and a hard place (social science research culture)” (Toye et al., 2014, p.13).

In this review, quality assessment was included for a number of reasons. As Toye et al. argue, if we want to use qualitative research to inform practice, we must ensure the research is high quality enough (Toye et al., 2013). It was also important to ensure that the findings of this review would be considered robust to facilitate knowledge translation (Toye et al., 2014). Additionally, for research with survivors of trauma, quality assessment can provide an avenue for reviewers to consider important aspects of quality that are not captured by standard quality assessments and may be important to how useful the findings are to clinical practice, such as whether researchers used trauma-informed approaches (Hermaszewska et al., 2022; Kennedy et al., 2022). Quality assessment measures can also be a useful tool to facilitate the close reading of studies that help reviewers engage critically with the studies (Toye et al., 2013). Therefore, in this review, studies were not excluded because of quality assessment, but quality assessment was a useful process that supported a close reading of the studies and assessed trauma-informed ethical considerations.

Assessing the quality of the review findings

I used the Reviews of Qualitative Research (CERQual) to assesses each finding against four criteria (Lewin et al., 2018):

1. Methodological limitations (Munthe-Kaas et al., 2018): the extent to which there were concerns about the design, conduct or ethics of the primary studies that contributed evidence to an individual review finding.
2. Coherence (Colvin et al., 2018): an assessment of how clear and cogent (i.e., well - supported or compelling) the fit was between the data from the primary studies and a review finding that synthesised those data. For interpretive review findings, “a ‘coherent’ finding would provide a strong account of the patterns in the data through convincing interpretations or explanations.” (p. 34).

3. Adequacy (Glenton et al., 2018): the degree of richness and quantity of data supporting a review finding.
4. Relevance (Noyes et al., 2018): the extent to which the evidence from the primary studies supporting a review finding was relevant to the context (perspective or population, phenomenon of interest, setting) specified in the review question.

Using the information gathered using the CASP and the COREQ, I categorised the overall methodological quality of each study using the following CERQual headings: 'no or minor concerns', 'minor concerns', 'moderate concerns' or 'serious concerns' (Tarzia et al., 2020 also did this). This rating contributed to developing the 'methodological limitations' component of the CERQual evidence profile. Each theme finding was rated with a confidence level of either high, moderate, low or very low, producing a CERQual evidence profile that summarises the overall confidence and rationale for each finding.

Process for determining how studies are related

This stage of meta-ethnography involved comparing the key findings, methodologies and contexts of the included reports. As all information was extracted into NVivo and assigned a unique study ID, I could easily compare the data extracted across studies. This helped preserve the structure of the relationships between concepts and themes within studies and ensure the synthesis remained grounded in the study's unique research contexts; two key tenets of meta-ethnography (Britten et al., 2002; Malpass et al., 2009). The number of reports included was relatively large, therefore, to compare findings across studies, the data extracted were first sorted into categories. A similar approach has been used by other authors for data reduction and management (Atkins et al., 2008; Erasmus, 2014; Toye et al., 2014). Categories were broad, descriptive and data-driven, e.g., 'communication'. Each category included a summary definition describing which key concepts and themes were included. Due to having a large amount of data, to compare findings across studies, the data (first-order and second-order constructs) were first sorted into categories.

Process for translating reports

This stage involved comparing concepts and themes from each report with all the other reports, highlighting relationships between them and leading to further conceptual categories. This is known as translation (Noblit & Hare, 1988). Studies were compared in ascending chronological order, using the oldest study as an ‘index paper’. When synthesising a large amount of data over a long period of time this helps to develop an understanding of how knowledge has progressed and developed over time (Sattar et al., 2021). Translating concepts was carried out using a method similar to constant comparison (France et al., 2014; Noblit & Hare, 1988) and the process was documented using an Excel matrix. In this matrix, each study cell contained a summary of the overall ‘story’ of each report, including key findings and key contextual information. Including this ‘story’ helped to preserve the context of primary studies as I began translating them into each other (Toye et al., 2014).

Starting with the oldest study (for example, study A), key concepts and themes in study A were compared with key concepts and themes in study B. Thoughts and reflections on relationships and inconsistencies between concepts were noted. Through this process, key concepts and themes in individual studies were translated, or merged into, similar concepts/themes from other studies. Once the translation of study A and B was complete, study A was compared with study C, and so forth. This translation process produced a translation table (Sattar et al., 2021). This table contained a list of translations in the first column with a second column linking the translations back to the relevant first order (participant interpretations) and second order (author interpretations) constructs. This ensured translations had a clear audit trail. Appendix C presents an excerpt from this translation table.

Synthesising the translations

In this phase, the translations produced were considered as a whole (Noblit & Hare, 1988). This generated the third order constructs (new interpretations), represented as themes and sub-themes in the findings. I initially conducted a reciprocal translation, focusing on the similarities between studies, before conducting a refutational translation, examining inconsistencies between studies. During the refutational translation I paid special attention to study assumptions, motivations, and ideology (France et al., 2014; Noblit & Hare, 1988). I documented inconsistencies and how they were resolved in a table, which I present in the findings.

Third-order constructs were further refined as the synthesis developed. Through an iterative process of considering similarities, inconsistencies and refutations between studies, I produced a 'line of argument' synthesis; a core concept or story that connected the studies together (Noblit & Hare, 198). Noblit and Hare state that a line of argument synthesis is an interpretation of the relationship between the themes, generating a key concept that may be hidden within individual reports in order to discover a whole from a set of parts (Noblit & Hare, 1988). I discussed and reviewed the themes and line of argument with my supervisors as the analysis progressed. I engaged in an ongoing process of reflexivity to help me refine and develop the third order constructs/themes and sub-themes.

4.9 Survivor Study Methods

This section describes the methods used to conduct a qualitative study exploring experiences of pregnancy, birth, early motherhood (up to 6 weeks post-birth) and maternity care among survivors of sexual violence using thematic narrative analysis.

4.9.1 Research question

The following research question guided this study: How do women experience pregnancy, birth, early motherhood, and maternity care after experiencing sexual violence in adulthood?

4.9.2 Ethical approval

This study was reviewed by and gained ethical approval from the NHS London – Camden and Kings Cross Research Ethics Committee (REC) and Health Research Authority (IRAS Project ID: 263099, REC Reference: 19/LO/0896). For a detailed discussion on ethical issues that were considered and addressed, see Chapter 5.

4.9.3 Inclusion/exclusion criteria

Participants met the following inclusion criteria:

1. Adult women (aged 18 years or older) who self-identified as having experienced any form of sexual violence and/or abuse at age 16 or older.
2. Received some form of maternity care in the UK. More than 6 weeks had passed since giving birth to allow time for women to adjust after these experiences.
3. Able to speak and read English proficiently enough to be able to consent and to participate in a research interview in English. This was because I did not have the financial resources available to employ a translator and ensure they were trained in trauma-informed practice and had access to support and supervision.

There was no upper time limit on the time passed since the experience(s) of sexual violence to as can take many women a long time to understand their experiences as sexual violence. There was also no upper time limit on time passed since accessing maternity care, because even if care was experienced many years ago the experience was still important and valid for the research aim. The cut-off age of 16 was used because this is the legal age of consent in the UK.

Exclusion criteria were:

1. *Anyone* unable to provide informed consent to participate or judged by the researcher to be too unwell or distressed to participate in a research interview.

4.9.4 Recruitment

Due to the stigma, shame and secrecy that surrounds sexual violence and abuse, several recruitment avenues were used to reach survivors. The following services agreed to advertise the study and identify potential participants: Rape Crisis South London, The Havens Sexual Assault Referral Centre (SARC) and Maternity Services at King's College Hospital and St Thomas' Hospital. See appendix D for the study poster. I had ethical approval for staff in these services to pass me details of potential participants with women's consent. However, to foreground choice and control the preference was that women contacted me themselves. I also advertised the research through the following newsletters and circulars:

- Violence, Abuse and Mental Health (VAMHN) Network newsletter[7].
- Rape Crisis England and Wales Staff and Volunteers Newsletter.
- Survivors Voices; a survivor-led peer support and research organization.
- King's College London Research Circular

Recruitment began in January 2020. After conducting 4 interviews the study was paused in March 2020 by the Research and Development Office and Guy's and St Thomas' Hospital. They paused studies to protect staff and clinical resources during the COVID-19 pandemic. When this

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[7] The Violence, Abuse and Mental Health Network (VAMHN) is a multi-disciplinary UKRI funded network that aims to reduce the prevalence of mental health problems among children, adults, and the elderly, by bringing together experts with different ways of thinking about violence, abuse and mental health.

pause was lifted after approximately 6 months, I was able to apply for an ethics amendment to continue recruitment and data collection online. Once this amendment was approved, recruitment and interviews continued online from March 2021 until June 2021.

Women could contact me by email or phone. I had a study mobile specifically for this research. I responded to all email and phone contacts with a copy of the participant information sheet (PIS; see appendix E) and an offer to answer further questions about the research via phone, Zoom (video call software) or email. The PIS contained detailed information about the purpose of the study, the kinds of questions participants may be asked and who will have access to their data.

4.9.5 Informed consent

See Chapter 5 for a discussion about how consent was approached in alignment with trauma-informed principles. Prior to starting interviews, I completed "Good Clinical Practice" (GCP) training for non-clinical trials studies, which includes training on informed consent for research studies. All participants received the Participant Information Sheet (PIS; appendix E) at least 24 hours before the interview so that they had enough time to consider the study and talk it through with others if they wished. For in-person interviews, participants completed a physical consent form which was securely stored in a locked cabinet in a room protected by swipe card access (appendix F). Participants received a copy of this consent form. For online interviews, participants completed an online consent form hosted on a secure online platform. Completed consent forms were downloaded and securely stored on MS SharePoint with access limited to me only before being deleted from the platform. Participants completed the form while in a Zoom meeting with me and after I verbally explained all aspects of the PIS after which survivors had an opportunity to ask questions. One participant sent me a written account due to vocal issues. This participant completed a consent form online after an email conversation about the research during which I answered her questions. I explained that consent to participate can be withdrawn any time during the interview or afterwards without having to give a reason why.

4.9.6 Interviews

In-person interviews were conducted in a private room at a location that the participant chose. For interviews conducted online, I asked participants to ensure that they were in a private place where they would not be overheard. De-identified transcripts from the first two interviews were shared with the PhD supervisors before conducting further interviews for review and feedback to help me develop my interview technique.

All interviews were audio-recorded. All participants were asked the same question at the beginning of the interview: 'please tell me about your experiences of pregnancy, birth, and motherhood, starting wherever you feel is best'. The point of one open-ended question like this was to encourage participants to begin to tell a story and start wherever they want to. I did not interrupt women unless they indicated they were finished. I aimed to remain alongside participants in their narratives, following the topics that they introduced. This is a key component of a narrative approach as the aim is for the approach to data collection to allow participants to tell the story the way they want to tell it (Jovchelovitch & Bauer, 2000). Some participants started telling me about their first experience of pregnancy while others started with describing an experience of sexual violence or abuse.

Although interviews were meant to be unstructured and guided by participants, I anticipated that some survivors may find it difficult to speak about their experiences at length with no prompting from me (I explain the reasons why this might be the case in Chapter 5). I therefore created a topic guide (see appendix G) which included prompts about experiences of pregnancy, birth and motherhood to serve as a flexible guide for interviews if I felt it would help a woman feel more comfortable. Women did not see the topic guide in advance, except for one woman who submitted a written account due to vocal issues.

I tried to avoid writing notes during the interview, although at times I wrote down a word to remind me to come back to a topic later in the interview if the woman did not go back to it. I let women know before the interview started that I might do this, explaining that it was merely to remind me to come back to a topic and I was not making notes about them. Additionally, I wrote field notes after each interview. I gave all participants a £15 voucher as a thank you for their time.

4.9.7 Data management

Ten interviews were transcribed by me. The eleventh participant submitted a written account. Each transcript was checked for accuracy by listening to the recording at the same time as reading the transcript. Personal details were removed from the transcript during accuracy checks. After these checks had been completed, the audio files were deleted. All transcripts were securely stored on MS SharePoint with access limited to me only. I offered all participants a copy of the transcript and let them know that they could change anything in the transcript if they wished, including removing information. I also reminded everyone that they could withdraw from the research. Only one woman (Maya) asked to see her transcript and she did change information in the transcript so that it reflected how racism impacted her experiences and expectations of care. I asked all women to if they wanted to choose a pseudonym. Two participants chose their own pseudonym. I assigned all the others.

4.9.8 Narrative theory and analysis

Data were analysed using thematic narrative analysis (Crossley, 2002; Riessman, 2008). The sections that follow describe what narrative theory and research is, why I chose this method, and the steps I took in the analysis.

What is narrative theory?

In narrative theory, stories[8] or narratives are seen as a key way of making sense of experiences and creating structure from the chaos of life (Riessman, 2008). Narrative theory posits that stories are everywhere. As an essential part of meaning-making, stories allow knowledge to be passed down through generations (Brown, 2017). Narrative theory argues that human beings make sense of events through imposing a meaningful pattern on what would otherwise be random and disconnected events (Riessman, 2008). Crossley refers to a note in a melody as a useful metaphor to illustrate this (2002). When we listen to a melody, each note is understood as part of a whole. We do not experience the individual notes as isolated components of that melody; rather, the meaning of each note is understood relative to the note that came before it and in anticipation of the note that will come after it. Similar to listening to a note in a melody, life events are interpreted in light of the past and in the context of a future (Crossley, 2002).

What is narrative research?

Narrative research is interested in both the 'personal' and the 'social' dimensions of experience (Crossley, 2002). It sees narratives as an important source of knowledge because it sees narrative as a crucial way of making sense of experiences (Crossley, 2002; Riessman, 2008). In narrative research, the storyteller (participant) is both the author and the protagonist of their

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[8] Using 'story' or 'narrative' can imply that the account is not considered to be true or real. To avoid inadvertently re-creating the silencing and disbelief endured by so many survivors, it is important to state that my use of the term 'story' and 'narrative' is tied to the underlying theory rather than any doubt about the event being real. I have tried to use 'account' or 'experiences' where possible, especially when speaking about participants' experiences.

story and so, through re-telling their story, they re-interpret their experiences, co-constructing the narrative with the audience (interviewer) (Crossley, 2002). Narrative approaches celebrate this re-interpretation and co-construction of narrative, seeing stories as “useful in research precisely because storytellers interpret the past rather than reproduce it as it was” (Riessman, 2008, p. 6). However, as Crossley (2000) argues in their approach to narrative research, when people tell stories about their experiences, these are still based on events that did happen. In this way, stories do have meaning beyond the ‘telling‘. When storytellers (participants) re-interpret their experiences through telling others about them, they are not inventing new experiences or a new past (Crossley, 2002). Therefore, narrative approaches have an experiential focus and aim to “understand specific experiences undergone by individuals” (Crossley, 2002, p. 40).

Life events are understood not only through the stories we tell, but also the stories that are told about us. In other words: “we story our lives into existence and, just as critically, have them storied into existence for us by powerful others more capable of making their views and values heard” (Evans, 2009, p. 107). Similarly, Plummer (2002) argues that stories are told when they can be heard. People tell stories to a receptive listener, often part of a wider community of support. Therefore, narrative researchers need to understand themselves “not as collecting data, but as being the addressee whose presence enables people to tell their stories” (Frank, 2010, p. 128). Thus, narrative research is able to shed light on how dominant cultural narratives constructed by socially powerful groups shape experiences, as well as how stories are told, and which stories get heard (Crossley, 2002).).

How do we define a narrative?

All narrative approaches keep the story or narrative intact, differing from other approaches to qualitative research that fracture narratives through conducting question-and-answer type interviews and coding answers to questions across participants (Riessman, 2011, 2008).

However, the definition of a story or a narrative varies. Some have focused on the structure and grammar of narratives to define a story. For example, Bruner states that a story must have an actor, an action, a goal, a scene and an ‘instrumentality’ and ’trouble’ (Bruner, 2009). Riessman (2008) argues that a story, or unit of analysis, can take many forms. It can be a narrative that develops over a whole interview or it can be a segment of interview text about a specific incident.

Defining a narrative becomes complicated in the context of trauma. When a person experiences trauma, this can challenge their whole sense of self as well as everything they thought they knew about the world (Crossley, 2002). Trauma can disrupt the beginning-middle-end structure of a person’s life narrative as “the whole complex configuration of memories, associations, plans, hopes and fear shatters like shards of glass – and with it our sense of who we are and why we are here” (Crossley, 2002, p. 56). This narrative breakdown reflects the lived experience of the aftermath of trauma, where events and actions in real life can feel like a mere sequence of events, disconnected from meaning and survivors’ only objective is to get through the day - to survive (Crossley, 2002). Because of this, traumatic experiences can lead people to lose any sense of narrative thread or chronology, but also to start a new story as they make sense of their experiences (Crossley, 2002).

What is thematic narrative analysis?

Narrative analysis refers to a group of analytic methods that are designed to interpret these stories (Figgou, 2015). Thematic narrative analysis is a type of narrative analysis that focuses on “‘what’ is said, rather than on “’how’, ‘to whom’ or ‘for what purposes’ it is told (Riessman, 2008, p. 53). Thematic narrative analysis, like other forms of thematic analysis, seeks to identify common themes or patterns across accounts. However, unlike thematic analysis, thematic *narrative* analysis preserves the structure of narratives and stories in research by working with a single interview at a time instead of coding discreet segments of text across interviews (Riessman, 2008).

The findings of a thematic narrative analysis can be presented in different ways. Some authors present themes along with participants' quotes, as is customary for other types of qualitative analysis. Some researchers produce a typology that illustrates central ideas or 'stories' identified that explain a phenomenon or experience (Frank, 2013). Others have illustrated key themes through presenting case studies (Riessman, 2008; Williams, 1984).

Why choose thematic narrative analysis?

Narrative analysis is well suited to research that aims to understand lived experience whilst recognizing the role of context in shaping what stories get told, how they get told, and what stories are heard (Crossley, 2002). Furthermore, thematic narrative analysis is particularly useful for applied health research (Riessman, 2008). Findings produced through thematic narrative analysis can "have effects beyond the meanings for individual storytellers, creating possibilities for social identities, group belonging, and collective action" (Riessman, 2008, p. 54). In narrative analysis, the way a person tells their story is centered in the analysis and this makes narrative analysis a useful approach for examining connections between personal stories and wider sociocultural narratives (Crossley, 2002). Because of this, narrative analysis is particularly useful for research about silenced and misunderstood topics like sexual violence and has been used to highlight traditionally silenced voices (Reinharz & Davidman, 1992).

The emphasis on both the individual lived experience and the wider sociocultural context is particularly salient to this research. Women live their lives against a backdrop of cultural assumptions about what women should do and how women should behave, and this shapes their experiences of healthcare, motherhood and sexual violence. For example, there is the myth and dominant ideology of the 'perfect mother' who is completely committed to her children and her role as a mother, which is often completely at odds with women's actual experiences of motherhood (Lewis & Nicolson, 2007; Shelton & Johnson, 2006). Additionally, sexual violence research has identified cultural or stereotypes that excuse violence against women and girls (Gavey, 2018; Tarzia, 2015).

4.9.9 Approach to analysis

Narrative analysis can be used with a variety of different epistemologies (Riessman, 2011, 2008). I was guided by Crossley (2002) which sees storytelling as a situated re-interpretation of past events and a co-construction of a new narrative that gives researchers useful insights into people's lived experience. As Crossley (2002) explains, there is "an approach which, while recognising, the inextricable connection between individual 'personal' experience and 'social' forms of meaning such as discourse and narrative, retains the capacity to accord a sufficient degree of 'reality' in the experiential 'domain' (p. 43). Therefore, analysing people's stories about their experiences is seen a way to access some sort of 'truth' (i.e., people's experiences), although the understanding and interpretation produced cannot be separated from the storyteller, the listener and the wider social, cultural and political context within which the story is told.

All narrative analysis keeps the narrative intact for analysis, but researchers still need to define what a narrative is for their study. I used a very broad and flexible definition of a story, recognizing that, due to impacts of trauma on memory and sense of self survivors may not have access to a chronological or neat account of their lives (Crossley, 2002. To address complex relationships between trauma, memory and storytelling, I aimed to be as inclusive as possible, including both 'small stories' that related to a specific event and 'big stories' that developed over the course of an interview (Riessman, 2008).

4.9.10 Steps taken in the analysis

There are no pre-defined guidelines for conducting a narrative analysis (Riessman, 2008). In this study, analysis was guided by and adapted from steps outlined in Crossley (2002) and the worked examples of thematic narrative analysis discussed by Riessman (2008). I used NVivo 12 to manage the data.

Familiarisation

The first step in analysis for narrative analysis was transcribing. Transcription presented an opportunity for reflection and increased my familiarity with the data (Nasheeda et al., 2019). During transcription I made note of changes in tone of voice, crying and laughter. When transcription was completed, I read each transcript several times, noting initial reflections.

Creating narrative summaries of 'big stories'

Working with one transcript at a time, I then created a narrative summary for each participant in Microsoft Word. In these summaries, I preserved the order in which women told their stories, noting the key events, imagery and symbols women included in their story (Crossley, 2002). Creating this summary helped me to see the whole narrative (or 'big story') that developed over the course of the interview and identify cross-cutting underpinning concepts and themes. I also drew (by hand) illustrations that captured salient concepts and themes in women's experiences. I photographed my illustrations and imported these into NVivo 12 along with the transcripts and narrative summaries. See appendix H for an extract of one woman's narrative summary.

Coding 'small stories'

After I had created the narrative summaries, working with one transcript at a time, I used NVivo 12 to code the 'small' stories within each woman's narratives. These were accounts of specific events or experiences. Codes were broad and, in some cases, reflected themes that I had identified from reading individual women's narrative summaries and transcripts. Some of these 'small stories' are presented in the findings as quotes. I have provided an example below. During coding, I kept these stories intact, so this whole story was coded as one unit.

Example of a 'small story':

> I wanted to give him a vaginal birth. And as a baby he deserved that chance. But actually it wasn't the best decision for me. I knew in my heart of hearts that the best decision for me at this stage was to have a caesarian section. […] But for some reason I wasn't able to – in some ways this is key from a sexual survivor's point of view – I wasn't able to listen to what was right for me. And I wasn't able to put my needs and what was good for my body at the centre of the decision. […] I needed to do what's best for the baby to give the baby the best birth. [...] Then when the consultant said 'I'm not sure we've got the right plan for you' and we talked it through, and she was like 'I think we should do this [emergency c section]', I had this massive sense of relief [sighs] 'I do too, thank you for giving me a get out'. - Aila

Looking across accounts

When I had finished coding all transcripts, only then did I begin looking across the transcripts, narrative summaries, illustrations and codes to identify themes and patterns. During this process, I identified dominant sociocultural narratives that featured in women's stories as well as ways that women resisted and challenged these dominant narratives (Riessman, 2008). For example, many women described an internalized and societal assumption that 'scientific knowledge', e.g., and providers' opinions, was more valid than women's' own experiential and embodied knowledge. I named this the 'dominant biomedical narrative'.

Refining and producing final themes

Refining and producing the final themes was an iterative process that involved going back to the original data and narrative summaries several times. The themes were further refined following feedback from survivors in public engagement workshops (described in Chapter 5). The themes that I generated captured accounts about a central concept or experience (e.g., narratives of shame). I draw out nuances in my discussion of each theme.

Writing up

When writing up my findings, each theme was named using a quote from a participant. I also drew on Williams' case study approach (1984; also discussed in Riessman, 2008). I present the majority of findings as themes, but I refer to one woman's experience in detail to illustrate the difference between a disempowering and empowering experience of care.

4.10 Provider Study Methods

This section describes the methods used to conduct a qualitative study about maternity care providers' needs and experiences regarding supporting sexual violence survivors, analysed using reflexive thematic analysis.

4.10.1 Research questions

Overarching research question: What are maternity care providers' experiences, expectations and needs regarding supporting survivors of sexual violence?

Other research questions were:

1) What are maternity professionals' experiences of providing care to women who have experienced sexual violence and abuse?

2) What do maternity professionals identify as barriers to identifying and responding to women's experiences of sexual violence and abuse?
3) What would help overcome barriers to identifying and responding to women's experiences of sexual violence and abuse?
4) How does working with survivors of sexual violence impact maternity care professionals?
5) What support do maternity care professionals identify they need to minimise the impact on their own well-being?

4.10.2 Ethical approval

This study was reviewed and gained ethical approval from the King's College London PNM Research Ethics Panel (ref. LRS-19/20-20244). For a detailed discussion on ethical issues that were considered and addressed, see Chapter 5.

4.10.3 Inclusion/exclusion criteria

Participants met the following inclusion criteria: (1) a maternity care professional (e.g., midwife, obstetrics/gynaecology doctor) who has practiced in the UK, and (2) able to speak and read English proficiently to be able to provide informed consent and to participate in an interview in English.

Potential participants were to be excluded if they: (1) were unable to provide informed consent to participate and/or who were judged by the researcher to be too unwell or distressed to participate in a research interview, (2) were maternity care professionals who had never practiced in the UK, (3) were healthcare professionals whose role was to provide general care, as opposed to maternity care, e.g., a GP.

4.10.4 Recruitment

I reached potential participants through convenience sampling. Before starting recruitment, I consulted with colleagues who are maternity professionals to find out about the best ways to approach recruitment. Multiple recruitment strategies were planned, anticipating that due to time and resource constraints these participants would be difficult to reach. However, the response from maternity care providers was enthusiastic despite recruitment occurring during the COVID-19 pandemic. Participants were recruited in the following ways:

- The study was advertised via the Violence, Abuse and Mental Health (VAMHN) Network newsletter.
- The study was advertised on Twitter.
- Colleagues (maternity care providers) sent study information around their team.
- Participants sent the study information to others they thought would be interested (snowball sampling).

Recruitment took place between September 2020 and February 2021. This period coincided with the global COVID-19 pandemic and accordingly all recruitment and data collection activities took place online. Unlike the survivor study (Study 2), this study was not paused or disrupted, because data collection started after the COVID-19 pandemic had already begun. Seventeen people contacted me to express an interest in participating. I responded to all contacts with a copy of the Participant Information Sheet (see appendix I) and an offer to answer further questions about the research via Zoom (video call software) or email.

Three people did not respond to my email or a reminder that I sent approximately one week later. One person was keen to participate but due to personal difficulties they were not able to commit to an interview. The remaining 13 participants indicated that they wished to schedule an interview after reading the information sheet and did not ask any further questions or request an initial conversation about the study.

4.10.5 Consent

See Chapter 5 section 5.2 for a further discussion about how consent was approached. All participants received the Participant Information Sheet (PIS; appendix I). At least 24 hours before the interview to ensure that they had enough time to consider the study. Participants completed an online consent form hosted on the Qualtrics platform (see appendix J). Completed consent forms were downloaded and securely stored on MS SharePoint with access limited to me only before being deleted from the platform. Participants completed the form while in a Zoom meeting with me and after I verbally explained all aspects of the PIS after which providers had an opportunity to ask questions. I explained that consent to participate can be withdrawn any time during the interview or afterwards without having to give a reason why.

4.10.6 Data collection

All interviews were audio-recorded. I asked participants to ensure that they were in a private place where they would not be overheard. Interviews were semi-structured and followed a topic guide (see appendix K) which asked participants to reflect on their professional experiences and observations. The topic guide was developed with guidance from my supervisors, my reading of the literature and my systematic review and the meta-ethnography findings. Additionally, one survivor and two midwives, one with expertise in sexual violence and another with expertise in perinatal mental health, reviewed a draft topic guide and made suggestions for amendments. The topic guide was initially piloted with a midwife to practice the interview questions and to test feasibility. This pilot was not recorded and was not included in the final analysis. The topic guide was further piloted for feasibility and acceptability with the first two recruited participants with plans to further revise it if needed. No revisions to the topic guide were made. The topic guide was not used prescriptively but served as a flexible guide for the interview. During the interviews, I aimed to remain alongside participants, following the topics that they introduced and returning to the topic guide only when needed. Most participants covered the topics on the topic guide organically with little need for reorientation from me. At the end of the interview, I asked all participants whether they wanted to remove information from the transcript. Additionally, I wrote field notes after each interview.

4.10.7 Data management

One interview was transcribed by me at the request of the participant and the remaining twelve interviews were transcribed by a professional transcription company that signed a confidentiality agreement with women's consent. Each transcript was checked for accuracy by me by listening to the recording at the same time as reading the transcript. Personal details were removed from the transcript during accuracy checks as well as any information that participants requested to be removed. After these checks had been completed, the audio files were deleted. All transcripts were securely stored on MS SharePoint with access limited to me only. One participant chose their own pseudonym. I assigned all the rest.

4.10.8 Reflexive thematic analysis

Data were analysed using inductive reflexive thematic analysis (Braun & Clarke, 2006, 2019b, 2020). The following sections describe what reflexive thematic analysis is, why I chose this method, and the steps I took in the analysis.

What is reflexive thematic analysis?

Reflexive thematic analysis is not tied to an inherent theory or philosophy about the nature of reality (ontology) or the production of knowledge (epistemology), as is the case for some other approaches to qualitative analysis (such as grounded theory or interpretative phenomenological analysis; Braun & Clarke, 2006, 2013, 2020). This means that it can be tailored to best suit the aims of the project (Braun & Clarke, 2006). However, although reflexive thematic analysis is theoretically flexible, it is not atheoretical: reflexive thematic analysis is firmly grounded in a qualitative, interpretive paradigm (Braun & Clarke, 2006, 2020).

The theoretical flexibility of reflexive thematic analysis is sometimes misunderstood as an indication that it is primarily a superficial, descriptive or positivist method of data analysis (Braun & Clarke, 2020). However, Braun and Clarke are critical of this standpoint, highlighting that when it is conducted within a qualitative paradigm, findings should progress from superficial description to interpretation (Braun & Clarke, 2019b, 2020). Other versions of thematic analysis exist (Boyatzis, 1998; Guest et al., 2011). However, these approaches locate thematic analysis within more realist/post-positivist paradigms because they promote practices which aim to reduce researcher influence, for example, by using fixed coding frameworks and inter-rater reliability (Braun & Clarke, 2020). Conversely, Braun and Clarke's (2006, 2020) reflexive thematic analysis approach sees the researcher's subjectivity as an analytic resource to be celebrated and nurtured. Reflexive engagement with theory, data and interpretation lies at the heart of this approach, grounded firmly in a qualitative, interpretive paradigm while allowing for different epistemological assumptions compatible with this paradigm (including critical realist and constructionist approaches; Braun & Clarke, 2020).

Why choose reflexive thematic analysis?

Braun and Clarke's reflexive thematic analysis approach was chosen because it is particularly useful for conducting applied research that aims to be translational. First, it offers a flexible and comprehensive toolkit for researchers to conduct robust and sophisticated analyses of qualitative data which also lend themselves to being presented in an accessible way to people outside of academia (Braun & Clarke, 2014). Second, reflexive thematic analysis is particularly well suited to topics where there is minimal prior knowledge and when the interest is how personal experiences sit within broader socio-cultural contexts (Braun & Clarke, 2006, 2020).

Approach to analysis

Due to its theoretical flexibility, researchers using reflexive thematic analysis must specify the epistemological assumptions underpinning their analysis (Braun & Clarke, 2006, 2020). I address this in section 1.3, where I discuss the epistemological approach underpinning this research (recognising both an external reality and researcher positionality). Researchers must also make additional decisions about how they plan to approach data analysis prior to starting data analysis (Braun & Clarke, 2006). To address this, I wrote a reflective note to document my responses to the questions outlined in Braun and Clarke (2006; see appendix L). Briefly, I made the following decisions prior to analysis: prioritising salience over prevalence of themes; aiming to provide a rich thematic description of the entire dataset rather than focusing on one aspect; taking a data-driven, inductive approach (recognising that this is often a continuum rather than a dichotomy; Braun & Clarke, 2020), instead of a theory-driven (deductive) approach; focusing on the semantic meaning of data i.e. the coding and theme development reflect the explicit (rather than implicit or latent) content of the data.

4.10.9 Steps taken in the analysis

The steps taken in the analysis were based on those outlined in Braun and Clarke (2006). As advised by Braun and Clarke (2006), I approached these steps as a set of tools to help me frame the analytic process and facilitate a rigorous process of data interrogation and engagement. I followed each of the below steps in order initially, but as the analysis progressed it became a recursive process as I moved back and forth between different phases revising codes and themes. These data were analysed concurrently with the meta-ethnography analysis (see section 4.8 in this chapter) and interviews with survivors of sexual violence (section 4.9 in this chapter). I used NVivo 12 to manage the data.

Familiarisation

This phase involved reading and re-reading the data to become immersed in its content (Braun & Clarke, 2006). The first stage of familiarisation, I listened to the interview audios to check the transcripts for accuracy. Second, I printed all of the transcripts and I read and re-read them, highlighting quotes that I felt were particularly salient and noting thoughts about the themes and patterns I saw in the data.

Coding

This phase involved generating codes that identified important features of the data for the entire dataset, and later collating the codes to generate initial themes (Braun & Clarke, 2006). I focused on the semantic (explicit) content of the data and on capturing just one aspect of an experience. Initially, I produced a set of codes that were very close to the topic guide and considered these my final themes and sub-themes. However, discussion with my supervisors allowed me to see that my findings were in fact a summary of the refined codes and remained largely descriptive rather than interpretive. Braun and Clarke (2020) highlight that confusion between codes and themes is a common issue with published research citing their approach to thematic analysis. Researchers who stop at this point present underdeveloped, overly descriptive themes due to stopping analysis before the higher-level interpretive work is done (Connelly & Peltzer, 2016). I therefore returned to the analysis and continued analysing the data until I generated interpretive, complex and nuanced themes.

Generating initial themes

This phase involved examining the codes to identify significant broader patterns of meaning (potential themes). I used NVivo 12 to collate data and codes relevant to each potential theme so that I could review the data within it and judge the salience of each potential theme. I distinguished between codes and themes by drawing on the following definition: “codes can be thought of as entities that capture (at least) one observation, display (usually just) one facet; themes, in contrast, are like multi-faceted crystals” (Braun & Clarke, 2020, p. 340).

Reviewing themes

This phase involved checking the potential themes against the data, to ensure they reflected the data and answered the research question. During this phase, I refined my themes, and this involved some themes being split, combined, or discarded. For example, the theme ‘personal beliefs and values’ was further refined to reflect the central idea that providers’ personal beliefs and values *conflicted* with the needs of the system.

Defining and naming the themes

This phase involved working out the scope and focus of each theme and determining each theme’s ‘story’ or central idea. It also involved deciding on an informative name for each theme. To continue with the previous example, the theme called ‘personal beliefs and values’ was later re-named to ‘sitting between women and the system’. This new name illustrated the idea that the conflict between providers’ personal beliefs (to provide individualised care) and the system (that prevented individualised care) created a tension that left providers feeling stuck between women and the system. This idea tied the theme together and advanced this theme from a code that captured one observation i.e., a description of providers’ beliefs and values, to a theme that captured a multi-faceted observation i.e., providers caught between women and the system.

Writing up

This final phase involved weaving together the themes and data extracts and contextualising the analysis in relation to existing literature. This process was iterative which each version building on and refining the next.

4.11 Summary of Chapter 4

This chapter began with a discussion of the qualitative paradigm and the epistemology that guided this PhD. I considered how a view that language provides a situated and socially influenced insight into lived experience underpins this research. I then described the methods used in three studies: a systematic review and meta-ethnography (Study 1), a narrative analysis of survivors' experiences (Study 2) and a reflexive thematic analysis of maternity care providers' experiences (Study 3). The next chapter will focus on ethics and reflexivity.

Chapter 5. Trauma-Informed Approach, Ethics and Positionality

Abuse of power and silencing are characteristic of sexual violence (Sweeney et al., 2019). For research to feel safe for survivors it therefore needs to be trauma-informed, promote empowerment and counteract silencing (Downes et al., 2014). This chapter details the trauma-informed approach taken in the research, ethical considerations considered and addressed, and finishes with reflections on researcher positionality and reflexivity.

5.1 Trauma-informed approach to the research

This section describes how the research was trauma-informed. In section 1.1, I outline the trauma-informed principles and values that guided all stages of the research. Section 1.2 details involvement and engagement activities, as meaningful involvement is a key component of trauma-informed approaches is meaningful involvement (Sweeney et al., 2018). Finally, in section 1.3, I discuss the ethical considerations that were identified and addressed in the context of the trauma-informed approach taken.

5.1.1 Principles and values underpinning the research

Charter for Engaging Survivors

All aspects of the study design and conduct were guided by the principles outlined in the Survivors Charter (Perôt et al., 2018). The key message of the Charter is that all contact with survivors, including research, should look and feel like the opposite of abuse. That means engagement should be safe, empowering, amplify survivor’ voices, promote self-care, be accountable and transparent, be liberating and be creative and joyful. These principles are illustrated in table 3.

Table 3. Principles of the Survivors Charter (adapted from Perôt et al., 2018).

Dynamics of abuse	**Principles for meaningful engagement**
Abuse is inherently unsafe. It leaves a long legacy of fear.	**Safe**. Engagement should be in a safe environment that begins with providing attentive listening and connections that are warm, collaborative and relational, which recognises and minimises triggers and may include safety protocols.
People who are abusive dominate and take away personal power.	**Empowering**. Engagement should be collaborative and must empower survivors to have control of decisions about their involvement.
Abuse is silencing.	**Amplifying the voices of survivors.** Engagement should help release and amplify survivors' voices, experiences and expertise.
Abuse is self-negating, destroys self-worth and damages wellbeing.	**Promoting self-care.** Engagement in research activism can impact coping mechanisms – thus radical self-care should be normalised by example, as well as in organisational processes.
Abuse is hidden, and abusers often act with impunity	**Accountable and transparent.** Engagement with survivors must have clear lines of communication and accountability. Processes and decision making should be relational, honest, real, transparent and open to feedback and dialogue.
Abuse restricts and arrests healthy growth, imprisoning people in physical, mental and emotional shackles.	**Liberating**. Engagement should be liberating, dynamic, life-giving, and help survivors experience a sense of possibility and life beyond the aftermath of abuse. Engagement should be a voluntary process and easy to withdraw from at any point.

Abuse is corrosive, restrictive and soul-destroying.	**Creative and joyful.** Engagement should be a creative process. Good engagement focuses on positive experiences and strengths, as well as negative ones, and can increase capacity for joy, creativity and imagination.

Empowerment model

The approach to the research is also grounded in a feminist, trauma-informed empowerment model that guided my work on the National Rape Crisis Helpline. This empowerment model emphasises the importance of believing and trusting survivors; it is "a holistic model which aims to facilitate a woman's ability to take back choice and develop trust in herself" (Rape & Sexual Abuse Support Centre, 2022). I have outlined the assumptions of this empowerment model in table 4 (adapted from RASASC website).

Table 4. Empowerment model. (Rape & Sexual Abuse Support Centre, 2022).

Empowerment is about:	**This means:**
Exploring options without providing direction.	Demonstrating belief in survivors' ability to know what is right for them.
Valuing the essence of being a woman and the resources that that in itself brings.	Not telling a survivor what to do or advising – she is the expert of and on her life.

Believing that a woman can care for and nurture herself.	Providing education/information and knowledge, sharing our information and tools.

5.1.2 Survivor and provider involvement

A critical component of trauma-informed approaches is that “survivors themselves are instrumental in bringing about change” (Oram et al., 2022, p. 509; see also Sweeney et al., 2018). Therefore, this section details how survivors were involved in this research. I also consulted providers to ensure that the research would produce outputs that made sense to providers. Some providers I consulted were also survivors.

Consultations

The following individuals and groups advised on the feasibility and acceptability of the study design and materials from study conception and throughout recruitment and data collection:

- Three survivors, some of whom also worked with survivors in a professional role.
- The clinical coordinator of a sexual abuse support centre
- An independent sexual violence advocate.
- A founder of a not-for-profit organisation that advocates for the needs of sexual violence survivors.
- Three midwives, one was also a survivor.
- A Patient and Public Involvement (PPI) group of service users of mental health services who are also parents. This group was not created for this research study. It is linked to the Section of Women’s Mental Health research group at King’s College London and provides advice and feedback on upcoming and ongoing research within the research team.

These consultations were done on an ad-hoc basis. The following changes were made as a result of this consultation work:

Addressing researcher well-being

Several groups and individuals considered addressing, preventing and managing vicarious trauma an essential part of conducting ethical, safe research. To address this, I sought out several opportunities to complement my training and experience working in a rape crisis centre. I referred to guides on managing vicarious trauma, such as the Sexual Violence Research Initiative (Sexual Violence Research Initiative, 2015). I attended a two-day workshop about vicarious trauma in researchers. I attended monthly group reflective supervision led by a clinical psychologist throughout the data collection, analysis and writing up phases of the research. My peer network and academic supervision supported well-being during data collection and analysis in particular.

Being inclusive

The PPI group raised a concern that the proposed advert did not address the experiences of women who have had children removed or had a loss or termination of pregnancy. They highlighted that women with these experiences can face additional barriers to participating in research, may think the research does not include them and may not feel it is valid to talk about these experiences during the interviews if they do participate. To address this, I highlighted when speaking with women that these experiences were valid and welcomed in the research, including just before starting the interview.

Signposting to relevant services

It was stressed that survivors should receive a comprehensive and up-to-date resource after interviews to signpost them to specialist sexual violence support services. To address this, I developed a list of national specialist sexual violence services that I gave to all participants. I developed this resource based on my experience working on the National Rape Crisis Helpline (as signposting was a key part of my role). I also referred all participants living in London to the Survivors Gateway (https://.survivorsgateway.london): a gateway to London-based specialist services that provide information, support and help to anyone who has been affected by rape, sexual assault and sexual abuse. I checked with women that it was safe to take any physical documents with them and offered to send resources by email as well. I set aside time after every interview to go through these resources. I approached this as information-sharing to empower women rather than directing women to services or telling them what to do, as accessing services should always be an individual’s choice.

Interviews with providers

The topic guide for the provider study was reviewed by a survivor with lived experience of sexual violence and maternity care and two midwives, one with expertise in sexual violence and another with expertise in perinatal mental health. The following suggestions were made: First, include questions in the topic guide to understand what maternity care providers understand by ‘sexual violence’ and what they think survivors may need. This is important to a trauma-informed approach, as providers' understanding of what survivors need can differ from those of survivors. Second, acknowledge that providers may also be survivors and let participants know they will not be asked about this but that they can talk about lived experience if helpful. Third, acknowledge that providers may talk about distressing experiences (not just in relation to sexual violence as there are other stressful aspects of the job), and reassure maternity care providers that they do not have to answer any questions and they can take breaks.

Public engagement and dissemination

I won a grant to conduct public engagement workshops with women who had experienced sexual violence. This public engagement and dissemination activity will be completed after the submission of this thesis. At the time of writing, I have held two public engagement workshops. Survivors who had taken part in the research were invited to take part in these workshops, and two accepted. In total, seven women participated; five in workshops and two spoke with me separately.

These workshops aimed to: (1) shape the research findings and (2) co-produce artwork about the lived experience of pregnancy, birth, motherhood, and maternity care after sexual violence and what 'good' care would look like. The artwork produced aims to humanize women's experiences, because many women told me that they felt dehumanised by maternity care providers and systems. Furthermore, trauma is so often beyond the reach of words (Fischer, 2019), and art can convey experiences in a way that words cannot.

The public engagement workshops were open to anyone with lived experience of sexual violence and maternity care. All women were paid £25 per hour for participation, which is the public engagement rate recommended by NIHR. I co-facilitated these workshops with a professional artist and a peer-facilitator from Survivors Voices - a survivor-led peer-support and research organization that co-produced the Charter for Engaging Survivors (Perôt et al., 2018) and which guided my research. Survivors Voices provided peer-support to women during and after the workshops. I offered everyone a chance to meet me and discuss the public engagement project before the workshops. A trauma-informed yoga instructor led a grounding session at the beginning and end of the workshops, to offer strategies for women to use both during the workshops and afterwards. All women received a thank you gift consisting of a grounding kit with sensory self-care items (shower gel, hand rub, aromatherapy, herbal teas) and, once the artwork is finalized, they will receive a print of the final artwork.

During these workshops, I presented preliminary research findings from my interviews with survivors, although we also discussed findings from the systematic review and provider study briefly. We wanted to ensure that these workshops focused on the survivor voice, and what survivors wanted to say to the world and to providers (through the art). Questions we asked women in the workshops included: (1) what aspects of the research findings they think we should highlight in the artwork (2) whether there are gaps in the research findings that you would like the artwork to highlight, and (3) how we should represent their experiences in art form.

In the workshops, women highlighted feelings of shame and isolation during their pregnancies and afterwards. If their experiences did not fit pictures of 'ideal' or 'perfect' motherhood, they felt that there must be something wrong with them, and that they must be the only one facing these difficulties. Consequently, I reviewed the findings of the survivor study to ensure that these experiences of shame and isolation were highlighted in the findings. The discussions I had with women in the workshops and individually therefore added richness and depth to my analysis and write-up of the survivor interview findings (presented in Chapter 7).

In the workshops, women noted that they had never talked to other women who had similar experiences to them. Although this was not intended as a therapeutic space, feedback from women indicated that they found connecting with other women and being able to voice the things that they had never been able to say before healing. To illustrate this, I have permission to share the following feedback from women in this thesis. I followed Survivors Voices' advice to ask all women if they wanted to be named, remain anonymous or wanted me to use a pseudonym to refer to them when talking about public engagement.

> Thank you for providing a safe and contained group. It was so wonderful to be with women who just understand. I have taken part in many research projects and my

> feedback is that it was an absolutely perfect example of trauma informed, Lived Experience coproduction. The yoga instructor was a thoughtful element. It was a respectful space. I would LOVE to join a future workshop, thank you so much for asking. I would suggest you change nothing at all!
>
> It was so lovely to see you as well, and meet the other women. It truly was a powerful and inspiring experience to share space with all the women, I felt incredibly moved by the bravery and resilience and honesty of all of us. Well done for creating a sacred space for vulnerability and truth telling. I really like that the session began and ended with breathing and mindfulness, it was really useful for me.
>
> Thank you for such a warm and kind email, I felt very held throughout. I was a bit tired, but I always am by 9pm, and I was fine. I thought it was an amazing space and I was so happy people felt they could be authentic about very sensitive personal stuff.
>
> What an amazing, moving, uplifting and healing space it felt to be, and I felt such an intense longing to support and recognise what others were saying. SO inclusive. It would be wonderful to meet up again and to explore the then thoughts from our sharedness, and the progression of that into art.

5.2 Ethical considerations identified and addressed

Trauma-informed ethics requires researchers to go beyond generic Institutional Review Board (IRB) requirements (Campbell et al., 2019; Downes et al., 2014). Furthermore, IRBs often operate from an assumption that survivors of violence and abuse are inherently ‘vulnerable’, which can create conflicts and tensions when researchers aim to empower participants and achieve social justice aims (Downes et al., 2014). This section details the ethical issues I considered and addressed in this research, guided by a trauma-informed and empowerment framework. Ethical issues are considered together for all studies, because I treated all participants as if they could have experienced trauma, but I have indicated if a point relates to a specific study. My considerations of ethical issues were informed by wider literature on trauma-informed approaches to research (Campbell et al., 2019; Downes et al., 2014; Isobel, 2021). However, I was primarily guided by the following survivor-produced ethical guidelines which are located outside of academia: the survivor-led ‘Turning Pain into Power’ charter (Perôt et al., 2018) and ‘The Ethics of Survivor Research’ (Faulkner, 2004).

5.2.1 Preventing vicarious trauma

Conducting research on trauma carries a risk of vicarious trauma (Sexual Violence Research Initiative, 2015). This is true for interviews as well as constant reading and re-reading emotionally demanding material involved in reviews. As argued by Schulz et al. (2022), emotional impact may be greater the closer one is to one’s research topic or participants and when we seek to conduct research as carefully as possible.

To look after my well-being I maintained separation between my work and home space by not working on data analysis at home. However, after the COVID-19 pandemic began, I had no choice but to conduct some interviews and data collection in my home. To manage my well-being at this time, I took regular breaks and worked shorter days if I needed. I introduced a transition activity to mark the end of the workday, such as exercise or putting on music. Schulz (2022) also highlight the importance of adequate supervision and institutional mechanisms to support, however. Notions of self-care risk placing sole responsibility on individuals to manage their well-being. Through my research team, I had access to reflective supervision that was organized through my research team and led by a clinical psychologist. As this was group supervision this connected me with other PhD students and staff members and was a vital source of support for me, especially during national lockdowns due to COVID-19. I also benefitted from having three wonderful, supportive and encouraging supervisors who understood what researching topics like this was like and were excellent role models for self-care and setting work-life boundaries. One of my supervisors was available after interviews to check in and debrief if I needed. Finally, throughout my PhD, I connected with other researchers who were also conducting similar research as well as other survivors who were also researchers, providing a community of peer support that I could turn to at difficult times.

5.2.2 Including trauma-informed quality indicators in the review

In the systematic review, I considered it an ethical issue to pay close attention to whether studies made any reference to using trauma-principles to guide their research (Faulkner, 2004). All work with survivors, including research, should look and feel like the opposite of abuse (Faulkner, 2004; Perôt et al., 2018). Yet trauma-informed aspects of research (such as involvement) are poorly reported (Kennedy et al., 2022). As systematic reviews may be used to inform policy and practice decisions, I felt I had a duty to document how trauma-informed the evidence in my synthesis was. I achieved this by adding several items to the quality assessment (in addition to the CASP) that captured aspects of quality that are particularly important to ethical research with survivors (see Faulkner, 2004; Perôt et al., 2018; Sexual Violence Research Initiative, 2015). For example, I included questions on survivor involvement (beyond being participants); and whether and how authors considered the potential impact of power relations between researchers and participants. Please see Chapter 4, section 4.8.7 for more detail on how I conducted the quality assessment.

5.2.3 Payment

All participants in the survivor study received a £15 voucher as a thank you for their time. Although I would have liked to pay more, the amount I could pay was limited by my funding. Providers were not given a voucher as I felt it was important to give survivors as much as possible. Survivors who contributed to the public engagement activities (described in section 5.1.2) were paid £25 per hour (£50 for a two-hour workshop), in line with payment guidance from the National Institute of Health Research (NIHR, 2022).

5.2.4 Self-identification

For the survivor study, I did not screen for sexual violence experiences or check with women whether their experiences met the criteria and definition used in this study. I trusted women to decide for themselves if they met the criteria based on information I gave them about the research. What mattered most to the study was whether women self-identified as a survivor of adulthood sexual violence. This was an important part of the trauma-informed approach of the research, because using researcher-led assessments or outcome measures positions the researcher as the expert and could be another form of silencing. What was important to the aims of the study was that women self-identified as a survivor of sexual violence in adulthood.

5.2.5 Sharing support resources

To recruit survivors, I decided to recruit through newsletters as well as through maternity and specialist sexual violence services. This allowed for a range of women to be interviewed (i.e., not just those currently using services). Many survivors will not be in current contact with services for various reasons. This may be because they finished their allowed sessions (counselling is usually offered for up to 12 months in rape crisis centres); do not feel ready to seek counselling; paid for private therapy; do not feel they need this support; or they have turned to more informal peer and grassroots support networks. However, some survivors may benefit from support from a specialist service and researchers have a responsibility to ensure that participants are aware of the support available to them. This issue was raised by PPI groups, and I addressed this by producing a comprehensive resource (see appendix P).

5.2.6 Approach to distress, disclosure and safeguarding

A detailed distress and disclosure protocol (see appendix M) outlined how I would respond to any participant that became distressed or told me that they or someone else was in imminent danger. For the interviews with survivors, a clinician who was a psychiatrist with expertise in women's mental health was on call during interviews with survivors in case I needed to discuss a safeguarding concern. I was transparent with participants about the limits of confidentiality and explained what would happen if I had to break confidentiality, i.e. if they disclosed a risk of harm to them or someone else (see Appendix for the safety protocol). I emphasised that if I had concerns, I would make every effort to speak with them first and to make joint decisions. I explained that the psychiatrist on call was a woman and fellow PhD student in my research team who worked clinically in trauma and violence. I also explained that this clinician was not provided with any details about participants unless, after speaking with them about any potential concerns, they felt they needed to take action.

I did not need to discuss or report any safeguarding concerns. All participants had accessed support through survivor-led, grassroots or third sector organisations, and some from mental health services, and many were involved in activism or supporting other survivors. Participants therefore seemed to be safe, had acknowledged their experiences, and had access to support.

It is important to highlight, however, that survivors may not have felt safe to disclose a risk of harm to me, given that safeguarding concerns were discussed with a psychiatrist. Many survivors have traumatic and disempowering experiences with psychiatrists as well as the mental health system (e.g., Sweeney et al., 2009, 2019). The failure of the mental health system to address trauma and harms caused by behaviours that re-traumatise survivors has led survivors to repeatedly call for its complete overhaul (Filson, 2016; Sweeney et al., 2018). Feminists have also argued that mental health diagnoses have been used as a means to control women and that “psychiatry is a patriarchal institution that is fundamentally oppressive to women” (Wright & Owen, 2008, p. 147). Similarly, Herman (1997) highlighted that mental health diagnoses have been used to silence women and disguise the pervasiveness of violence in women’s lives by conceptualising trauma as ‘hysteria’. Because survivors have been repeatedly failed by the mental health system, and indeed participants may themselves have experienced psychiatric harm, it is therefore possible that the clinician’s role as a psychiatrist could have impacted participants’ sense of safety to disclose any risk of harm to me. Although I knew this clinician well and trusted that she understood trauma and was well placed to use trauma-informed principles to make decisions about safeguarding, participants may not have felt the same.

Women who participated in the public engagement workshops had access to peer support provided by a survivor-led peer support organisation (Survivors Voices), funded by a King’s College London Public Engagement Grant. All women were given the phone number of a peer support facilitator who they had met in the workshops and were encouraged to contact them if they felt they needed support after the workshops. Several women availed of this offer. In addition, I checked in with all women after each workshop, asked them how they were feeling, and reminded them that they could access peer support.

5.2.7 Not asking about experiences of violence and abuse

It was important to me that the interview created a space that countered the shaming and silencing that survivors routinely experience, regardless of whether I was interviewing providers or survivors. It was also important that participants knew what to expect from me and had control over what information they shared. To achieve this, I took the following steps: before every interview, I explained to all participants in both studies that they would not be asked about lived experiences of abuse, but that they were welcome to talk about anything they felt was relevant, including experiences of violence and/or abuse. I told all participants about my reasons for doing this research, including that I myself had experienced sexual violence, and that I had worked in a feminist rape crisis centre. I did this to increase transparency, minimise the inherent power imbalance between the researcher and participants, and to reiterate that I am able and ready to hear stories of violence and abuse. Doing this was important because it set a clear boundary so that women knew what to expect from me (i.e., that I would not ask about abuse), but it also invited those that wished to include these experiences to do so at their own pace. It reassured survivors that I am ready to bear witness to their full experience, as some survivors may not feel able to tell all aspects of their experiences for fear of distressing or upsetting others. Most women in the survivor study (Study 2) shared experiences of violence and abuse, but this happened at different points of the interview. Two providers (Study 2) also incorporated lived experience into their interview.

5.2.8 Omitting participant quotes from the systematic review findings

Many systematic reviews use participant quotes to evidence their findings. However, following discussions with my supervisors, and drawing on my own lived experience and survivor-led ethical guidance (Faulkner, 2004), I decided not to re-produce survivors' words in this systematic review. In this section, I will explore in detail the different elements that led to my decision.

There appears to be a lack of consensus over what data should be used to support meta-ethnography findings (France et al., 2014). For instance, a systematic review of 32 peer-reviewed meta-ethnographies by France et al. (2014) noted that six out of 32 studies did not report participant quotes in support of their findings (e.g., Cook et al., 2012; Embuldeniya et al., 2013). In terms of violence research, Feder and colleagues' (2006) meta-synthesis on healthcare experiences and expectations after intimate partner violence also omitted quotes from the report. Although most meta-ethnographies do present quotes, some peer-reviewed meta-ethnographies have omitted the words of participants from their findings, indicating that this is acceptable in the scientific and research community.

My decision to omit quotes was guided primarily by the aim and purpose of meta-ethnography. Unlike other approaches to qualitative synthesis, meta-ethnography does not aim to produce a summary or aggregate account of existing research findings but instead aims to generate new conceptual interpretations (France et al., 2014). An active, engaged and reflexive process of translating concepts therefore lies at the heart of meta-ethnography, an approach that involves “systematically comparing conceptual data from primary qualitative studies to identify and develop new overarching concepts, theories, and models” (France et al., 2019b, p. 2). It is partially due to this explicit aim to generate *new* conceptual insight that re-producing survivor quotations in meta-ethnographies became an ethical dilemma for me. Although it is important to amplify survivors’ voices, survivor-led approaches to ethics also foreground survivor control over data and research findings (Faulkner, 2004, Perôt et al., 2018). I unpack this tension further below.

Literature on the ethics of social media research can be partially applied to this situation. In a systematic review of attitudes towards the ethics of social media research, Golder et al. (2017) note that when including publicly available social media data in research, researchers should consider whether the person who posted information would have reasonably expected that it may be used in research. Applying this to qualitative health research, researchers should have sought consent to make survivors’ quotes publicly available in the original research report. However, survivors may not necessarily understand that these same quotes could be used to support a different research study’s finding, and therefore be used to support a potentially different interpretation of their words. This tension is thus particularly significant in meta-ethnography research as, again, meta-ethnography aims to produce a *new* understanding rather than summarise or aggregate existing studies' findings (France et al., 2014).

It could be argued that researchers must therefore exclude participant quotes from analyses as well as the final report. However, this is problematic for two reasons. Unlike other disciplines (such as sociology), qualitative health research findings tend to lack the rich, thick description that is central to translating concepts in meta-ethnography (France et al., 2014). Indeed, in my meta-ethnography, I found that authors tended to prioritise presenting a large quantity of quotes over providing a nuanced and rich interpretation of the data. This may be due to journal word limits, as authors may want to ensure survivors' voices are represented, but it could also be due to a tendency to conduct 'small q' or 'confused q' qualitative research in health-related topics, so conceptual interpretation is avoided or limited (Braun & Clarke, 2019b; Kidder & Fine, 1987). If I had excluded quotes from the analysis, my findings may therefore have lacked depth.

Most importantly, however, researchers' and survivors' interpretations can differ significantly. As I discussed in Chapters 1, 3 and 4, biomedical understandings of distress dominate health research (Ashcroft & Van Katwyk, 2016), including qualitative research (Faulkner, 2017). Biomedical interpretations and priorities often stand in direct opposition to those of survivors (Sweeney et al., 2009), and due to the power of the biomedical model (Ashcroft & Van Katwyk, 2016; Faulkner, 2017), survivors' interpretations may be re-framed to fit dominant narratives or their perspectives excluded (see my discussion of Dyson and Brown, 2005 in Chapter 4, section 4.4, and see also Sweeney et al., 2009). This re-telling of survivors' experiences, stories and interpretations to fit dominant narratives may easily remain hidden in research, since authors may (intentionally or not) choose quotes that support their own assumptions. The risks of re-telling survivors' experiences in ways that do not resonate with them is why self-awareness and critical reflexivity are so central to both trauma-informed and survivor research (Sweeney et al., 2009).

Because interpretations between researchers and survivors may differ, I decided I had a responsibility to include survivors' words in my review. Survivors' interpretations should always be prioritised, valued and encouraged to meaningfully shape research evidence (Faulkner, 2017; Sweeney et al., 2009). However, using survivors' words from one study to my new interpretation of them also sits uncomfortably with survivor-led ethical principles of transparency, ownership and control (Faulkner, 2004). Furthermore, as research is a curated process (Toye et al., 2014), and health research is dominated by positivism (Faulkner, 2017), survivor quotes presented in research reports may not present a mirror reflection of survivors' lived experiences or perspectives. I therefore felt it was important to recognise that the original study participants had no control or ownership over my systematic review findings. Indeed, due to the to low levels of involvement reported in my systematic review, as well as others' (Kennedy et al., 2022), survivors may also have had little control even over the original study findings.

In my review, I therefore chose to omit quotes from the findings both because I was unable to seek consent from survivors to use their words to support my new interpretation of them, and to make clear and transparent my significant role (as well as that of the original authors) in shaping the review findings. My decision was underpinned by my own lived experience of having my experiences re-told and my words re-framed in ways that harmed me, as well as wider survivor-led literature on research ethics (Faulkner, 2004; Perôt et al., 2018; Sweeney et al., 2009). Although I consider the inclusion (and omission) of survivors' words an ethical consideration, it is not my intention to argue that quotes should always be omitted from meta-ethnographic findings. This decision may be shaped by the aims and context of the review and the body of evidence to be reviewed. For instance, a review of research that foregrounds situated knowledge and reflexivity, such as feminist or survivor-led research (Sweeney et al., 2009; Rose, 2017), would provide a different ethical context to a review of qualitative health research.

To help readers verify the findings and conclusions of the review (whilst acknowledging the interpretive aims of meta-ethnography), the CERQual table in the meta-ethnography chapter (Chapter 6) includes information on the studies that contributed to each review finding. I also reference study numbers in the detailed description of themes in the 'Findings II: Outcome of synthesis process' section. This information may be used to access survivor quotes and author interpretations in the original studies.

5.2.9 Participant access to and control over data

For the two qualitative studies, I took several additional steps with all participants (both survivors and providers) to ensure I was seeking informed, ongoing, and active consent. These steps are in addition to basic consent procedures outlined in Chapter 4.

I offered all participants an opportunity to see the transcript and to make amendments to it, highlighting that their account belongs to them and should resonate with what they want it to be. Two participants, both survivors, one from the provider study (Study 2) and one from the survivor study (Study 3) said they would like to see the transcript of their interview. When sending it, I explained that there was no obligation for them to read it or comment, and to do so only if they wished. No one sent back amendments or comments at the time but one participant from the survivor study did change her transcript later in the research to reflect how racism had influenced her expectations and experiences of care. This change was made whilst the public engagement workshops were being held. This meant that the findings and analysis were being revised and finalised, and therefore left enough time for this change to be incorporated into the analysis.

I also highlighted that sometimes people say something in an interview that they would rather not be included in the transcript, and that if this happened, they were welcome to indicate this at the time they said it, or any time after the interview and I would omit or remove this part. I checked again after the interview was finished. No participants in the survivor study (Study 3) asked me to omit information, but three participants in the provider study (Study 2) asked me to remove information. I offered all participants the option to be sent any quotes that I hoped to use in publications or this thesis so that they could approve their inclusion, or not. Three participants indicated that they would like to see their quotes.

5.2.10 Conducting trauma-informed interviews

For survivors to have a positive experience of a research interview, interviewers need to be aware of the impacts of sexual violence, including an appreciation that these impacts are unique and individual to each woman (Campbell et al., 2010). Interviewers also need to be aware that they may be interviewing people at different stages of healing or recovery after sexual violence and be flexible enough to work with this. Lastly, interviewers need to be comfortable, so that participants feel able to talk openly about their experiences (Campbell et al., 2010). My experience and training gained from working in a sexual violence support centre and providing emotional support to survivors of sexual violence prepared me for conducting these interviews in a sensitive and trauma-informed way. Below, I describe my approach to conducting all interviews (both survivors and providers) and link this to the principles outlined in the Survivor's Charter (Perôt et al., 2018).

To ensure that the interview felt safe (charter principle #1), I approached the interviewees from a place of empathy and communicated with warmth and respect. I welcomed emotions in the interview. The distress protocol helped with this process but ultimately, I responded to each woman differently whilst being guided by the core qualities of being responsive, attentive and warm.

To ensure that the interview amplified the voices of survivors and was empowering (charter principles #2 and #3), I intended for the research interviews to be led by participants. I was mindful of going at the participants’ pace and we took steps to try to ensure participants felt control during the interview, such as those outlined concerning asking about experiences of violence and abuse. All interviews asked women to tell me about their experiences starting wherever they felt was appropriate and I did not interrupt unless they indicated they were finished or wanted me to ask a question. Some participants spoke uninterrupted for the majority of the interview while others invited more questions and responses from me. I adapted my approach to whatever they seemed most comfortable with.

To ensure that the interviews promoted self-care (charter principle #4), I let participants know that they could take a break at any time. I also modelled self-care by letting participants know that we have a certain amount of time for the interview and that we could schedule to continue the interview another day if they felt they had more to say when we come to the end of this time. This normalised self-care and set a clear boundary for both me and the participants and ensured that I could stay attentive and responsive throughout. After I finished the interview, I checked in with participants and asked them how they felt and how they found the interview. I also told them that sometimes it can take a while for things to come up after an interview and that they are welcome to check back in with me at any point. One participant did this. I shared the prepared resources with participants (appendix P) and offered to talk through them. Most participants were already accessing some sort of support. I told participants about my plans for the public engagement event and asked if they would like to be informed about it.

I ensured accountability and transparency (charter principle #5) and that the research was liberating (charter principle #6) by clearly communicating the questions that would and would not be asked and creating a space that felt contained whilst not silencing women, and being transparent about processes for responding to safeguarding issues and what would happen to women’s data as well as how they can have control over their data. I spoke to participants about my hopes and aspirations for the research, including the public engagement event, and shared my reasons for doing this research with them, answering any questions they had about this. Most importantly, I was open with participants about how much I appreciated them sharing their experiences with me, recognising that it took a leap of faith for them to do this.

I tried to ensure that the interview experience was creative and joyful (charter principle #7). The interview invited women to tell me about their experiences the way they wanted to, and I hoped it would be a reflective and interesting experience for them whilst recognising that this may not be the case for everyone. I welcomed discussions about the positive, healing and empowering aspects of pregnancy, birth, motherhood and maternity care as much as stories about difficult and re-traumatising experiences. Some participants indicated that the interview had been a positive experience that helped them reflect, although it did sometimes bring up new memories or difficult feelings for them. Participants told me about both highs and lows in their experiences, and because I approached the interviews with empathy, I laughed along with them as well as hearing their painful and fearful moments.

5.2.11 Implications of conducting trauma-informed interviews to a narrative approach

The trauma-informed approach I took to interviews is detailed in Chapter 5 However, due to a focus on only giving non-verbal feedback in narrative research, it is important to address this issue separately for the survivor study. Some narrative researchers advocate for only giving non-verbal feedback and encouragement during narrative interviews (Jovchelovitch & Bauer, 2000). The purpose of the researcher staying silent is to avoid shaping the narrative and to create space for it to unfold the way the teller intended (Jovchelovitch & Bauer, 2000). However, women who have experienced sexual violence may have had very traumatising experiences of someone ‘just listening’, such as in a child protection or criminal justice context. Therefore, I believed that a lack of verbal engagement could indicate judgement or disinterest and inadvertently silence women. Therefore, I ensured that empathy came before ‘pure’ forms of collecting narrative data, and I verbally encouraged and validated women’s narratives if I felt this was appropriate. This meant that at times interviews were more conversational in style. I have addressed this by including questions from me in the participant quotes where relevant and reflecting on how I may have shaped the data collected in the reflexivity and positionality section of this chapter, discussed next.

5.3 Reflexivity and positionality

To conduct high quality qualitative research researchers must examine how their own experiences, beliefs, assumptions and values shaped the research (Braun & Clarke, 2013). Qualitative, trauma-informed and survivor-led approaches to research encourage reflection, reflexivity and self-awareness and welcome complexity, nuance and contradiction (Braun & Clarke, 2013; Sweeney et al., 2018). Examining shared identities may be especially important when conducting research with marginalised groups that have been historically objectified, silenced and othered (Chhabra, 2020), such as survivors (Sweeney et al., 2009; Sweeney & Beresford, 2019). Openly stating one’s status as a survivor researcher is not without its risks, however. Norms about “who gets to study whom” exclude survivor-produced knowledge from the research and scientific community on multiple levels (Sweeney & Beresford, 2019, p. 1189). Whilst recognising the inevitable risks involved in openly and explicitly identifying my survivor standpoint, I accept these risks in the interests of struggling against the harms caused by hierarchies of knowledge that exclude survivors’ experiential knowledge from research, practice and policy decisions.

Both survivor-led and interpretive qualitative research embrace experiential knowledge, seeing it as a powerful and important source of knowledge (Braun & Clarke, 2019b; Faulkner et al., 2021; Kidder & Fine, 1987; Sweeney et al., 2009). Survivor researchers have argued that robust and rigorous survivor research may increase the ecological validity of knowledge generated (Faulkner & Thomas, 2002). However, *how* the identity is used is important. As Sweeney and Beresford argue: “whilst all academics hold multiple identities – be they clinician, service user, survivor, mother, grandson, lesbian, neighbour or tennis player – having access to an identity is not sufficient to engage in critical reflexive looping. Instead, it is the way in which identity is used that is critical." (Sweeney & Beresford, 2019, p. 1190). In my research, I openly shared with participants that I was also a survivor of sexual violence. Doing so rejects positivist ideas of the value-free, objective researcher and may help participants feel safe. My lived experience of violence and services also guided my ethical and methodological decisions (e.g., see '5.2.8 Omitting participant quotes in the systematic review findings' in this chapter) as well my focus on challenging biomedical dominance and naming system harm. My own experiences of being silenced, dismissed and misunderstood underpin my primary research aim: to amplify and listen to survivors' voices. Reflexivity was supported by keeping a reflective research diary, attending personal therapy, engaging with group reflective supervision, and through discussions with supervisors and peers.

In the sections below, based on entries in a research diary that I kept throughout my PhD, I consider how my position as white, middle-class woman and a survivor of sexual violence influenced the research. In section 5.3.1 I examine the lived, research and work experiences that I feel have been critical in shaping the research and my analysis and interpretation of data. Next, in section 5.3.2, I outline my beliefs and assumptions that underpinned the research. Section 5.3.3 describes reflections on the research as it progressed, how my experiences and identity may have shaped the research, and what I learned as the research progressed.

5.3.1 Lived, research and work experience

Lived experience

I decided to do this PhD because of my own experiences of sexual violence and abuse. I wanted to use my research skills to improve services for survivors, as so many survivors are harmed, rather than supported to heal, by those they turn to for support. Therefore, all aspects of my research are shaped both by this aim (to amplify the voices of survivors) and by my lived experience as a survivor.

It is also important to highlight however that I am not a mother and I have therefore not experienced the uniquely silencing and shaming experience of motherhood that I discuss in my theoretical framework (Chapter 3) and that women reported in my research (see the theme ‘something weird and wrong’ in Chapter 7, section 7.3.2). It is therefore to explore my lack of direct experience of motherhood because I understand pregnancy, birth and motherhood as epistemically transformative experiences that give people access to experiential knowledge not available to people without direct experience (Paul, 2014; Woollard, 2021). As I see qualitative interviews as a social interaction and narratives as co-produced (Braun & Clarke, 2013), it is important to highlight how my lack of lived experience of being a mother may have shaped the findings.

The women in the public engagement groups emphasised that shame was an important part of their experience as both a survivor and a mother. Women described how they were made to feel as if they had failed at motherhood if they found aspects of pregnancy, birth or mothering distressing or difficult. This societal shaming of mothers compounded shame women already felt due to sexual violence. They had already been dehumanised by perpetrators only to be further (and unexpectedly) dehumanised by the label ‘mother’. Yet, before the public engagement workshops, my initial findings focused on issues of power, consent and control – not shame. It was only when I returned to the transcripts after the public engagement workshops that I could clearly see the multiple accounts of the shaming and silencing of mothers and how these intersected with the shaming and silencing of sexual violence. Although women *did* tell me about shame – I just needed to look for it – it is also possible that women omitted aspects of their experience because they did not think I would understand or because they did not want to terrify, discourage or upset me. Indeed, after telling me about difficult experiences (particularly of birth), some women told me that they hoped they did not discourage me from having my own children.

Although I do not have experiential knowledge of motherhood, I have been exposed to the concept of motherhood and the narratives that surround motherhood my entire life. As a woman in her early 30’s, motherhood is something that is expected of me, and my research cannot be separated from this social position. My ideas about what it means to be a mother changed significantly as I did this research. I realised that what initially brought me to perinatal research was the idea that motherhood is a joyous, wonderful and beautiful experience that is the essence of womanhood. I now realise that motherhood can be both joyous and devastating (sometimes at the same time), neither of these, and everything in between. Above all, I learned that motherhood is experienced very differently by different people and that this individuality should be acknowledged and celebrated. I have a greater awareness of the multiple and overlapping ways that women and mothers are blamed, silenced and shamed. If I ever choose to have children, I feel I am armed with knowledge that most mothers do not have because difficult experiences of motherhood are so often silenced, unheard and overlooked.

Working in the NHS

Prior to my PhD, I worked as a researcher in the NHS in a variety of settings, including in psychiatry, neurology and genetics. Although I am not a clinician, this work gave me an insight into the environment that healthcare providers work in. I worked closely with, and hugely respected, many healthcare providers, noticing how hard they worked in a largely thankless system. I noted that providers had a big impact on the lives of the people that used their services through witnessing people’s pain and suffering and showing caring and compassion, and that many took this part of their role very seriously. However, I also witnessed power imbalances and abuses between staff and service users/patients, and between different members of staff (often linked to seniority or discipline). I have also seen (and been on the receiving end of) insensitive behaviour from healthcare providers who prioritised their own needs (for power or convenience) over their colleagues' or service users. I have worked with healthcare providers who were trauma-informed without knowing what that was, and healthcare providers who *should* have known what being trauma-informed was but were not. I have also worked with healthcare providers that I believe did the best they could but had to practice in ways that protected the system over service users in order to protect themselves. I have also had to behave in ways whilst working within this system that I disagreed with because this what was required or expected of me.

Working in the Violence Against Women and Girls Sector

I also worked in a rape crisis centre on the National Rape Crisis Helpline for a year and a half. To do this work I completed a 10-week training course on supporting survivors of sexual violence. This training taught me that sexual violence is about power and that it is rooted in gender inequality. I also learned that the term 'survivor' can counter the pathologisation of women who are subjected to sexual violence, and that empathy should underpin all work with survivors. Importantly, I learned that all work with survivors should empower women in order to counteract the disempowerment involved in sexual violence. Through working with survivors as well as my own lived experience I gained an understanding that trauma, and especially sexual violence, can have significant impacts on what women need from healthcare and how they/we experience it. This understanding is reflected in my beliefs and assumptions (summarised in the 'My beliefs and assumptions' section).

My work in the rape crisis centre also taught me that sexual violence is extremely common, that it is a form of gender-based violence directed at women because of their gender, and that anyone can be subjected to sexual violence. I started volunteering because of my personal experiences and a wish to support other women who had had similar experiences. I also learned through this work that difficult feelings and emotions were not necessarily bad or harmful – if trauma comes to the surface, it can be uncomfortable, but it can also be an opportunity for that trauma to be processed.

Previous perinatal research experience

I started my career in perinatal research in the final year of my undergraduate degree. For my final year project, I interviewed Eastern European migrant mothers about their experiences of pregnancy and their expectations of maternity care in Ireland (Dempsey & Peeren, 2016). I do not have children, so my experience of conducting this research and what I found largely shaped the following thoughts and assumptions about maternity care.

In my interviews with migrant women, they told me that they experienced maternity care in Ireland as very different compared to Eastern Europe. While the Irish maternity care system was midwife-led and involved little medical intervention, their experience of maternity care in Eastern Europe was highly medicalised, led by obstetricians with much more frequent scans and more intervention regardless of risk level. Many women I spoke with believed the Eastern European system must be safer than the Irish maternity care system precisely because of this more medicalised and obstetrician-led approach. For these women, receiving midwife-led care with minimal intervention in Ireland was a source of huge anxiety for them; they spoke about pregnancy as if it was an illness that must be monitored, and often felt out of control and afraid. Other women described maternity care in Eastern Europe as paternalistic, with the doctor leading care and making all decisions with little information or power sharing. These women preferred the Irish system because they felt more connected to and in tune with their bodies and they felt more respected and cared about by the Irish maternity care providers. These women also trusted their bodies to be able to grow and give birth to a healthy baby and saw medical intervention as distracting from their bodies' ability to do what it was able and supposed to do.

Through this work, I learned that cultural experiences and expectations shape both the delivery of healthcare and the experience of it, but also that healthcare providers have a duty to understand women's perspectives and beliefs. One reason why women I spoke with felt so distressed by care in Ireland was because Irish maternity care providers had neither explained to women how the Irish maternity care system worked nor reassured them about why it was safe to have a child in Ireland. They did not take the time to understand why women were so distressed, and instead women were labelled as 'hysterical' or 'difficult' and disregarded and dismissed. So, ironically, a system that on the surface promoted more choice and empowerment (a midwife-led system) was experienced as very limiting and disempowering for these women because no one reassured them. To summarise this learning, this was particularly significant for me while I was doing this work: "all beliefs about health, including the practices of medicine itself, are culturally shaped" (Bhogal & Brunger, 2010, p. 994).

5.3.2 My beliefs and assumptions

The experiences I have outlined in the previous sections have shaped my beliefs and assumptions about healthcare, maternity care, and motherhood. I outline these below.

I believe that sexual violence is a common, but silenced and misunderstood experience in society, as is abuse generally. People often do not want to know about abuse and many people subscribe to unhelpful stereotypes about abuse survivors that place blame on survivors and silence them. Because of this, there is very little research about what survivors need from healthcare from survivors' perspectives, and no survivor-led research. Therefore, I believe that, at present, 'evidence-based healthcare' does not take into account the needs of survivors.

I believe that 'evidence-based healthcare' is culturally mediated. Powerful people, historically white men, have made decisions about what to research, how to research it and what voices to include in research. Therefore, the 'evidence' cannot be separated from the sociocultural context within which it was created, and the ‘healthcare’ aspect cannot be separated from the sociocultural context within which it is delivered. When I started this research, I believed that what people expect from healthcare is determined by what their friends and family have experienced and the messaging they get from society– especially in relation to something as socially significant as pregnancy, birth and motherhood. My previous research with migrant mothers therefore taught me that dominant beliefs about healthcare and healthcare delivery are socially constructed. For this reason, I understood healthcare expectations to be socially and culturally shaped. As this research progressed, however, I gained an understanding that expectations about motherhood and experiences of maternity care are shaped by epistemic, gender and other inequities (e.g., race, class). In other words, I learned that the treatment of pregnant and birthing people by providers and systems is shaped by patriarchal ideas that devalue and dismiss pregnant and birthing people’s voices, rooted in historical ideas about links between femininity, subjectivity and credibility.

I believe that maternity care is as much about relationships and communication as it is about ‘medicine’. I assume that women should have full control of their healthcare and I believe women should feel respected and listened to in order to feel safe. I believe that if women do not feel safe in healthcare this is not only a violation of their rights as human beings, but it is counter-productive in the long-run, as they may experience further difficulties due to the stress or may feel they have no choice but to disengage from care. Through this work, I learned that although in theory the ethics are clear (i.e., women legally have full ownership of their own bodies), in practice maternity care’s complex and unique environment presents specific challenges that devalue and sometimes violate women’s autonomy.

Prior to starting this PhD, I had only conducted research with mothers and had little experience with maternity care providers. During my PhD I worked in a research team and worked collaboratively with maternity care providers including midwives, obstetricians, perinatal psychiatrists and perinatal clinical psychologists. One of my supervisors, Dr Elsa Montgomery, is a midwife and helped me develop my understanding of the challenges that midwives face, as well the systemic and structural barriers to good care. I also interviewed maternity care providers in this research and worked alongside two midwives working in local hospitals to set up the study.

Building these relationships with maternity care providers gave me an understanding of the stressful and pressured environment that maternity care providers work in. It also helped me understand that maternity care providers also have a right to feel safe in their work and to work in a way that aligns with their values. Although I do not believe that insensitive or poor treatment is ever acceptable, I did gain an understanding and an empathy for the harms caused by working in a harmful system. I heard first-hand the exhaustion and moral injury experienced by maternity care providers who genuinely wanted to provide safe, kind, empowering care but were prevented from doing so, or, painfully, had behaved in ways that caused or allowed harm to women. Working with maternity care providers taught me that focusing on systemic and structural problems is critical to transforming maternity care. Although individual maternity care providers do cause harm and this must not be forgotten, I learned that this harm is facilitated, minimised and perpetuated at a systemic level.

Working in a rape crisis centre and providing direct support to survivors of sexual violence at different points of their experience helped me understand first-hand the impacts of bearing witness to the pain and suffering caused by sexual violence as well as the systems to which survivors turn to for help. However, during my time in the rape crisis centre I received monthly clinical supervision delivered by a highly experienced and specialist therapist and I was part of a community of peers that provided validation, encouragement and shared my anger at the pervasive and normalised nature of sexual violence. I do not believe anyone can sustainably bear witness to trauma without structural and peer support – yet many healthcare providers have no choice but to try.

I believe that trauma is often pathologised and that this pathologisation can lead to further silencing. For me, sexual violence is a human rights issue and requires a human, kind and empathic response. Therefore, I believe that sexual violence is an issue that the whole world has a responsibility to address, and that healthcare providers have a responsibility to address it, not because sexual violence requires a 'medical' or 'clinical' response, but because healthcare providers are important to communities. I do not deny that some women may experience physical and mental health impacts or may find medication or a diagnosis helpful. However, I believe that reducing sexual violence and its impacts to a list of signs and symptoms fails to address the fact that it is a gross violation of human rights and rooted in power inequalities. I believe that sexual violence requires a community response, and that the health system is just one part of the response that is needed, albeit a very important one.

5.3.3 Reflections on the research as it progressed

How I may have shaped the research

After the public engagement workshops, I received emails from several women saying that they hoped that hearing their stories about re-traumatising and difficult experiences of pregnancy and birth did not impact me personally. As a fellow survivor and someone they knew was not a mother, they were worried that sharing their stories with me may have put me off wanting to have children myself, or that if I have children in the future that knowing how disempowering care could be could make me very anxious. This made me reflect on how women may have felt about telling me their stories of pregnancy, birth and motherhood and maternity care in the interviews. I wondered whether they held back anything because they were worried about upsetting me. When training for the helpline, we learned that survivors often avoid telling people what happened to them because they want to protect others. I have experienced this myself too. It also made me think about how silenced both sexual violence and traumatic birth experiences are. Women may be afraid to talk to other women about difficult birth experiences so as not to alarm or terrify other women, leading to silencing.

How the research impacted me

When reflecting on how the research may have impacted me, I realised that, if anything, the research will help me in the future if I decide to have children. Knowing that motherhood is not always ‘perfect’ and ‘full of joy’ is powerful – and not a message we often hear. It has also given me a lot of knowledge about rights in maternity care that I would not otherwise have known. Indeed, many women told me they did not know they were *allowed* to decline maternity care. I think that knowing how difficult it can be, especially for survivors, would help me feel less ashamed if I did struggle with aspects of the experience. Many women also found motherhood empowering and healing, even when they had been subjected to extremely disempowering and terrifying care practices. I think this balanced perspective of motherhood is not often seen in the literature or in society generally and would be a powerful resource for me if I ever do have children. I have felt continually inspired and moved whilst conducting this research. It is a privilege to have been able to bear witness to these women’s’ experiences and I hope that I do their words justice in this PhD.

How my thoughts changed on collecting demographic information

I did not collect demographic information about my participants because when I was designing the studies, I did not think that it was ethical to collect information I was not going to use. It was not raised in my survivor engagement and involvement discussions. However, as the research progressed, I realised that not collecting demographic information limited my ability to highlight and amplify more marginalised voices, such as those of racially minoritised women, as well as my ability to state clearly what communities my findings can speak to (Braun & Clarke, 2013). This is important because women and birthing people's social location significantly shaped the way they are treated by providers – especially race and class (Chadwick, 2018). During my PhD, the Black Lives Matter movement encouraged me to reflect on my own privilege as a white person, and to realise that perhaps I did not think about the importance of collecting demographic information because, as a middle-class White woman, I had never experienced discrimination or oppression because of my race or class. In future research I will make sure that I do collect demographic information to avoid inadvertently silencing already silenced voices further and to ensure that I can include a meaningful discussion about whose experiences the findings represent.

5.4 Summary of Chapter 5

This chapter described the trauma-informed approach that underpinned this research. I discussed ethical issues I identified and how they were addressed and finished with a discussion of reflexivity and positionality. The next chapter will present the findings from the first of three studies in this PhD: a systematic review and meta-ethnography of healthcare experiences and expectations among survivors of adulthood sexual violence and/or abuse.

Chapter 6. Healthcare Experiences and Expectations after Adulthood Sexual Violence: A Systematic Review and Meta-Ethnography of Women's Experiences.

This chapter details the findings from a systematic review and meta-ethnography about healthcare experiences and expectations among female survivors of sexual violence in adulthood. This review was conducted to provide an overview of extant literature on healthcare needs after sexual violence and to identify gaps in the literature to inform the other studies in this PhD. The methods used are detailed in Chapter 4, section 4.8.

6.1 Background

Well-established links between sexual violence and health outcomes and healthcare use coupled with barriers to identification, disclosure and response mean that it is imperative that we understand what survivors need from healthcare (Jewkes et al., 2002). Consequently, the World Health Organisation (WHO) has repeatedly called for a global strengthening of the health systems response to sexual violence (García-Moreno, Hegarty, et al., 2015b; García-Moreno, Zimmerman, et al., 2015). This call to action was recently reinforced by a Sexual Violence Research Priority Setting Partnership which identified a research gap in how mental and physical health services can better meet the needs of survivors and provide the kind of support that is valued by survivors themselves (James Lind Alliance, 2022). Yet, despite increased awareness of the prevalence and impacts of sexual violence in recent years, evidence on how to address adulthood sexual violence in health settings remains scarce (Hegarty & Tarzia, 2019) with existing reviews focusing on survivors of intimate partner violence (Feder et al., 2006; Korab-Chandler et al., 2022; Tarzia et al., 2020) and childhood sexual abuse (Broaddus-Shea et al., 2021; Havig, 2008; Montgomery, 2013).

Qualitative evidence synthesis is a robust and rigorous way to bring together qualitative research to inform healthcare policy, practice and decision making, and meta-ethnography is one of the most frequently used and influential approaches to qualitative evidence synthesis in health research (France et al., 2014, 2019b). This systematic review and meta-ethnography therefore addresses a gap in the literature by examining healthcare experiences and expectations among female survivors of adulthood sexual violence and/or abuse. Meta-ethnography was used to develop a unique understanding and work towards a conceptual model, grounded in survivor perspectives, that could inform policy and practice. See Chapter 4 for a detailed description of the systematic review and meta-ethnography methods used. Findings are reported in accordance with eMERGe reporting guidance (France et al., 2019a). Page numbers for each eMERGe reporting item are detailed in appendix B.

The overarching review question was: what are women's experiences and expectations of healthcare after experiencing sexual violence in adulthood?

Additional review questions:

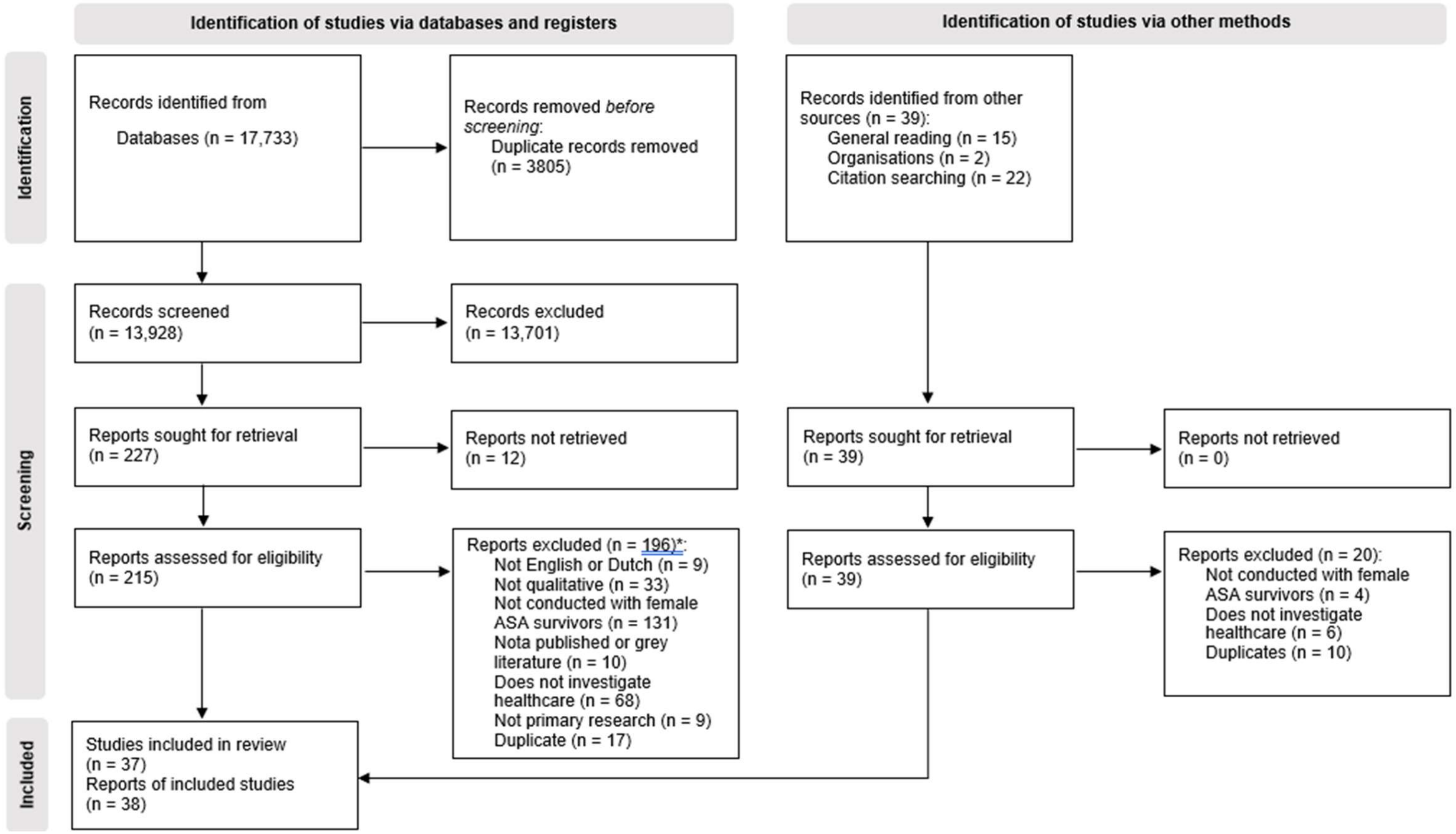
- What are women's experiences of accessing and using healthcare services after experiencing sexual violence in adulthood?
- How do women experience being asked about, and disclosing, adulthood sexual violence within healthcare services?
- What do women survivors of adulthood sexual violence find helpful and unhelpful about their interactions with healthcare workers?

6.2 Findings I: Contextualising the synthesis

6.2.1 Outcome of study selection

The search process and outcome of study selection are outlined in a PRISMA diagram presented in Figure 1 (Page et al., 2021). A total of 17,733 records were identified through systematic searches and 39 records through other methods. Records were imported into CADIMA software (Kohl et al., 2018). After 3,805 duplicates were removed, 13,928 abstracts were screened and 13,701 excluded. Following this, full texts were sought for 227 records identified through systematic searches and 39 records identified through other methods. Of these, 12 reports could not be retrieved because the full text was not available, despite efforts to contact authors and making special requests for access through the library where possible. This left 215 reports identified through systematic searches and 39 reports identified through other methods to be assessed for eligibility. A further 216 reports were excluded (196 from searches and 20 from other methods). Two reports described different findings from the same study (study number 35 and number 36; study numbers are detailed in table 5). Therefore, 38 reports, representing 37 studies, met the inclusion criteria.

Figure 1. Outcome of study selection: PRISMA flow diagram (following guidelines by Page et al., 2021).



*Reports could be excluded for multiple reasons. Therefore, the total number of reports excluded does not add up to the number of reports excluded for each criterion.

6.2.2 Characteristics of included studies

Table 5 describes the characteristics of the included studies and details the study numbers. Additional information about the studies is provided below.

Year published and research location

All studies were published in English between 1999 and 2020. Most studies (n = 29) were conducted in high-income countries: 20 in the USA (2, 6, 7, 8, 11, 13, 14, 16, 19, 21, 22, 23, 26, 28, 32, 33, 34, 35, 36, 37), three in the United Kingdom (5, 12, 27), two in Canada (9, 10), and one each in Australia (30), The Netherlands (18), New Zealand (20), Norway (15) and Iceland (31). Eight studies were conducted in low- and middle-income countries: three in South Africa (1, 17, 38), two in Brazil (3, 4), and one each in Tanzania (24), Bangladesh (25) and Guatemala (29).

Healthcare setting

Most reports (n = 30) focused on healthcare experiences and expectations, and the remaining reports focused on general well-being or help-seeking of which healthcare was one aspect. Some studies included experiences of more than one clinical setting. Three reports focused on maternity care experiences (5, 15, 32), one on abortion care (28) and three on gynaecological care (14, 31, 36). Eight reports described experiences of mental healthcare (1, 8, 12, 14, 25, 26, 33, 34), including one about experiences of an inpatient psychiatric forensic unit (12). Ten reports focused on specialist sexual violence services, including medical forensic examinations (3, 4, 6, 9, 10, 11, 17, 18, 20, 35). Nine reports focused on general healthcare seeking experiences and expectations (7, 13, 14, 16, 22, 24, 29, 36, 37), one included primary care experiences (30) And two studies included experiences of emergency healthcare (27, 30). Two studies focused on HIV care (1, 38). Three studies focused on experiences and expectations of the Veteran’s Health Administration among veterans (19, 21, 23).

Table 5. Study characteristics

Study #	Authors (N = 38)	Sample size (no. included in review if different)	Data collection	Healthcare setting	Sample	Healthcare focus
1	Abrahams & Gevers (2017)	43 (14)	In-depth interviews	Mental Health	Mixed**	Y
2	Ahrens (2002)	8 (5)	Interviews	General/Mixed	ASA	
3	Barros et al. (2015)	11	Semi-structured interviews	Specialist Sexual Violence	ASA	Y
4	Batistetti et al. (2020)	11	Semi-structured interviews	Specialist Sexual Violence	ASA	Y
5	Birthrights & Birth Companions (2019)	12 (NR)	Semi-structured interviews	Maternity Care	Mixed**	Y
6	Campbell et al. (2013)	20 (11)	In-depth qualitative interviews	Specialist Sexual Violence	Mixed**	Y
7	DeLoveh & Cattaneo (2017)	14 (13)	Semi-structured interviews	General help-seeking	ASA*	
8	Draucker (1999)	33	Interviews	Mental Health	ASA	Y
9	Du Mont et al. (2009)	19	Semi-structured interviews	Specialist Sexual Violence	ASA	Y

Table 5. Study characteristics (cont'd)

Study #	Authors (N = 38)	Sample size (no. included in review if different)	Data collection	Healthcare setting	Sample	Healthcare focus
10	Ericksen et al. (2002)	8	Semi-structured interviews	Specialist Sexual Violence	ASA	Y
11	Fehler-Cabral et al. (2011)	20	Semi-structured interviews	Specialist Sexual Violence	ASA	
12	Fish & Hatton (2017)	16 (5)	Interviews and ethnographic fieldwork	Mental Health	Mixed**	Y
13	Guerette & Caron (2007)	12 (6)	Structured interviews	General/Mixed	ASA	
14	Gutzmer et al. (2016)	19	Semi-structured interviews	General/Mixed	ASA	
15	Halvorsen et al. (2013)	10	Semi-structured interviews	Maternity Care	ASA	Y
16	Hellman (2016)	9 (2)	In-depth, semi-structured interviews	General/Mixed	ASA	
17	Holton (2016)	10 (7)	In-depth interviews	Specialist Sexual Violence	ASA	Y
18	Hutschemaekers et al. (2019)	12	Semi-structured interviews	Specialist Sexual Violence	ASA	Y

Table 5. Study characteristics (cont'd)

Study #	Authors (N = 38)	Sample size (no. included in review if different)	Data collection	Healthcare setting	Sample	Healthcare focus
19	Jacobs (2016)	16	Unstructured interviews	Veterans' Health Administration	ASA	Y
20	Jordan (2001)	48 (34)	In-depth interviews	Specialist Sexual Violence	ASA	Y
21	Kehle-Forbes et al. (2017)	37	Semi-structured interviews via telephone	Veterans' Health Administration	ASA	Y
22	Kelly (2004)	17 (4)	Hermeneutic open-ended interviews	General/Mixed	IPV**	Y
23	Monteith et al. (2020)	50 (32)	Semi-structured interviews	Veterans' Health Administration	Mixed**	Y
24	Muganyizi et al. (2011)	30 (10)	In-depth interviews	General/Mixed	Mixed**	Y
25	Naved et al. (2009)	30 (11)	In-depth interviews (Mixed Methods)	Mental health	IPV**	Y
26	Nichols et al. (2018)	27	Semi-structured interviews	Mental Health	ASA	
27	Olive (2017)	6 (2)	Semi-structured interviews	Emergency healthcare	IPV**	Y

Table 5. Study characteristics (continued)

Study #	Authors (N = 38)	Sample size (no. included in review if different)	Data collection	Healthcare setting	Sample	Healthcare focus
28	Perry et al. (2015)	9	In-depth interviews	Abortion Care	ASA	Y
29	Place et al. (2019)	23 (13)	In-depth interviews	General/Mixed	Mixed **	Y
30	Reisenhofer & Seibold (2013)	6 (5)	Semi-structured interviews	Emergency and primary care	IPV**	Y
31	Sigurdardottir & Halldorsdottir (2018)	1	Several in-depth interviews	General/Mixed	ASA	Y
32	Sobel et al. (2018)	30 (27-30)	Semi-structured interviews	Maternity Care	Mixed **	Y
33	Starzynski et al. (2016)	15 (6)	Semi-structured interviews	Mental Health	Mixed **	Y
34	Ullman & Lorenz (2020)	18	Mixed methods	Mental Health	ASA	Y
35	Wadsworth (2015)	22	Semi-structured interviews	General/Mixed	ASA	
36	Wadsworth & Krahe (2019)	22	Semi-structured interviews	General/Mixed	ASA	Y

Table 5. Study characteristics (continued)

Study #	Authors (N = 38)	Sample size (no. included in review if different)	Data collection	Healthcare setting	Sample	Healthcare focus
37	Washington (2001))	12 (10)	In-depth, semi-structured interviews	General/Mixed	Mixed**	
38	Watt et al. (2017)	15 (14)	Semi-structured interviews	HIV	ASA*	Y

ASA = Adulthood Sexual Violence and/or Abuse (≥ 16 years); IPV = Intimate Partner Violence; NR = Not reported

* 90%+ of the sample met the inclusion criteria.

** Findings were disaggregated for female ASA survivors or quotes which were from female ASA survivors could be separately identified and extracted. Quotes from ASA survivors were either identified through information found in the paper or through information obtained from the author.

Participants

At least 499 survivors were included in this review. Most studies included only or 90%+ female adulthood sexual violence and/or abuse survivors (n = 23 studies/24 reports), although participants in some studies had also reported experiencing sexual violence at other points. The remaining studies/reports (n = 14) included adulthood sexual violence survivors alongside others, such as survivors of: sexual violence generally (12, 29, 32); childhood sexual abuse (37); sexual violence in adolescence (6, 33) intimate partner violence (IPV), some of whom had experienced sexual violence from their partners (22, 25, 27, 30). One study focused on the experiences of women facing multiple disadvantage (5). Two studies included healthcare providers or supporters (1, 24) and one study included both male and female survivors (23), but in these studies findings were disaggregated by experiences of sexual violence and sex/gender. Three studies only included survivors of military sexual trauma (MST) (19, 21, 23).

Most studies reported race/ethnicity. Apart from studies that focused on the experiences of racially minoritised women, most participants in these studies were white. Six studies focused on the experiences of minoritised women, namely African American/Black women (14, 34, 37), Latina women (22) or Xhosa women (38). One study focused on women facing multiple disadvantage and included women seeking asylum in the UK (5). Two studies focused on the experiences of women living with mental health or behavioural disabilities (26) and intellectual disabilities (12). Most studies included mainly young women aged 20 – 40.

Methodological and theoretical orientation of studies

Nine studies mentioned using a feminist approach or framing their analysis through theories about oppression and power (2, 8, 12, 14, 22, 25, 30, 35, 37). Other theoretical approaches included intersectionality theory (26), ecological theory (33) and Heideggerian (16, 19, 24). One study reported being guided by a critical realist perspective (27). Data analysis methods and approaches reported included Corbin and Strauss' (1990) grounded theory (7), constructivist grounded theory (36), phenomenology (16, 22, 23, 31), content analysis (4), Clarke's (2005) Situational Analysis (30), and ethnographic methods (12). Others outlined approaches that indicated a general qualitative approach by describing their approach as 'interpretive '(10), 'exploratory' or 'qualitative' (17). Fourteen reports did not report any methodological or theoretical orientation (1, 6, 8, 9, 11, 13, 15, 18, 21, 25, 28, 32, 34, 38).

Type of sexual violence reported

Just over half of the studies (n = 17) focused on rape and sexual assault (1, 2, 3, 6, 9, 10, 11, 13, 14, 15, 16, 17, 18, 20, 24, 28, 29); the rest used broader definitions of sexual violence and/or abuse or did not specify a definition. Across the studies, women reported experiencing sexual violence from partners, friends, acquaintances, family members and strangers, although most women included in these studies (where this was reported) reported experiencing sexual violence from someone they knew. Women also reported sexual violence at different times in their lives, including sexual abuse experienced in childhood.

6.2.3 Quality assessment

Quality assessment outcomes can be found in Appendix N and Appendix O. Appendix N presents the outcome of the CASP assessment (CASP, 2018) and the additional measures of quality that were added to address ethical issues specific to survivors. These were: (1) Do the authors report ethical considerations specific to research with survivors that go beyond standard ethical considerations? (2) Do the authors report survivor involvement in the research? And (3) Do the researchers address power imbalances? Information on the outcome of the COREQ assessment (Booth et al., 2014) can be found in appendix O.

CASP and COREQ items

Overall, key methodological issues identified in the included papers were lack of justification for the research design and lack of consideration of relationships between researchers and participants, such as reflexivity and positionality. Additionally, very few published studies included information on the characteristics, training and experience of who collected and analysed the data. The theses included in this review (2, 16, 17, 19, 22) all scored higher on quality assessments than the studies which were published in journals, especially with regards to clarifying epistemological and ontological underpinnings to their methodology, transparency about the approach to analysis, justification of the research design and discussing researcher positionality and reflexivity. This difference between published research and theses may be due to word limits set by journals.

Additional quality indicators

Fifteen studies did not address any ethical issues beyond standard ethical considerations (3, 4, 8, 10, 13, 16, 18, 21, 23, 24, 28, 30, 33, 34, 36). Two studies referenced guides on trauma-informed research with survivors (1, 29). Several studies highlighted that they did not ask about experiences of sexual violence unnecessarily to avoid causing secondary trauma (17, 32, 29). Six studies highlighted the importance of foregrounding empathy, avoiding silencing and building trust (2, 20, 17, 19, 38) or had a clear social justice aim (5, 12). Three studies highlighted the interviewers either received training in working with sexual violence/trauma survivors or had relevant clinical or qualitative research experience (1, 10, 11, 14, 15, 17, 35, 38). One study with adolescent survivors created a new consent process that avoided needing to ask for parental consent, recognizing that survivors may have been assaulted a parent, family member, or family friend, and recognizing the need to protect survivors’ ability to decide whom to tell about the sexual violence (6). One study included a thoughtful and sensitive discussion on the importance of self-identification. They considered that if researchers turned survivors away when they (survivors) felt they met the criteria this could be experienced as a potential second attack (37).

In terms of survivor involvement, only one study indicated that survivors had any influence over the research design and interpretation through an advisory group (5). Although one study indicated they co-developed some questions in the interview guide with an advisory group that included survivors, they indicated that survivors' role was to check phrasing, so it is unclear whether survivors had any influence on the research beyond their wording (11). Another study said the participant 'verified' the author's interpretations of their experiences, but it is unclear whether this participant could disagree with the interpretation (31). The main ways authors addressed power was through recognizing the systems of oppression that participants were living in (2, 5, 12, 26, 25, 27) and addressing the inherent power imbalance that arose from them being attached to a university or healthcare facility (17, 19).

CERQual assessment

Using the information gathered using the CASP and COREQ statement, the majority of studies (n=23) were rated as having 'no or minor concerns' (2, 5, 6, 7, 9, 11, 12, 16, 17, 18, 19, 21, 22, 24, 26, 27, 28, 30, 31, 35, 36, 37, 38), around half (n = 14) were rated as having 'moderate concerns' (1, 3, 4, 8, 10, 14, 15, 20, 23, 25, 29, 32, 33, 34) and one study was rated as having serious concerns (13). The CERQual assessment of confidence in each finding and explanation for this assessment are presented in the findings section (6.3). See Appendix Q for the full CERQual evidence profile.

6.2.4 Outcome of relating studies

Disconfirming cases are summarised in table 6 (see Chapter 4 for description of how inconsistencies between studies were identified). As is demonstrated, I found that some studies were dissimilar but related, as the inconsistencies identified through translation could be explained when the studies were considered together and when their context was considered. All studies contributed to an understanding of what survivors need from healthcare providers and services to help them feel safe and work towards healing and recovery, although some studies contributed to the final synthesis more than others. This is indicated throughout by referencing relevant studies to back up the synthesis findings.

6.2.5 Outcome of translation

Despite the studies being conducted in different clinical settings and geographical locations, with differing health system infrastructure and policy contexts, the concept of trust, both giving and receiving, was a golden thread that ran through all the studies. This was captured in a line of argument synthesis named ‘trusting and being trusted’.

Table 6 Apparent inconsistencies and their synthesis.

Majority	Minority	Synthesis
Confidentiality is important, do not rush women, wait until they are ready, do not force disclosure, do not go to the police, do not tell them they should go to the police.	Kelly (2004) wanting the GP (General Practitioners) to call the police and make her talk.	This participant felt completely out of control and feared for her life as a previous disclosure had been dismissed and she was in imminent danger from her partner. This therefore seems more likely to be an expression of wanting her GP to acknowledge the seriousness of the violence, wanting someone to care about her and help her rather than wanting someone to take control away from her.
Majority	**Minority**	**Synthesis**
Clinical touch as violating or unwanted.	Reisenhofer (2012) survivor recalled the desire to be touched with compassion; not getting this increased her sense of being	Touch is a form of communication and can communicate caring. If coupled with a lack of consent or wrapped in power dynamics, then clinical touch can be experienced as a

	'untouchable'. Ericksen (2002) discussed the importance of caring touch to survivors' positive experiences of care.	violation. Ericksen noted that the fact providers were all women was important, indicating power and gender were important to positive experiences of touch. Survivors needed to be treated warmly, and compassion could be communicated through positive, consensual and caring touch as much as words. Positive touch was also about not reinforcing survivors' feelings of shame, i.e., that they are 'untouchable', contaminated or not worthy of positive touch.
Being treated in a cold or impersonal way is unhelpful	Holton (2016) stated that being treated in a "brusque manner" (p. 50) may be more in line with women's needs when they first present to health services after recent sexual violence.	Women needed time and space which is what being treated brusquely provided them with. There is no evidence that women did not want to also be treated with warmth and respect, just that they did not want to be bombarded with "incessant chatter" (Holton, 2016, p. 50).

6.3 Findings II: Outcome of synthesis process

Three themes and eight sub-themes were generated and connected by a line of argument named 'trusting and being trusted'. This line of argument explains how trust can be built in healthcare after sexual violence and critical importance of trust being reciprocal. Table 7 provides an overview of review findings, the studies contributing to each finding, and the CERQual outcome and explanation (see appendix Q for the full CERQual evidence assessment).

Table 7. Overview of review findings, studies contributing to each finding, and CERQual outcome and explanation.

Line of argument:Trusting and being trusted (6.3.4).
Reciprocal trust was central to re-building the trust in self and others that had been shattered by sexual violence. To build reciprocal trust providers must first trust women in order to show that they (providers) are trustworthy and to support survivors to re-build trust in themselves. Each theme explores an aspect how this trust can be built in healthcare.

Theme	Summary of review finding	CERQUAL assessment outcome and explanation
Acknowledgement: shifting shame and blame (6.3.1). Societal perceptions which positioned women as responsible for sexual violence shaped how women made sense of their experiences and how they were treated by providers. When presenting to healthcare women expected to be blamed and not be believed (n = 24 studies; 2, 7, 8, 9, 11, 12, 14, 15, 16, 18, 19, 20, 22, 26, 28, 29, 30, 31, 33, 34, 35, 36, 37, 38).	**Alienation and shame.** Shame alienated survivors from their bodies as well as other people. Fear of being blamed prevented disclosure. Blaming responses to disclosures re-enforced shame.	This finding was graded as high confidence as it is likely that the finding is a reasonable representation of women's experiences and expectations of healthcare after experiencing sexual violence in adulthood. Twenty-seven studies with minor or no methodological limitations. No or very minor concerns about coherence and adequacy.
	Acknowledging sexual violence. Providers gently naming the experience(s) as sexual violence could shift shame and self-blame. Societal misconceptions about 'real rape' prevented women from having the language to name experiences as sexual violence.	
Being Seen: Respect, validation and responsiveness (6.3.2). Survivors felt that both they and their experiences of sexual violence were invisible. This was counteracted by providers and services that acknowledged sexual violence, respected their feelings, validated their experiences, and responded to their health care and emotional needs (n = 26 studies; 1, 2, 4, 5, 6, 8, 10, 11, 14, 15, 17, 18, 19, 20, 22, 24, 25, 26, 28, 29, 30, 31, 33, 34, 35, 36).	**Invisibility and disconnection.** Survivors felt that both they and their experiences of sexual violence were invisible in healthcare. When services and providers did not understand or did not want to know this led to disconnection and silence.	This finding was graded as high confidence as it is likely that the finding is a reasonable representation of women's experiences and expectations of healthcare after experiencing sexual violence in adulthood. 25 studies with minor or no methodological limitations. No or very minor concerns about coherence and adequacy. The finding 'shining a light on sexual violence' had a smaller number of studies contributing to it compared to other findings, but 75% were of high methodological quality and directly relevant to the review topic
	Shining a light on sexual violence. The invisibility of sexual violence could be counteracted by providers and services that wanted to know about sexual violence and treated it as an unacceptable violation of human rights that was within their remit to respond to.	
	Facilitating human connection. Providers who helped women to feel seen and heard as whole people facilitated connection. Thid involved respecting women's feelings, validating their experiences and responding to their individual health and emotional needs.	
Being Heard: Choices, empowerment, and shared decision-making (6.3.3). Survivors needed to reclaim their bodies and their lives after sexual violence. Provider behaviours and service delivery influenced women's ability to connect with their needs and either amplified or dampened their voice when women tried to communicate these needs. Experiences captured in this theme were largely negative, although women suggested ways to improve care through ensuring full, ongoing, active and informed consent and having continuity of care (n = 29 studies; 1, 2, 3, 4, 5, 6, 8, 9, 10, 11, 12, 13, 15, 16, 17, 18, 19, 20, 21, 23, 27, 29, 30, 31, 32, 33, 35, 36, 37).	**Intersecting power imbalances.** Providers had power and authority and the power imbalance was widened by inequalities due to gender and race. Survivors felt safer with women and racially minoritised survivors felt safer with racially minoritised providers.	This finding was graded as high confidence as it is likely that the finding is a reasonable representation of women's experiences and expectations of healthcare after experiencing sexual violence in adulthood. 30 studies with minor or no methodological limitations. No or very minor concerns about coherence and adequacy.
	Healthcare mirroring abuse. Healthcare could mirror the coercion and silencing of sexual violence through unconsented touch and examinations and/or dismissing or ignoring women's needs. Women could re-experience traumatic memories in response to procedures and examinations, but the same procedure could be experienced differently depending on how in control a woman felt.	
	Silence and silencing. Women were silenced when their efforts to disclose and seek support for sexual violence were repeatedly dismissed, misunderstood or overlooked. Biomedical dominance and standardisation of care contributed to this silencing. For instance, mental health diagnoses were used to dismiss women's concerns and ignored the role of trauma in their distress.	

6.3.1 Acknowledgement: Shifting shame and blame

Women felt responsible for sexual violence; this shaped how they made sense of their experiences, how they were treated by others and what treatment they expected from healthcare providers. This theme contains the following sub-themes: ‘alienation and shame’, which describes how isolated and ashamed women felt when they presented to healthcare services, and ‘acknowledging sexual violence’, which relates to how understanding their experience as violence and disclosure of sexual violence created opportunities to shift this shame and blame. Women were at different stages of their journey of acknowledgement when they presented to services and needed different things from care depending on where they were.

Alienation and shame

Sexual violence led women to feel alienated from their own bodies as well as from other people. Some survivors described embodied feelings of shame after sexual violence, such as feeling ‘dirty’ or ‘untouchable’ (30, 35). Others reported feeling incomplete, broken (15, 31). Several studies highlighted that many survivors expected not to be believed by providers (7, 9, 28, 11) and blamed themselves for the violence they were subjected to (8, 11, 15, 18, 26, 33, 35). Studies discussed how women’s shame was rooted in societal stereotypes that blamed women for sexual violence (8, 30, 35) and how these were readily exploited by perpetrators (8).

Women expected to be blamed by healthcare providers, which prevented disclosure (2, 26, 33, 36, 37). Blaming responses to disclosure that reinforced these stereotypes furthered women’s sense of alienation and shame (8, 16, 19, 29, 30, 35 36). Specifically, women experienced being called promiscuous (35), that they had caused their partner’s violence (30), that distress at a partner’s abusive behaviour may be due to a thyroid issue (36), being told to move on (16) and being called a liar (29) Survivors of intimate partner sexual violence felt blamed for staying in the relationship as well as the sexual violence (8, 30). Studies explored how negative past experiences of disclosures led to women disengaging from care or avoiding future disclosure (30). One study noted that only women who had experienced sexual violence in casual relationships disclosed, compared to none of the women who had experienced sexual violence from their husbands (14).

Acknowledging sexual violence

Acknowledging sexual violence took women time, sometimes many years (20, 26, 31, 34, 35, 37). Acknowledgement was linked to survivors believing they did not deserve the abuse (12, 26, 33, 34). This process needed to be supported by sensitive responses to disclosure from healthcare providers that validated women's' distress, named their experiences as sexual violence and treated it as serious (18, 35, 36). Additionally, healing or recovery was not linear but instead could involve engaging and disengaging from support at different times (18).

At the time of seeking healthcare, many women did not have the language to label their experience(s) as a form of violence and abuse. This impacted disclosure. The labels 'sexual violence' or 'rape' did not fit with women's own understandings of their experiences (26, 31). Some women were aware that they had experienced something that felt 'wrong', but they blocked it out or minimized it in order to cope (19, 38) or they did not have the language to define their experience as abuse or violence (26, 31). Studies with survivors of intimate partner violence highlighted how co-occurring psychological abuse and emotional manipulation disoriented and confused women, disrupting their ability to understand their experiences as sexual violence (22) and that normalizing the abuse made it easier to live with (14, 30).

Societal stereotypes shaped women's ability to acknowledge their experiences as sexual violence (9, 11, 30, 35). Women assumed abuse must be physically violent to qualify as sexual violence, and if it was not physically violent then the woman must be lying, misremembering or overreacting. Women saw injuries as proof that they had experienced a sexual assault particularly in relation toto the Medical Forensic Examination (MFE) (9, 11), but also arose in general healthcare (35). Women felt validated when healthcare providers told them about injuries and when they attributed injuries to the sexual violence (11, 35). However, when survivors were not told about injuries, either because none were found or because the provider did not communicate the results of the MFE, women doubted their memory of the event and blamed themselves (11). In this way, some women relied on the findings of the Medical Forensic Examination to validate their experience as one of sexual violence.

6.3.2 Being Seen: Respect, validation and responsiveness

Survivors felt that both they, and their experiences of sexual violence, were invisible in healthcare (‘invisibility and disconnection’). This invisibility could be counteracted by providers and services that acknowledged and addressed sexual violence and treated it as an unacceptable violation of women’s human rights that was within their remit to respond to (‘shining a light on sexual violence’). Providers who helped women to feel seen and heard as people by respecting their feelings, validating their experiences and responding to their healthcare and emotional needs opposed the disconnection women felt because of the invisibility of sexual violence (‘facilitating human connection’).

Invisibility and disconnection

Various barriers to disclosure and enquiry led to the invisibility of sexual violence in healthcare settings and services. Aspects of healthcare environments, including frequent interruptions, lack of privacy, rushed appointments and a lack of continuity of care, made it more difficult for survivors to feel safe or grounded enough to initiate a conversation about sexual violence (17, 19, 24, 25, 26, 33).

Women also experienced invisibility through feeling disconnected from providers. Survivors were highly attuned to clinicians’ sense of time and comfort, which they used as an indicator of a provider’s receptiveness to disclosure (5, 17, 35). Women tested the safety of disclosure by providing ‘clues’ without explicitly naming or describing the sexual violence (22). Clinicians’ receptiveness and sensitivity were crucial to whether these clues led to disclosures (5, 17, 36). Survivors also reported feeling disconnected from providers who acted in a clinical, cold, or impersonal manner (2, 8, 11, 15). This was particularly evident in studies about women’s experience of care during birth (15) and the Medical Forensic Examination (MFE), where women felt particularly vulnerable due to the invasive nature of healthcare. When speaking about the MFE, survivors described how a disconnect between their own feelings of shock, confusion and distress, and their observation that the examiner approached the task as routine and normal minimized their experiences (11).

For some, the invisibility of sexual violence continued after a disclosure through responses that disempowered and silenced women. These responses included needs or disclosures being dismissed or minimised (8, 17, 19, 33, 36), being told what to do or how to feel (2, 8, 11, 19) and being disbelieved or blamed (8, 29, 35, 36). The invisibility of sexual violence also continued in the pathologisation of women’s distress following sexual violence. When providers equated sexual violence with the mental and physical health impacts, survivors felt silenced. For example, when providers medicalised their difficulties, women felt like they were ‘just a diagnosis’ (19) or women reported being treated like a ‘crazy woman’ (36). Related to this was feeling objectified in healthcare, such as being treated as a machine to be fixed (15) or ‘some rubbish on the street’ (20), rather than a human being who has experienced a gross violation of their human right to safety and bodily integrity. This reinforced the invisibility and disconnection women associated with the abuse.

Shining a light on sexual violence

Through ‘shining a light on sexual violence’, providers invited women to share their experiences of sexual violence and showed their understanding of the health and emotional impacts of trauma. Survivors reported wanting to be asked about sexual violence in a sensitive, supportive and non-judgemental way, regardless of whether they were ready to disclose (19, 22, 31, 35). One study explored how a poster invited a survivor who did not understand their experience as abuse to begin to re-frame their experiences as such (22). Increasing the visibility of sexual violence via posters and enquiry could send a message that providers cared about sexual violence (19, 22, 31, 35). Survivors found it helpful when providers named the sexual violence and gently challenged self-blame while respecting women’s autonomy and validating their feelings and responses (8, 28). Women needed to be allowed to feel difficult but natural feelings of shame, blame, shock, disbelief, and fear whilst hearing that they did not deserve to feel this way (8, 18, 34, 35).

Facilitating human connection

Human connection and emotional safety helped survivors feel visible and seen in healthcare and healthcare encounters facilitated connection through actions as much as words. Emotional safety could be communicated by compassionate touch from a provider (10, 30). Women needed compassion, kindness and warmth (11, 20) – one woman felt relieved when the provider was more than an ‘evidence collector’ (11). Providers’ attunement to a woman’s needs was also important to creating emotional safety (1, 6, 8, 17, 19, 36), but to achieve this, women needed providers to set aside their own needs and truly listen to women’s spoken and unspoken communication (8). Women needed providers to create space and avoid trying to ‘fix’ an unfixable situation (2, 8, 10, 33, 35, 36). Women also needed time to process the trauma and space to connect with their needs (18). Space did not mean isolation – in some instances, companionship was important and for some could mitigate some effects of trauma such as flashbacks and numbing (1, 4, 10) and reminded survivors of life before the assault (6). Women who were left alone without information about when they would be seen felt abandoned and unsafe (1, 2, 19, 29).

6.3.3 Being Heard: Choices, empowerment, and shared decision-making

Provider behaviours either amplified or dampened the survivor's voice. When women's needs were unheard or unspoken this mirrored abuse through taking power away from women and silencing them further. As explored in 'intersecting power imbalances', providers held a powerful position of authority, which intersected with other power inequalities to shape women's expectations and experiences of healthcare. These experiences and expectations are further elaborated on in 'healthcare mirroring abuse' and 'silence and silencing'; the former relating to how care mirrored abuse through taking choices away and the latter to systemic factors that perpetuated the silencing of sexual violence survivors. The key experience being conveyed in this theme is the impact of women not being listened to because providers were unable to set aside what *they* (providers) needed to truly listen to women. Experiences captured in this theme were largely negative, although women suggested ways to improve care through ensuring full, ongoing, active and informed consent and having continuity of care.

Intersecting power imbalances

Several studies highlighted that healthcare providers were in positions of power and authority in relation to women (5, 11, 12, 17, 19, 33, 37). Women complied with health care that they did not want or did not understand because they were told to do so (5, 9, 11, 17, 29) or because they feared being refused care if they did not agree (17). Some women spoke about touch from healthcare providers as authoritarian and unilateral, invading their bodies without consent (12, 15, 19, 35). This meant that women had procedures done *to* them instead of being active participants in their care.

Power imbalance due to gender compounded the power imbalance between providers and women. Some studies highlighted that women felt safer with other women, whether they be providers (4, 5, 10, 13, 16, 17, 21, 35, 36) or service users (21, 23). One study highlighted this was true even if they had been assaulted by a woman (36). Survivors felt that women providers might be more understanding (16, 20). However, this expectation was not always met and when women were treated insensitively by women care providers this could lead to women feeling betrayed by both their own gender and the healthcare provider who was meant to care for them (16). For some women it was culturally inappropriate to have a male healthcare provider (5). One study explicitly illustrated the gendered nature of experiences of restraint for women on locked wards (12). Women felt more humiliated and more disempowered when they were restrained by a male provider compared to a female provider and described male providers' approach to restraint as more authoritarian and less predictable compared to their female counterparts. Differences between male and female providers were not explored in this gendered way by other studies.

Taken together, these findings indicate that preference for a female healthcare provider may be linked more to feeling safer with women generally and less safe around men, possibly due to gender inequalities between men and women, rather than about feeling unsafe with people the same gender or sex as the perpetrator. Survivors noted that women should be able choose providers and services that they felt comfortable with, even if they themselves had no preference.

Although very few studies explored the experiences of minoritised women, the few that did emphasised that power inequalities due to race also shaped women's experiences and expectations of healthcare. Two studies mentioned that Black women felt more understood by Black providers (2, 37) with one study linking this explicitly to racism (37).

Healthcare mirroring abuse

Many women reported feeling re-traumatised by healthcare that mirrored abuse. Some studies used the metaphor of a second attack or assault on the body to illustrate this (6, 12, 18). Healthcare mirrored sexual violence and abuse through unexpected and/or unwanted examinations which invaded women's bodies and personal space (12, 15).

Re-living abuse in healthcare was linked more to the way in which care was approached than the procedures themselves. The same procedures were experienced differently by different women depending on how in control they felt. This was demonstrated mostly by studies looking at the Medical Forensic Examination (MFE), where lack of informed consent underpinned the MFE feeling like another attack on the body (9, 11, 20). Women had their choice and control taken during the assault and therefore needed to have their choice and control reinstated (6, 11). Therefore, full, informed, ongoing consent through providers explaining everything and feeling able to say no was key to avoiding re-traumatisation and ensuring the healthcare environment did not mirror abuse (3, 11). An important part of this was women setting the pace for examinations (10) and having control over the initiation and termination of procedures/examinations (10, 11, 32).

Women's experiences of healthcare were also shaped by the impacts of sexual violence, which included numbing, dissociation and disorientation, shock, and flashbacks (1, 15, 27, 32, 35). This was especially salient for studies focusing on healthcare immediately after sexual violence, although these impacts of sexual violence could be experienced long after an incident of sexual violence as well. The impacts of trauma created barriers for women to process or retain information, tune into what they needed and communicate their needs, especially when healthcare environments added to their disorientation and distress (2, 4, 5, 9, 11, 12, 32). To address this, women needed clear and consistent and written communication.

Silence and silencing

For some women, efforts to seek support from healthcare systems and providers were continuously met with silence or dismissal (8, 17, 19, 33, 36). Some women reported that providers used sexual violence-related mental health diagnoses such as PTSD to dismiss their physical health-related concerns (19) or treated a disclosure of sexual violence as a mental health concern (19, 30). Not being able to access the care they wanted and needed meant women were left imprisoned by their difficulties.

Some studies explored how inadequate communication between providers resulted in women being forced to repeatedly disclose their trauma to multiple providers (11, 17, 19, 23, 32). Women found it empowering to tell their story if they had a choice about whether and how to do so (2, 31). However, when survivors were not able to choose when, how and to whom they told this risked re-traumatisation through re-living the details of the event and put women at risk of insensitive responses from providers (17, 19, 23, 32). When a disclosure did not result in a change to care, women felt silenced and unheard (19, 32). Being required to repeatedly disclose experiences of trauma was also experienced by women as provider convenience being prioritised over women's well-being (19).

Women valued continuity of care or carer (5, 18). Having a named provider created a 'safety net' and fostered the consistency, accountability, and responsibility that women needed to build trust (18). However, many women experienced fragmented, inconsistent care, making it difficult to access support (17, 19, 23, 32) The importance of continuity of care was therefore highlighted by the impact of its absence in women's experiences.

Taken together, these experiences could be understood as an active silencing of women rather than women passively 'experiencing' silence or dismissal, because their efforts to speak about and seek support for the impacts of sexual violence on them were repeatedly dismissed or misunderstood. Healthcare services in this sense reflect a society that does not understand, and perhaps does not always *want* to understand, the needs of sexual violence survivors.

6.3.4 Line of Argument: Trusting and Being Trusted

The line of argument underlines the critical importance of reciprocal trust. Each theme identifies a different aspect of *how* trust may be built in healthcare (summarised in Figure 2). When providers trusted women, they signalled to women that providers and services were trustworthy, and empowered women by trusting women to make decisions about their own care. In the first theme, ‘acknowledgement: shifting shame and blame’, providers facilitated women’s trust in their own memories and bodies by supporting women to label their experiences as violence and abuse, providing the space and time for women to reach this understanding, and gently challenging blaming stereotypes that silenced women. In the second theme, ‘being seen: respect validation and responsiveness’, providers signalled to women that they were trustworthy by counteracting the invisibility of sexual violence and treating women with kindness, respect and validation. In the third theme, ‘being heard: choices, empowerment and shared decision-making’, providers empowered women through genuinely listening to women’s self-identified needs and trusting women to make decisions about their care.

This line of argument, ‘Trusting and Being Trusted’ conceptualises trust as reciprocal and this places responsibility on providers and services to *earn* women’s trust. Conceptualising trust as reciprocal therefore challenges ideas that survivors are ‘vulnerable’ or ‘broken’ because it recognises that sexual violence involves a betrayal of trust and power and therefore women have good reason to need evidence of trustworthiness from those in positions of power. Relational approaches to care that re-build women’s trust in themselves and others, counteracts the alienation women can feel from their own bodies and other people after sexual violence. Healthcare providers in a position of power and responsibility to facilitate, support and nurture this healing through centering women’s voices and choices.

Figure 2. Overview of how meta-ethnography findings relate to trust.

Line of argument: trust is reciprocal	6.3.4 Trusting and Being Trusted: Trust is Reciprocal		
Themes illustrate *how* trust is built	6.3.1 Acknowledgement: Shifting Shame and Blame	6.3.2 Being Seen: Respect, Validation and Responsiveness	6.3.3 Being Heard: Choices, Empowerment and Shared Decision-Making
How theme relates to trust	*Women re-learning to trust themselves*	*Providers earning women's trust*	*Providers trusting women*
Sub-themes	Alienation and shame Acknowledging sexual violence	Invisibility and disconnection Shining a light on sexual violence Facilitating human connection	Navigating power imbalances Healthcare mirroring abuse Silence and silencing
How theme counteracts messages sent by sexual violence	Sexual violence is shrouded in silence, secrecy, and shame. Survivors face blame from themselves, perpetrators, and wider society.	Sexual violence is dehumanising. It tells women that they are not worthy of respect, kindness, and love.	Sexual violence takes power and control away. It tells survivors that their needs do not matter and that their wishes are unreasonable.
Provider values to guide actions	Patience Flexibility Understanding	Empathy Kindness Responsiveness	Accountability Transparency Respect

6.4 Summary of findings

The findings of this review relate to adulthood sexual violence and/or abuse survivors' healthcare experiences and expectations across a variety of clinical settings and personal circumstances, irrespective of disclosure. Women had experienced sexual violence from partners, acquaintances, and strangers, and some women had also experienced other forms of violence or abuse at different points in their life, including in childhood. Three themes were generated through synthesising and translating concepts. 'Acknowledgement: Shifting Shame and Blame', 'Being Seen: Respect, Validation and Responsiveness', and 'Being Heard: Choices, Empowerment and Shared Decision-Making'.

The first theme, 'Acknowledgement: Shifting Shame and Blame', explored how women's relationships with themselves were impacted by societal perceptions of sexual violence that placed responsibility and blame for sexual violence on survivors rather than perpetrators. Providers had a role in supporting women to challenge these perceptions and shift blame away from them and onto perpetrators and thus start to lift the shame that kept women silent. This theme highlighted a journey where survivors re-learned to trust themselves by trusting their memories and acknowledging that their experiences were indeed violence or abuse, overcoming a multitude of barriers created by societal and cultural myths about sexual violence. It is important to recognise that not all women had the time, resources and opportunities to reach this place of acknowledgement.

The second theme, 'Being Seen: Respect, Validation and Responsiveness' related to women's need to feel valued, respected, and cared about in order to combat the dehumanising nature of sexual violence. Women described situations where they were expected to trust providers when they had not yet been given reason to do so. Being treated with empathy and kindness was key to building a relationship that showed women that providers could be trusted. Survivors reported wanting to be asked about sexual violence in a sensitive, supportive and non-judgemental way, regardless of whether they were ready to disclose.

The third theme, ‘Being Heard: Choices, empowerment and Shared Decision-Making’, illustrated how sexual violence involved women losing power and control. Survivors needed to reclaim their bodies and their sense of autonomy to feel safe. This could be facilitated by having open dialogue and being provided with transparency, accountability and choices in healthcare. When healthcare providers, services, and systems tried to impose their needs on survivors, this only led to disempowerment and disconnection. Thus, to provide the personalised care that was important to survivors, providers needed to set aside their own needs and truly listen to the woman in front of them; they needed to trust women.

Overall, a line of argument synthesis which I named ‘Trusting and Being Trusted’ expressed the importance of reciprocal trust. To build reciprocal trust providers must trust women in order to signal that they (providers) are trustworthy and to support survivors to re-build trust in themselves.

6.5 Conclusion

The findings of this systematic review and meta-ethnography suggest that sexual violence in adulthood impacts women’s experiences and expectations of healthcare irrespective of disclosure. Supportive experiences of healthcare can act as a powerful force to support healing after sexual violence. Conversely, insensitive care that takes power away from women and compounds shame can disrupt healing and be retraumatising. A central concept of reciprocal trust, summarised in the line of argument ‘trusting and being trusted,’ highlighted how it is critical that healthcare providers trust women as much as they are asking women to trust them. Below, I explore the knowledge gaps that my review highlighted and how my findings shaped the other studies in my thesis.

6.5.1 Knowledge gaps

This systematic review identified several gaps in the literature on healthcare experiences and expectations among survivors of sexual violence in adulthood. Many studies focused on specialist sexual violence care, specifically sexual violence support centres and medical forensic examination experiences. However, the women who use these services may represent a specific group of survivors. To use these services women must disclose, and therefore have acknowledged, at least on some level, that they had experienced sexual violence. We know that disclosure can take survivors time, sometimes years (if they ever disclose at all). No studies looking at dental care experiences and expectations among survivors were found. Very few studies focused only on mental health service needs, and out of those that did, most focused on therapy experiences (rather than, for instance, secondary mental health services).

In terms of women's healthcare, only three studies included the maternity care experiences of survivors of sexual violence in adulthood. One of these studies only included survivors of stranger rape (Halvorsen et al., 2013), another focused on experiences of women facing multiple disadvantage and did not focus on sexual violence specifically (Birthrights & Birth Companions, 2019) and the third study compared experiences of survivors and non-survivors where most participants (15 out of 20) had disclosed sexual violence to their maternity care team (Sobel et al., 2018). No studies were found that focused on sexual healthcare or gynaecology care alone, although some did address experiences as part of general healthcare experiences.

Four studies examined the healthcare experiences and expectations of women who had experienced intimate partner sexual violence (IPSV), a particularly under-studied and poorly understood type of sexual violence against adult women with significant impacts on health and help-seeking (Wright et al., 2021). In this review, one study (examining mental healthcare needs) disaggregated survivors' experiences of IPSV (often co-occurring with physical violence) from non-partner sexual violence (Draucker, 1999). For the other studies focusing on IPV, quotes and author interpretations relating to IPSV survivors' experiences were separately extracted for the purposes of this review, reflecting wider issues with the intimate partner violence (IPV) literature that often tends to position IPSV within the umbrella of IPV (Tarzia, 2020b). Trust (and the betrayal of it) is a central concept in both this synthesis and the experience of IPSV (Tarzia, 2020b), indicating potentially unique healthcare experiences and expectations among IPSV survivors. However, further research examining IPSV survivors' unique healthcare experiences and expectations is needed.

The studies in this review largely centered the experiences of white, heterosexual, young women, reflecting wider issues with literature on violence against women and girls (Bows, 2020; McCauley et al., 2019). Survivors who are traditionally underserved by healthcare, including racially minoritised survivors, survivors living with disabilities, survivors with mental health diagnoses and older survivors (Bach et al., 2021) are still largely missing from the literature. Since power and privilege can have a significant impact on the prevalence and impact of sexual violence as well as healthcare needs and encounters (McCauley et al., 2019), future research must focus specifically on the needs of these underserved survivors.

No survivor-led research was found. Only one study reported any involvement activities that could have allowed survivors to influence the research. This study included survivors in an advisory group, although it is not clear if this group also included providers or whether there were separate groups for survivors and providers (Birthrights, & Birth Companions, 2019). This reflects low levels of survivor involvement in the design, analysis and dissemination stages of the research (Kennedy et al., 2022). A critical but often unrecognised principle of trauma-informed approaches is that of partnership working with survivors (Oram et al., 2022; Sweeney et al., 2018). To achieve this, research with survivors must involve survivors in meaningful, impactful and empowering ways so that systematic reviews like this one can inform practice and policy with survivors' voices truly at the centre.

6.5.2 How this review provides justification for my other studies

Using a survivor-led, trauma-informed lens, my research aims to increase understanding of adulthood sexual violence survivors' experiences of pregnancy, birth, early motherhood and maternity care with the aim of improving care. This review highlights a number of evidence gaps that my research directly addresses.

Only one study involved survivors beyond being participants; this was the only study with survivor involvement out of all 38 studies included (Birthrights, & Birth Companions, 2019). While the Birthrights and Birth Companions report is extremely important, it focused on the maternity care needs of women facing multiple disadvantage, with no disaggregated findings on sexual violence. Sobel et al.'s (2018) findings were based on comparing maternity care narratives of survivors and non-survivors. In Chapter 2, I critique Sobel et al.'s (2018) assumption that sexual trauma can be separated from systemic harm. Their approach suggests that their epistemological, theoretical and ethical orientation differs significantly from the trauma-informed, survivor research principles guiding my research. Furthermore, the majority of participants in Sobel et al. (2018) had disclosed sexual violence to their maternity care team and therefore their findings do not address instances where women remained silent (or were silenced; Montgomery, 2013).

All except one participant in Halvorsen et al. (2013) had experienced stranger rape. While all experiences of sexual violence may have devastating consequences for survivors, Halvorsen et al.'s (2013) findings cannot address how maternity care may re-create the relational harm (Kelland, 2011) caused by being subjected to sexual violence by someone a woman knows, trusts, and may even love (Tarzia, 2020b). Halvorsen et al.'s (2013) findings consequently focus on re-experiencing rape through physical sensations and feelings (as does Sobel et al., 2018). Furthermore, all three studies focused primarily on negative experiences, but, although rarely explored in existing literature, the perinatal period may provide important opportunities for healing (Montgomery, 2013). My survivor-led, trauma-informed qualitative study about survivors' experiences of pregnancy, birth early motherhood and maternity care (Chapter 7) addresses these important gaps in knowledge.

My systematic review found that survivors were silenced on multiple levels. Systemic factors both prevented disclosure (e.g., busy, uninterested staff) and led to care that failed to meet survivors' needs (e.g., through pathologising sexual violence). My review findings include experiences of silencing created by a health system predicated on diagnosis; facilitated through provider misconceptions about sexual violence; and perpetuated through healthcare environments that impede or de-prioritise informed consent. Trauma-informed approaches posit that to create sustainable, meaningful change research must explore providers' working environments, their needs, and the systemic and structural factors that shape the care they deliver (Sweeney et al., 2018). My systematic review findings, coupled with my trauma-informed framework (Sweeney et al., 2018), therefore compelled me to include maternity care providers' experiences and needs in my PhD (see Chapter 8).

6.6 Summary of Chapter 6

This chapter described the findings from the first study presented in this PhD: a systematic review and meta-ethnography about healthcare experiences and expectations among female survivors of sexual violence in adulthood. This comprehensive systematic review identified only three studies that included maternity care experiences among survivors of adulthood sexual (Birthrights & Birth Companions, 2019; Halvorsen et al., 2013; Sobel et al., 2018). Most research on women's health focused on forensic medical examinations or gynaecological care. While these healthcare fields overlap with maternity care, maternity care is a medically unique and highly complex healthcare environment in which one person may be harmed (usually the mother) to benefit a different person (usually the unborn baby; Kingma, 2021). This suggests an even greater need for autonomy and consent compared to other areas of women's health, but paradoxically, in maternity care, autonomy and consent are at an even greater risk of being violated (Kingma, 2021). This paradox has important implications for sexual violence survivors who may be uniquely harmed by consent and autonomy violations (Montgomery, 2013, 2015a, 2015b). Overall, the existing evidence base on maternity care is limited by extremely low levels of survivor involvement, a focus on negative, one-dimensional aspects of women's experiences, and findings and conclusions that obscure or overlook the role of systemic harm. This underlines an urgent and significant need to conduct trauma-informed, survivor-led research. In Chapter 7, I discuss findings from a qualitative narrative study with survivors to build on and address the limitations identified.

Chapter 7. Survivors’ Experiences of Pregnancy, Birth, Early Motherhood and Maternity Care: A Thematic Narrative Analysis

This chapter presents findings from a qualitative study with survivors of sexual violence in adulthood about their experiences of pregnancy, birth, early motherhood (up to 6 weeks post-birth) and maternity care. After briefly discussing how this study builds on and addresses gaps in extant literature, I present the findings from a thematic narrative analysis of women’s experiences. I end the chapter with a summary of key findings. Please see Chapter 4 section 4.9 for a description of methods used and analytic approach taken.

7.1 Introduction

As detailed in Chapter 2, sexual violence is a common, but hidden, public health issue and human rights violation (Jewkes et al., 2002). Sexual violence has particular significance to maternity care. An estimated 17% of women using maternity care services worldwide have been exposed to sexual violence (Bazyar et al., 2018). Yet, research finds that survivors of sexual violence can find loss of control during pregnancy and birth and invasive and intimate aspects of care re-traumatizing (Halvorsen et al., 2013; LoGiudice, 2016; Montgomery, 2013; Sobel et al., 2018). Most of this literature has focused on the experiences of childhood sexual abuse survivors, and despite high prevalence of adulthood sexual violence and/or abuse (Office for National Statistics, 2021), research examining maternity care experiences among survivors with these experiences remains scarce.

The systematic review detailed in Chapter 6 identified two peer-reviewed qualitative studies that have focused on maternity care experiences among adulthood sexual violence survivors. However, the findings of these studies are limited in several ways. Halvorsen (2013) included mainly survivors of stranger rape, yet most survivors experience multiple, overlapping forms of abuse often from someone known to them (Roelens et al., 2008; Sweeney, Perôt, et al., 2019).

Halvorsen et al.’s (2013) findings may therefore be limited in terms of developing theoretical perspectives on how the relational harm of sexual violence caused by the objectification of women’s bodies and violation of their autonomy (Kelland, 2011) may be re-created in maternity care. Sobel et al. (2018) included mainly survivors that had disclosed sexual violence to their maternity care team (15/20), but research suggests low disclosure of sexual violence among pregnant women – for example, 6.6% of survivors in a regional probability sample in Belgium (Roelens et al., 2008). Sobel et al.’s (2018) findings may therefore be limited in terms of developing theoretical perspectives on how the silencing of sexual violence (Herman, 1997) may be re-created, re-enforced, and perpetuated during the perinatal period, and how motherhood may intersect with the impacts of sexual violence.

Sobel (2018) analysed data from both survivors and non-survivors concurrently as their aim was to “explore similarities and differences between the effects of sexual trauma from baseline obstetric trauma” (p. 1462). However, extant research emphasises complex and multi-layered relationships between sexual abuse, care needs and traumatic birth experiences, indicating that these experiences cannot be easily separated without losing meaning (Chadwick, 2017; Montgomery, 2013; Montgomery et al., 2015; Reed et al., 2017). Their conclusion that survivors experience ‘negative trauma cues’ in response to obstetric violence, reveals an epistemic, theoretical and ethical orientation incompatible with my trauma-informed and survivor-led approach (Faulkner, 2014; Sweeney et al., 2009). Indeed, Both Halvorsen (2013) and Sobel (2018) both focused mainly on negative and re-traumatising experiences of birth, although Sobel (2018) does mention that some survivors may find breastfeeding healing. An emphasis on re-traumatisation obscures the full range of experiences survivors can have; particularly the potential for pregnancy, parenting and motherhood to be a source of mastery, strength and healing for some women (Montgomery, 2013; Simkin & Klaus, 2004). Furthermore, an individualistic focus on survivors ‘re-living’ rather than on providers and systems ‘re-creating abuse can neglect sociocultural, systemic and structural factors that may underpin disempowering care practices (Montgomery, 2013). This highlights a need for a strengths-based, trauma-informed approach in research.

These limitations highlight an urgent need for survivor-led, trauma-informed research. In particular, the emphasis on re-traumatising birth experiences in this literature indicates a need for survivor-led, trauma-informed research that uses a flexible, narrative approach that privileges survivors' perspectives, allows for a full range of experiences, and considers the wider social and cultural context that surrounds maternity care. Thus, the sections that follow describe the findings of a thematic narrative analysis that explores how women survivors of sexual violence in adulthood experience pregnancy, birth and maternity care.

7.2 Participants

Eleven women took part in this study. Ten interviews were conducted, with the shortest lasting 42 minutes, and the longest lasting almost 2 hours (104 minutes). On average, interviews were 75 minutes long. Four interviews were conducted in person and six were conducted online with both the participant and me in our homes. Of the in-person interviews, two were held in a private room in the rape crisis centre where women were accessing support at the time, and two interviews were held in a private room at King's College London. Of the online interviews, five women had their cameras on, but one woman chose to keep her camera off. Additionally, one participant chose to send me a written account instead of an interview, due to difficulties speaking. Table 8. Provides an overview of participant's pseudonyms and mode of data collection.

Table 8. Survivor participant pseudonyms and mode of data collection.

Participant number	Pseudonym	Mode of data collection
1	Ava	In-person interview
2	Paige	In-person interview
3	Maya	In-person interview
4	Caroline	In-person interview
5	Evelyn	Online interview
6	Georgia	Online interview
7	Audrey	Online interview
8	Valerie	Online interview
9	Janine	Online interview
10	Andrea	Written account
11	Aila	Online interview

As I discuss in Chapter 5, interviews were unstructured, open-ended and led by women to encourage women to tell me about their experiences in narrative form and in a way that made sense to them. I asked all women one question: ‘please tell me about your experiences of pregnancy, birth, and motherhood, starting wherever you feel is best'. Most participants relayed their experiences freely with little prompting from me. However, as I had anticipated (again, discussed further in Chapters 5 and 6) some participants indicated that they needed more interaction from me. I referred to the topic guide in these instances to help move the conversation forward and try to put women at ease.

The study generated a high level of interest from survivors. For one participant, her rape crisis centre counsellor told her about the study which prompted her to contact me herself. All other participants found out about the research through flyers and newsletters. Two participants contacted me because they saw a flyer in a rape crisis centre; eight participants were recruited via newsletters from the Violence Abuse and Mental Health Network, Survivors Voices, or Rape Crisis England and Wales (staff and volunteers only).

Herman (1997) proposed that healing proceeds through three stages: (1) establishing safety, (2) remembrance and mourning (and telling the story) and (3) re-connecting with others, which may include, for some survivors, participating in activism or supporting other survivors. All women who took part in this study had links with groups and organisations related to violence and abuse. This indicates a certain level of awareness that their experiences constituted violence and abuse that had led to engagement in activism or seeking support for experiences.

All the women I spoke with had experienced sexual violence in adulthood, and the majority told me about these experiences of violence. Most women also told me about different forms of violence and abuse in childhood, including childhood sexual abuse. When speaking with women, I emphasised that they would not be asked about experiences of sexual violence and abuse. Although many chose to tell me about specific experiences of sexual violence and abuse to contextualise their experiences of pregnancy, birth and early motherhood, I believe that the emphasis that I put on me not *needing* to know about their experiences of sexual violence would lead participants to assume that these experiences would not appear in the final report.

Faulkner (2004) warns against including information that might identify participants unless it is possible to check with them. I have therefore not reported individual women's specific experiences of sexual violence unless they occurred during pregnancy or early motherhood (i.e., the time period that this study covered), and they explicitly linked their experiences to the topic of the research (so they could reasonably expect this to appear in the report).

Experiences of violence and abuse are often multiple and overlapping, and therefore focusing on specific incidences or experiences may not always be helpful (Sweeney et al., 2019). In my research, most participants experienced multiple and overlapping experiences of different kinds of abuse, and for many women abuse started in childhood and continued into adulthood. Some women also reported intimate partner violence (including sexual violence from partners). Therefore, while the recruitment focused on adulthood sexual violence, it is important to state that most women had had multiple experiences of different types of violence at different times in their lives.

All participants had at least one child; some women had also had miscarriages and terminations. The time that had passed since giving birth to their last child ranged from 25+ years to just two months. One woman had had her children removed. Most pregnancies were planned, and most women wished to have a vaginal birth with no medical intervention. Several participants experienced extreme mental distress and two had received a diagnosis of borderline personality disorder. One participant later had this changed to Complex PTSD and experienced dismissive treatment from maternity care providers due to this highly stigmatised diagnosis (Lomani, 2022). Most participants did not disclose sexual violence to their care team. Of the two women who disclosed, one had a positive experience whereas the other woman experienced harmful response to her disclosure. One woman suspected her husband had told her care team about her experiences but did not disclose herself. Below, I provide an overview of what participants told me about their lives, which provides context for the findings which are presented in the next section.

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7.3 Themes generated

I produced four themes as a result of conducting a thematic narrative analysis of women's narrative accounts of their experiences. These themes, and the experiences captured within, are summarised in table 9 below. I named each theme using a quote that summarised a key aspect of the experiences captured within that theme.

The sections that follow will discuss the following themes: experiences of empowerment and connection ('the most empowering moment of my life'), experiences of shame and isolation ('something weird and wrong'), experiences of dehumanisation and objectification ('I was just a body') and experiences of kindness and collaboration ('it's about so much more than just saying it'). To finish, I present a case study to illustrate a contrast between one woman's experience of dehumanising and objectifying care in her first birth and an empowering and collaborative experience of care in her second birth. This provides an example of what 'good' care looked like that also connected to, and reflected, other women's experiences in this study.

Table 9. Overview of themes generated, their key concepts, and the 'story' of each theme.

Theme	Key concepts	What this theme was about
'The most empowering moment of my life'	Empowerment Connection	When supported by emotionally safe care, for some women, pregnancy, birth, motherhood offered opportunities to heal from sexual violence through feeling empowered, strong and connected to their bodies and other people.
'Something weird and wrong'	Shame Isolation	Needs or experiences that did not align with societal expectations on women to be the 'perfect' mother, and care that reinforced these ideas, exacerbated and interacted with feelings of shame from sexual violence.
'I was just a body'	Dehumanisation Objectification	Care that prioritised the baby's, provider's and the system's needs over the mother's needs mirrored abuse through dehumanising them and objectifying their bodies. Women challenged this by arguing that women-centred care that provided genuine choice would lead to safer outcomes.
'It's about so much more than just saying it'	Kindness Collaboration	Kind, empathic and respectful care helped survivors feel safe enough to connect with maternity care providers and communicate their needs and wishes. When this was achieved, usually by a single provider, this could change the trajectory of a woman's whole experience from one of being invisible and re-traumatised to feeling seen, heard and valued.

7.3.1 ‘The most empowering moment of my life’: stories about empowerment and connection

This theme discusses stories about how pregnancy, birth and motherhood created opportunities for empowerment and connection, especially when women were supported by sensitive care from maternity care providers. For some women, pregnancy, birth and motherhood offered opportunities to heal the relational harms of sexual violence by fostering a sense of connection and belonging. The transition to motherhood represented the beginning of a new story and counteracted the shame and isolation they felt because of sexual violence.

> Motherhood is the most empowering moment of my life. I felt more connected to my family than I have ever done so, and my feelings of belonging increased more. The previous violence in my life affected my self-worth and value. I thought very little of myself and this changed immensely after having our child. - Andrea

Being able to give and receive love through their new identity as a mother gave some women a sense of meaning and purpose that increased their self-worth, even if they did not acknowledge the sexual violence they had been through at that time (which most women had not).

> I was so happy to be pregnant. So happy to be pregnant. Even though I was living in this relationship. I never knew what mood my husband was going to be in. Police were called out a few times a week because the neighbours complained [….] But I was happy. I loved it. I wanted a child, you know, I so wanted a child. I wanted to love something like I felt I hadn’t been loved. - Georgia

Prior to pregnancy, many women felt let down by their bodies, feared their bodies had been damaged due to sexual violence, or blamed their bodies for the violence they had been subjected to. Pregnancy and birth allowed some women to re-connect with their bodies and feel proud of their bodies' ability to conceive, grow, and give birth to a baby. For example, Aila, who had blamed her breasts for the sexual violence that she had been subjected to, reported feeling happy with the shape of her body for the first time in pregnancy.

> I started to feel – probably for the first time in my life – really proud of my body. Really at peace with my physicality. Being able to get dressed really easily, not hiding stuff. And actually just feeling really happy in my bigness. And really proud of what my body was doing. - Aila

Similarly, Valerie reported fearing that she would not be able to conceive because of the sexual violence she had experienced and how proud she was of her body when she was able to conceive.

> Me and my partner were planning for quite a while to have a child. So we did a lot of ovulation tests. So it was a big relief when it finally did occur. I was really excited because I thought… I was just really scared that perhaps past events would affect my likelihood to have a child. So it was very satisfying when I realised it wouldn't. We had a celebration. - Valerie

However, the healing potential for pregnancy and birth needed to be experienced in the context of safe, empowering care that trusted women and their bodies, so that women felt safe to trust their bodies too.

> I had a great labour. If I could go back and do it again I would. It was such an amazing experience. I just felt quite in tune. Quite intuitive about what was going on. Whilst I was in the pool I was moving into positions that felt comfortable for me.

> And I guess she [the midwife] just recognized that and recognized… She was very hands-off. Yeah, it was good. - Audrey

> And then I learned about water birth, and I really wanted to do that. I also use swimming as one of my healing techniques for sexual abuse. You're weightless in the water and you're free. I realised that because I chose to give birth in the water, connected to having been sexually abused would be why I felt so in control. - Paige

This theme discussed how for some women, pregnancy, birth and motherhood offered opportunities to heal from sexual violence by countering shame, building trust in their bodies and fostering connection and belonging. However, this healing had to be facilitated by emotionally safe care that trusted women, worked with their strengths, and helped them to feel in control.

7.3.2 'Something weird and wrong': stories about shame and isolation

This theme discusses stories about how shame and isolation silenced women. Many women experienced shame and judgement due to dominant (and harmful) narratives about motherhood and sexual violence which disrupted the healing potential of pregnancy, birth and motherhood. Women discussed ideals of motherhood that presented it as being a 'perfect' time full of love and joy but felt shame when their experienced did not match this ideal. One way in which women's experiences did not align with dominant narratives of the 'perfect mother' was when they felt distressed or worried about aspects of pregnancy, birth, motherhood or care linked to their previous experiences of sexual violence. When distressing feelings arose, women assumed that there must be something wrong with them as their lived experience of motherhood did not align with ideas around being the 'perfect' mother.

Maya summed up how survivors may struggle to meet this ideal of the ‘perfect’ mother and how they are shamed for it. She countered the unrealistic expectations placed on mothers to be content and full of joy, explaining that if a woman is ‘triggered’, this did not mean she is a bad mother.

> If they do get triggered that doesn’t make them a bad mom, you know? I feel like there’s so much pressure on how you’re supposed to feel, and it’s all supposed to be great. It’s just ‘love every moment of everything’, and it’s not always like that. - Maya

However, Maya, Georgia, Aila and Ava did not get this messaging at the time, either from the providers they encountered or from society, leading to shame and silencing. For example, both Maya and Aila described feeling distress during pregnancy as aspects of pregnancy, such as physical changes and loss of control means that they did not meet societal expectations of the joyful, happy mother-to-be. For instance, for Maya, the idea of growing a boy inside her was reminiscent of her trauma as it related to men controlling her body and her behaviour.

> He was taking over my body. He was controlling what I could eat, and what I couldn’t eat, or whether I threw up or not. He was moving all my organs around and making me pee. He was literally running the show from the inside. And even though I wanted to be pregnant, I was happy with the pregnancy and seeing him on scans and all of that, there was this underlying thing of ‘another guy is taking control of your body in a different way’. - Maya

Aila had a sense of her trauma physically erupting from her body due to the embodied, physical nature of both pregnancy and her trauma. Her body needed to make space for the baby and so there was no more room for her trauma to be held in her body. Carrying both her trauma and her baby led her to suddenly experience overwhelming and hugely distressing memories of trauma. However, she felt unable to talk about these memories and thus she stayed silent and maintained a “containing mode”.

> I never told a soul. I’d envisage it was in a cave and I put it all in there and then I bouldered it all up and I just carried it around with me all the time and hid it. It’s only in recent years I realised how hard I had to work in order to hide all that stuff and how exhausting it was. So I carried that around forever. But as soon as I settled into the pregnancy, it all just came up. It was almost like the baby was like ‘there’s no room for that in there, I’m here’. And it literally all came up. All this stuff that I had been hiding. I started to experience really horrendous flashbacks, panic attacks… I had not dealt with it in myself or spoken to anybody about it. I was doing a kind of containing mode, so it was out of the cave but still hidden. - Aila

Although these experiences were distressing, they could have represented opportunities for women to uncover and begin to process their trauma. As Maya explained:

> I had trauma that was based on men being inside me. And I was growing a boy inside me. And I needed to figure out how to deal with those issues before I gave birth to him. - Maya

The shame attached to not being a totally happy, joyful mother compounded shame from sexual violence and silenced women, however. This shaming intersected with other ways in which women might be ‘othered’. For instance, Ava had at the time been diagnosed with borderline personality disorder (BPD) and was open with her maternity care team about her worries. She requested an elective C-section, explaining to her maternity care team her fears that a vaginal birth would feel like being “raped from the inside”. Her disclosure was met with silence and dismissal, which sent a message to her that what she had said was shameful and wrong. Not being listened to and not being taken seriously exacerbated her fear of birth and reinforced her fears of not being a good enough mother.

> The comment I remember making when the psychologist was asking why I wanted it [an elective C-section], was that I felt that a vaginal birth would be like being raped from the inside. And she didn’t say anything to that. She didn’t… I think she… I don’t know, I felt like I was saying something weird… And wrong. - Ava

Although Ava disclosed her diagnosis of borderline personality disorder (BPD; later changed to Complex PTSD) to her care team so that they could support her, this diagnosis was used to dismiss her needs and silenced her further. Ava explained that her care team dismissed her fears and requests for an elective C-section because of her diagnosis of BPD as it labelled her as difficult and dramatic. Ava experienced numerous dehumanising, disempowering and dismissive interactions with staff. These interactions reinforced her fears that she would not be a good enough mother and led her to experience extreme distress that subsequently led to a safeguarding referral and a child protection conference. She explained that being constantly treated as if she was a “mad woman” became a “self-fulfilling prophecy” in which she became more and more distressed and afraid. Below, Ava considers how her diagnosis shaped the care she received.

> I started to question the personality disorder diagnosis. … I was bringing up that diagnosis of a way of saying ‘look, I am experiencing difficulties’. But I think there were certain [sigh] preconceptions and prejudices about that diagnosis related to the idea that people – women – with that diagnosis are difficult, are angry, are inflexible, are untreatable, are difficult to help, are unstable [laughs], as the name

> suggests. Not to be trusted, you know? Not people who can be trusted with a level of agency and choice. So, that I think may have played a part in why I was treated with contempt, suspicion, lack of empathy, lack of compassion by professionals, because I think that label comes with all sorts of baggage and problems. - Ava

Georgia blamed herself for her partner’s abusive and violent behaviour during her pregnancy and in early motherhood. This prevented her from being able to disclose to her GP, despite wanting to. As she described below, she did not want to feel she had “failed”. But she also noted that the assumption that everything was ‘fine’ meant the conversation was not opened by providers, or questions were not asked in a way that made her feel safe to disclose.

> I didn’t tell him [the doctor] there was anything wrong because when I look back at it, I guess it was because I was a survivor, you know? I was like that independent... How could I admit something was wrong? It was as though I had failed. […] I remember seeing posters on the walls that said if anybody in your family is taking drugs or you’re worried, ‘call this number’. And I remember looking at that poster, staring at it every time and thinking ‘I should say something’ […] But I never said anything. I never said anything. And I didn’t say anything to the person that was doing my checks ‘is everything alright Mrs [last name]?’ ‘Yes, everything is fine’. ‘We’ll just weigh your baby then. That’s fine’. And off they went. There’s no real asking questions. - Georgia

Some women had lost trust in their bodies or felt their bodies were broken after sexual violence, and if women’s bodies did not follow what was expected of them – conceive, give birth ‘naturally’, and breastfeed easily – women felt that they or their bodies had ‘failed’ them again. For example, for Aila, her pride in her body when she became pregnant was shattered by experiencing a miscarriage. Although becoming pregnant was a symbol of strength and vitality for several women in this study, including Aila, a miscarriage symbolised a broken body that would not be able to nurture and grow a baby.

> I felt… Just really heartbroken that we had lost the baby. And that my body had failed, I suppose was kind of the main thing. And a real anxiety that this was going to be our story. That every time we were going to get pregnant we were going to miscarry. And that this was just the beginning of a path towards being parents that maybe wasn't going to happen for us. - Aila

Feeling like her body would 'fail', carried into experiences of birth for Aila, as she saw medical intervention as a sign that she, and her body, had failed. Although many women reported wanting a vaginal birth because they wanted to feel in control and empowered, women also expressed a societal expectation that this was the 'right' way to birth. For example, Aila was prepared to have a vaginal birth even when complications meant this would be a very painful and distressing way for her to birth. As she highlights, she wanted to give her baby this vaginal birth, but she also felt relief when the maternity care provider gave her a "get out". Aila's experience captures a theme that was present in many women's stories about women putting their baby's needs before their own due to feeling pressure from themselves, society and maternity care providers, even when this would harm or re-traumatise them. W

> I wanted to give him a vaginal birth. And as a baby he deserved that chance. But actually it wasn't the best decision for me. I knew in my heart of hearts that the best decision for me at this stage was to have a caesarian section. […] But for some reason I wasn't able to – in some ways this is key from a sexual survivor's point of view – I wasn't able to listen to what was right for me. And I wasn't able to put my needs and what was good for my body at the centre of the decision. […] I needed to do what's best for the baby to give the baby the best birth. [...] Then when the

> consultant said, ‘I’m not sure we’ve got the right plan for you’, and we talked it through, and she was like ‘I think we should do this [emergency C-section]’, I had this massive sense of relief [sighs], ‘I do too, thank you for giving me a get out’. - Aila

Aila’s experience showed that a cultural expectation of mothers to be self-sacrificing intersected with sexual violence and medical authority in complex ways. For instance, Aila noted an overwhelming internal need to give her baby “the best birth” despite fearing a vaginal birth would harm her, highlighting that silencing nature of abuse may create additional challenges for survivors to tune into and express their needs. Aila’s experience also highlights the power of an authority figure reassuring her that she had choices, which broke through the expectations on her and gave her space to tune into what she needed. Many women found it difficult to understand and tune into their needs and felt afraid challenge the authority of maternity care providers. Care that created the space and safety to express their needs, and to change their mind as things changed, was therefore critical.

Evelyn highlights how, when giving birth to her first child, she was refused pain relief by a midwife who said that she was not allowed to change her mind. She described a “nice midwife” who wanted to give her the pain relief she had asked for, and a “nasty midwife” who told her she was not allowed pain relief because she had stated in her birth plan she did not want this. Evelyn reflects how her experiences of trauma made it difficult for her to challenge authority, and this midwife’s refusal to listen to her meant that she silently suffered. Not being allowed to change her mind and having previous decisions held over her reminded her of abuse through being punished and told she deserved pain and suffering.

> At that point I was that person who does what they’re told. So although I was saying I wanted gas and air, when she pointed out that I said in this birth plan that I had wanted to be in the water, then I was like ‘oh yeah, so I better shut up because I did

> say I wanted that’. […] Whatever the word is that sums up [how] the nasty midwife was treating me was what my take out was: ‘you deserve this’. Whatever the word is, that’s what it comes down to: ‘you deserve this. You deserve this pain. You deserve not to have any pain relief. You deserve to be ripped end to end. You deserve to get stitched up badly because you chose to do all of this and have all of this. - Evelyn.

Breastfeeding was a particularly powerful symbol of ‘perfect’ motherhood in women’s accounts. This topic was also an important area in which women felt pressure to give their babies what was expected, even if this was re-traumatising for them. Women recounted strong assumptions from maternity care providers that breastfeeding was the only acceptable way to feed their baby – a dominant narrative that was reinforced by care practices that promoted breastfeeding over and above the mother’s wishes or well-being. This shamed women and told them that if they had difficulties breastfeeding or they chose to feed their babies another way, this reflected negatively on their ability to mother their child.

> The thing about the abuse I suffered, it wasn’t so much that it left me with physical scars. It was more psychological and emotional, kind of like ‘you’re not worth having a relationship with. You’re not worth marrying. All you’re worth is having a bit of sex with and then leaving you to deal with how you feel about that. It’s not my problem’, sort of thing. And the contrast of being in a relationship where I was wanted and loved and the child was wanted and loved, and everything should be wonderful... Somehow there was always a slight… [sigh]. I did all the breastfeeding, and then he’s got jaundice. […] You’re trying your utmost to give them the best experience, and it still isn’t good enough. - Caroline

This dominant narrative was countered by Janine who stated that she was not ashamed of giving her baby a bottle because it didn't "kill him". Her maternity care provider wanted to tick that she was exclusively breastfeeding but Janine refused to agree. When speaking about this experience, Janine referred to a systemic expectation that women should exclusively breastfeed their babies and noted the pressure that this puts on women.

> I went to one visit where they asked if he was exclusively breastfed. I was like, 'no, he's not. Because I went to a hen do last week and he had a bottle. And they're like 'oh, I'll tick that he's exclusively breastfed'. I was like, 'no, he's not exclusively breastfed. He hasn't been'. And they so wanted me to say 'yes, you can tick the exclusively breastfed box'. Because I was going to add to their statistics. Hello? It's like, no, I'm not ashamed that I gave my baby a frickin' bottle. It hasn't killed him. And they shouldn't be putting pressure on women like that. - Janine

This theme discussed how women identified dominant narratives around 'perfect' motherhood that shaped how they made sense of their experiences and interactions with maternity care providers. When women's experiences of pregnancy, birth, motherhood and care needs did not align with these dominant narratives around 'perfect' motherhood, this exacerbated and compounded the shame women already felt because of sexual violence. Feeling frightened or worried about aspects of pregnancy, birth, or motherhood or re-traumatised by care linked to sexual violence made women feel as if there was something wrong with them. This shame was compounded by care practices that judged or shamed women. Women needed care providers who were attuned to their individual needs and created space for them to express their needs, including changing their mind on decisions they had previously made about their care, but often felt they could not. As a result, aspects of care mirrored their experiences of abuse.

7.3.3 ‘I was just a body’: stories about dehumanisation and objectification

This theme discusses stories about how dehumanisation and objectification within maternity care mirrored abuse. In this theme, women referred to a dominant biomedical narrative that privileged medical knowledge and devalued women’s intuition and embodied knowledge, pathologised women and their bodies if they experienced distress or difficulties, and prioritised short-term health outcomes, especially their babies’, over other aspects of well-being. Many women challenged and resisted this dominant biomedical narrative in some way, and the findings reflect this.

Multiple women spoke about how the idea of someone else controlling and doing things to their bodies mirrored the abuse they had experienced. Women understood that they could not control everything, that pregnancy and birth were unpredictable and that medical intervention may be necessary at times. However, it was particularly distressing and re-traumatising to them when providers made no attempt to offer them choices.

> Some of the medical staff are forcing stuff on you. That’s exactly what they’re doing. It’s not in your head. They are. They’ve got an idea of what you should do, and they don’t want to present you with a choice. Because they want you to do this thing. And so, it leads to things [abuse experiences] that you’ve experienced previously. - Janine

When women recounted these experiences, they were re-traumatised by the expectation that they should comply with care and ‘do as they’re told’, rather than by the procedures, examinations or intimacy of care. Elaborating on this point, Evelyn gave an example of how frightened she felt by a midwife suddenly telling her to take her underwear off for a vaginal examination when she was early in her labour, but how a different midwife during the same labour did not “trigger” her at all. The key difference was that the second midwife was actively offering her choices and checking in with her about what she would like.

> ‘She said ‘right you just need to take your pants off’. And I started screaming, I started screaming, and I don’t really remember because I was really lost in it, but everyone was like ‘what’s the problem? Obviously you’re going to have to take your pants off’. […] By the time I actually gave birth to him, we had moved back downstairs again, and *that* midwife who delivered the baby was brilliant. She didn’t trigger me in any way. She was really, really good at handling getting me into a good position to give birth. And she was asking me, ‘how would you like to... Do you want to be on all fours? Do you want to kneel down? Do you want to lean on your husband? Do you want to lean on this bouncing ball?’ - Evelyn

Some women described an early experience of being objectified that subsequently impacted their ability to trust providers. They linked this to a system that dehumanised women, reducing them to their body parts. When women talked about their bodies being objectified in this way, they often referred to maternity care providers in general, as reflected in Evelyn’s use of the plural ‘they’ and ‘medical professionals’. Being objectified and dehumanised was a common and expected, but very much unwanted, aspect of care.

> At every stage I tried to avoid contact with medical professionals if I possibly could. And I think the pattern for that was set right with my first pregnancy when I had to go to the hospital – I didn’t really understand what they were doing – but I seemed to be moved between cubicles with just curtains drawn around them for various different members of staff to decide whether I was capable of having a baby, and if I had a baby, whether I was capable of breastfeeding or not. I just remember not really knowing what was going on. Being put in a cubicle and ‘take your clothes off’

> and sort of sitting there naked and then some horrible old man doctor coming in and examining my nipples and saying ‘yes’, I was OK to go ahead. - Evelyn.

In addition to the dehumanisation experienced by women due to biomedical dominance, some women were silenced further when they did not fit cultural ideas of what constitutes a ‘good mother’. Women in this research described being dehumanised, dismissed and overlooked due to mental health diagnoses (e.g., Ava), race (e.g. Maya, discussed later) and being a young and/or single mother. For instance, Audrey describes below why she decided to attend maternity care appointments alone (without her mother) because she was treated as if she were invisible by one provider in particular who spoke to her mother about her care, instead of her.

> I had this midwife who sat down in the room next to my mom. And I’m very aware even now that I look quite young now, a lot younger than my age. She wouldn’t look at me, she didn’t really address me. She spoke about me to my mom. And I was mortified. I just remember feeling awful. They were telling me that there had been a mistake and they were going to have to retake all my bloods. But she wasn’t interacting with me. I just found it so overwhelming. … After that experience I was like, I can’t see this woman. I can’t go back to her. So I changed and I had a really lovely midwife and also I was like I need to do this on my own. So I would just turn up to the appointments without my mom or any support. So I felt maybe a bit more in control. - Audrey

Dehumanisation and objectification of women’s bodies led to coercion (women being forced to comply with care). Many women recounted traumatic experiences of care where things were done to them and their bodies without any attempt to get their consent. Again, in these experiences, providers’ opinions and wishes were considered more important than the woman’s, reducing her to a vehicle to deliver a baby, rather than recognising her as a whole person. As Janine describes, having things done to their bodies in this way was not only reminiscent of abuse, but it was also an abusive and violent act itself. However, Janine highlights a point made by several other women – that some providers appear to be unaware of the impact that such actions have on women and may even be “well meaning”. However, good intentions did not lessen the degradation and significant disruption to women’s sense of safety caused by these actions.

> The [first] pregnancy just ended up being really horrific. Had an epidural in the end. It was just, yeah traumatic. I just remember that feeling of I was just a body. Nobody explained things to me. They just did it, told you what needed to happen next. A well-meaning midwife had sort of just gone, ‘I think you should take the drugs’. I think she was well meaning, but she didn’t explain options to me. She was just like, ‘I’ve decided you’re getting drugs, so I’m going to put drugs into you’. And I think I was just gone. And I look back now and wonder how medically necessary that was. - Janine

In addition to experiencing physical coercion, many women recounted experiences of being pressured or manipulated into complying with care. Women were treated as selfish if they declined or questioned care and seen as putting their babies at risk rather than providers trying to understand their concerns and listen to them. This was not helped when providers bombarded women with threats and, as Aila described below, “horror story scripts”. These behaviours exacerbated women’s fears, leading them to further disengage and their bodies to remain frozen, as Aila explains:

> I’d come in and they’d give me the horror story script. They would be talking to me about the risk I was putting my baby in and that the statistics show that the chances

> of still birth are increased by x amount every time you go over. So really pressurizing me into this induction which I absolutely didn’t want. But they were doing it in a way where I didn’t feel they were relating to me, they didn’t try to understand what my concerns were. They were just like trying to frighten me into agreeing to this process. And the more they tried to frighten me the more I was like ‘no no no no no’. Because I just don’t want to go into labour when I’m frightened. - Aila

In some cases, women became more frightened of re-traumatising care than the potential for negative consequences of disengaging from care. Janine decided to avoid going to hospital when she went into labour with her second child until her son “was on his way out”, because her first birth had been so traumatic, but explains this did not feel like a choice. She described her experience of this labour as empowering and “amazing”, because outside of the hospital she had space to listen to and trusted in her body – a stark contrast to her first experience of a traumatic and disempowering hospital birth. However, although her second experience of labour was empowering, her decision to labour on her own was because she was afraid of further trauma and re-traumatisation and did not trust the hospital to provide the care she needed. She described having “that rush of hormones” with her second child, which she had not had with her first child, and she understood that to be due to the trauma of her first hospital birth experience.

> Janine: You have to listen to your body. You can’t do that when somebody is telling you what you should be doing now. Like, actually shut up and let me listen to my body. And that’s why my second one [labour and birth] was good, because I blocked everything out. And I just listened to my body. And I did it. And it was, it was like a weird, biological, hormonal experience. Out of body experience.

Siofra: What was it that made you able to trust yourself?

Janine: I think I was more scared of the hospital than I was being on my own. And I didn't have a choice. I just did it.

Women also spoke about being dehumanised through standardised care. A "tick-box" approach prevented providers from seeing and responding to the individual woman and her needs. This intersected with stereotypes about what 'good' mothers looked like. As Janine highlights, because everything "looked great" – she was married, she had a tidy home, and she was breastfeeding – she was not able to access the support she asked for. Despite disclosing that she was feeling overwhelmed, the health visitor would not tick the box that indicated she was not coping. Janine's experience illustrates how standardisation created barriers for women to access support, with providers becoming gatekeepers.

> Everything looked great. I was breastfeeding, which was like tick tick tick. … I literally remember her sitting there and being like, 'so, do you feel like you're coping well?' And I was like, 'if I'm honest, I really don't think I am'. And she was like, 'I know, but what it means is, like, are you managing?'. And I was like, 'honestly, I'm kind of holding it together, but no'. And I remember it got to a point where she kept trying to push me to say yes, that I was OK, and then she just went, 'I'm just going to tick yes'. - Janine

Due to lack of continuity of care, women felt they had no choice but to engage in a system that dehumanised both them and the providers who were meant to care for them. Aila compares the maternity care the system to a factory where women are reduced to bodies and providers to factory operators. She argues that this is at odds with the social significance of "the beginning of human life", both to women personally and in society generally.

> It just feels a bit like you're on a factory conveyor belt. And I think that they [maternity care providers] feel that they’re operating a factory conveyor belt. And motherhood and babies are not that, are they? It's the beginning of human life. It's one of the most - *the* most amazing thing that we do. And we seem to have lost our power with it. It's just too systematic. And all the love, empathy, femininity has just been taken from it. - Aila

This theme described the ways in which women were dehumanised in care through being reduced to a body with the needs of their babies, providers and the system being prioritised over their own needs. Being dehumanised and having their power taken away in this way mirrored abuse. Women described a dominant biomedical model that devalued their emotions, needs and knowledge, leaving no space for their voices and emotions to be expressed or heard (silencing). This model created an environment in which things could be done ‘to’ women or where women could be manipulated into making decisions that benefitted providers or the system without regard for women’s wishes or feelings, leading to coercion. In most women’s stories, this dehumanisation became an expected part of care and was reinforced at a systemic level: experiences of dehumanisation were repeated and involved many different providers at various points behaving in similar ways. Women described how being dehumanised and having their bodies objectified disrupted their sense of safety and in some cases led to them disengaging from care to protect themselves and their babies.

7.3.4 ‘It’s about so much more than just saying it’: stories about kindness and collaboration

This theme captures stories about how kindness and collaboration created both emotional and physical safety. For care to feel safe, providers needed to show kindness, compassion and empathy. However, women explained that it was down to luck whether they would get an understanding, empathic maternity care provider or one who would dehumanise and silence them. As Janine highlights, women had little or no control over who they would see, and they were forced to accept whatever care was offered to them.

> You could be the really fortunate where it's lovely and this totally empathetic midwife who walks through your door totally and completely gets it. Or you could get this person who is horrible. And at a point where you're so vulnerable, you're incredibly vulnerable. And they have so much more power than they realise. They have all the power in that moment. - Janine

Evelyn also shared a powerful example of how a small act of kindness from one provider could make a significant difference to women's self-worth. When she had a miscarriage, she was distraught. She noted how one doctor noticed her pain, held her hand and asked kindly if she wanted to see a counsellor. Evelyn was so used to people ignoring and dismissing her pain due to experiencing a lifetime of abuse that this doctor seeing her pain and showing caring represented the first time anyone had ever been kind to her in her life.

> Evelyn: Looking back now it was one of the only times where anyone was really kind to me. […] I was in a ward (tearing up). And this really lovely young female doctor, Irish with long red hair, and really kind, came and sat next to my bed and was kind of holding my hand saying 'do you want to see a counsellor?'
>
> Siofra: You said it was one of the only times that anyone was really kind to you. In a healthcare setting, is that what you mean?
>
> Evelyn: No, I mean in life generally.

Most women highlighted that getting a reassuring, empathic maternity care provider was a rare experience. Ava recounted the stark contrast between the care she received from one perinatal psychotherapist and all the other maternity care providers she had met in her journey, who had reinforced her fears of not being a good mother. Instead of dismissing her or shaming her, this psychotherapist worked with her strengths and reassured her that she would be a good enough mother, and he was the only provider who treated her like an “intelligent person” rather than a “mad woman”. This made a significant difference to her well-being at that time – especially since she had experienced repeated judgement and dismissal from providers previously when she was requesting an elective C-section due to her fear of birth.

> One professional spotted that what I needed was reassurance and somebody to go ‘yeah you’ve had some difficult experiences but you’re probably gonna be an ok mum; you’re probably gonna be a good enough mother’. He talked to me about John Bowlby, and he talked to me about ‘good enough mother’. He talked to me about attachment. He treated me like I was an intelligent person. So many professionals treated me like a mad woman. […] He provided very good care and was trauma-informed, and was supportive, and was reassuring, and was positive, and was respectful, and wasn’t patronising, and wasn’t alarmist, and wasn’t reinforcing my fears, he was challenging my fears and saying ‘it will probably be ok’, rather than ‘let’s inventory everything that could possibly go wrong with you as a mother’. There was a really stark contrast between the kind of care that I was offered by that perinatal psychotherapist, and lots of other professionals. So the gatekeepers to the planned caesarean, the midwife teams, the staff in hospital. It was a really really stark contrast. - Ava

Janine explains her belief that feeling psychologically safe in pregnancy and birth can be the difference between having an intervention and not.

> But she just said to me ‘you are doing great’. She said ’you're doing amazing. Ignore all the people that are just opinionated’. If everyone was like that, the difference it would make. You can *feel* it when you get somebody that's in that right headspace and then it doesn’t matter about the medical stuff. And giving birth, it’s a psychological thing as much as a physical thing. It really is, in my experience anyway… Where your head is at and your anxiety levels... It's the difference between having an intervention. And not. - Janine

Ava’s and Janine’s examples echo a point that many other women in this study also highlighted: that taking power away from women created a logical fallacy. Instead of helping women have safe experiences of pregnancy, birth and motherhood, the distress that women experienced because of dehumanising care practices created further emotional and physical problems that then required additional interventions.

When describing safe care women also referred to care that created genuine choice within an environment of collaboration. This involved much more than asking for consent – it was about creating a space for women to have all the information they needed to make an informed choice, to create an environment in which women trusted providers and felt able to say no or raise concerns.

> I feel like she [the midwife] was trauma-informed in a way that midwives hadn’t been in my previous experiences. […] When they examine you, they just tell you they’re going to do it and then do it. Whereas she was very much giving me options. And at the end when he got stuck, she still asked for my consent to help him out. It was so skilled. And I look back now… She did it in a way where she had been promoting my choice throughout it. And then her tone just shifted. Or maybe I just trusted her? And she was like ‘look, I really think this is what I need to do. Can I have

> your consent to do that? And I was like ‘whatever you need to do, you just do it’. And it was like that trust was there between us. Because she had been so good all the way through, really giving me choices. - Janine

Janine highlighted how genuinely promoting choice was especially important for survivors who have previously had their choices taken away. She also noted that maternity providers often said things were her choice but did not act in a way that promoted her choice. In this way, Janine highlights how the words alone were not enough to create genuine choice – it needed to be underpinned by values such as equality, empathy and respect.

> All of them I had that conversation with [about declining aspects of care] were like ‘oh no, it’s your choice’. They know to say it. But you can say ‘it’s your choice’ and all of that. But it’s about making sure that they have the information to make those choices. And you have to create the space and the trust for them to be able to do that. You have to honour what they say. There’s so much you have to do to make that come alive, where they really do have a choice, when they haven’t been socialised in that way. - Janine

This theme discussed what ‘good’ care looked like for women. This meant being treated with kindness and respect and having a genuine choice, including the ability to say no. Women wanted to work together with providers – they wanted to know what providers had to say but they also needed to be listened to and have their needs respected. Women reflected on how, as survivors, they sometimes found it difficult to challenge authority or connect with their needs and that good care needed to actively create safety to counteract the silencing created by abuse. This safety was created through kindness as much as it was through promoting choice. Creating genuine choice was about much more than just ‘saying it’ – it involved creating an environment underpinned by kindness and respect, and embedding choice within that environment, to create a truly collaborative relationship.

7.3.5 Maya’s experience: exploring differences between a traumatic and re-traumatising birth experience

In this section, I present a brief case study of Maya’s experience of two emergency C-sections. Maya had two children who were both born via an emergency C-section. Ostensibly, Maya experienced medically similar events during her two birth experiences, but the way she felt during her care could not have been more different. During her first birth, Maya felt dehumanised, objectified and dismissed by providers. During her second birth, Maya felt seen, heard and valued. Although both emergency C-sections were frightening and traumatic, the second birth experience was not re-traumatising in the way her first birth had been.

During her first birth Maya was treated as if she were ‘just a body’ and overlooked and as if she was invisible to providers. In contrast, Maya felt included and listened to by the care team involved in her second emergency C-section. Her first (profoundly dehumanising) experience of an emergency C-section was re-traumatising, and she re-lived her experience of rape both during the C-section and for a long time after. Her second C-section, while posing an immense physical and emotional challenge and being a frightening experience, did not feel like re-living abuse.

In both instances, Maya identified that the difference was that she was treated as a whole person with feelings and experiences in her second C-section, whereas her humanity was denied in her first. Maya’s story presents an important example of how care could be experienced as collaborative and supportive even during an emergency, and that medical intervention does not need to be inherently dehumanising and silencing. Her experience is also the only example of a woman who had a whole care *team* that felt supportive – other women who described supportive interactions with individual providers described them as irregularities among a sea of principally dehumanising interactions. For Maya, her whole team treated her like a whole person, cared about her feelings and took steps to involve her in her care, despite the urgency of the situation, meaning that she felt consistently supported.

Table 10 summarises Maya's two birth experiences, breaking each down into four phases: (1) realising that they needed to take the baby out, (2) reflections on care before the C-section, (3) experience of the C-section and birth and (4) reflections on the experience of the C-section and birth.

Table 10. Overview of Maya’s experience

Event	First birth	Second birth
Realising that they needed to take the baby out.	They put us in a room and I remember her being really cold. She was delivering this message to me but almost in a way that it wasn’t earth shattering? Or like I shouldn’t be shattered by it. So she basically said we need to take the baby out as soon as possible and you can’t go home. […] ‘We have to book you in. We’re going to do a C-section’. I said ‘can I call my husband?’. They said ‘you can call him but you’re not going home’.	His heart rate was falling and in that moment, she was like ‘yeah we have to take him out now’. And the room went into panic mode. I had orders from people around me, someone was putting an IV in me, someone was giving me an injection, they were putting in a catheter. It was pandemonium. And then the contraction ended, and his heart rate went back to normal. And she said ‘ok it doesn’t seem like it’s urgent [..] we have a choice. We can wait for a couple more contractions, see how he does’. So I was like ‘let’s wait, let’s wait’. So we waited and it didn’t get any better.
Reflections on care before the C-section.	We think it started from there, just not having a lot of communication about what was being done to me, or what was going to happen next.	She was really good. She talked me through everything. She was letting me know everything while we were making these decisions.

Event	First birth	Second birth
Experience of the C-section and birth.	So [during the C-section] I was lying on this bed naked, and they've cut me open and like I can feel them inside me, like even though you don't feel pain, you feel the tugging and like you know there is something going on. So, and they're standing over the bed and they're just having normal conversations while they're taking the baby out. I remember one of them was talking about his weekend and this guy he had slept with and taken back to his house and then on, and they were just having all of this normal banter conversation while I am just so scared.	I had spoken to her about the conversation in the room and the music and how off-putting the first experience was. And I don't know if they did this on purpose because the first C-section was all men – apart from the midwife that was with me – it was all men in the room doing the actual surgery. It might have just been luck of the day, but my whole team were women. And that made me feel more at ease from the beginning. They kept talking to me, checking in with me, making sure I was okay, letting me know what was happening.
Reflections on the C-section and birth experience.	Lying there and wanting it to be over. Wanting it to be finished and waiting for them to finish what they're doing so I can go back to a sense of normality. Or to be given my body back. Because right now it's not – I can't even move my legs, I'm numb. And that numbness is so reflective of trauma of feeling like you want to scream but you can't scream or wanting to move but you're not moving. And dissociating in your mind	I don't know if I was completely present in my body during the time that the [second] C-section happened. Because I'm still working on that now, being connected to my body. But I definitely felt more in control, more heard, and more aware of what was happening. It didn't feel like it was happening outside of me. It felt like collaboratively we made this decision.

Event	First birth	Second birth
	to a different place just to get through what’s happening.	

When comparing Maya’s two birth experiences, it is clear that her feelings were consistently overlooked and treated as unimportant by providers in her first birth. This dehumanising treatment was present from the time they realised they needed to “take the baby out”. However, the total loss of power and control over her own body during the C-section, such as her inability to physically move, coupled with the complete disregard for Maya’s feelings by the (all male) providers performing the C-section led to her second C-section being extremely frightening. As a result, Maya re-lived the same feelings of fear, shock, freezing and numbness that she had experienced during rape.

Ostensibly, Maya’s two birth experiences involved similar events, in that both of her children were born via emergency C-section; an experience that may cause significant psychological and physical trauma to any person. However, kind maternity care providers who valued her voice, promoted her choice and treated her as a whole person worthy of respect and kindness prevented her second birth from being *re*-traumatising in the way her first birth had been. The team around her in her second birth placed Maya’s voice at the centre from the very beginning and created a collaborative, respectful environment that helped her feel as safe as she could feel given the urgency of the situation. The profoundly dehumanising experience of her first birth was shaped by her social location as both a survivor and a Black woman. Maya highlighted that the team in her second birth were all Black women, which, as a Black woman herself, made her feel instantly safer. She later explained that during her first birth she was aware that she was likely to receive inadequate, poor or harmful care due to racism.

Maya’s birth experiences illustrate that *traumatic* birth experiences are not necessarily the same as *re-traumatising* birth experiences. Therefore, medical intervention need not be inherently dehumanising or re-traumatising (even if it is traumatic). Furthermore, Maya’s experience indicates that dehumanising and silencing interactions with maternity care providers lie at the heart of re-traumatising experiences. Importantly, Maya’s experience also emphasises that experiences of sexual violence may intersect with other experiences or aspects of their embodiment, such as race, to shape their experiences, the care they are offered, and their feelings of safety.

I will end this section with Maya’s words as she explains to maternity care providers the importance of treating women as whole people with feelings and recognising the significance of pregnancy, birth and motherhood to them:

> I know this is normal and routine for you because this is your job, but this is a significant moment for me. You might forget because you do so many of these, but I’m not going to forget this experience. - Maya

7.4 Summary of findings

When supported by emotionally safe care, pregnancy, birth, and motherhood offered women opportunities to heal from sexual violence through feeling empowered, strong and connected to their bodies and other people (‘the most empowering moment of my life’). However, care needs or experiences that did not align with societal expectations on women to be 'perfect’ mothers, and care that reinforced these ideas also exacerbated and interacted with feelings of shame from sexual violence (‘something weird and wrong’). When talking about re-traumatising care experiences, women spoke about how care that deprioritised their needs relative to the babies’, providers’ or the system’s mirrored abuse by dehumanising them and objectifying their bodies (‘I was just a body’). Women experienced dehumanising care against a backdrop of a maternity care system that dehumanised both women and providers, widening the distance between them and silencing women in the process. Women challenged this, arguing that provided real, genuine choice would lead to safer outcomes. Emotionally safe and supportive experiences of care had to be underpinned by values of kindness, empathy and respect and support survivors to feel safe to connect with and communicate their needs and wishes.

Supportive interactions with providers, positioned by women as an irregularity among a sea of dehumanising, dismissive and harmful interactions, could change the trajectory of a woman's experience from one of being invisible and re-traumatised to feeling and being seen, heard and valued ('it's about so much more than just saying it'). A case study example of Maya's experience illustrated the difference between a *traumatic* and *re-traumatising* birth experience showing that medical intervention need not be inherently dehumanising.

7.5 Summary of Chapter 7

This chapter described the findings from the second study presented in this PhD: a thematic narrative analysis exploring experiences of pregnancy, birth and maternity care among survivors of sexual violence in adulthood. This chapter focused on women's maternity care needs, whereas the next chapter (Chapter 8) explored maternity care providers' experiences and needs in relation to supporting sexual violence survivors.

Chapter 8. Maternity Care Providers' Experiences and Needs in Relation to Supporting Sexual Violence Survivors: A Reflexive Thematic Analysis

This chapter presents findings from a qualitative study with maternity care providers about their experiences and needs relating to supporting survivors of sexual violence. After briefly reviewing relevant literature, I present the findings of a reflexive thematic analysis of providers' experiences. I then summarise key findings and cross-cutting concepts. The research questions, methods of data collection and steps taken in the analysis are detailed in Chapter 4, section 4.10.

8.1 Introduction

As discussed in Chapter 2, almost one in three (31%) pregnant women have experienced sexual violence (Shen et al., 2021) and survivors may be re-traumatised during pregnancy, birth, early motherhood and maternity care (e.g., Montgomery, 2013). Trauma-informed approaches may prevent re-traumatisation (Blackpool Better Start, 2021). However, a comprehensive, women-centred and trauma-informed health systems response to sexual violence must support providers as well as service users and requires system-wide change (García-Moreno, Hegarty, et al., 2015a; Sweeney et al., 2018; Sweeney & Taggart, 2018). It is therefore critical that research explores individual, systemic, and structural barriers and facilitators to delivering trauma-informed care (Sweeney et al., 2018). Yet, research exploring maternity care providers' own needs and experiences in relation to supporting survivors is scarce. Existing research focuses on healthcare generally, domestic violence, and post-disclosure needs and experiences (Hegarty et al., 2016; Hudspeth et al., 2022; McLindon et al., 2019, 2021; Tarzia et al., 2019b). Maternity care is a complex health setting which poses unique challenges to both survivors and maternity care providers. Midwives are exposed to dysfunctional working cultures, traumatic professional events and a system where they are consistently unsupported (Pezaro et al., 2016). Furthermore, autonomy and consent may be especially at risk of being violated in maternity care compared to other health settings (Kingma, 2021). Working in a disempowering system can have an enormous negative impact on staff (Knight, 2015) changing identities “from ‘I am a compassionate, caring person who is here to help others’ to ‘Just get me through one more day’” (Sweeney et al., 2018, p. 322). The professional distancing that providers may use to cope may lead to survivors feeling silenced, dismissed and overlooked (Garratt, 2011; Montgomery, 2012). The lack of research focusing on maternity care providers, along with the high risk of re-traumatising survivors and a working environment that is highly stressful, emotive and potentially traumatic, all signal an urgent need for research to explore maternity care providers’ own needs and experiences.

The small number of research studies with midwives and other healthcare professionals highlight these complex difficulties. One study focusing on violence against women and girls (VAWG) found that midwives saw themselves as ‘active protectors’ of women and felt it was important to avoiding silencing women further, but that they were unsure about how to ask about VAWG and were concerned pregnancy was not the right time to ask as well as noting a lack of pathways to specialist support if women did disclose (Siller et al., 2022). Another study focusing on childhood sexual abuse found that midwives could sense through a ‘gut feeling’ that a woman was struggling, but they were afraid to invite disclosures or responses from women because they did not have the resources to address them (Montgomery, 2012). Providers found working with survivors of childhood sexual violence emotionally challenging and to function within the system and protect themselves they unintentionally silenced women (Montgomery, 2012).

In addition, a substantial proportion of maternity care providers are survivors of trauma, with prevalence rates between 12.1% - 49% (de Klerk et al, 2022; McLindon et al., 2018, 2022). Research finds that the prevalence of intimate partner violence, sexual violence and childhood abuse is much greater among nurses, midwives and carers than the general population

(McLindon et al., 2022). Research indicates that lived experience may be an important source of empathy and understanding for midwives and other healthcare providers who are also survivors, leading to improved levels of identification and response among this group (de Klerk et al., 2022; Garratt, 2011; Montgomery, 2012). However, being part of a system that disempowers service users and staff may be especially difficult for survivor-providers for whom the disempowerment may mirror the abuse they experienced and who may understand on a more personal level the harm that is caused to survivors when their power is taken away. The sections that follow describe the findings of a reflexive thematic analysis that explored maternity care providers' experiences, expectations and needs regarding providing care, knowingly or not, to survivors of sexual violence.

8.2 Participants

Table 11 outlines participant pseudonyms and job roles. Thirteen participants took part in a semi-structured interview, lasting 41 to 205 minutes, on average 72 minutes. Interviews were conducted remotely on Zoom, all during the COVID-19 pandemic. Three interviews were conducted without video. Twelve interviews were conducted with the participant and I in our own homes and one interview was conducted at a participant's place of work with me at my own home. Seven participants were midwives, three were student midwives, two were doctors and one was a social worker. All participants had experience of working with survivors of sexual violence, including childhood sexual abuse, many had received disclosures. Participants also had experience of providing care to survivors of intimate partner violence (including intimate partner sexual violence) and female genital mutilation. The participants in this study all had a link to violence and abuse. This was either through their work as a maternity care provider (e.g., specialising in perinatal mental health, safeguarding, or tokophobia/fear of birth settings), previous experience (e.g., through working in the violence against women and girls sector, activism in women’s rights), or having lived experience of violence and abuse, including sexual violence. No potential participants were excluded.

Table 11. Provider participant job roles and pseudonyms.

Role	Pseudonym
Midwife	Atty
Consultant midwife with remit in public health and safeguarding	Kelsey
Safeguarding midwife	Jean
Student midwife with experience working in the sexual violence sector	Raegan
Specialist midwife for perinatal mental health and substance misuse	Robin
Midwife	Jamie
Obstetrician and gynaecologist	Sam
Obstetrics and gynaecology trainee and previous forensic medical examiner	Elliott
Perinatal mental health social worker	Tracy
Student midwife	Charlie
Student midwife	Ashley
Safeguarding midwife and specialist midwife for fear of birth	Leslie
Specialist mental health and community midwife	Sloan

8.3 Themes Generated

Three themes were generated through a reflexive thematic analysis of interviews with maternity care providers, summarised in table 12.

Table 12. Overview of themes, sub-themes and the central idea in each theme

Theme	Sub-themes	Central idea in theme
A window of opportunity for healing and harm	Care can be restorative Mirroring abuse through lack of consent Taking power away through safeguarding	Maternity care providers were uniquely placed to support healing after sexual violence through showing respect and facilitating choices. The maternity care system could also re-traumatise survivors through practices that took power and control away or re-enforced judgement and shame.
Creating safety in the face of uncertainty	Managing unpredictability Being curious and empathic	Providers discussed tensions between women's need for control and the unpredictability of pregnancy and birth. Providers tried to create safety by being curious and treating women with empathy. To achieve this, providers needed to trust their instincts and respond to women's individual needs but support for this was often not available on a systemic level.
Caught between women and the system	Burden of responsibility Fear of causing harm Old school superhuman	Providers felt stuck between women's individual needs for choice and control and the system that took power and control away from women. They felt a significant burden of responsibility to ensure care was healing, compounded by expectations of them to be "superhuman".

8.3.1 A window of opportunity for healing and harm

This theme captures how maternity care was seen as an ideal context in which to support survivors, but that aspects of maternity care also had the potential to cause significant harm through taking choices and power were away from women, mirroring abuse. Specifically, providers understood that choice and control could be taken away and mirror abuse through lack of consent and safeguarding processes.

Care can be restorative

Providers discussed how the perinatal period and the holistic context of maternity care was an ideal time to support healing through restoring women's choice and control and validating women's experiences. Although providers recognized that the power for healing remained with the woman, they discussed how a restorative experience of maternity care could build on women's own resources, supporting her long-term healing.

> If we do the right things at such a significant point in their lives, based on our understanding of long-term impact of trauma, we might just be putting something in their armoury for their recovery. That they're not then faced with another level of distress and trauma that has come about because of inappropriate or insensitive care during such a significant time in their lives as childbirth. - Atty (midwife)

> We have an opportunity to make some really good interventions, potentially, because of this window where survivors are coming into contact with healthcare services in a way they might never have done in their lives. - Raegan (student midwife with experience working in the sexual violence sector)

Providers also discussed maternity care as creating a window of opportunity for women to disclose sexual violence and access a pathway of additional support, although all participants recognized that many women would never disclose. However, providers stressed that women were unlikely to feel safe to disclose if they saw a different midwife every time, and that trust needed to be built through continuity of care.

> I’ve seen a study where it said people that have suffered domestic violence, it did take them three times. If their midwife hadn’t asked that third time then they wouldn’t have ever said anything. I don’t know. I just think, for someone that’s a victim, it’s easier to say no once to someone but if it’s the same face every time eventually you might break that barrier down and confide in the midwife. - Ashley (student midwife)

Similarly, some providers discussed how maternity care could be a pathway into additional, specialist support and advocated for linking up with other agencies (such as sexual assault referral centres) to create a streamlined pathway for support. They saw this as reducing the emotional labour on women to seek support from multiple sources and repeatedly disclose. However, providers who discussed this agreed that any specialist pathway should be optional, and that it should not make women feel like they were being judged to be less able to mother than women who had not experienced sexual violence.

> [if women disclose] I think you can go above and beyond that then and make it more personalised if a woman has been brave enough or felt able to come and say ‘actually I am a survivor and this is what’s going on for me at the moment’. - Atty (midwife)

Several providers spoke about how they did not just want to avoid re-traumatisation - they wanted women’s experiences of maternity care to be the ‘opposite’ of abuse. Many providers focused on avoiding, or mitigating the impact of, ‘triggers’, and creating a space where women could voice concerns and have these listened to. Related to this was the importance of giving women as much control as possible, counteracting the loss of control women would have felt due to the abuse.

> Whatever that family looks like, you're there for them. Their choices need to be their choices. I feel like for something as incredibly emotive as having your choices taken away, I think it's so important to give them some choice back so that they start feeling in control again. - Leslie (safeguarding midwife and specialist midwife for fear of birth)

Providers also suggested that maternity care providers who responded to women with understanding and validation could offer an environment which felt completely different to the silencing environment in which the abuse occurred. To illustrate this, Atty who was also a survivor spoke about how the secrecy that surrounds sexual violence is “toxic”. She suggested that disclosures that were met with validation and understanding could be potentially restorative, creating an environment that was the opposite of the silencing and secrecy that surrounds abuse.

> That compassionate validation of somebody’s experience. And humanising their responses to trauma, can be vital to their healing. And also prevent another episode in their life where they’re having to hide, hide things, you know. And continuing to have to hide their trauma is just toxic and harmful to them. So if they feel safe enough in that really seminal time in their life [to disclose], what better time to feel held by others. It’s a key opportunity for us, I think. - Atty (midwife)

Some providers also discussed the opportunity for relationships built in maternity care to be healing if they were equal and respectful. For example, Raegan, who had previously worked in the Violence Against Women and Girls Sector, talked about the healing power of safe relationships and interpersonal interactions. She reported believing that safe, compassionate relationships between women and maternity care providers could be key to supporting survivors to heal from sexual violence by showing them what an equal and validating relationship feels like.

> We want to show that there is a different way for their experiences to be heard and a different way for people to relate to one another that can be founded in compassionate, empowerment and wanting the best for them – listening to them, believing in them and recognising their strengths. Those things are important for all maternity care, but I think they're so, so, so important when people have past experiences of trauma as well. - Raegan (student midwife with experience working in the sexual violence sector)

Mirroring abuse through lack of consent

All providers discussed how maternity care practices could take power, choice and control away from women due to lack of appropriate consent taking. Most participants spoke about consent as a process where women had the knowledge and the time to consider all options, were able to change their mind and, importantly, felt safe to say no.

> Consent is informed, it's ongoing, there is time to ask questions and to go over things with people and for them to give their input, to help them weigh the risks and the consequences of different decisions, to give them all the information they

> need, not just the information we know or that we think is important. - Raegan (student midwife with experience working in the sexual violence sector)

Providers described that some colleagues focused on “getting” consent through a focus on obtaining (documenting) consent rather than engaging in an active process of informed consent. This positioned the provider as being the one to decide which information was important or relevant, prevented opportunities for women to decline, and assumed consent would be given, leaving little space for women to say no. Furthermore, as Sloan highlights, consent was not always sought.

> If a woman is in labour and we’ve got any kind of concern and she needs a doctor’s review, doctors will often come in… They might introduce themselves, but I don’t know that they [women] really, fully consent to a vaginal examination. If they [providers] do [seek consent], it’s more ‘I’m going to do this now. Is that okay?’. - Sloan (specialist mental health and community midwife)

> We might explain what is going to happen and say, ‘Is that okay?’ but then, to me, that's not the standard for consent. - Raegan (student midwife with experience working in the sexual violence sector)

Other providers talked about how fear of litigation or concerns for “professional safety” could lead to an approach to consent that was more based on fear and self-protection than on creating safety for women. Again, this led to a view of consent as an outcome – something to be obtained and documented - rather than an ongoing process and dialogue. Through this lens of fear, consent was there to create safety for the *provider* rather than the woman.

> I always wait [for confirmation of consent], because of course, you don’t want to be accused later of doing something inappropriate and you can’t be sure unless they have said. - Elliott (obstetrics and gynaecology trainee and previous forensic medical examiner)

Many acknowledged that power and knowledge imbalances between providers and women interfered with women’s ability to consent, particularly for survivors. Providers considered how women may feel pressure to agree to procedures they do not fully understand or want, and how women may fear negative consequences if they do not comply with the medical advice or interventions offered. Providers considered how this might be particularly important for survivors of sexual violence who may feel frightened by or find it difficult to challenge people in positions of power and authority and may fear that they will be punished if they resist or decline care.

> When you have got someone in authority and they are in their uniform, you just feel like you are under their control. Whatever they say, you are just going to say yes to, because you probably feel that they know best. … Maybe they are worried that if they say no, they won’t get such good care, or people won’t like them so much, or things like that. - Jean (safeguarding midwife)

One provider recounted an experience with one survivor to illustrate both how consent was not always sought and how difficult it may be for survivors to challenge authority when they are not given space to decline. Despite making a birth plan that highlighted this survivor’s anxiety around vaginal examinations, during her labour, a medical student conducted a vaginal examination first, and then told the doctor his findings before the doctor did one. Jean reflected on how difficult it would have been for this woman to say no to a doctor and their distress at hearing how this woman had been used as an educational tool and her wishes in her birth plan ignored.

> I had a woman who had experienced trauma who was really anxious about the birth and vaginal examinations and thing. We made a lovely plan and everything, but then I found out that when she was in labour they got a medical student to first of all do a VE [vaginal examination] and tell the doctors what his findings were before the doctor did a VE. I was just so upset that that happened to her, because she wasn't the type of person… Even though I said 'you can say no. You can say no.' You know, when you see doctors and things, women' don't say no. - Jean (safeguarding midwife)

Providers also discussed how the systems within which they worked were not designed with full, informed and ongoing consent in mind. An example given by one provider was that in early pregnancy women often do not realise that they are likely to be offered an internal rather than an abdominal scan because no one tells them this. Women therefore do not realise what is being offered until immediately before the procedure is about to begin, leaving them no time to consider the procedure and discuss any concerns. As Leslie highlights, although not letting women know what to expect is unacceptable in any case, survivors may need more time than other women to consider invasive procedures like this. Coupled with the point above, that survivors may find it more difficult to decline care or challenge people in authority, this created an environment where it was very difficult for women to truly consent.

> I think as well, in early pregnancy – most women don't know unless you've been involved in early pregnancy scanning – when you're in really early pregnancy, the scan isn't done with the abdominal ultrasound, it's done with an internal probe. Obviously they ask consent, but there's no time for women to get their head

> around, ‘Okay, I need to build myself up for this’. - Leslie (safeguarding midwife and specialist midwife for fear of birth)

Most providers also discussed how medical complications disrupted informed consent. Kelsey explains how time pressures and deprioritisation of the mother’s needs relative to the baby’s can disrupt full, informed consent, leading to events that mirror the loss of power and control involved in sexual violence.

> The time pressures of the situation can lead… Or it makes it difficult to have a properly considered informed consent period where the pros and cons laid out, the woman is given time to think about it and then she says yes or no. Those kinds of situations, they get really hairy. And also with the focus on neonatal outcomes above all else. The baby’s needs can overtake those of the mum in that situation really. Which, if you’ve had this experience of power and control of sexual violence, and having those things taken away, that situation can be so reminiscent of what you’ve experienced before that it really doesn’t surprise me that people end up feeling like it’s a similar experience. - Kelsey (consultant midwife with remit in public health and safeguarding)

Providers also emphasised, however, that it was still possible to keep women at the centre during emergencies through clear communication about what is happening, explaining who the people in the room are and why they need to be there, and what and why procedures are being done. Providers stressed the importance of reassurance and for women to feel seen and heard despite the chaos. They suggested that having a consistent and dedicated person whose main purpose is to communicate with the woman may help her make more informed choices. Again, this was seen as important for all women but especially important for women who had experienced trauma. This reassurance also offered a way to avoid women being re-traumatised by yet another event in which they felt completely powerless. Being able to foster a sense of control and agency in an uncertain and confusing situation presented a powerful contrast to women's experiences of sexual violence.

> I think actually as a midwife in that room while something like that is going on you have such an opportunity to do something that can really make a difference to how somebody experiences a situation like that, by being with them and sort of sticking with them. We talk a lot when we do emergency drills about that, it's really important to have somebody who the only thing they do is they talk to the woman, tell her what's going on, communicate with her and the partner and just do that reassurance. - Kelsey (consultant midwife with remit in public health and safeguarding)

Taking power away through safeguarding

Safeguarding referrals could both take power away and re-enforce judgement and shame through positioning survivors as a 'bad mother'. The threat of safeguarding referrals silenced women, and safeguarding referrals made due to misconceptions about survivors (rather than there being an immediate risk) harmed survivors through exacerbating shame and judgement.

Many providers referred to the ways that fear of being judged to be a bad mother silenced women. Jean described how women may fear judgement from providers due to societal perceptions that a woman who has experienced abuse is 'vulnerable' and therefore will not be a 'good mother'. As Jean emphasises, being a survivor does not make a woman any less able to look after her baby, but she and other providers noted that women may still fear that maternity care providers will respond to disclosures by making a safeguarding referral. This 'threat' of a safeguarding referral silenced women.

> I think a lot of it could be, you know, the shame of it, the embarrassment. I think also fear. Women fear a lot midwives are going to contact social workers and their babies are going to be removed. I think they want to appear that everything is very safe and nothing bad has happened, and they can look after the baby. Which they *can* do even if they have experienced this, of course. - Jean (safeguarding midwife)

When safeguarding referrals were made, they could mirror abuse through both taking power and control away and exacerbating feelings of shame and judgement. Although all providers considered safeguarding referrals to be necessary if there was an immediate risk to the woman or child, some noted that misconceptions about survivors being vulnerable or unable to protect their child could lead to significant harm if safeguarding referrals were made when there was indeed no risk (e.g., in response to disclosures of historic abuse). For instance, below, Raegan reflects on the significant impact a safeguarding referral can have on a survivors' sense of choice and safety.

> I always just try and get people to think about, 'If you've had all your choice taken away from you in this context, can you imagine what it would be like for that to happen again when you try and get help?' - Raegan (student midwife with experience working in the sexual violence sector)

In the quote below, Charlie discusses how, in practice, a woman's consent becomes "negligible" when there are concerns about her safety or others' safety, including her unborn child. Through this view of consent, the pregnant or labouring woman is not afforded the same legal rights as other people.

> Obviously, the idea is that women consent to it [a safeguarding referral], but the reality is if there is an immediate risk, the consent is negligible... if there is an immediate risk to anybody, both the unborn, the children that already exist in her life and herself, or in fact her partner. - Charlie (student midwife)

Raegan highlights below that an appropriate assessment of risk is only possible if providers have the resources to accurately assess risk. Although Raegan was a student midwife at the time of this research, before beginning her studies she had a career in the specialist sexual violence sector. In her interview she drew on many years of experience of working with survivors and making safeguarding referrals in her previous job. Because of her unique experience, Raegan was able to compare approaches to safeguarding in maternity care and the specialist sexual violence sector and noted that they differed significantly in two main ways: (1) understanding of the dynamics of trauma and (2) having access to systemic support to accurately assess risk.

Raegan reflected on how misconceptions about survivors that position them as inherently vulnerable or unable to protect their child from abuse could lead to unnecessary (and harmful) safeguarding referrals. Raegan discussed how, in maternity care, safeguarding referrals may be made unnecessarily (e.g., in response to a disclosure of historic abuse) when providers lacked both knowledge about trauma and systemic and structural support to check a concern with someone. Unless there was an immediate risk, Raegan suggested that providers should be supported to think “beyond safeguarding”, consider the seriousness and impact of a safeguarding referral on survivors, and what support a woman may need outside of a safeguarding context.

> Overreacting to safeguarding sounds really bad, but I think you can totally overreact to a safeguarding concern. I think that's much more likely if you feel that you don't have support with it and you feel like you can't check your decision with someone.

> So I think again that's a structural thing about, ‘How can we help people to think beyond safeguarding?’ They have to feel secure in their safeguarding to be able to think beyond that, if that makes sense. - Raegan (student midwife with experience working in the sexual violence sector)

Theme summary

In this theme, providers positioned maternity care as having the potential either to heal or to harm, and pregnancy and birth as windows of opportunity in which to promote healing following abuse. Providers discussed how healing care that empowered women, listened to women, built on women’s strengths, counteracted the silencing of sexual violence, modelled compassionate, equal relationships and provided access to additional, specialist support if that was what women wanted. Providers expressed concerns that interactions that took power away from women, such as non-consented touch or examinations or safeguarding processes, re-traumatised survivors through silencing or disempowering them. Safeguarding referrals took power away in a way that was similar to the disempowerment of other consent violations (e.g., non-consented examinations), but in addition safeguarding referrals also re-enforced ideas that shamed and judged survivors, i.e., that they were not a ‘good mother’. Safeguarding referrals could therefore cause significant harm if made inappropriately due to providers believing misconceptions about survivors and/or lacking structural support to check concerns with colleagues.

8.3.2 Creating safety in the face of uncertainty

This theme summarises how providers tried to create safety despite tensions between the unpredictability of pregnancy and birth and survivors’ needs for safety, consistency, and security. Providers described how the potentially disempowering aspects of maternity care could compound previous experiences of sexual violence. Providers were also living with uncertainty because they may at any point be unknowingly providing care to a survivor. They also discussed how their lived experience of violence and abuse facilitated their openness to disclosures and confidence to trust their intuition and respond.

Managing unpredictability

Most providers expressed an awareness that they may at any time be unknowingly providing care to a survivor of sexual violence. They understood that many survivors do not feel able to disclose sexual violence to anyone, let alone a person in a position of power and authority such as a maternity care provider. This created uncertainty for providers because they never knew if someone may have experienced abuse. Therefore, many providers agreed that being trauma-informed was important to ensure that care was healing for all women.

> All of our care should be trauma- informed, because we don't always know. - Atty (midwife)

Providers understood that women may cope with the impacts of sexual violence by needing to feel in control of their care. This need for control created a tension, because pregnancy and birth were unpredictable and uncertain times for both women and providers.
Providers highlighted that aspects of pregnancy, birth, and maternity care can be experienced as disempowering, frightening and traumatic for all women, especially if there were complications, but that this was particularly an issue for women who had experienced a loss of control through sexual violence previously. Kelsey discusses how the unpredictability and loss of control associated with pregnancy and birth may be particularly difficult for survivors.

> If you were a person who has coped with your experience of sexual violence by arranging life so that you have as much control over what happens and how and when as possible, then to go into this experience where that is the complete

> opposite… - Kelsey (consultant midwife with remit in public health and safeguarding)

Participants described how women often had an idea of how they wanted their birth experience to be. Midwives were tasked with both planning this ideal birth and managing expectations around the reality of how the birth might progress and the ability and willingness of the labour staff team to meet women's needs. Many participants spoke about how survivors may prefer female care providers, and that women may want to specify this in their birth plan. However, they also felt a responsibility to warn women that their needs may not be met as they had little control over who was on duty or available at the time. This created tension because women made a birth plan in order to have their needs heard and met. Midwives noted that women's and providers' expectations about the importance of the birth plan might differ and felt a responsibility to mentally prepare women for this.

> Yes, sure. For example, I would say to her, 'Okay.' I will say, 'I will write on your electronic notes that you want to avoid having any male caregivers if at all possible,' but I will say to her, 'That will be on your notes, but I have to say that there is a chance that a) that you'll come in and that there'll only be a male caregiver available'. - Robin (specialist midwife for perinatal mental health and substance misuse)

> If there was an emergency during that delivery, it would be whoever is there that would come in and help, because you hit the bell and everyone is running in. Although we would try and say 'female only', we had to explain that if it is an absolute emergency and there is a male doctor, it will be a male doctor that comes in to support. We wouldn't not treat a serious obstetric emergency because the only

> person available was a man. We have a duty to provide that medical care. - Leslie (Safeguarding midwife and specialist midwife for fear of birth)

Being curious and empathic

Participants reported that they tried to tailor their care to women's needs by being alert to indicators that a woman may have experienced or may be experiencing abuse. The providers in this study reported being sensitive to both spoken and unspoken communication from women, ranging from subtle, internalized responses such as dissociating or freezing, to more outward expressions of distress, apprehension, or declining care. Specific examples given included: women who 'left the room', froze, or became very distressed during procedures or examinations; women who requested an elective caesarean due to fear of birth; and women who seemed to want to please the provider or be a 'good patient'.

> Somebody who kind of just does sort of the freeze mode and kind of seems to leave the room and you find it difficult to actually speak to them because they're dissociating, and they're not there, and you're trying to ask them something, but they're not responding. - Kelsey (consultant midwife with remit in public health and safeguarding)

> They're just… I can't think of the word. I think they just want to please you, almost. - Ashley (student midwife)

However, most providers noted that to be able to pick up on these indicators of trauma required both the willingness to do so and the knowledge to understand these may be indicators of abuse. All participants reported having a good understanding of trauma, gained through training, professional experience, personal interest and/or lived experience, but noted that most maternity care providers would not be sensitive to these indicators of trauma. Furthermore, Atty, who was a survivor, explained that providers' role is to help women feel safe enough to voice their own understanding of how difficulties might relate to sexual violence experiences.

> Many women will, even if they're not verbalising it, they may quietly know that some of the challenges that they're facing are actually related to their sexual violence experience. So it's about making them feel safe enough to voice that. - Atty (midwife)

Participants with lived experience of abuse or violence spoke about how this helped them empathise with women and be more attuned to women's trauma-related responses and needs. Lived experience increased providers' awareness about trauma responses and facilitated an openness and willingness to lean into the uncertainty created by adopting a questioning and curious approach. Lived experience gave them confidence to trust their intuition and respond to women's unspoken communication, including asking directly about sexual violence and other forms of abuse.

> I think, for me, I've witnessed it first-hand so I can… I'm quite good at picking up those signals when, maybe, the man is not acting in a way he should do and the woman - like the fear from the woman. - Ashley (student midwife)

> Because of my awareness of trauma responses, and just looking at her notes and seeing what had been going wrong for her and the way she presented in that appointment, it felt very easy for me to say, to ask explicitly… I can't remember my exact words at the moment, but it was along the lines of what I said earlier on of 'is there something in your history that's happened, that has been traumatic, that has been distressing…' - Atty (midwife)

Other participants spoke about how their experience and knowledge gained through activism in women’s rights complemented their professional work and facilitated a greater understanding, openness and confidence to follow their instincts and be curious.

> I learned to ask questions. ‘Has anything happened to you?’ or you’d say, ‘How are things?’ ‘Not too bad.’ ‘Does that mean not too good?’ ‘Well my husband has been a bit cross.’ ‘When you say cross, how cross?’ So I think that the skill of getting a disclosure… That sounds like extracting a disclosure - that’s very powerful - the skill of being trusted enough to receive the gift of information. - Sam (obstetrician and gynaecologist)

These participants described themselves as highly motivated to facilitate disclosures of sexual violence. They spoke about the importance of genuinely wanting to know whether that woman had a history of abuse – described by the above provider as the “gift of information” - and believed that knowing information about violence and abuse would help them to provide better help and support.

Theme summary

In this theme, providers described the inherent unpredictability of pregnancy and birth as providing many challenges, which both they and the women they worked with had to overcome. They described different ways in which they tried to manage this and create a sense of safety and security for survivors, who may need different things from providers at different times but who providers understood may need more choice and control in their care than women who were not survivors. Lived experience was a source of empathy and confidence to trust their instincts, as was experience gained in professional, activism and advocacy settings.

8.3.3 Caught between women and the system

The final theme – ‘being caught between women and the system’ captures how providers in this study wanted to promote choice and control and treat women with empathy and respect but felt unsupported by the system in which they worked.

Burden of responsibility

Providers had different roles, responsibilities and levels of experience, but they all spoke about personal beliefs and values that gave them a commitment to working with survivors. All providers reported that they wanted to advocate for women’s needs, support women’s choices and be alongside women during this time. They all wished for women to feel physically and emotionally safe and supported through pregnancy and birth. They had decided to become a maternity care provider to help women and many saw themselves as an advocate for women.

> One of the reasons that I wanted to move out of child protection was that I enjoy building relationships with women, with adults, and wanting to do it from a position of where it respects their decision-making completely and isn't trying to enforce a view. - Tracy (perinatal mental health social worker)

The midwives in particular expressed a strong belief that advocating for women’s right for choice, control and dignity was an important part of their role.

> Our job is to advocate as well, and, you know, if we see something that doesn’t feel appropriate, then it is the midwife’s job, absolutely, to be trying to advocate for that woman. - Sloan (specialist mental health and community midwife)

As such, providers described feeling a significant burden of responsibility to make sure that maternity care was empowering, healing and restorative for women. Providers reported feeling anxious that if they did not create a healing environment, they could traumatise or re-traumatise women, with long-term impacts.

> I think you can help someone to have a transformative birth experience or you can accidentally help them to have a really, really awful re-traumatising experience that stays with them for the rest of their life. So I think the stakes are high. - Kelsey (consultant midwife with remit in public health and safeguarding)

All participants spoke about situations in which they had witnessed insensitive or re-traumatising care by colleagues that had upset them deeply. Providers explained that even one instance of insensitive care could cause significant harm, as it could undo all of the safety and trust created by trauma-informed care before that.

> You know like you could have a trauma-informed, like, midwifery workforce and then if you can’t get the engagement from the other professionals who are involved in people’s care, you can actually then undo that if somebody feels like they’ve been violated during a vaginal examination they didn’t feel they consented to. - Kelsey (consultant midwife with remit in public health and safeguarding)

Providers discussed how when they felt unable to challenge insensitive care this left them feeling shame and traumatized by what they had witnessed. As Jamie discusses, when providers had less experience they generally felt less able to challenge more senior colleagues. However, with age and maturity, they felt more able to challenge care. Despite having the confidence to challenge care, it still took emotional resources to do this.

> I think now I'd probably roar like a lion [laughs] if somebody did that. But back then, I think I probably just didn't… You know. I was quite a young midwife. I didn't really feel I was able to. Um [pause]. Yes, I felt quite powerless in those situations to say. I think, other than to try to make it better by providing really nice care for the women … back then I think I just wasn't so assertive, didn't feel able to challenge it, I suppose, that kind of practice. - Jamie (midwife)

> [to advocate for a woman] I'd normally say 'I don't think that's quite what she wants', or, 'that's not really what we were planning on doing'. If there's an opportunity to pull the doctor outside the room and talk about it outside, I would do that, but it takes quite a bit of experience and confidence to be able to do that. When I was newly qualified there's no way I could've done that and, you know, it's still hard, obviously, to challenge your colleagues. - Sloan (specialist mental health and community midwife

Most participants expressed a wish to build relationships with the women they provided care to. Continuity of care was positioned as important to all women, but particularly important to survivors' need for emotional safety as well as providers' ability to provide appropriate support to survivors. As Kelsey describes one instance where continuity of care meant that they could support a survivor throughout a distressing court process during her pregnancy

> We were able to support her to follow that up and go through a court process and all sorts. I think there's a point where continuity just pays for itself. Being able to offer somebody that care that lasts through their whole pregnancy and afterwards, and then through the next one and then afterwards. […] Just having people that you feel safe talking to really helps. - Kelsey (consultant midwife with remit in public health and safeguarding)

Importantly, continuity of care also gave providers sense of meaning and purpose in their work, because it allowed them to practice in line with their values. For example, Sloan below described continuity of care as "special" and a fundamental part of "true midwifery".

> [continuity of care] is called the gold standard, but it's true midwifery, you know, to be with someone for that whole journey. And it's pretty special for the midwife as well. You know, you get so much more job satisfaction. - Sloan (specialist mental health and community midwife)

Most providers were not working within a continuity of care model, and for those providers, not being able to provide continuity of care was described as very frustrating and disempowering and an unfortunate characteristic of the system they worked in. Most participants reported feeling a sense of hopelessness about the system's ability to support survivors and that it was unfair to expect women to disclose if this would not lead to better care. Providers also linked this with the reality that most women did not have continuity of care – they may never see a woman again after she discloses and often had no way of ensuring that she got the follow-up care she needed. In this way, providers saw the system as silencing survivors through a lack of response.

> 'Thanks for telling me. I am probably never going to see you again. You may never be asked this again. Nobody may ever follow up on it.' It feels… It is not right. - Jamie (midwife)

Fear of causing harm

Providers reported feeling afraid of causing harm to women and survivors through reminding them of sexual violence or not responding appropriately. They suggested that some maternity care providers may avoid asking about violence and abuse due to fear of causing distress or harm, especially when providers did not have the training and external support to know how to respond to disclosures.

> And I think the fear of not knowing how to respond to somebody often I think holds people back from opening up the subject. - Kelsey (consultant midwife with remit in public health and safeguarding)

> I think people are worried about creating distress [if they ask about abuse]. Potentially upsetting someone and changing the nature of an appointment which might be going absolutely fine. And that feeling of ‘well we don’t want to make somebody think about it if it’s not bothering them’. - Atty (midwife)

Linked to this idea of avoiding harm, some participants questioned whether it was ethical to ask women about sexual violence when women were unlikely to get appropriate follow-up support. Many providers expressed fear that asking a woman to disclose could lead to harm if the disclosure did not lead to long term-care and trauma-informed support. Some providers also noted that appropriate supported needed to be in place for maternity care providers too.

> I don’t think you can introduce a proper detailed screening for these kinds of experiences before you’ve got a trauma-informed workforce, because otherwise you’re just going to be upsetting people left, right and centre. Another thing you have to think about is the experiences of the midwives who are asking these questions. There are going to be people who have experienced sexual violence themselves or domestic violence because we all know the stats of how common it is an experience for women. - Kelsey (consultant midwife with remit in public health and safeguarding)

However, one participant, who was a survivor herself, reported how just having someone notice that a woman is feeling distressed can be validating in and of itself. She reflected on when she felt validated by a nurse who noticed that she was distressed and asked what had happened. This experience gave her confidence that asking about sexual violence in an empathic and compassionate way could be healing, even if women are not able to disclose at that time, and even if no one ever followed up again afterwards, because noticing and asking showed women that they mattered. This countered the silencing of abuse survivors.

> There was a situation where a nurse came and said to me ‘what’s really going on? what’s happened? You can speak to me. I’m here to help you.’ And I couldn’t say a word because I wasn’t ready because [of] all the self-blame. I didn’t know how to articulate what happened to me. But I have never, ever forgotten that nurse asking me. And I have never forgotten the sense of ‘oh my god there’s somebody who can help me’. And it has stayed with me all these years. And I would dearly love to have at some point been able to find that nurse, and say ‘I know I physically couldn’t answer your question but in my head I was screaming out the answer. I just couldn’t say it. I wasn’t ready.’ - Atty (midwife)

Old school superhuman

Providers spoke about the many different emotional demands of their work, which depleted their emotional resources but were not necessarily directly related to working with survivors of sexual violence. In other words, their job was already stressful and involved a risk of secondary trauma at multiple levels. The multiple stressors providers experienced in their job left them with low emotional resources to provide additional support to survivors, especially when there was little systemic or structural support for providers’ own well-being.

> I mean, you know, certainly with the trauma-informed care stuff, if you're thinking about it in that way, like the secondary trauma risk of working with women who you know have experienced things like this is really obvious. But then actually, there's the risk of that just from somebody in normal labour who doesn't have any history of anything difficult it's still like if things go wrong, there's so much scope for really feeling very difficult things. - Kelsey (consultant midwife with remit in public health and safeguarding)

The stress of their job was compounded by pressure to be a 'good provider'. Providers reported feeling a lot of pressure from multiple sources to be perfect. This linked to their sense of responsibility to get care right (or risk re-traumatising women) and the idea of being a person who helps and fixes, rather than there being room for error or an allowance for them to have periods of vulnerability themselves. Participants described this expectation being present at a systemic level, such as for them to work long hours and ignore their own needs in order to look after others. Elliott described this view as providers being expected to be "and old-school superhuman":

> It's, kind of, I think old-school superhuman. Working for all these hours and not eating lunch and not taking breaks and stuff like that. I don't think that serves anyone. - Elliott (obstetrics and gynaecology trainee and previous forensic medical examiner)

Participants reflected on how accepting their own limitations both as a practitioner and a human being was important to their ability to set boundaries and look after their own well-being.

> So I think I spent a lot of time always wanting to be a good doctor and realising that you can’t. You can only be better tomorrow than yesterday. - Sam (obstetrician and gynaecologist)

> Yes. I think, probably, a lot of people in this line of work have some slight rescuing tendencies, which you have to watch really carefully with supervision and things like that. Sometimes, just accepting your own limitations as a practitioner, I think, can be challenging. - Raegan (student midwife with experience working in the sexual violence sector)

Linked to this idea of providers needing to be “superhuman”, some providers also discussed a societal assumption that maternity care providers cannot be survivors, which fed into pressure on providers to be ‘resilient’ and able to cope with the stresses and demands of the job.

> You know ‘There are survivors over here and there are professionals over here and we're two separate groups.’ I think that is really artificial and that can lead to some of the things about just expecting people to be able to cope and resilience. You think, ‘Well, you're just hearing about it. You're not experiencing it because you're not in *that* group. You're in *this* group. So why would it be really affecting you on a personal level?’ - Raegan (student midwife with experience working in the sexual violence sector)

Many spoke of having to keep a “professional distance” in order to cope with the stresses of their job and the reality that so many women have experienced, and are experiencing, sexual violence and/or abuse. Others reported that they struggled to keep this emotional distance. For example, some talked about their emotional reactions to working with survivors. Sloan and Jean described two sides of this – feeling overwhelmed by wanting to help and needing to avoid thinking about it too much in order to protect themselves.

> Yes, it's devastating. I mean, I don't think I cry about it. I would try not to think about it too much because, obviously, you have to maintain a professional distance, but yes, it is really shocking. - Sloan (Specialist mental health and community midwife)

> Sometimes you just feel like you just want to be these people's mums. That's what they need really. They just need a lot of love. That is hard, sometimes. Sometimes it is hard to stay within the parameters of your job. - Jean (Safeguarding midwife)

Some providers discussed how an important way to address this tension was to remember that survivors do not need to be 'rescued'. One specific example was given by one provider on how to 'hold' the consultation and set boundaries so that they would not be burnt out. This involved trusting women that they can continue to deal with their struggles but also responding in some way.

> Part of the way we set up the services was to reassure people that you're not going to open Pandora's Box. You've only got 10-minute consultations, there's a queue outside. You can hold it. If you give people the idea that they have got the skills to hold a problem, because actually the person has been living with it for years, it's not going to all pour out all over you. You just hold it and say, 'I see there's more here than meets the eye.' Or, 'I can't deal with this now, I will come back at the end of the ward round.' Or, 'I've got a friend, here's a card or a phone number.' Actually, giving people confidence to just hold a problem… - Sam (obstetrician and gynaecologist)

Many providers discussed how they and their colleagues wanted to fix things for women, again referring to this idea of rescuing or saving women. For some, the realisation that some situations could not be fixed, when providers saw fixing as an important part of their job, could lead to frustration and conflicting feelings. For example, many providers reported experiences of working with women who became extremely distressed during labour and birth, reporting behaviours that indicated that these women may be experiencing flashbacks to trauma. Kelsey describes how working with women experiencing these extreme states of distress could give rise to conflicting feelings – wanting to help this person but not knowing how, and realising they may be powerless to help in the way they want to.

> I think midwives often want to fix things, which I think is good, but also can backfire a little bit sometimes. Because it's very difficult when you can't [fix things], and people find that really challenging. So when you're caring for somebody like that, you might have lots of conflicting feelings and then feel terrible for thinking, 'God, I wish this day was over'. It just gets really complicated because you might end up feeling like you're not practising in the way that you usually want to practice but you don't know what to do with this person. - Kelsey (consultant midwife with remit in public health and safeguarding)

Theme summary

In this theme, providers spoke about multiple ways in which they were personally connected to their work. Their jobs were described as emotionally demanding, and they recounted witnessing and working with distressing experiences and events, not limited to sexual violence, that depleted their emotional resources. Providers tried to cope by setting boundaries, but they felt system pressure to be 'perfect'. Providers needed structural support to prevent burnout as they saw themselves as sitting between women and the system, with the system's needs taking precedence before their own.

8.4 Summary of findings

Providers described how they were uniquely placed to support healing after sexual violence, and that they could do so by treating women with respect and restoring the power and control taken away from women through sexual violence. The maternity care system could also re-traumatise survivors, however, and take power and control away through safeguarding and through unconsented touching or examinations. Providers also discussed tensions created between survivors' need for choice and control, unpredictability around pregnancy and birth and uncertainty around care women could receive during birth (due to lack of continuity of care). They tried to create safety for women by listening to women's spoken as well as unspoken communication, being curious and treating women with empathy. In order to create this safety, providers needed the knowledge and the confidence to trust their instincts and respond to women but support for this was often not available on a systemic level. Providers reported feeling stuck between women who needed validation, empathy, choice and control and the system that took power and control away from women. They felt a significant burden of responsibility to ensure care was restorative and healing, compounded by expectations of them to be "superhuman", and this conflicted with the way they had to protect themselves by distancing or delivering care that went against their values.

8.4.1 Key findings and cross-cutting concepts

Among the key findings was that while providers felt a significant burden of responsibility to create a restorative, healing care environment, systemic issues created conflicts between their values and their work. In this sense, the system did not only take power and control away from the women it was meant to serve – it also took power and control away from maternity care providers.

Another important finding was that lived experience of violence and abuse was an important source of empathy and understanding for providers. Providers challenged an unrealistic binary between providers and survivors that widened power imbalances and contributed to ideas that providers should be ‘superhuman’. If providers were well supported by the system, their lived experience could be a significant source of empathy, knowledge and strength. Having an experiential understanding of what it means to be seen and heard in healthcare helped give providers confidence and overcome the fear (of causing harm or getting into trouble) that (often inadvertently) contributed to silencing women in care.

Continuity of care was a cross-cutting concept that was relevant to all three themes. Providers highlighted that they often did not work within a continuity of care model (although some did – such as community midwives) but being able to see women over a period of time and build a relationship with them was important to them personally. As one provider described it, continuity of care was “true midwifery”. Providers saw continuity of care as helping to facilitate disclosures and respond to survivors’ individual needs in the absence of disclosure as they would get to know a woman over a period of time. The lack of continuity of care on a systemic level also prevented providers from trusting that the system they worked in, and their colleagues, would provide trauma-informed care. The importance of continuity of care linked to providers needs to protect and advocate for survivors.

8.5 Summary of Chapter 8

This chapter detailed the findings from the third, and final, study presented in this PhD: a reflexive thematic analysis exploring maternity care providers’ experiences, expectations and needs regarding providing care to survivors of sexual violence. In the next chapter (Chapter 9), I discuss my findings in the context of wider empirical and theoretical literature, consider strengths and limitations of my research, and make recommendations for practice and policy.

Chapter 9. Discussion and Conclusion

Trauma is not for words to articulate: it is a tale of the body. - Fischer (2019, para. 1).

This chapter begins with a brief summary of each study's key findings. I then synthesise my findings across the three studies and contextualise them with reference to wider empirical and theoretical literature. I also consider how my thesis' unique contribution to knowledge was shaped by my survivor standpoint. Finally, I discuss implications for survivors, providers, organisations and future research.

9.1 Summary of findings

My research, which was conducted from an explicit survivor standpoint, explored experiences of pregnancy, birth, early motherhood (up to 6 weeks post-birth) and maternity care among adulthood sexual violence survivors. I also explored maternity care providers' experiences in relation to supporting survivors, to understand their needs and structural barriers, and facilitators to trauma-informed care. My research was timely - improving health system responses to sexual violence is a key policy and research priority in the UK (Department of Health and Social Care, 2022a) and globally (García-Moreno, Hegarty, et al., 2015a; García-Moreno, Zimmerman, et al., 2015). Survivors and clinicians have also identified my topic as important to them. A sexual violence research priority setting partnership involving survivors, clinicians and researchers identified that understanding what trauma-informed care looks like in health settings was one of the top ten research priorities (James Lind Alliance, 2022). Similarly, a survivor-led research priorities consultation with people who had experienced violence, abuse and mental health difficulties emphasised that research must understand ways that systems harm survivors (Robotham et al., 2019).

In this thesis, I presented findings from three studies that addressed these research priorities. I conducted three studies: (1) a meta-ethnography and systematic review synthesising qualitative research on adulthood sexual violence survivors’ healthcare experiences and expectations; (2) a qualitative narrative study exploring adulthood sexual violence survivors’ experiences of pregnancy, birth, early motherhood (up to 6 weeks post-birth), and maternity care; and (3) a qualitative study with maternity care providers about their experiences and needs in relation to supporting sexual violence survivors. Below I briefly describe each study and its findings before synthesising findings across the three studies.

In Study 1 (Chapter 6), I conducted a meta-ethnography and systematic review synthesising 38 qualitative studies about healthcare experiences and expectations among female adulthood sexual violence survivors (but many had multiple and overlapping experiences of abuse). Studies covered a variety of health settings. The three themes I produced explored how survivors’ perspectives on how safety can be built into healthcare. These themes were: 1) Acknowledgement: shifting shame and blame; (2) Being Seen: respect, validation and responsiveness; and (3) Being Heard: choices, empowerment, and shared decision-making. Women’s trust in themselves and others was impacted by societal perceptions that blamed and shamed sexual violence survivors, preventing survivors from acknowledging and speaking about their experiences. Providers could counteract this cultural silencing by labelling women’s experiences as violence. Survivors needed to feel valued, respected and cared about to combat the dehumanising nature of sexual violence. Providers who treated women with empathy and kindness signalled to women that they could be trusted, but women were often expected to trust providers when they had not yet been given reason to do so. Survivors needed to reclaim their bodies and their sense of autonomy to counteract the loss of power and control, characteristic of sexual violence. When healthcare providers, services, and systems prioritised their needs over survivors’, this led to disempowerment, disconnection, and disengagement. I developed a line of argument in which I argued that reciprocal trust was essential to building safety. Providers who trusted women signalled that they were trustworthy and supported survivors to re-build trust in themselves and others.

In Study 2 (Chapter 7), I conducted unstructured interviews with 11 survivors of sexual violence and analysed the data using thematic narrative analysis. All participants had experienced adulthood sexual violence, but most participants had multiple experiences of sexual violence and other forms of violence and abuse at different times in their lives, including childhood. The four themes I generated described both healing and distressing experiences of pregnancy, birth, early motherhood, and maternity care. Themes were: (1) 'The most empowering moment of my life', (2) 'Something weird and wrong', (3) 'I was just a body' and (4) 'It's about so much more than just saying it'. Some women felt distress during the perinatal period but remained silent due to a fear of being judged or shamed. The societal shaming and silencing women who do not meet expectations of 'good' mothers intersected with the shaming and silencing of sexual violence survivors. For some women, pregnancy, birth and early motherhood created opportunities to heal some of the embodied and relational harms of sexual violence. The embodied and personally significant transition of becoming a mother could re-build connections with women's bodies and other people. However, dehumanising approaches to care led to disempowerment and disconnection, and facilitated environments that re-created the silencing and sometimes violation of sexual violence. Although survivors experienced (and valued) empathic, respectful and kind interactions with individual providers, they noted that that such interactions were the exception rather than the norm and were experienced against a backdrop of a dehumanising system.

In Study 3 (Chapter 8), I conducted semi-structured interviews with 13 maternity care providers and analysed the data using reflexive thematic analysis. The three themes I generated describe several tensions negotiated by these maternity care providers in the context of working with sexual violence survivors. Participants worked in a range of settings and had varying levels of clinical experience, but all shared a deep commitment to supporting sexual violence survivors in their work. Some participants also brought lived experience expertise. Themes generated were: (1) A window of opportunity for healing and harm, (2) Creating safety in the face of uncertainty and (3) Caught between women and the system. Providers balanced the challenges created by the deeply emotive, unpredictable, and exposing context of maternity care, with women’s need to feel safe and in control. They felt significant responsibility to create a restorative, healing care environment for survivors, but systemic priorities conflicted with their personal values. Providers felt constrained by a system that prioritised reductionism, efficiency and standardisation, over relationship- and trust-building, which were important to both providers and survivors. Providers’ lived experience of violence and abuse could be a significant source of empathy, knowledge and confidence. Having an experiential understanding of the importance of feeling seen, valued, respected and heard for survivors gave survivor-providers confidence, and overcome the fear (e.g., of causing harm) that prevented some providers from appropriately responding to sexual violence in their work.

9.2 Discussion of research findings

I have argued in this thesis that sexual violence can be understood as an attack on subjectivity and personhood that can profoundly change a survivor's sense of herself (see Chapter 3). I noted that sexual violence harms survivors, in part, by reducing them to little more than a sexual object (Kelland, 2011). This violation of autonomy and personhood is so dehumanising because, as argued by Cahill (2011), a survivor “must have a subjectivity that can be eclipsed, she must occupy the role of ‘person’ or ‘subject’ in order for her assailant to feel the thrill of violence” (Cahill, 2011, p. 136; see also Cahill, 2009). In Chapter 3, I argued that a survivor’s embodiment is central to her sense of self (e.g., de Beauvoir, 2011), her lived experience of sexual violence (i.e., Kelland, 2011), her experience of becoming a mother (i.e., Woollard, 2021), and the way she is treated by providers (e.g., Kingma, 2021). Alienation – when a person’s experience or action “is defined or controlled by a subject who does not share one's assumptions or goals” (Young, 1984, p. 55) – is also central to survivor’ experience of her own body, sexual violence, pregnancy, birth, early motherhood and maternity care. I situated survivors' experiences within wider cultural narratives. For instance, I considered what 'counts' as valid, credible knowledge in Wester society and how this works to devalue the voices of pregnant, birthing people in maternity care (e.g., Davis-Floyd & Sargent, 1997). I linked this understanding of survivors, as embodied and situated agents, to literature on trauma-informed approaches. Trauma-informed approaches consider survivors' experiential knowledge to be critical to creating safety in care and to creating system-wide transformation (Sweeney et al., 2018).

The synthesis of my findings arises from this perspective, and I will discuss my findings under the following five headings:

- Pregnancy, birth, early motherhood, and maternity care created opportunities for embodied and relational healing.
- Survivor mothers experienced silencing on multiple levels.
- Medicalisation mirrored the dehumanisation and silencing of sexual violence.
- A medicalised system prevented the delivery of trauma-informed care.
- Working in a trauma-uninformed system led to vicarious trauma, moral injury and burnout among providers.

9.2.1 Pregnancy, birth, early motherhood and maternity care created opportunities for embodied and relational healing

Participants experienced pregnancy, birth and becoming a mother as a deeply embodied, emotive life event intertwined with relationships and involving profound physical and personal transformation. For some women, the perinatal period presented a unique and significant context in which some of the embodied and relational harms of sexual violence could be healed. Several theorists have argued for a narrative model of recovery, which proposes that narratively understanding experiences of sexual violence may help survivors to heal from its harms (Brison, 2002; Herman, 1997; Kelland, 2012b). Similarly, Filson (2016) powerfully noted that “in part, healing happens in the re-storying of our lives” (p. 23). Narrative models of recovery highlight ways that healing can restore the embodied, relational self after violence. Narratively understanding experiences of violence may facilitate empowerment through increasing self-awareness and self-understanding (Herman, 1997; Kelland, 2012). For a survivor to have her story heard and, importantly, *understood* by others may rebuild the relational trust and safety that was shattered by sexual violence, helping to restore her sense of self (Herman, 1997). This restores her sense of self because the embodied, situated self is fundamentally relational (Brison, 2002). Healing through remembering, mourning, and processing may therefore happen at an embodied level that transcends the limits of language (Herman, 1997; Van der Kolk, 2014). My findings support narrative models of recovery and Herman’s (1997) assertion that healthcare providers can facilitate healing by bearing witness to survivors’ pain and capacity to heal. I will explore this further in the following sections.

In my research, healthcare providers could counteract the cultural silencing of sexual violence by creating conditions that facilitated women’s narrative understanding of their experiences. Naming and labelling sexual violence were critical to shifting shame and counteracting silencing. Similarly, Herman (1997) asserted that naming and talking about their experiences can lead survivors to be “no longer imprisoned by the wordlessness of their trauma” (S99). The research in this thesis (mainly Study 1) suggested that survivors valued behaviours that made sexual violence visible, such as noticing, listening, responding, asking, and actively communicating to women that providers wanted to know and could respond. Providers and services that 'shone a light' on sexual violence, whether through sensitively asking or putting up posters, could communicate caring irrespective of whether these behaviours led to a disclosure. An important contribution of this thesis, particularly the review (Study 1), is the finding that providers who actively named the violence could help women understand their experiences differently, highlighting the critical importance and healing power of healthcare providers ‘bearing witness’ and supporting survivors to understand their experiences as violence, and therefore not their fault (Herman, 1997).

A disclosure was not needed for survivors to feel seen and the invisibility of sexual violence to be challenged. Although survivors often felt unsafe to disclose, survivors across Studies 1 and 2 found healing when they felt a sense of human connection, that their voice was important, and that they were seen as whole human beings with feelings, irrespective of disclosure. Other studies in this field have also emphasised the power of healthcare to challenge the invisibility of sexual violence if care is sensitive (Montgomery, 2013). Similarly, in a systematic review and meta-ethnography examining healing after gender-based violence, Sinko and colleagues (2021) highlighted the importance of 'letting people in'; a process whereby survivors re-connected with others, rebuilding trust and relational safety. Herman (1997) also noted that re-connecting with other people was an essential part of healing. My findings suggest that healthcare providers hold both the power and the responsibility to facilitate survivors to feel connected to others.

Across Studies 1 and 2, touch was one important way in which caring could be communicated without a need for words. Although medical touch could be disempowering (see 9.2.3), touch could also be a form of communication that transcended language and communicated caring beyond words (Kelly et al., 2018). Since experiences of trauma are often also “beyond the reach of language” (Fischer, 2019, para. 1), the ability of touch to communicate care at an embodied, intuitive level may highlight a particular strength of healthcare when responding to sexual violence, as touch can be an expected and accepted part of healthcare (Kelly et al., 2018). For instance, in my findings care could be communicated by holding a woman's hand while grieving the loss of her pregnancy (as Evelyn experienced in Study 2). The absence of kind, caring touch in health settings may also re-enforce feelings of dehumanisation. For instance, Reisenhofer and Seibold (2013) noted that a lack of touch re-enforced ideas that a survivor was untouchable. Similarly, Tarzia et al.’s (2020) review of healthcare experiences and expectations following intimate partner violence highlighted that survivors wanted providers that are "loving and kind” as well as noting the potential of touch to shift shame (p. 20). In Chapter 3, I argued that sexual violence is not merely sex-minus-consent (Archard, 2007; Brison, 1996/2022; Maung, 2021; Woollard, 2019). Similarly, feeling violated was not necessarily linked to the presence or absence of touch, it was about the way in which touch was used.

For some women, motherhood presented a new narrative that provided opportunities and encouragement to acknowledge and process trauma. Pregnancy was not just a physical transformation but a deeply personal one (e.g., see the Study 2 theme 'The most empowering moment of my life'). Although it is important to emphasise that no woman experienced motherhood as wholly empowering so as not to re-enforce harmful expectations of mothers to find motherhood joyful, easy or fulfilling (Kukla, 2008), survivors emphasised the personal importance of finding moments of healing, even if these occurred among other moments of distress, re-traumatisation or mistreatment. In these healing moments, becoming a mother presented a different narrative about survivors, their bodies, and their lives, countering singular narratives of the traumatised, damaged, vulnerable survivor. For some women, pregnancy symbolised that their body was strong, healthy, and undamaged by sexual violence; giving birth led to a sense of achievement and feeling a deep, intuitive connection with their body; and motherhood and mothering provided opportunities to give their child the love, nurturing and protection that they had often been denied.

Other researchers have also highlighted the potential for motherhood to embody a new personal and life narrative. For instance, Chamberlain et al. (2019) argue that the perinatal period is a critical 'life course opportunity', a window of opportunity for relational healing and processing past trauma. Many of the findings in my thesis echo the idea that the perinatal period could be a time for “healing the past by nurturing the future” (Chamberlain, 2019, p.1). Like Chamberlain’s (2019) review, for the women in this research, a new beginning led to hope, compassionate care reassured them, and having choices helped restore safety. Similarly, Lasiuk (2007) and Sinko et al. (2021) also explored how becoming a parent represented an opportunity for a new beginning and a motivation to begin to face, process and heal trauma. This opportunity for motherhood to facilitate a new narrative helped women to heal some of the relational harms of sexual violence. A powerful example of this relational healing is given by Brison (2002), where she describes her son as "the embodiment of my life's new narrative" (p. 325); a new life where trust and safety were rebuilt:

> Having him [son] has also enabled me to rebuild my trust in the world around us. He is so trusting that he stands with outstretched arms, wobbling, until he falls, stiff-limbed, forward, backwards, certain the universe will catch him. So far, it has, and when I tell myself it always will, the part of me that he's become believes it (Brison, 2002, pp. 325 – 326).

The embodied quality of pregnancy, birth and mothering intersected with the embodied experience of trauma to produce healing on an embodied level for some women. Some women described pregnancy, birth and becoming a mother as a personal and physical achievement that they had feared the violence had taken from them. Survivors in Study 2 described that they felt a sense of pride and mastery due to their bodies' ability to conceive, give birth and breastfeed their babies, symbolising strength and vitality body and countering ideas that their bodies were 'broken' or 'damaged' due to sexual violence (a fear that has also been reported in the literature on childhood sexual abuse, e.g., Montgomery, 2012). Conversely, having a miscarriage, experiencing difficult labour or birth, or having challenges breastfeeding could make women feel betrayed by their bodies again and reinforce the idea that their bodies were broken.

Others have also acknowledged that healing experiences during the perinatal period can give survivors a sense of achievement and pride in their bodies (Montgomery, 2013; Palmer, 2004;

Rhodes & Hutchinson, 1994). However, linking my work to feminist literature about the harms of sexual violence suggests a potential mechanism behind such healing experiences. In Chapter 3, I discussed feminist work that argued that women, due to their situation under patriarchy, experience their bodies in a fragmented way (Kelland, 2011; Young, 1990). Due to the pervasive nature of sexual objectification in women's lives (Kelland, 2011), women experience their bodies as a burden or obstacle, leading them to become alienated from their (sexually objectified) bodies (Kelland, 2011; Young, 1984, 1990). Writing about the embodiment of pregnancy, Young (1984) proposed that, if pregnancy is chosen, the embodied changes and personal and social meaning of pregnancy, birth and becoming a mother may re-connect women with their alienated bodies and provide a temporary retreat from the pervasive sexual objectification of the non-pregnant female body. My findings align with this proposition, indicating that for some women, the unique process of becoming a mother could re-build women’s relationships with their bodies in a way that actively counteracted the harm done by sexual violence.

A wealth of literature emphasises the power of healing trauma through the body. Theoretically, Van der Kolk (2014) notes that the body is both the site of violence and healing and thus advocates for embodied and movement-based approaches to releasing and processing trauma memories. Empirically, several reviews have examined the potential for yoga to facilitate healing from trauma (Nguyen-Feng et al., 2019; Taylor et al., 2020; Telles et al., 2012). However, this work tends to focus on reducing or managing trauma-related symptoms. In my research, women’s empowering, healing experiences were meaningful in a deeper way and actively changed their narrative understanding of themselves, their bodies and others. Survivors described empowering experiences of pregnancy, birth and motherhood as ones where they felt an intuitive connection with their body; saw their body as a source of power and agency; felt in control of their body (and their care); felt proud of what their body could do; and felt a sense of meaning, purpose and connection. These experiences countered ideas that they were vulnerable, damaged, weak or deserving of pain or suffering and brought them closer to their bodies. A meta-synthesis by Levine et al. (2016) highlighted similar healing mechanisms for dance/movement therapy among trauma survivors. They found that these therapies helped through (1) increasing mind-body connection, (2) feeling empowered and a sense that one is reclaiming the body, and (3) creating a new relationship with self and/or others.

My findings suggest that the embodied, personally significant, and potentially transformative experience of becoming a mother may serve as a natural intervention that counters alienation and disconnection for some survivors, helping them build trust and safety in their bodies. However, the importance of agency and control in women's experiences of empowerment highlights that care must be respectful and collaborative. Young (1984) noted that while pregnancy may counteract alienation, medicalisation may re-enforce it. My findings similarly suggest that embodied healing needed to be facilitated by care that respected women's autonomy and treated them humanely. As outlined in Study 2, creating this safety was more than saying women had choices or asking for consent; it was about communicating a deep respect for women’s autonomy, humanity and experiential, embodied knowledge. Although care that encouraged women to connect with their bodies could facilitate embodied and relational healing, women often experienced care within a dehumanising system, as will be explored later in this chapter.

It is essential to consider healing experiences in the context of broader narratives about sexual violence and motherhood. Kukla (2008) warns against fuelling romanticised views of motherhood, such as those that position (primarily White, middle-class) ideas of a 'good' birth as "maternal achievement tests" (p. 74) and label (often socially marginalised) mothers whose experiences deviate from these norms as failures. For some survivors in my research, aspects of pregnancy, birth, and motherhood were incredibly empowering and rebuilt trust and safety in their bodies and others. However, it is also important to recognise that events that participants described as 'empowering' experiences fit with White, middle-class ideals of 'good' mothers and 'good' birthing bodies (Chadwick, 2017). For instance, many participants became pregnant in the context of a committed, long-term heterosexual relationship and often had a relatively uncomplicated vaginal birth. Women felt shame when their bodies did not fit these ideals, such as if they had medical intervention or experienced distress during pregnancy, birth or early motherhood. It is therefore critical that while the opportunities for healing are acknowledged, they are interpreted in the context of powerful, dominant cultural norms that may also 'other' and shame mothers whose experiences do not align with expectations.

9.2.2 Survivor mothers experienced silencing on multiple levels

Like Herman (1997), Sweeney et al. (2019) argued that “to experience sexual violence and abuse is to experience silence” (p. 598). In a narrative model of recovery, to begin healing from sexual violence, survivors must have the language to name and understand their experiences of violence (Brison, 2002; Herman, 1997; Kelland, 2012b). However, Herman (1997) notes that sexual violence is considered unspeakable in society, preventing survivors from acknowledging the violence. Therefore, narratively understanding their experiences may not be available to many survivors. The unspeakable nature of sexual violence prevents women from telling their stories or having their experiences heard and understood by others, even if they are aware of them (Herman, 1997). In this section, I will explore how this contradiction manifested in services and shaped women’s experiences of them. I will also consider how the silencing of sexual violence survivors intersected with silencing surrounding motherhood.

In my research, sexual violence was shrouded by misunderstanding and misconceptions. Study 1 emphasised the invisibility of sexual violence in healthcare services and that many survivors did not have the language to name their experience as violence. Similarly, many survivors in Study 2 had not acknowledged their experiences when they were pregnant and did not expect their experiences of sexual violence to impact their experiences of pregnancy, birth, motherhood and maternity care. In Studies 1 and 2, even when survivors did acknowledge their experiences, many still felt unsafe to disclose in the absence of a trusting relationship with providers. Some were met with silence, dismissal or judgement when they did disclose, signalling the high risk of re-traumatising responses to disclosure. For some survivors in Study 2, trauma-related memories or feelings emerged during pregnancy and birth but remained unacknowledged, unspoken or unheard due to fear, shame or misunderstanding. Providers in Study 3 described numerous barriers to identifying and responding to sexual violence survivors' needs in maternity care, including colleagues' lack of awareness about trauma, the threat of safeguarding referrals, and working within a system that prioritised efficiency over empathy. It is important to highlight that even if providers implemented trauma-informed principles, factors outside providers' immediate control or knowledge could still impede disclosure. For instance, some survivors did not consciously remember the abuse, as was the case for some women in Study 2 (see also Montgomery, 2013).

Although such factors are outside individual providers' control, many barriers to disclosure were created, facilitated and perpetuated at the system level. For instance, the review (Study 1) found that women may not disclose for fear of losing children, even if they have a regular and trusted provider. Survivors in Study 2 reported that fear of social care intervention and safeguarding referrals kept them silent (or resulted from disclosure, as in the case of one survivor in Study 2). Providers in Study 3 noted that inappropriate safeguarding referrals might be made in response to disclosures based on stereotypes about survivors being vulnerable and unable to protect their children, especially without appropriate education and support in place for providers. Wider literature also finds that societal misunderstanding of sexual violence permeates healthcare systems and healthcare provision and contributes to silencing (LoGiudice, 2016; Montgomery, 2012, 2013a). This pervasive misunderstanding of sexual violence and culture of fear has been highlighted as important barriers to disclosure in research with childhood sexual abuse survivors also (Montgomery, 2013; Montgomery et al., 2015a).

Illustrating the unspeakable nature of sexual violence (Herman, 1997), survivors across studies 1 and 2 rarely felt safe to disclose unless they were directly, gently and sensitively asked. They often needed providers to initiate the topic. Both Montgomery (2013) and Korab-Chandler et al. (2022) found that women needed conversations to be initiated by providers and that survivors found it difficult to disclose violence themselves. In line with previous research on intimate partner violence, the survivors in Studies 1 and 2 did not necessarily experience sensitive and empathic enquiry negatively, even when they were not ready to disclose (Feder et al., 2006a; Korab-Chandler et al., 2022). Korab-Chandler et al. (2022) concluded that having enough time to talk, using straightforward language, and asking questions about violence more than once, over a period of time, was key to signalling that providers are trustworthy and that it is safe to disclose. Although providers could facilitate survivors' narrative understanding of their experiences by inviting conversations about violence experiences, my research found multiple barriers to enquiry. Providers in Study 3 highlighted that providers may avoid asking about experiences of violence for fear of offending women because they feel unequipped to respond to a disclosure or due to fears of further harm caused by inviting a disclosure in the absence of systemic support to respond. Similar barriers have been reported in research examining midwives' responses to intimate partner violence (Siller et al., 2022). Providers identified that personal commitment and lived experience were key enablers of enquiry, supporting other research that finds lived experience as an important resource for empathy, confidence and knowledge (de Klerk et al., 2022a).

My research (primarily Study 2) found that the silencing of sexual violence intersected with the silencing of motherhood in complex ways. In addition to the cultural silencing of sexual violence, the societal expectations and pressures placed on mothers created additional barriers to voicing the trauma at a time when survivors could be experiencing greater distress. Before I explore this, it is important to first unpack the findings that indicate that some survivors may experience distress during the perinatal period. For these women, the physical and personal transformation of becoming a mother could also uproot embodied trauma and trauma-related memories (e.g., flashbacks) and feelings (e.g., shame, being controlled) that emerged during pregnancy, birth and early motherhood (see the theme ‘Something weird and wrong’ in Study 2). Although noting that survivors may experience distress during the perinatal period is not a new finding (e.g. Halvorsen et al., 2013; Montgomery, 2013; Montgomery et al., 2015a; Sobel et al., 2018), authors have generally explained this by noting that the physical changes and sensations of pregnancy, such as loss of control, may feel similar to those of sexual violence (e.g. Halvorsen et al., 2013; LoGiudice, 2016). However, my findings suggest a more nuanced, complex relationship between becoming a mother and the re-emerging of traumatic memories.

In my theoretical framing of survivors as embodied, relational subjects (e.g., de Beauvoir, 1949/2011; Merleau-Ponty, 2004; Sartre, 1956), becoming a mother shifts and changes a person’s embodied sense of subjectivity in fundamental ways (Woollard, 2021; Young, 1984). This framing suggests that this deeply embodied transition may erode the protective barriers that separate a survivor’s traumatic memories from her conscious, subjective experience. Herman (1997) also noted that significant life transitions could uproot trauma through breaking down a survivors' coping mechanisms. However, my findings develop this insight further by considering how the *embodied* - not just social - nature of this transition may intersect with the embodiment of trauma (e.g., see Van der Kolk, 2014).

Seeing embodied subjects as both socially and historically situated also highlights the importance of recognising that female reproduction is linked to the control and oppression of women (Holmes, 2016; Simonds, 2022). For instance, de Beauvoir (1949/2011) noted that pregnancy might, for some women, be experienced as an invasion or label that strips them of their identity. Considering experiences of distress through such social, embodied and historical lenses highlights that relationships between traumatic memories re-emerging during the perinatal period and the embodied transition of becoming a mother are complex. Young (1984), noted that the embodied experience of pregnancy and birth could bring women closer to their *bodies*, my findings suggest that pregnancy and birth may bring women closer to their *embodied experience of trauma*. Interpreting my findings within an understanding of pregnant and birthing women as embodied, situated agents develops theoretical understanding in relation to why and how traumatic memories may emerge during the perinatal period, and what this may mean for survivors.

My findings suggest that rather than seeing pregnancy as a trigger it may be more helpful to consider instances of trauma memories re-emerging as an opportunity. Although remembering these experiences may be distressing, it may also offer an opportunity for the trauma to be acknowledged, voiced and heard (Herman, 1997). However, these experiences are remembered within a society that considers stories of sexual violence unspeakable (Herman, 1997), and my findings show that motherhood may create an additional layer of silencing for survivors. Experiences of motherhood that did not align with the “romanticised imagery of new mothers and babies triumphantly awash in flowers, breast milk and champagne” (Johnson, 2010, p. xi) were also considered unspeakable (e.g., as described in the theme ‘Something weird and wrong’ in Study 2). Survivors may also experience additional judgement due to misconceptions about sexual violence survivors being vulnerable (Study 2 and Study 3). If women and pregnant people lived in a society in which they were allowed to speak about difficult experiences of pregnancy, birth or motherhood without being labelled as bad, selfish, ungrateful or even ‘mad’ (Sweeney & Taylor, 2021), these 'triggers' may instead become critical turning points for women to remember, acknowledge and begin to narratively understand their experiences (Brison, 2002; Herman, 1997; Kelland, 2012b).

9.2.3 Medicalisation mirrored the dehumanisation and silencing of sexual violence

In my research, dehumanisation lay at the heart of the re-traumatising experience of maternity care. The reductionism of medicalisation compounded the silencing and dehumanisation of sexual violence. In my thesis, I conceptualised medicalisation as an active *process* “in which birthing bodies materialise as medical objects, birth becomes a medical event, technology is valorised over embodied knowledge and the social and personal significance of birth is erased” (Chadwick, 2018, p. 27). In Chapter 2, I argued that an individualistic focus on survivors 're-experiencing’ trauma during pregnancy, birth, and maternity care could overshadow or obscure ways the maternity care system may mirror the silencing and dehumanisation of sexual violence. In Chapter 3, I showed how my theoretical framing of women as embodied, situated agents allowed me to place individual experiences of care, re-traumatisation and distress in their wider social and historical context (e.g., ideas about ‘valid’ knowledge). In this section, I will consider how health and maternity care systems that pathologised sexual violence and medicalised pregnancy harmed survivors by mirroring the dehumanisation and silencing of sexual violence.

Dehumanisation was key to experiences of re-traumatisation and occurred both due to the pathologisation of sexual violence and the medicalisation of pregnancy. Both survivors and providers across Studies 1, 2 and 3 described that reductionism and medicalisation underpinned dehumanising approaches to care. A prevailing biomedical model devalued women’s experiential, embodied knowledge, privileging providers' voices and their 'professional’ knowledge. This left no room for individual needs to be heard, widened power divides between women and providers, and facilitated behaviours that mirrored the coercion, violation, and dehumanisation of sexual violence. Both survivors and providers described the medical voice as a powerful voice that had the strength and force of an entire system behind them, upheld by procedures, protocols and checklists. The system gave them authority in encounters that were difficult to challenge. In Study 1, women reported feeling invisible and silenced because of a healthcare system that reduced sexual violence to a disease or a symptom, which could be 'treated' or ignored if it did not fit with provider conceptualisations of survivors’ difficulties. Women felt dehumanised when mental health diagnoses such as borderline personality disorder were used to dismiss their experiential, embodied knowledge and own understanding of their needs (Study 2). Similarly, Filson (2016) describes how, when survivors are told that only their mental health diagnosis matters, providers become “another perpetrator” (p. 21).

Survivors in Study 2 reported that they were also re-traumatised in environments where they were reduced to their bodies and objectified, disrespected, humiliated, and silenced. Women were reduced to a body due to instances of coercion, such as unconsented examinations, manipulation or threats, as well as more subtle experiences, such as feeling devalued and dehumanised by the maternity care system. Such experiences are widely reported in research on maternity care and sexual violence (e.g., Montgomery, 2013). For instance, Halvorsen et al. (2013) found that when women felt reduced to a “birth machine” (p. 186), this mirrored the objectification, violation and degradation they had experienced during sexual violence. Importantly, my research has similar themes to traumatic birth (e.g., Leinweber et al., 2022) and obstetric violence (e.g., Chadwick, 2017) fields. Chadwick (2017, 2018) highlights ways in which women and birthing people’s humanity is erased in care and Leinweber et al. (2022) noted that dismissive, disrespectful interactions with providers were at the heart of traumatic experiences. Similarly, Reed et al. (2017) reported that women felt distressed when maternity care providers prioritised their agendas over women's needs, dismissed women's embodied knowledge in favour of the care provider's clinical assessments, and used lies and threats to coerce women into complying with procedures. This highlights the fundamental importance of understanding survivors’ experiences within wider issues of mistreatment in maternity care.

Placing my findings within this wider literature on mistreatment in maternity care suggests that dehumanisation may be more important to understanding some experiences of re-traumatisation than individualistic concepts such as ‘control’. As I discussed in Chapter 2, research in this field often argues that (loss of) control underpins re-traumatising experiences of pregnancy, birth, motherhood and maternity care (e.g., see LoGiudice, 2016 and Montgomery, 2013 for reviews). For example, the conclusion in LoGiudice's (2016) review uses language firmly located within individualistic ways of understanding distress:

> Overall, this review has shown that *lack of control, dissociation, and flashbacks* were themes commonly reported by women regarding their childbearing experiences. Re-experiencing of the trauma occurred during various stages of labour and birth and was re-traumatising to survivors. Often, common procedures associated with labour and birth, such as vaginal examinations and pushing during the second stage of labour, were triggers for survivors; however, it is important to note that less commonly thought of triggers, such as having an epidural, were also reported (p. 591).

Such accounts cannot explain why some survivors may find the loss of control during pregnancy or birth healing; for instance, when they experienced an altered state of consciousness and allowed their bodies to 'take over' (Study 2; see also McKenzie & Montgomery, 2021). My findings emphasise that losing control due to aspects of pregnancy and birth was qualitatively different to providers taking control away. While the former could be distressing (but not always), the latter represented yet another person who violated a survivor's autonomy and disregarded her consent.

For instance, consider the sub-theme 'Healthcare mirroring abuse' (Study 1). For some survivors, a forensic medical examination felt like another attack on the body, whereas others felt empowered. Survivors felt violated when they felt reduced to a site of evidence collection or had their feelings of fear, devastation or extreme distress dismissed by uninterested, emotionally distant providers. In Study 2, the 'I was just a body' theme intentionally names the dehumanisation that underpinned experiences of violation, silencing and re-traumatisation. What was so deeply distressing was the erasure of the woman's humanity, by people she should be able to trust, in a setting where she should feel safe and supported. Women thus felt violated when they felt reduced, dehumanised, and objectified, and the invasiveness of care did not necessarily shape this. Like instances of sexual violence, it was therefore essential to recognise that control was not merely and passively lost; it was actively taken (Cahill, 2009, 2011). Like many instances of sexual violence, control was not necessarily taken through direct, physical violence but often more hidden, subtle modes of power were at play, such as medical power (Chadwick, 2017). My findings suggest that, in these instances, loss of control may be better seen as a *symptom*, whereas the erasure, attack or disregard of a women's humanity is the root cause.

Although it is crucial to recognise unique and distressing challenges that sexual violence survivors may face during the perinatal period, my focus on system harms challenges the tendency for existing literature to assume survivors' distress during maternity care is due to their trauma alone (e.g., Sobel et al., 2018). My work rejects assumptions that care is appropriate by virtue of being "common" (e.g., LoGiudice, 2016, p. 591) and that healthcare is an inherently benevolent context (Shabot, 2021). Chadwick (2017) similarly argued that conceptualisations of obstetric violence need to go beyond isolated acts involving individual agents, and that we must understand obstetric violence as rooted in inequities due to class, gender, race and medical power. In other words, instances of obstetric violence cannot and should not be understood in isolation from their social, cultural and systemic context, and research with sexual violence survivors should be no exception. Understanding the systemic roots of such harms shifts shame and blame from all individuals - both survivors and providers (Chadwick, 2021a) - and aligns more closely with trauma-informed approaches (Sweeney et al., 2018).

Linking my findings with theoretical and conceptual literature on the ways in which sexual violence harms women suggests potential mechanisms behind why being dehumanised may be particularly distressing for survivors. In Chapter 3, I discussed Kelland's (2011) conceptual analysis of sexual objectification in which they developed the work of Nussbaum (1999), Bartky

(1990), Cahill (2009) and Langton (1995). Kelland (2011) showed that sexual objectification creates a ‘threat’ of rape and that, therefore, rape may be best understood as “a threat fulfilled” (Cahill, 2001, p. 162; Kelland, 2011). Kelland (2014) argued that to experience sexual violence is “to have one’s personhood threatened *in virtue of one’s sex*" (p. 2783, emphasis added). In my research, the objectification and dehumanisation of women in the maternity care system were facilitated by norms of femininity and medical power that shaped expectations of 'good patients', 'good women' and 'good mothers'. For instance, the Study 1 sub-theme, 'Intersecting power imbalances,' and Study 2 themes, 'Something weird and wrong' and ‘I was just a body’, considered these intersections. The maternity care environment, even without direct, physical 'violence', could thus mirror the deeply gendered ways that sexual violence attacks subjectivity and personhood. Developing Kelland (2011)'s work suggests that the reductionism of medicalisation may feel partially similar to the dehumanisation of sexual objectification and sexual violence. Being dehumanised in care may therefore be especially distressing for survivors of sexual violence, who have previously experienced the ‘threat’ of sexual objectification fulfilled (Cahill, 2001; Kelland, 2011).

These findings contribute knowledge that is important to implementing system-wide trauma-informed principles in maternity care (Sweeney et al., 2019). Existing studies have noted (1) links between sensations of pregnancy, birth or breastfeeding and those of sexual violence (e.g., Montgomery, 2013) and (2) ways that mistreatment, violence and abuse in maternity care may mirror the violation of sexual violence (e.g., Halvorsen et al., 2013). However, situating my findings about dehumanisation within broader feminist conceptual literature on objectification (Kelland, 2011) suggests that (3) medicalised maternity systems predicated upon reductionism may harm sexual violence survivors by mirroring the objectifying, dehumanising, degrading and silencing nature of sexual violence, *even in the absence of (1) and (2).* This suggests that system-wide transformation is needed to provide the care that survivors need; educating or training individual providers is not enough to create sustainable, lasting change (Sweeney et al., 2018).

My research also develops feminist arguments that medicalisation may turn a potentially empowering pregnancy and birth experience into a traumatic one (Davis-Floyd, 1992; Kitzinger, 1984; Martin, 1987; Oakley, 1980; Rothman, 1982). My findings support Young's (1984) theoretical work on pregnant embodiment, where she noted that medicalisation may lead to alienation reducing women to parts and devaluing their experiential, embodied knowledge. Alienation is a well-established concept in understanding women’s responses to sexual objectification (e.g., Young, 1983), but Kelland (2011) also argued that alienation may partially explain how sexual violence harms women. Alienation, therefore, appears to be central to both sexual violence and the medicalisation of pregnancy and birth. However, my findings also highlight that medicalisation and medicine differed, and that "one can desire medicine without desiring medicalisation" (Garry, 2001, p. 262; see also Chadwick, 2018). Women in my study valued medical intervention when they understood why it was offered, were given options, were involved in decisions, and were treated with humanity. For instance, consider Maya's case study in Study 2, which illustrated the difference between a traumatic and re-traumatising experience of an emergency C-section. For Ava, in Study 2, an elective C-section gave her an option to birth in a way that she felt would be less psychologically traumatic for her. However, some survivors felt shame at having 'failed' at birth because they had medical intervention. Therefore, relationships between medical intervention, choice, shame, and re-traumatisation appear to be complex and worthy of further exploration.

9.2.4 A medicalised system prevented the delivery of trauma-informed care.

Providers in this study felt personally motivated to support survivors and demonstrated a commitment to addressing violence in their work. In other words, they were personally ready to address sexual violence. They described maternity care as a "window of opportunity" to intervene. Creating and embodied and relational safety for survivors was personally important to them. A recent systematic review found that having a commitment facilitated by lived experience or a social justice-based belief system was vital to providers advocating for and being allies to survivors (Hegarty et al., 2020). Hegarty and colleagues (2020) highlighted that an essential first step for personal readiness was that healthcare providers saw the clinical setting as an ideal place for this work. The providers in this study certainly demonstrated personal readiness to address sexual violence, yet they felt constrained and frustrated by the system in which they worked. In this section I will explore how this tension shaped the care that providers were enabled to deliver and how these findings provide support for trauma-informed approaches.

Both survivors and providers understood experiences of dehumanisation and disempowerment in maternity care to be partially rooted in systemic and structural factors. Most women in Study 2 and the providers in Study 3 reported experiencing or witnessing obstetric violence, including unconsented vaginal examinations and other invasive interventions, and using threats and force to coerce women into complying with care (Chadwick, 2017; Garcia, 2020). Survivors in Studies 1 and 2 valued interactions with kind, respectful and reflective providers; such interactions could restore a sense of humanity and trust at a critical time. However, survivors and providers across all studies noted that trauma-informed interactions were the exception rather than the norm, and were experienced within a dehumanising, unpredictable system (e.g., the theme 'it's about so much more than just saying it' in Study 2, and ‘caught between women and the system’ in Study 3). Biomedical dominance (and reductionism) prevented the connection and validation that was so important for healing (see Brison, 2002; Herman, 1997; Sweeney et al., 2019). Similarly, another study found that mental healthcare providers who want to provide trauma-informed care can feel constrained and frustrated by systems not designed to meet survivors' needs (O'Dwyer et al., 2019). A qualitative study with midwives found that they felt “stuck between two philosophies” (Rice, 2013, p. 1056). This tension was created by midwifery’s aim to provide women-centred, individualised, strengths-based care, and the realities of working within a medicalised system. Although it is also important to note that some providers will not be receptive (O’Dwyer et al., 2019), my findings highlight important points of difference between biomedical and trauma-informed priorities.

By highlighting these tensions between women's and the system's priorities, my findings develop theory underpinning trauma-informed approaches and support implementing trauma-informed approaches in maternity care. My findings support trauma-informed approaches by recognising that healing could be facilitated without a need for disclosure but that a dehumanising system prevented the long-term relationships and trust-building needed to facilitate healing and avoid re-traumatisation (Sweeney et al., 2018). As discussed in Chapter 3, trauma-informed approaches require system-wide transformation and prioritise relationships (Sweeney et al., 2018). Therefore, individual providers do not implement trauma-informed approaches, although providers may practice in line with trauma-informed principles even in "trauma-uninformed" systems (Sweeney et al., 2018, p. 319).

Providers also highlighted personal resources that allowed them to implement trauma-informed principles, and lived experience was a particularly important source of empathy and confidence. Survivor providers in my research reported that their own experiences of violence helped them to identify violence (for instance, by being curious and listening for hints or suggestions rather than direct disclosures) and to respond (as they knew on an intuitive level that the most important response was to ensure that a survivor felt heard and cared about). Similar findings, that lived experience helps providers to identify and respond to gender-based violence, have been reported in other research. For example, research has been conducted with midwives who had experienced sexual violence (de Klerk et al., 2022; Garratt, 2018a), healthcare providers who had experienced domestic violence (McLindon et al., 2019), and primary care providers who had experienced trauma (Candib et al., 2012). Taken together, research strongly suggests that lived experience may empower providers with confidence to address sexual violence in their work (Candib et al., 2012; de Klerk et al., 2022).

I have previously argued that experiencing interpersonal violence and abuse is an epistemically transformative experience (Carel & Kidd, 2020; Paul, 2014). Such experiences give people access to (experiential) knowledge they could not have gained through other means. Theoretically, my findings develop this concept, applying it to maternity care providers, lending support for trauma-informed and survivor researcher arguments that experiential knowledge is a powerful, valuable form of knowledge (Sweeney et al., 2009). However, although providers in my research felt ready to address sexual violence in their work, many felt caught between women and the (trauma-uninformed) system. As I will explore next, this impacted their well-being and safety at work.

9.2.5 Working in a trauma-uninformed system led to vicarious trauma, moral injury and burnout among providers.

As discussed in the previous section, conflicts between women's and system priorities limited the ability of providers in my research to deliver trauma-informed care. In this section, I will explore the personal impact of negotiating this conflict on them. Despite high violence prevalence rates among healthcare providers - especially female healthcare providers (McLindon et al., 2018, 2019, 2022) - there are few examples of in-depth qualitative studies with maternity care providers about their experiences or needs. Existing research has focused on intimate partner violence and on healthcare providers more generally (e.g., Hudspeth et al., 2022; McLindon et al., 2021; Tarzia et al., 2019a, 2019b), and none have been conducted from an explicit survivor standpoint. Even fewer qualitative studies have been conducted with maternity care providers who are themselves survivors of violence (but see Garratt, 2018; Montgomery, 2012 for exceptions). Maternity care is an ethically complex setting in which autonomy and consent is at risk of being disregarded (Kingma, 2021). In addition, maternity care providers in the UK work within a dangerously under-funded and short-staffed system (Department of Health and Social Care, 2022) and in complex, high-risk settings where they are exposed to traumatic professional events (Pezaro et al., 2016). Motherhood is also a highly complex transition in a person's life, and a time where women are subjected to multiple and sometimes conflicting pressures and expectations (Woollard, 2021). The dearth of research focusing on maternity care providers' needs is therefore concerning for the future implementation of trauma-informed approaches in maternity care. Providers' specific structural support needs be addressed on a system level for change to be both possible and sustainable (Sweeney et al., 2018). My research therefore fills an important gap in understanding of maternity care providers' specific experiences and needs, providing information that may support the implementation of trauma-informed approaches in maternity care settings.

Herman (1997) argued that no one can face trauma alone and the World Health Organisation has argued that for providers to provide women-centred care, they need to be supported by the health system (García-Moreno et al., 2015). In my research, providers felt a significant individual burden of responsibility to provide restorative, trauma-informed care to women. However, the lack of systemic support led to exhaustion, guilt and emotional distancing. Constantly negotiating this tension between system priorities, women's priorities and providers' values negatively impacted providers' well-being. Providers have a right to be protected from the exhaustion that results from bearing witness to trauma without appropriate support and from the erosion of self-worth caused by working within a harmful system (Sweeney et al., 2016). Trauma-informed approaches, therefore, argue for providing provider support at every level of the system (Sweeney et al., 2009). They also highlight that working in a trauma-uninformed system risks burnout, vicarious trauma and moral injury (Sweeney et al., 2018). Vicarious trauma is when providers become traumatised when working with trauma without support (Dunkley & Whelan, 2007), and moral injury is when providers feel they have not done enough to prevent suffering or actively participate in delivering harmful care when structural support is absent (Čartolovni et al., 2021).

As providers in my study often lacked systemic and structural support, they sometimes had to participate in care practices that they knew were harmful to protect themselves. For example, the providers in this thesis reported feeling exhausted and needing to emotionally distance themselves to cope with the emotional demands of the job. Similarly, a qualitative study found that midwives needed to "continue to function within the system" to protect themselves, and this need prevented them from responding to survivors’ needs (Montgomery, 2012, p. 277). As detailed in Study 1 and Study 2, the lack of empathy and responsiveness that can result from emotional distancing may lead survivors to feel dehumanised. Participating in a damaging system therefore significantly impacted providers' well-being at work, especially when they understood the impact that dehumanising and disempowering care could have on a survivor. In Study 3 (interviews with providers), maternity care providers reported feeling deeply disturbed at witnessing obstetric violence, including unconsented vaginal examinations. Maternity care providers' exposure to multiple sources of trauma has also been found in other research (Oliveira & Penna, 2017). My findings, therefore, support Dean et al.’s (2019) argument that health systems must address the moral injury caused by working in a broken system that prioritises efficiency (through reductionism) over relationships.

McLindon et al. (2021) noted that a trauma-informed health system promotes healing for both women *and* provider survivors. Seeing providers as human beings whose own life experiences, values and beliefs shape their emotional responses is critical to trauma-informed approaches (Esaki et al., 2018; Sweeney et al., 2018). Trauma-informed approaches also recognise the prevalence of trauma among staff (Sweeney et al., 2018). The providers in this thesis challenged assumptions that ‘survivor’ and ‘healthcare provider’ identities are mutually exclusive, supporting findings that this dichotomy creates additional barriers for providers to seek support and perpetuates unhelpful myths about survivors' vulnerability (Donovan et al., 2021). In the previous section, I discussed that my research found that lived experience can be a critical source of empathy, confidence and knowledge that providers could use in their work (see also de Klerk et al., 2022; Hegarty et al., 2020). However, working within a system that disempowers both service users and staff might impact survivor-providers more deeply, precisely because they may be able to connect to the harms caused by such experiences of dehumanisation and silencing. Therefore, to sustainably draw on their experiential knowledge without burning out, survivor-providers' experiential knowledge should be nurtured, supported, and celebrated on a structural level.

9.2.6 Situating my contribution to knowledge within my survivor standpoint

No other study in this field, to my knowledge, has been conducted from an explicit survivor standpoint. Indeed, survivor involvement was absent from all except one study in my systematic review (Chapter 6), and this study was located in grey literature. Other authors have also found that survivor involvement in violence and abuse research is poor (e.g., Kennedy et al., 2022). I argued in Chapter 1 (Introduction) and Chapter 4 (Methods) that conducting research from an explicit survivor standpoint produces a different kind of knowledge – one borne out from lived experience (Beresford, 2005). The experiential knowledge held by survivor researchers may lead to more ecologically valid research (Faulkner & Thomas, 2002). My explicit survivor standpoint also challenges dominant positivist assumptions that exclude survivor voices from both research and service delivery (Sweeney et al., 2009). In-depth, interpretive, and trauma-informed qualitative research with high survivor involvement is incredibly important (yet scarce). However, I follow Rose's (2017) argument, which draws on feminist standpoint theory (Harding, 2004) to explain that explicitly sharing a (stigmatised, silenced and marginalised) *survivor* identity with my participants differentiates my research topic, my approach and my findings from even in-depth, trauma-informed qualitative research. Below, I consider some examples of this.

In Chapter 3, I argued that locating trauma within a person's mind is influenced by Cartesian dualism where the thinking 'mind' is assumed to be separate from the natural 'body'. My theoretical framework focused on embodiment. I considered the embodied, situated nature of trauma, motherhood and of subjectivity. My theoretical framing therefore rejects dualist assumptions that separate the individual experience of trauma (i.e., the mind) from the situated, material body, and the meanings that this body (and person) is imbued with by the world. Throughout this thesis I critiqued the tendency for existing research to separate individual (largely negative) experiences (e.g., re-living trauma responses or experiencing ‘triggers’) and needs (e.g., control), from historical, cultural and societal beliefs that shape ideas about ‘good’ survivors, women, mothers, and maternity care. Feminist scholars writing on obstetric violence have similarly argued that a focus on individual agents (i.e., women, birthing people or providers) or needs (e.g., choice) obscures the systemic and structural modes of harm that remain normalised, hidden and invisible (Chadwick, 2018). Focusing on system harm is important to survivors. For instance, a survivor-led consultation identified “structural and systemic injustices” as a key research priority (Robotham et al., 2019, p. 6). My approach, whereby I focus on system harm, is shaped by my unique epistemological position as a survivor researcher. This framing shaped my findings, such as my focus on *reciprocal* trust in the review. While it is often recognised that survivors may find it difficult to trust providers (e.g., Sperlich et al., 2017), the responsibility of providers to *signal* they are trustworthy is less often acknowledged (but see Korab-Chandler et al., 2022).

My findings on healing opportunities and experiences make an important contribution in a field dominated by a focus on re-traumatisation (e.g., see Montgomery, 2013). There is a tendency for research to focus on re-experiencing and re-living trauma and to position pregnancy, birth, aspects of motherhood and maternity care as triggers (e.g., see LoGiudice, 2016). In my systematic review (Study 1), I found two other studies that explored experiences among adulthood sexual violence survivors, neither Halvorsen et al. (2013) nor Sobel et al. (2018). Although Sobel et al. (2018) note that women may find breastfeeding healing, neither explored healing opportunities in-depth. Healing was also the smallest theme in Montgomery (2013)’s synthesis and largely influenced by just one study (Lasiuk, 2007). It is important to allow for both healing and harmful experiences in research to counter singular, one-dimensional narratives about ‘vulnerable’ survivors. For instance, the survivor-led ‘Turning Pain into Power Charter’ (Perôt et al., 2018) advises that those engaging survivors “enable people to describe the full range of their experiences of abuse and recovery, both helpful and unhelpful” (p. 4). In my research, I took care to represent the full range of experiences that survivors could have so as to remain sensitive to survivors’ own understandings of their experiences and how they wanted these represented.

9.3 Strengths and limitations

9.3.1 Strengths

Trauma-informed approach and survivor standpoint

This research was strengthened by the trauma-informed approach and survivor standpoint that underpinned it. Despite partnership working and listening to survivors being essential to trauma-informed approaches (Sweeney et al., 2018), trauma-informed ethics and survivor involvement was poorly reported or non-existent among the studies included in the systematic review (Chapter 6). The explicitly survivor-led and trauma-informed approach taken in my research was therefore a significant strength. Brunner (2019) argued that research with survivors must address the underpinning mechanisms and ingrained cultural beliefs that drive social injustice, including “who and what is ‘normal’; who and what is seen as rational; who is seen as valuable; who has the power to define and determine ‘illness’ or ‘disorder’ and how it should be treated” (p. 201). My explicit survivor standpoint and theoretical framing of subjectivity as embodied allowed me to link my research findings to assumptions about what or whose knowledge ‘counts’ in maternity care (Chapter 3). For instance, I identified subtle, hidden ways that the silencing and dehumanisation of sexual violence may be re-created in maternity (e.g., through medicalisation; see section 9.2.3). In so doing, my work challenged deeply ingrained beliefs that lead to the systemic denial or exclusion of experiential and embodied knowledge in both research and services (Fricker, 2007; Slade & Sweeney, 2020). My survivor standpoint shaped the way I conducted all aspects of this research. Table 13 lists the trauma-informed principles outlined in the Survivors Voices Charter for Engaging Survivors and describes how I applied the principles in the research.

Table 13. How I put each principle from the Survivors Voices Charter into action (Perôt et al., 2018).

Dynamics of abuse	Principles for meaningful engagement	How I put these principles into action
Abuse is inherently unsafe. It leaves a long legacy of fear.	**Safe**. Engagement should be in a safe environment that begins with providing attentive listening and connections that are warm, collaborative and relational, which recognises and minimises triggers and may include safety protocols.	My experience and training working with survivors on the helpline taught me to foreground empathy in every interaction. I shared with survivors that I was also a survivor, to indicate that I came from a place of understanding and wanted to achieve a social justice aim. I created a safety protocol for interviews. I did not ask about experiences of sexual violence as this was not necessary for the purposes of the research and I reassured participants that they would not be asked for details about abuse or violence experiences. I collaborated with a survivor-led organisation to run the public engagement workshops to address power imbalances that may arise due to my association with a university.
People who are abusive dominate and take away personal power.	**Empowering**. Engagement should be collaborative and must empower	Women and providers were encouraged to review their transcripts and change and amend details if they wished. I checked with women and providers at the end of interviews whether they wanted me to omit any details

	survivors to have control of decisions about their involvement.	from the transcript. I offered all providers the choice for me to transcribe their interview instead of a transcription company (all survivor interviews were automatically transcribed by me). Survivors were asked to choose their pseudonym. I offered survivors a number of ways to participate in the public engagement workshops.
Abuse is silencing.	**Amplifying the voices of survivors.** Engagement should help release and amplify survivors' voices, experiences and expertise.	I engaged survivors from the study conception all the way through to dissemination. Survivors self-identified for the research – I did not use screening tools that position researchers as the expert. The public engagement workshops allowed me to check my survivor study findings and these workshops also influenced the final findings produced. Feedback from women indicated that they felt heard and valued in the workshops. I used a narrative approach in the survivor study that encouraged survivors to tell me about their experiences in a way that made sense to them. I empathised with and validated participants' feelings during interviews. I reassured survivors that they were welcome to speak about experiences of violence and abuse if that felt helpful and that I was ready and able to hear these experiences

		(because survivors may avoid talking about abuse to protect others).
Abuse is self-negating, destroys self-worth and damages wellbeing.	**Promoting self-care.** Engagement in research activism can impact coping mechanisms – thus radical self-care should be normalised by example, as well as in organisational processes.	I attended regular reflective supervision led by a clinical psychologist as well as my own personal therapy. I shared support resources with survivors and offered to talk through them if helpful. The public engagement workshops included trauma-informed yoga and I gave everyone a self-care kit with sensory items such as herbal tea, essential oil balm etc. I also felt it was important to recognise that the burden of care should not lie only with women. Peer support was offered through a survivor-led organisation during and after the public engagement workshops.
Abuse is hidden, and abusers often act with impunity	**Accountable and transparent.** Engagement with survivors must have clear lines of communication and accountability. Processes and decision making should be relational, honest, real, transparent and open to feedback and dialogue.	I was transparent with survivors about our shared identity and my motivations for doing this research. I communicated about research progress and will share findings with participants in both summary and full versions. I worked with survivors to co-produce artwork that will form part of the dissemination plan of this research. I worked with a survivor-led organisation to organise public engagement workshops.

Abuse restricts and arrests healthy growth, imprisoning people in physical, mental and emotional shackles.	**Liberating**. Engagement should be liberating, dynamic, life-giving, and help survivors experience a sense of possibility and life beyond the aftermath of abuse. Engagement should be a voluntary process and easy to withdraw from at any point.	Women and providers contacted me if they wanted to take part in the research. I offered all participants an informal chat about the research to build a relationship. I let everyone know that they could see and amend their transcript. In my interviews with survivors, I tried to give them the space to tell their story the way they wanted to tell it.
Abuse is corrosive, restrictive and soul-destroying.	**Creative and joyful.** Engagement should be a creative process. Good engagement focuses on positive experiences and strengths, as well as negative ones, and can increase capacity for joy, creativity and imagination.	Findings include the full range of survivors' experiences – both healing and harmful. The public engagement workshops were designed to incorporate creativity and fun and offer a different way to think about abuse and trauma. I thanked all the people I spoke with about the research for sharing their experiences with me. I gave women a thank you grounding kit after the public engagement workshops (shower gel, hand rub, aromatherapy, herbal teas).

Systematic review (Study 1) strengths

Meta-ethnography is one of the most frequently used and influential approaches to qualitative evidence synthesis in health research (France et al., 2014; France et al., 2019b). My approach was rigorous and included a comprehensive and systematic search of a large number of databases (n = 14). Included studies were assessed against two quality assessments: the CASP (CASP, 2018) and COREQ (Booth et al., 2014). I added additional indicators of quality to capture critical aspects of high-quality trauma-informed research with survivors that are not captured in general quality assessment instruments (Hermaszewska et al., 2022; Kennedy et al., 2022). Authors were contacted for further information if it was unclear whether a study met the inclusion criteria. When conducting this review, I referred to Noblit and Hare's original text (1988) as well as numerous worked examples of meta-ethnographies related to qualitative health research (Atkins et al., 2008; Britten et al., 2002; Campbell et al., 2003; France et al., 2019b; Malpass et al., 2009; Sattar et al., 2021). Furthermore, I followed eMERGe reporting guidelines throughout to ensure all phases were reported transparently and robustly (France et al., 2019a; see appendix B).

Another strength of the review was including grey literature and theses. Survivor researchers have argued for the inclusion of grey literature in reviews because this can be where survivor research and survivor-produced knowledge are located (Fleischmann, 2009). As collaboration and partnership working are essential to trauma-informed approaches (Sweeney et al., 2018), to ensure that survivor voices are prioritised in the evidence that guides practice and policy decisions, researchers must ensure that survivor research and survivor-generated knowledge is included in systematic reviews. Although I did not find any survivor-led research, excluding grey literature from my review would have missed the only study including women facing multiple disadvantage and involving survivors in the research beyond merely being participants (Birthrights & Birth Companions, 2019). Furthermore, the theses scored higher on the additional trauma-informed quality criteria I added (see Chapter 6), providing important ethical information.

Survivor study (Study 2) strengths

An unstructured narrative approach to data-collection encouraged survivors to lead the topics to be discussed. This is a strength because, as a recent systematic review highlighted, flexible, survivor-led narrative approaches to data collection as more likely to be empowering, liberating, and to amplify the voices of participating survivors (Kennedy et al., 2022). Such approaches also lead to research where "full experiences and voices are heard, heeded and allowed to have significant impact" (Perôt et al., 2018, p.2). This may be one reason why the findings in this PhD examined a range of experiences – from healing to re-traumatising, unlike most literature related to this topic to date (see a review by LoGiudice, 2016 and a synthesis by Montgomery, 2013). Discussing findings with survivors at public engagement workshops (which included study participants) was another important strength that furthered the trauma-informed, applied aims of the research. As these workshops shaped the final research findings, they could be seen as a form of "member reflection", offering an "opportunity for collaboration and reflexive elaboration", resulting in richer analyses that are hoped to be more meaningful to the people the research is meant to serve (Tracy, 2010, p. 844).

Provider study (Study 3) strengths

Two maternity care providers (with expertise in sexual violence and women's mental health) and a survivor with lived experience of maternity care commented on the acceptability and feasibility of the topic guide. The topic guide was also piloted with one midwife prior to starting data collection. Despite recruiting during a global pandemic, I recruited to target and conducted rich interviews. Reflexive thematic analysis is a robust and sophisticated method of analysis that is able to produce insights that are accessible to key stakeholders, including providers (Braun &

Clarke, 2006, 2020). A further strength of this study is that some providers disclosed having lived experience of violence and abuse, meaning they were able to combine their professional and lived experience and see issues from the perspectives of survivors as well as providers.

9.3.2 Limitations

Missing marginalised voices

Most survivors in Studies 1 and 2 were White, middle-class, heterosexual women, which means that my findings are limited in being able to identify and explore important and often invisible inequities. The voices of minoritised survivors and providers were largely missing from my research due to a mixture of my failure to collect demographic information (see Chapter 5, section 5.3.3), actively seek participants from marginalised communities, or ask participants directly about minoritised and intersectional experiences. This is a significant limitation as maternity care outcomes and experiences are profoundly shaped by women and birthing people's social locations (Toh & Shorey, 2022). For example, maternal mortality in the UK is approximately four times higher for Black women, two times higher for mixed ethnicity women and almost twice as high for Asian women (Birthrights, 2022; Knight et al., 2021). Minoritised survivors are also underserved and overlooked in other systems, including the criminal justice system (McCauley et al., 2019).

In maternity care, medicalisation intersects with racialised and classed norms to create inequities (Chadwick, 2017). Colonial ideas that cast Black women as 'uncivilised', animal and savage like and therefore primed to easily deal with the animalistic, 'natural' process of birth underpins neglectful care practices (Chadwick, 2018; Holmes, 2016) with fatal consequences (Birthrights, 2022; Knight et al., 2021). Providers pathologise some (mostly White, privileged) pregnant and birthing people whilst overlooking, ignoring, and neglecting other (racially minoritised and socially marginalised) pregnant and birthing people (Chadwick, 2018). For instance, Chadwick (2017) found that being poor, Black, young or HIV+ positioned some birthing women as ‘bad’, leading to mistreatment, punishment and silencing from providers. Similarly, Sweeney and Taylor (2021) discuss how White, middle-class, cisgender, heterosexual mothers experiencing mental distress are more likely to be labelled as ‘mad’ but ultimately ‘good’ mothers, whereas deprived, racially minoritised mothers or those mothering outside of dominant cultural norms were more likely to be labelled as ‘bad’, policed, and have their child(ren) removed from their care.

My failure to collect demographic information prevented me from systematically identifying which voices were missed (Braun & Clarke, 2006) and illuminating ways that different race, class, sexual or gender identities may intersect to shape survivors’ maternity care experiences (e.g., see Crenshaw, 1990; McCall, 2005). To partially address this limitation, I provide an overview of what was known about participants’ lives in the ‘Participants’ section in Chapter 7. In terms of marginalised identities, one participant was a Black woman, several participants were young mothers and three participants had experienced extreme mental distress; two of whom received diagnosis of borderline personality disorder (BPD) and one of whom received a diagnosis of psychosis. In the findings, I discuss how these identities intersected with trauma to create further harm and further barriers to sensitive, respectful care. For instance, one woman had her multiple requests to have an elective C-section due to extreme fear of birth dismissed because of her diagnosis of BPD (a label that ‘others’ those given it, through positioning them as dramatic, manipulative and untrustworthy; Stiles et al., 2023); young mothers were dismissed, judged and overlooked because they did not fit normative ideas of ‘good mothers’, and systemic racism shaped disrespectful and dehumanising treatment from staff for one woman. Nevertheless, my findings are limited by the fact that I did not explicitly seek to understand how these identities may shape experiences of intersect with each other, and because most participants were privileged. Therefore, my research reflects a wider problem in violence research where White, heterosexual, middle-class, cisgender perspectives are universalised and other more marginalised perspectives excluded (McCauley et al., 2019).

Conducting online interviews

Some of the interviews in Study 2 (survivor study) and all of the interviews in Study 3 (provider study) were held online due to the COVID-19 pandemic. I did not notice substantial differences in rapport or data quality between the online and face-to face interviews. In fact, conducting interviews online increased access to busy clinical staff, which was especially important during a pandemic. I collected enough data to answer my research questions within the timeframes that I had set for both Study 2 and Study 3. However, the findings of the survivor study should be interpreted in light of the fact that I used different approaches to data collection. I addressed this by outlining the mode of data collection when presenting the findings.

9.3.3 Scope

Systematic review and meta-ethnography (Study 1)

The applicability of the findings of Study 1 (systematic review) are limited to white, young cisgender women survivors living in high income countries. This is due to the low numbers of studies conducted in low- and middle-income countries or focusing on experiences of minoritised survivors. Limiting searches to only English and Dutch may partially explain this. However, this also reflects a wider tendency for sexual violence research to focus on White, middle-class, heterosexual, cisgender women (McCauley et al., 2019). The resulting intersectional invisibility (Purdie-Vaughns & Eibach, 2008) has led to systems, responses and services being designed for women who possess these identities and may fail to address the needs of women who do not (McCauley et al., 2019).

Survivor study (Study 2)

The recruitment materials stated that this study was looking for women who had experienced sexual violence since age 16. As a result, the applicability of the findings is limited to survivors who identified as women and who labelled their experiences as ‘sexual violence’. However, women rarely use the labels of ’rape’ and ’sexual assault’ to describe unwanted sexual experiences (Rousseau et al., 2020) so when such labels are used in research, they may prevent some survivors from participating. Using the term ‘sexual violence’ would have missed survivors for whom language such as ‘unwanted sexual experiences’ may have better fit their understanding. This means that the women who took part in this research may have been further along in their journey towards acknowledging and naming their experiences as sexual violence. Indeed, many women interviewed in Study 2 reported being unaware of their experiences as sexual violence when they were pregnant.

I had planned to recruit survivors from maternity services and a Sexual Assault Referral Centre (SARC). No participants were recruited through these services. Difficulties recruiting through maternity services and SARCs may have arisen because I relied on staff to speak to survivors about the study whilst they were juggling clinical commitments that intensified during the Covid-19 pandemic (my period of recruitment). This unsurprisingly became a greater problem after the Covid-19 pandemic began. The midwives also told me that very few women met the study criteria, potentially reflecting low disclosure rates.

Provider study (Study 3)

Despite efforts to recruit providers with little or no experience of working with survivors of sexual violence, the providers in Study 3 all had a strong understanding of and commitment to addressing trauma, gained through professional or lived experience. Given that providers in this study described tensions working with colleagues who did not implement trauma-informed principles, the findings may not apply to providers who lack both professional and lived experience. This limits the scope of the findings and may have led systemic and structural issues to be emphasised. For instance, after interviewing 40 health professionals working in psychiatric inpatient units about trauma-informed care, O’Dwyer et al. (2019) produced three provider typologies: (1) dismissing and denying, (2) acknowledging but unprepared and (3) empathising but despairing. O’Dwyer’s (2019) found that providers in the first group may dismiss and deny that there is a systemic problem, suggesting that the system may not be seen as ‘broken’ to providers who are not already receptive to addressing sexual violence in their work. Most providers in Study 3 fell into the third group, as most felt prepared to respond to sexual violence but felt limited by (and often despairing about) the system they worked in, and this may explain the importance of systemic barriers and harm in these providers’ narratives.

Three participants were student midwives, and one participant was an obstetrics and gynaecology trainee. These participants had less direct clinical experience than the other maternity care providers, some of whom were working in highly specialist roles. While staff at all levels play an equally important part in implementing trauma-informed approaches and must be appropriately supported (Elliott et al., 2005), it may be helpful to contextualise these participants’ contributions. All had direct experience of supporting sexual violence survivors. Two (out of three) student midwives and the obstetrics and the gynaecology trainee were working in a maternity ward at the time of the interview and were independently seeing service users in a clinical capacity. In addition, the obstetrics and gynaecology trainee had previously worked as a medical forensic examiner and one of the student midwives was a survivor, bringing significant lived experience expertise. The only student midwife who was not working in a maternity ward at the time of the research had extensive experience in the specialist sexual violence sector. This placed her in a unique position to compare approaches between specialist sexual violence organisations and maternity care services e.g., safeguarding processes.

Although participants in my study had different levels of clinical experience, research suggests that personal readiness is more indicative of providers' knowledge of trauma-informed approaches than professional experience. Synthesising 41 qualitative studies on health practitioners' readiness to address domestic violence, Hegarty et al. (2020) found that providers' personal readiness to address interpersonal violence was shaped, not by professional knowledge, level of experience or access to training, but by (1) having a commitment, (2) viewing violence as a social justice issue, and (3) having lived experience. I previously noted that providers in my study fell into O'Dwyer et al.'s (2019) 'empathising but despairing' group as they all shared a commitment to addressing sexual violence in their work but often felt constrained by a dehumanising system. Therefore, although participants varied in terms of clinical experience, findings by Hegarty et al. (2020) and O'Dwyer et al. (2019) suggests that seeking the views of providers who are committed to addressing sexual violence may be useful to research about how care may be improved.

9.4 Implications and recommendations

In my theoretical framework chapter (Chapter 3), I noted that trauma-informed approaches require system-wide change (Sweeney et al., 2018). Drawing on an ecological model (Bronfenbrenner, 1979, 1986, 1996), I discussed theoretical perspectives at several levels: (1) the individual level which captured the individual level factors (e.g. embodiment), (2) the microsystem/mesosystem/exosystem which included factors at the maternity system level (e.g. culture of disregarding consent), and (3) the macrosystem/chronosystem, which included cultural assumptions, beliefs and values and their historical context (e.g. whose knowledge 'counts'). I also argued that my explicit survivor standpoint differentiated my research from most other research in this field. It is from this standpoint that I make recommendations. I will begin with recommendations for wider healthcare systems before discussing recommendations for survivors, providers, policy/system and future research.

9.4.1 Wider healthcare systems

My findings raise a number of implications relevant to wider health systems that are important to outline before discussing specific implications for addressing sexual violence in maternity care settings. These considerations develop existing guidance on delivering women-centered care in response to intimate partner violence (IPV) and non-partner sexual violence. The World Health Organisation recommends that the LIVES model be used to respond to IPV or non-partner SV (listening, inquiring about needs, validating experiences, enhancing safety, and offering ongoing support; World Health Organisation, 2014). Tarzia et al. (2020) proposed the CARE model for IPV (choice and control, action and advocacy, recognition and understanding, and emotional connection), which can be used alongside LIVES to guide health practitioners to deliver women-centred care. These best practice guidelines highlight the critical importance of service providers responding in ways that show empathy for and directly address the harms of interpersonal violence. What all these guidance documents have in common is that facilitating choice, control and relationships is fundamental to trauma-informed care, irrespective of the health setting or the type of violence experienced. I will briefly consider my findings' implications for women-centered and trauma-informed care in wider healthcare systems, before discussing implications specific to adulthood sexual violence and maternity care.

My findings highlight barriers to delivering trauma-informed care in wider health systems. On a systemic level, barriers to safety included lack of continuity of care, lack of privacy in clinical settings, lack of time available in clinical appointments and a general lack of understanding about sexual violence. In line with trauma-informed approaches, this suggests an important implication to put structural support in place for all providers so that they are enabled, on a system level, to create humanising, respectful care environments.

Furthermore, my findings underline the importance of respecting autonomy and consent in healthcare. I found that focusing on 'obtaining' consent may harm survivors. Instead, consent should be seen as an active, ongoing, engaged process, and one where the woman's voice is actively amplified and listened to. The importance of engaging in an active *process* of consent applies across all health settings, but particularly those that may involve invasive procedures or examinations (e.g., gynaecology, primary care, dentistry, sexual health).

My findings also showed that a lack of disclosure is not necessarily a reflection on the provider or service, but a consequence of the nature of sexual violence: shrouded in secrecy, highly misunderstood, and potentially life-threatening. What is critical is that disclosure is a choice. Therefore, the goal should not be to 'get' disclosures but to make the invisible visible, to communicate that the provider and service cares about, and understands, sexual violence and that when, or if, women are ready, they will be there.

Finally, the lived experience focus of my research emphasises that survivors' experiential knowledge is not only useful for informing their *own* care (e.g., in shared decision-making) but that health systems must also create opportunities for survivors to shape *others'* care. It is therefore critical that services are co-produced with and led by service users so that "survivors themselves are instrumental in bringing about change" (Oram et al., 2022, p. 27; Sweeney et al., 2018). As this essential aspect of trauma-informed approaches is sometimes overlooked (Oram et al., 2022; Sweeney & Taggart, 2018), it is important that I state this as an implication for all health systems here.

In terms of maternity care, recent guidance has been produced which outlines four key principles of trauma-informed care in the perinatal period: (1) recognition and compassion; (2) communication and collaboration; (3) consistency and continuity; and (4) recognising diversity and facilitating recovery (Blackpool Better Start, 2021). This guidance includes important practical advice for maternity care providers, such as information on how to sensitively respond to disclosures, create safe healthcare environments for survivors of trauma, prioritise relationship and trust-building, and maximise choice and control in maternity care. The recommendations that I make here aim to build on these general trauma-informed recommendations and consider what *sexual violence* survivors may need from maternity care. For instance, Blackpool Better Start (2021) addressed ways in which care may re-traumatise survivors (e.g., unconsented touch), but did not address the unique context of silencing and shame experienced by survivor mothers in my research. In the following sections, I aim to unpack what might be particularly important for sexual violence survivors in terms of maternity care, based on my survivor-led research findings and grounded in the trauma-informed lens that guided my work.

9.4.2 Sexual violence survivors

The power of coming together

The public engagement workshops exemplified that there is enormous power in survivor mothers coming together. Several survivors noted that the workshops were their first experience of being able to speak honestly and openly about their experiences of motherhood, potentially reflecting the cultural silencing and shaming of mothers discussed in Chapter 3. Survivors experienced the workshops as a unique opportunity to connect with, and feel understood by, other survivor mothers. The power of survivor mothers connecting with each other may be linked to both sexual violence and motherhood being epistemically transformative experiences (Paul, 2014; Woollard, 2021). Sharing space with others who ‘get it’ may explain why coming together with survivor mothers may have been particularly healing and powerful. Survivor researchers have emphasised the critical importance of community-based and grassroots support for survivors (Sweeney et al., 2019), suggesting an important implication for trauma-informed, peer support for survivor mothers. An NHS-supported living library that connects parents who had difficult experiences of birth already exists (beyondlivinglibrary.org). However, my findings suggest a potential need for peer support not focused only on difficult experiences of birth. For instance, shame when women experienced a miscarriage, or silencing around distressing aspects motherhood, were equally important, and so were sharing moments of healing. My findings suggest that a survivor-only space to talk about the full range of experiences – both healing and harmful – is critical.

Empowering survivors with information

Survivor mothers experienced multiple, sometimes conflicting, demands and expectations in maternity care, produced by intersections of ideas about ‘good women’, ‘good mothers’ and ‘good patients’ (see Chadwick, 2017). The expectations and pressures placed on mothers created an additional layer of shame and silencing, compounding what is already an incredibly silenced experience. Motherhood therefore created additional and complex barriers to both disclosure and acknowledgement. Given the high rates of sexual violence among those using maternity and perinatal services (Jewkes et al., 2002; Martin-Storey et al., 2018; World Health Organisation, 2021), and evidence in both my research and others’ (e.g., Montgomery, 2013) that survivors may experience increased distress at this time, it may be beneficial to provide universal education to all service users in perinatal settings. A similar recommendation was made by Korab-Chandler et al. (2022) in relation to intimate partner violence; survivors saw universal education as empowering survivors with information. Although a co-produced resource exists for childhood sexual abuse survivors (Montgomery et al., 2021), there is currently no resource for survivors of sexual violence. Work should be done with (and/or by) survivors to explore further whether and how universal education might be helpful in this setting, any potential harms of providing universal education in maternity care settings (i.e., at a particularly vulnerable and exposing time for some women), and how it should be made available to survivors (e.g., so that survivors choice is maximised). Based on my research, a resource for survivors could include the following:

1. Recognise the potential for healing as well as harm.
2. Acknowledge the importance of survivors’ embodied knowledge.

3. Challenge unhelpful expectations placed on mothers and counter conceptions that shame mothers who experience distress.
4. Provide clear information about the care that survivors can expect to be offered (e.g., the possibility of an internal scan in early pregnancy).
5. Provide information on human rights during pregnancy and birth (e.g., to decline care).
6. Provide transparent information about safeguarding in maternity settings. The threat of safeguarding referrals arose as a significant barrier to disclosure in all three studies.
7. Emphasise the individual and nuanced nature of experiences whilst providing information about commonly reported difficulties and experiences.
8. Provide information about specialist, grass-roots support services that support survivors and/or help women understand their rights. For instance, the My Body Back Project (https://mybodybackproject.com/) or BirthRights (https://www.birthrights.org.uk/) in the UK.

9.4.3 Maternity care providers

Facilitating embodied connection and healing

An important and contribution of this thesis is that the deeply embodied, socially and personally significant transformation of pregnancy, birth and motherhood could facilitate the re-building of embodied trust and safety for some survivors, *if supported by respectful maternity care*. These healing mechanisms are similar to those reported by survivors who have found movement-based interventions healing (Levine et al., 2016; van der Kolk, 2014). This indicates a significant opportunity for maternity care providers to not only avoid re-traumatisation, but to actively to support embodied healing after sexual violence. Healing experiences were linked to environments in which survivors were encouraged to listen to their bodies and where their voice was genuinely valued. A key recommendation to providers is therefore to value women and birthing people's embodied knowledge. This recommendation comes from an understanding that ‘professional’ or ‘medical’ knowledge is powerful and that providers may (sometimes inadvertently) silence women if they do not take intentional steps to listen to them. As Ava in Study 2 said, “the mother’s voice has got to be the most important one in the room”. As Maya’s experience in Study 2 showed, women could feel their voice was valued even in emergency situations. Although others have recommended that choice and control be maximised (e.g., Blackpool Better Start, 2021), the focus is often on avoiding re-traumatisation, whereas my findings suggest an important opportunity to actively facilitate healing.

Co-producing provider education

Other guidelines have recommended staff training on trauma to create a workforce that feels confident to deliver trauma-informed care in the perinatal period (e.g., Blackpool Better Start, 2021). Sexual violence literature often emphasises that providers should avoid subscribing to ’rape myths’ (e.g., Lanthier et al., 2018). However, I found that intersections between sexual violence motherhood and maternity care are complex, signalling a need for more targeted support from maternity care providers. For instance, as misconceptions about sexual violence survivors’ ability to protect their children may lead to ‘just in case’ safeguarding referrals there is an urgent need to support providers to accurately assess risk when they receive a disclosure so that trust is not unnecessarily broken. In addition to understanding ways that re-traumatisation can be avoided (e.g., through seeking full, informed, ongoing consent), training should also address the multiple layers of silencing and shame faced by survivor mothers. It is critical that training and education positions sexual violence as a social justice issue and a violation of human rights. This places a social responsibility on providers, explains why silencing is so important, and is essential to providers’ personal readiness to address violence and abuse in their work (Hegarty et al., 2020). Most importantly, survivors should be instrumental in designing all education and training materials. Partnership working is an essential tenet of trauma-informed approaches (Sweeney et al., 2018) and is needed to ensure provider training and education addresses survivors’ own priorities (e.g., inter-connecting system harm; Robotham et al., 2019).

9.4.4 Maternity systems

Overall, my findings support a need for trauma-informed care in the perinatal period. In trauma-informed approaches, trauma-informed principles are implemented at a system-wide level (Sweeney et al., 2018, 2019). Implementing a trauma-informed approach means that disclosures are not needed to facilitate healing and avoid re-traumatisation. Findings that provide support for trauma-informed approaches include:

1. Survivors could experience greater distress during the perinatal period but rarely felt safe to disclose.
2. The perinatal period created unique opportunities for embodied and relational healing for some survivors. Importantly, healing experiences did not require a disclosure, but they did need to be facilitated by safe, respectful care.
3. The reductionism of medicalisation could harm survivors. For many survivors, distress during the perinatal period was caused or compounded by dehumanising approaches to care. Survivors needed to be treated with humanity and their experience and feelings respected and acknowledged.
4. Providers who implemented trauma-informed principles whilst working in a trauma-uninformed system felt exhausted and burnt out.
5. Survivor-providers’ lived experience was an important source of empathy and knowledge, but working in a harmful system may cause additional harm to survivor-providers.
6. My findings raise the critical importance of relationships and trust to both survivors and providers. Relationships helped survivors feel safe and made providers’ work more meaningful.

Providers and survivors often suggested potential solutions to conflicts between women's needs and the system's needs, such as being a constant companion for women when informed consent is difficult or not possible or advocating for women's choices. These solutions required support for providers on a systemic and structural level, as the provider was sitting between the woman and the wider system. In alignment with definitions of trauma-informed approaches, maternity services must work in partnership with survivors to understand how they may better respond to survivors' needs (Blackpool Better Start, 2021; Sweeney et al., 2018). Staffing and funding shortages must be addressed to enable committed, knowledgeable providers to implement trauma-informed principles (Department of Health and Social Care, 2022b). System-wide delivery of co-designed training that addresses both general trauma-informed principles and specific needs of sexual violence survivors is essential to support providers who may lack knowledge or confidence to address sexual violence in their work. In alignment with trauma-informed approaches, survivors should also be instrumental in shaping training design, delivery and evaluation.

One critical maternity system level implication is a need to support providers. The medically unique context in which one person (the mother) may be harmed in order to help a different person (the baby) creates a complex environment (Kingma, 2021), and one in which full, ongoing, informed consent was complicated and true 'choice' not always possible. Providers in this research – who were all deeply committed to supporting survivors - reported feeling traumatised and disturbed by witnessing women's autonomy and consent being violated in maternity care. It is therefore important to recognise that maternity care providers work in environments in which they are exposed to trauma on multiple levels – especially providers who are committed to support survivors. Working in a trauma-uninformed system may be even more harmful to survivor-providers, who may understand, on an experiential level, the profound harm that being dehumanised, violated and silenced may cause to survivors. This indicates a need for structural support (e.g., ongoing, reflective supervision) for providers and potentially targeted support for survivor-providers.

9.4.5 Future research

An important finding from this research was that the embodied experience of pregnancy and birth could bring survivors closer to their bodies – and sometimes their embodied, buried, hidden trauma. As I argued in this chapter, rather than seeing pregnancy as a ‘trigger’, if traumatic memories arose at this time, they may instead present an opportunity to begin a process of acknowledgement and healing (Herman, 1997; van der Kolk, 2014). My findings on embodied healing aligned with findings on the healing mechanisms behind dance/movement therapies, i.e., pregnancy and birth facilitated mind-body connection, some women felt empowered and that they were reclaiming the body, and the perinatal period presented an opportunity for survivors to build a new relationship with themselves and other people, including their baby (Levine et al., 2016; Van der Kolk, 2014). Importantly, some survivors experienced trauma memories re-emerging but felt unable to speak about them, highlighting the unspeakable nature of sexual violence (Herman, 1997). Taken together, my findings suggest that a trauma-informed movement-based intervention may help some survivors process and express trauma-related memories earlier in pregnancy, in a safe environment, without a need to disclose or use language to speak about what happened to them. Although some survivors may be unaware of their experiences at the time of pregnancy, and for others the perinatal period may not be a helpful time to intervene, survivors who have already begun a process of acknowledgement may find an intervention focused on re-building their relationships with their bodies helpful (Herman, 1997; Van der Kolk, 2014). Future research could explore this.

In Chapter 2, I noted that survivor partnerships – a central tenet of trauma-informed approaches (Sweeney et al., 2018) - are often omitted from definitions of trauma-informed approaches within perinatal literature (e.g., Sperlich et al., 2017). The perinatal literature lacks discussion and consideration of collaborative partnerships with survivors at higher levels of the system (e.g., in designing services), focusing instead on ways that individual providers may implement trauma-informed principles in their practice (Long et al., 2022; Nagle-Yang et al., 2022; Sperlich et al., 2017). The survivor voice is therefore largely invisible in peer-reviewed guidance on trauma-informed care in the perinatal period (but see Blackpool Better Start, 2021). This suggests an urgent need to reach a consensus on principles of trauma-informed maternity care in the research community. Without a clear understanding of what trauma-informed approaches are in a maternity context they cannot be implemented. Mitchell et al. (2021) recently conducted a Delphi study on the principles of trauma-informed care for early intervention psychosis, although it did not involve service users. A survivor-led, trauma-informed Delphi study that foregrounds survivor involvement could be conducted to reach consensus on principles of trauma-informed maternity care that would provide a platform for further research and implementation. Given the complex ways that being a survivor may intersect with other areas of marginalisation and systems of oppression (McCauley et al., 2019) this research should actively include survivor perspectives across different races, classes, gender identities and sexual orientations. Researchers must collaborate with community partner agencies to ensure the research is transparent and accountable, and prioritises trust, relationships, and safety (Perôt et al., 2018).

My research highlighted ways that systemic and structural factors shaped women’s experiences of pregnancy, birth, motherhood and maternity care. Although I aimed to explore a range of experiences, my findings primarily highlight intersections between the harms caused by medical power and gendered expectations of mothers. Through this work, I explored how violence and abuse may be mirrored in services which survivors may use, placing instances of re-traumatisation within a wider social and historical context, i.e., the maternity system. However, my research centers the experiences of white, middle-class cisgender and heterosexual women. Expectations of mothers in my research were profoundly shaped by middle-class ideals of normative femininity (i.e., that women should be nurturing, self-sacrificing etc.), highlighting a need for research to explore experiences among pregnant people, birthing people, and parents whose identities and bodies may not meet normative expectations of 'good women', 'good mothers' and 'good (feminine) birthing bodies' (Chadwick, 2017). As medical power could silence women's voices, researchers should explore how other areas of marginalisation may devalue some women and birthing women's voices further. Much more work needs to be done to understand how survivors' experiences are shaped by wider systems of oppression, and how different areas of marginalisation may intersect. Future work should not only meaningfully involve survivors but take active steps to involve survivors whose voices are even less often heard.

Research with providers with lived experience is crucial to understanding the ways in which maternity care can be improved for survivors, as well as how the health system generally can better support providers. Having intimate knowledge of both being a survivor and being a provider may provide a source of expertise and knowledge that is largely untapped by existing research and policy. In my research I used the concept of epistemically transformative experiences (Paul, 2014) to explain how and why survivor providers may have knowledge that may be more difficult for non-survivor providers to access. Additionally, research with survivor providers challenges vulnerability framings of survivors and tackles the artificial binary divide between survivor and practitioner, instead celebrating survivors' knowledge and skills. My findings suggest that it may be particularly important for future research to explore how working in a system that takes power away from providers may harm survivor-providers and what kind of support survivor-providers may need.

9.5 Summary and conclusion

In this thesis, I argued that a focus on individual experiences has obscured ways that maternity care may re-traumatise survivors. Although my research echoes others' in highlighting that pregnancy, birth, motherhood and maternity care can indeed create challenges for sexual violence survivors, my work challenged assumptions that re-traumatising experiences can be separated from the system and social context within which they are experienced. In my work, I conceptualised women and birthing people as embodied, situated agents. This perspective, guided by my lived experience as a survivor, allowed me to situate my findings within an understanding that being pregnant, giving birth, or being a mother places women in certain situations – situations that intersect with the lived experience and aftermath of sexual violence in complex, but often silenced and hidden ways. In so doing, my thesis bridges a gap between two fields that rarely overlap – that of survivor research; examining, naming and challenging system (primarily psychiatric) harm, and that of qualitative health research on sexual violence and pregnancy, motherhood and maternity care primarily located within midwifery and psychology fields.

My findings highlighted that dehumanisation was key to understanding re-traumatising experiences of care. Humanity, kindness and respect were therefore as important as choice, empowerment and control for survivors. Going forward, there is a need to place these principles at the heart of maternity care as well as all work with survivors. Overall, both survivors and providers spoke about the maternity care system as a microcosm of a society that shames women, blames survivors, and judges mothers. They highlighted that when a woman experiences sexual violence, she is harmed by another person. This is often a person who she trusted. My research found that the maternity care system holds both the power and the responsibility to re-build trust and facilitate embodied and relational healing following sexual violence, and that motherhood presented an opportunity to begin a new narrative. To support healing and avoid re-traumatising survivors, maternity and health systems must listen to survivors, prioritise relationships, and work in ways that earns survivors’ trust.

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Appendix A: Ovid Search Strategy

1 exp rape/ or rape.mp. (12437)

2 sexual violence.mp. or exp sexual violence/ (37885)

3 sexual abuse.mp. or exp sexual abuse/ (26217)

4 sexual assault.mp. or exp sexual assault/ (35763)

5 exp interview/ or interview*.mp. (481838)

6 experience*.mp. (1486466)

7 qualitative.mp. (302418)

8 exp qualitative research/ or qualitative research.mp. (75777)

9 primary healthcare.mp. or exp primary healthcare/ (167957)

10 health service.mp. or exp health service/ (5373913)

11 exp sexual health/ or sexual health clinic.mp. (14970)

12 exp mental health service/ or mental health service*.mp. (64115)

13 exp maternal care/ or maternity service*.mp. (45548)

14 perinatal care.mp. or exp perinatal care/ (58237)

15 exp dentist/ or dentist*.mp. (130397)

16 community care.mp. or exp community care/ (123400)

17 1 or 2 or 3 or 4 (46727)

18 5 or 6 or 7 or 8 (2039514)

19 9 or 10 or 11 or 12 or 13 or 14 or 15 or 16 (5497067)

20 17 and 18 and 19 (5120)

Appendix B: eMERGe Reporting Criteria

No.	Criteria Headings	Reporting Criteria	Section number.
Phase 1—Selecting meta-ethnography and getting started			
Introduction			
1	Rationale and context for the meta-ethnography	Describe the gap in research or knowledge to be filled by the meta-ethnography, and the wider context of the meta-ethnography	4.8.5
2	Aim(s) of the meta-ethnography	Describe the meta-ethnography aim(s)	4.8.1
3	Focus of the meta-ethnography	Describe the meta-ethnography review question(s) (or objectives)	4.8.1
4	Rationale for using meta-ethnography	Explain why meta-ethnography was considered the most appropriate qualitative synthesis methodology	4.8.5
Phase 2—Deciding what is relevant			
Methods			
5	Search strategy	Describe the rationale for the literature search strategy	4.8.3
6	Search processes	Describe how the literature searching was carried out and by whom	4.8.3

No.	Criteria Headings	Reporting Criteria	Section number.
7	Selecting primary studies	Describe the process of study screening and selection, and who was involved	4.8.3 and 4.8.4
Findings			
8	Outcome of study selection	Describe the results of study searches and screening	6.2.1
Phase 3—Reading included studies			
Methods			
9	Reading and data extraction approach	Describe the reading and data extraction method and processes	4.8.7
Findings			
10	Presenting characteristics of included studies	Describe characteristics of the included studies	6.2.2
Phase 4—Determining how studies are related			
Methods			
11	Process for determining how studies are related	Describe the methods and processes for determining how the included studies are related: - Which aspects of studies were compared	4.8.7

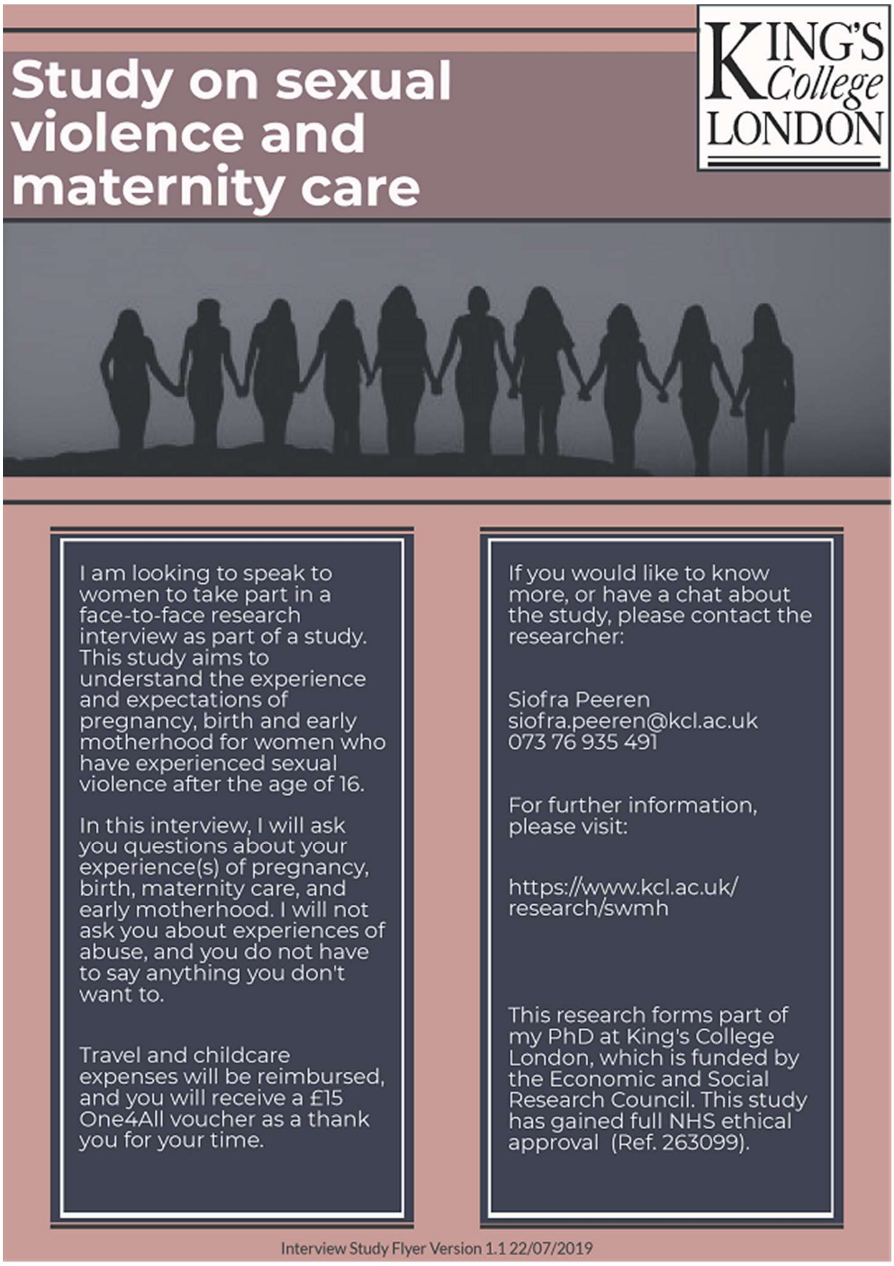
No.	Criteria Headings	Reporting Criteria	Section number.
		AND - How the studies were compared	
Findings			
12	Outcome of relating studies	Describe how studies relate to each other	6.2.4
Phase 5—Translating studies into one another			
Methods			
13	Process of translating studies	Describe the methods of translation: - Describe steps taken to preserve the context and meaning of the relationships between concepts within and across studies- Describe how the reciprocal and refutational translations were conducted- Describe how potential alternative interpretations or explanations were considered in the translations	4.8.7
Findings			
14	Outcome of translation	Describe the interpretive findings of the translation.	6.2.5
Phase 6—Synthesising translations			
Methods			
15	Synthesis process	Describe the methods used to develop overarching concepts (“synthesised translations”). Describe how potential alternative interpretations or explanations were considered in the synthesis	4.8.7

No.	Criteria Headings	Reporting Criteria	Section number.
Findings			
16	Outcome of synthesis process	Describe the new theory, conceptual framework, model, configuration, or interpretation of data developed from the synthesis	6.3
Phase 7—Expressing the synthesis			
Discussion			
17	Summary of findings	Summarize the main interpretive findings of the translation and synthesis and compare them to existing literature	6.4 and 6.5
18	Strengths, limitations, and reflexivity	Reflect on and describe the strengths and limitations of the synthesis: - Methodological aspects—for example, describe how the synthesis findings were influenced by the nature of the included studies and how the meta-ethnography was conducted - Reflexivity—for example, the impact of the research team on the synthesis findings	9.3
19	Recommendations and conclusions	Describe the implications of the synthesis	9.4

Appendix C: Example of Meta-Ethnography Translation Table

Category: Communication	
Translated theme/concept	Examples of second order constructs*
Feeling unable to communicate needs	Survivors became “passive beneficiaries of care through acceptance of the healthcare provider’s authority; the path of least resistance was to tolerate the necessities of the forensic examination” (Holton, 2016). Feeling like the exam was not a choice or she didn’t have options (Fehler-Cabral, 2011). Consenting not properly done before procedures; not being aware of what she was signing (i.e. consent form); parent signing consent form instead of survivor; being unaware of the course of treatment until the procedure was already underway (Place, 2019). Anxiety of exposure of bodies during labour was a reason they wanted control over who is in the labour room; relief at need for urgent caesarean delivery (Sobel, 2018). Labouring in water despite feeling it wasn’t safe (Birthrights, 2019) Participants felt uncomfortable discussing the SV repeatedly; at initial consultation was expected to repeat story to numerous providers from various disciplines; just wanted to move on and not focus on what happened;led to disengagement due to fear of having to repeatedly tell story again (Holton, 2016) Some women wished that they had refused to undergo certain components of the kit e.g. needles and internal examinations; several women framed the experience as a re-victimisation (Du Mont, 2009)
Communication needs to be appropriate to needs	Individualised care led to women feeling calmer, secure and welcomed (Batistetti, 2020). Survivors preferred written information that they could refer to at a later stage; difficult to retain information provided during initial consultation (Holton, 2016). Difficult to retain information or concentrate which led to the forgetting instructions on how to take medication (Holton, 2016). Setting the pace for the examination was important to women (Ericksen, 2002). Information was important to women and was overwhelming for some women. Providing time, repetition and clear explanations were important. Written information also helpful (Ericksen, 2002). In her state of shock and anxiety she needed clearer and repeated information. Sessions with counsellors felt rushed at times (Abrahams, 2017). Providers readily offered them medical information but the quantity and timing of information was problematic (Place, 2019). Did not feel a connection or like she was being listened to by counsellor. Dissatisfied with slow pace of therapy (Starzynski, 2017). Feeling scared and overwhelmed by hospital environment. Providers not explaining everything clearly, being uninformative and in one case being insensitive. (Ahrens, 2002). Advocate explained some procedures which was helpful; helpful she was the same race as survivor. (Ahrens, 2002).

Appendix D: Survivor Study Poster



Study on sexual violence and maternity care

KING'S College LONDON

I am looking to speak to women to take part in a face-to-face research interview as part of a study. This study aims to understand the experience and expectations of pregnancy, birth and early motherhood for women who have experienced sexual violence after the age of 16.

In this interview, I will ask you questions about your experience(s) of pregnancy, birth, maternity care, and early motherhood. I will not ask you about experiences of abuse, and you do not have to say anything you don't want to.

Travel and childcare expenses will be reimbursed, and you will receive a £15 One4All voucher as a thank you for your time.

If you would like to know more, or have a chat about the study, please contact the researcher:

Siofra Peeren
siofra.peeren@kcl.ac.uk
073 76 935 491

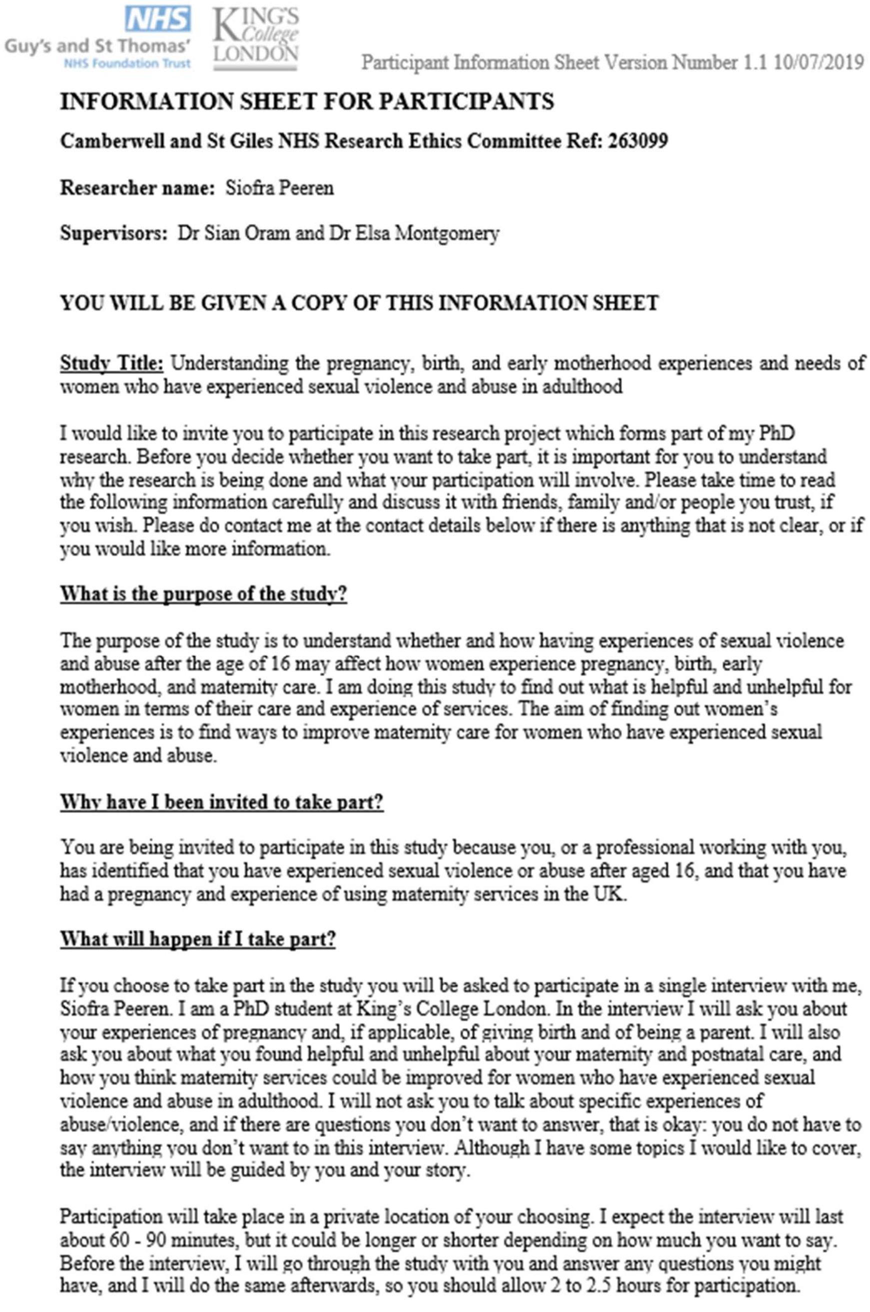
For further information, please visit:

https://www.kcl.ac.uk/research/swmh

This research forms part of my PhD at King's College London, which is funded by the Economic and Social Research Council. This study has gained full NHS ethical approval (Ref. 263099).

Interview Study Flyer Version 1.1 22/07/2019

Appendix E: Survivor Study Participant Information Sheet



Participant Information Sheet Version Number 1.1 10/07/2019

INFORMATION SHEET FOR PARTICIPANTS

Camberwell and St Giles NHS Research Ethics Committee Ref: 263099

Researcher name: Siofra Peeren

Supervisors: Dr Sian Oram and Dr Elsa Montgomery

YOU WILL BE GIVEN A COPY OF THIS INFORMATION SHEET

Study Title: Understanding the pregnancy, birth, and early motherhood experiences and needs of women who have experienced sexual violence and abuse in adulthood

I would like to invite you to participate in this research project which forms part of my PhD research. Before you decide whether you want to take part, it is important for you to understand why the research is being done and what your participation will involve. Please take time to read the following information carefully and discuss it with friends, family and/or people you trust, if you wish. Please do contact me at the contact details below if there is anything that is not clear, or if you would like more information.

What is the purpose of the study?

The purpose of the study is to understand whether and how having experiences of sexual violence and abuse after the age of 16 may affect how women experience pregnancy, birth, early motherhood, and maternity care. I am doing this study to find out what is helpful and unhelpful for women in terms of their care and experience of services. The aim of finding out women's experiences is to find ways to improve maternity care for women who have experienced sexual violence and abuse.

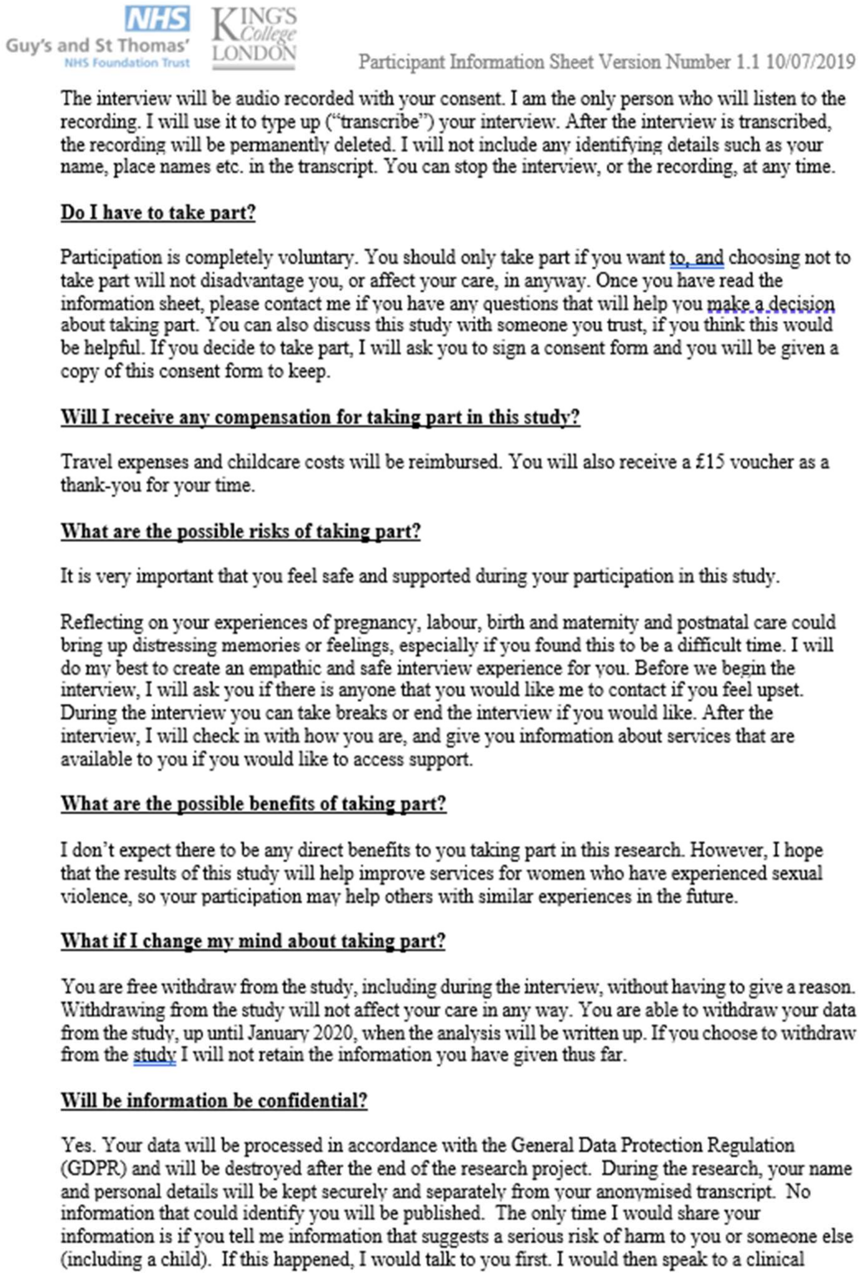
Why have I been invited to take part?

You are being invited to participate in this study because you, or a professional working with you, has identified that you have experienced sexual violence or abuse after aged 16, and that you have had a pregnancy and experience of using maternity services in the UK.

What will happen if I take part?

If you choose to take part in the study you will be asked to participate in a single interview with me, Siofra Peeren. I am a PhD student at King's College London. In the interview I will ask you about your experiences of pregnancy and, if applicable, of giving birth and of being a parent. I will also ask you about what you found helpful and unhelpful about your maternity and postnatal care, and how you think maternity services could be improved for women who have experienced sexual violence and abuse in adulthood. I will not ask you to talk about specific experiences of abuse/violence, and if there are questions you don't want to answer, that is okay: you do not have to say anything you don't want to in this interview. Although I have some topics I would like to cover, the interview will be guided by you and your story.

Participation will take place in a private location of your choosing. I expect the interview will last about 60 - 90 minutes, but it could be longer or shorter depending on how much you want to say. Before the interview, I will go through the study with you and answer any questions you might have, and I will do the same afterwards, so you should allow 2 to 2.5 hours for participation.



NHS Guy's and St Thomas' NHS Foundation Trust
King's College London
Participant Information Sheet Version Number 1.1 10/07/2019

The interview will be audio recorded with your consent. I am the only person who will listen to the recording. I will use it to type up ("transcribe") your interview. After the interview is transcribed, the recording will be permanently deleted. I will not include any identifying details such as your name, place names etc. in the transcript. You can stop the interview, or the recording, at any time.

Do I have to take part?

Participation is completely voluntary. You should only take part if you want to, and choosing not to take part will not disadvantage you, or affect your care, in anyway. Once you have read the information sheet, please contact me if you have any questions that will help you make a decision about taking part. You can also discuss this study with someone you trust, if you think this would be helpful. If you decide to take part, I will ask you to sign a consent form and you will be given a copy of this consent form to keep.

Will I receive any compensation for taking part in this study?

Travel expenses and childcare costs will be reimbursed. You will also receive a £15 voucher as a thank-you for your time.

What are the possible risks of taking part?

It is very important that you feel safe and supported during your participation in this study.

Reflecting on your experiences of pregnancy, labour, birth and maternity and postnatal care could bring up distressing memories or feelings, especially if you found this to be a difficult time. I will do my best to create an empathic and safe interview experience for you. Before we begin the interview, I will ask you if there is anyone that you would like me to contact if you feel upset. During the interview you can take breaks or end the interview if you would like. After the interview, I will check in with how you are, and give you information about services that are available to you if you would like to access support.

What are the possible benefits of taking part?

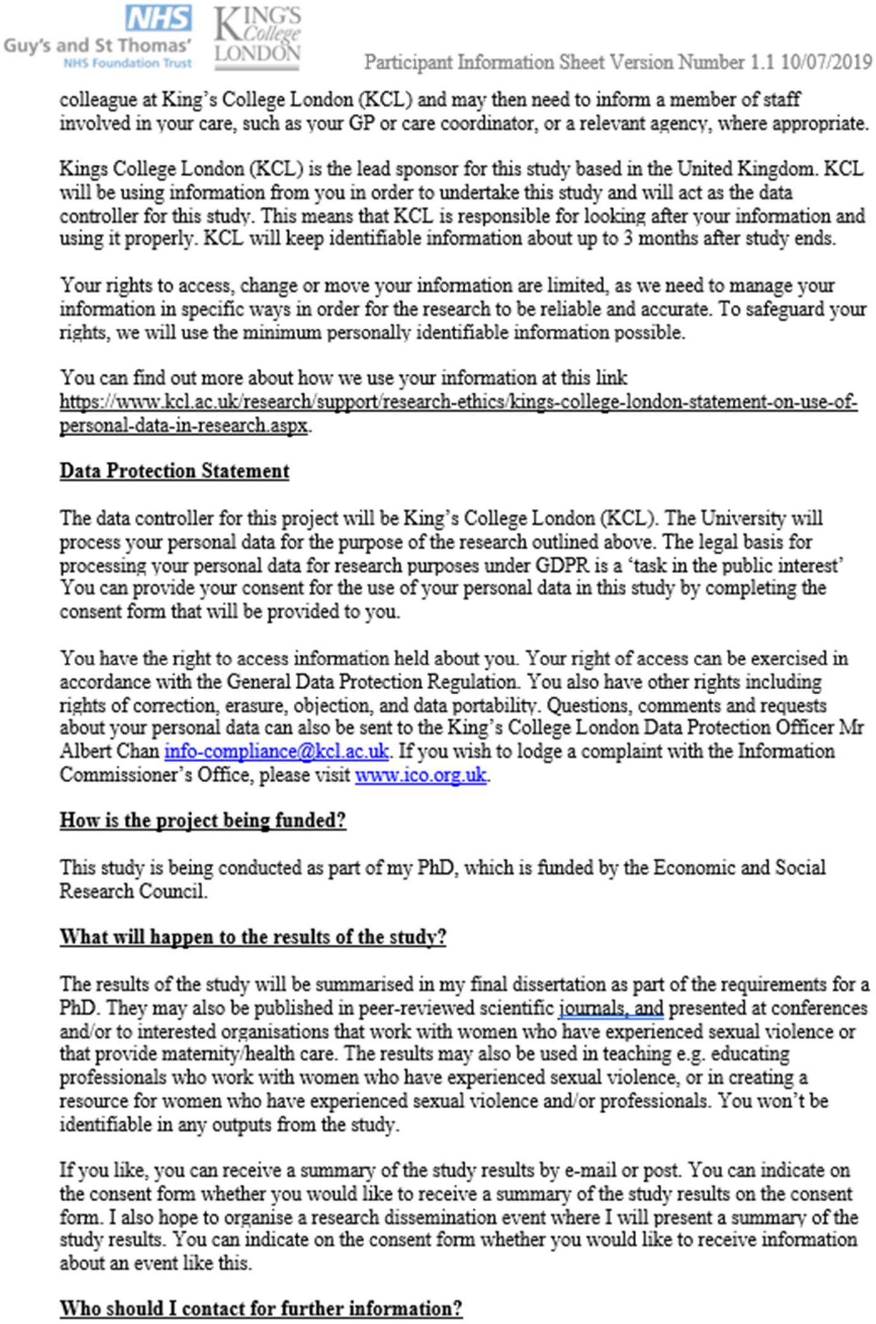
I don't expect there to be any direct benefits to you taking part in this research. However, I hope that the results of this study will help improve services for women who have experienced sexual violence, so your participation may help others with similar experiences in the future.

What if I change my mind about taking part?

You are free withdraw from the study, including during the interview, without having to give a reason. Withdrawing from the study will not affect your care in any way. You are able to withdraw your data from the study, up until January 2020, when the analysis will be written up. If you choose to withdraw from the study I will not retain the information you have given thus far.

Will be information be confidential?

Yes. Your data will be processed in accordance with the General Data Protection Regulation (GDPR) and will be destroyed after the end of the research project. During the research, your name and personal details will be kept securely and separately from your anonymised transcript. No information that could identify you will be published. The only time I would share your information is if you tell me information that suggests a serious risk of harm to you or someone else (including a child). If this happened, I would talk to you first. I would then speak to a clinical



colleague at King's College London (KCL) and may then need to inform a member of staff involved in your care, such as your GP or care coordinator, or a relevant agency, where appropriate.

Kings College London (KCL) is the lead sponsor for this study based in the United Kingdom. KCL will be using information from you in order to undertake this study and will act as the data controller for this study. This means that KCL is responsible for looking after your information and using it properly. KCL will keep identifiable information about up to 3 months after study ends.

Your rights to access, change or move your information are limited, as we need to manage your information in specific ways in order for the research to be reliable and accurate. To safeguard your rights, we will use the minimum personally identifiable information possible.

You can find out more about how we use your information at this link https://www.kcl.ac.uk/research/support/research-ethics/kings-college-london-statement-on-use-of-personal-data-in-research.aspx.

Data Protection Statement

The data controller for this project will be King's College London (KCL). The University will process your personal data for the purpose of the research outlined above. The legal basis for processing your personal data for research purposes under GDPR is a 'task in the public interest' You can provide your consent for the use of your personal data in this study by completing the consent form that will be provided to you.

You have the right to access information held about you. Your right of access can be exercised in accordance with the General Data Protection Regulation. You also have other rights including rights of correction, erasure, objection, and data portability. Questions, comments and requests about your personal data can also be sent to the King's College London Data Protection Officer Mr Albert Chan info-compliance@kcl.ac.uk. If you wish to lodge a complaint with the Information Commissioner's Office, please visit www.ico.org.uk.

How is the project being funded?

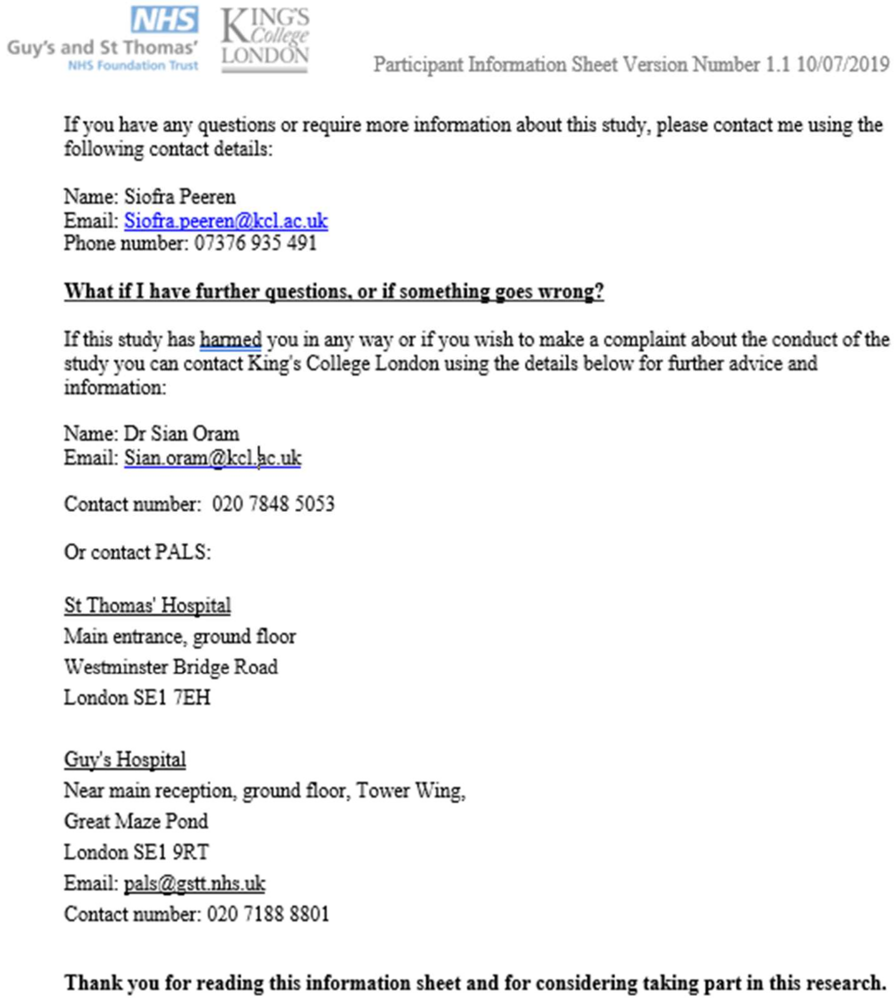
This study is being conducted as part of my PhD, which is funded by the Economic and Social Research Council.

What will happen to the results of the study?

The results of the study will be summarised in my final dissertation as part of the requirements for a PhD. They may also be published in peer-reviewed scientific journals, and presented at conferences and/or to interested organisations that work with women who have experienced sexual violence or that provide maternity/health care. The results may also be used in teaching e.g. educating professionals who work with women who have experienced sexual violence, or in creating a resource for women who have experienced sexual violence and/or professionals. You won't be identifiable in any outputs from the study.

If you like, you can receive a summary of the study results by e-mail or post. You can indicate on the consent form whether you would like to receive a summary of the study results on the consent form. I also hope to organise a research dissemination event where I will present a summary of the study results. You can indicate on the consent form whether you would like to receive information about an event like this.

Who should I contact for further information?



Participant Information Sheet Version Number 1.1 10/07/2019

If you have any questions or require more information about this study, please contact me using the following contact details:

Name: Siofra Peeren
Email: Siofra.peeren@kcl.ac.uk
Phone number: 07376 935 491

What if I have further questions, or if something goes wrong?

If this study has harmed you in any way or if you wish to make a complaint about the conduct of the study you can contact King's College London using the details below for further advice and information:

Name: Dr Sian Oram
Email: Sian.oram@kcl.ac.uk

Contact number: 020 7848 5053

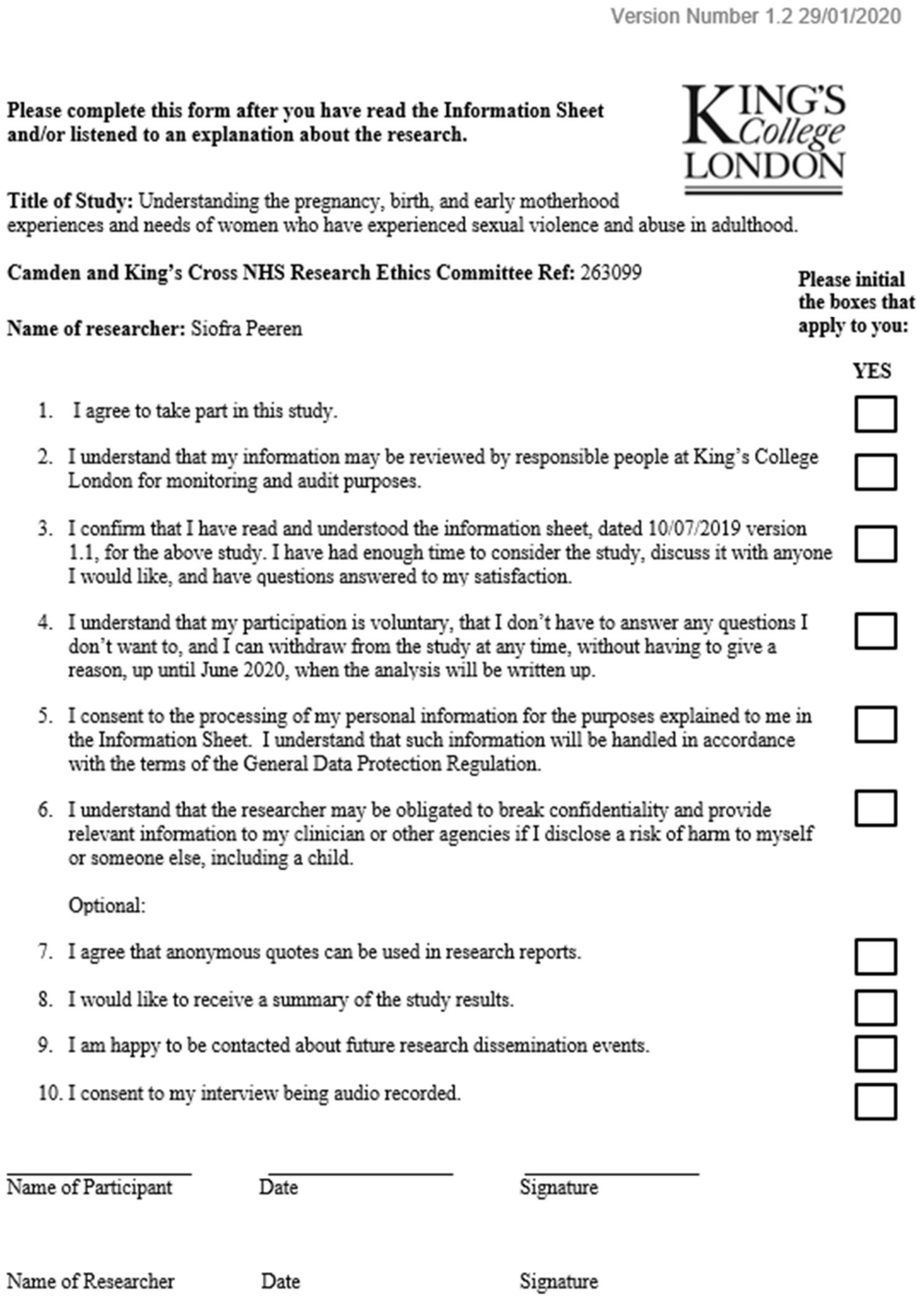
Or contact PALS:

St Thomas' Hospital
Main entrance, ground floor
Westminster Bridge Road
London SE1 7EH

Guy's Hospital
Near main reception, ground floor, Tower Wing,
Great Maze Pond
London SE1 9RT
Email: pals@gstt.nhs.uk
Contact number: 020 7188 8801

Thank you for reading this information sheet and for considering taking part in this research.

Appendix F: Survivor Study Consent Form



Version Number 1.2 29/01/2020

Please complete this form after you have read the Information Sheet and/or listened to an explanation about the research.

KING'S College LONDON

Title of Study: Understanding the pregnancy, birth, and early motherhood experiences and needs of women who have experienced sexual violence and abuse in adulthood.

Camden and King's Cross NHS Research Ethics Committee Ref: 263099

Name of researcher: Siofra Peeren

Please initial the boxes that apply to you:

YES

1. I agree to take part in this study. ☐
2. I understand that my information may be reviewed by responsible people at King's College London for monitoring and audit purposes. ☐
3. I confirm that I have read and understood the information sheet, dated 10/07/2019 version 1.1, for the above study. I have had enough time to consider the study, discuss it with anyone I would like, and have questions answered to my satisfaction. ☐
4. I understand that my participation is voluntary, that I don't have to answer any questions I don't want to, and I can withdraw from the study at any time, without having to give a reason, up until June 2020, when the analysis will be written up. ☐
5. I consent to the processing of my personal information for the purposes explained to me in the Information Sheet. I understand that such information will be handled in accordance with the terms of the General Data Protection Regulation. ☐
6. I understand that the researcher may be obligated to break confidentiality and provide relevant information to my clinician or other agencies if I disclose a risk of harm to myself or someone else, including a child. ☐

Optional:

7. I agree that anonymous quotes can be used in research reports. ☐
8. I would like to receive a summary of the study results. ☐
9. I am happy to be contacted about future research dissemination events. ☐
10. I consent to my interview being audio recorded. ☐

Name of Participant ____________ Date ____________ Signature ____________

Name of Researcher Date Signature

Appendix G: Survivor Study Topic Guide

How do survivors of adulthood sexual violence and abuse experience pregnancy?

- How did you feel when you first found out you were pregnant?
- What was pregnancy like for you?
    - What did you enjoy about it?
    - What did you find difficult about being pregnant?
    - Did your feelings change over time?
- How, if at all, do you think having experienced sexual violence affected your experience of pregnancy?
- What helped you during this time? What further support would you have liked?
- How did you feel about the maternity care you received during the time you were pregnant? (e.g. GP appointments, midwife appointments, scans)
- Did any of the staff looking after you during your pregnancy know about your experiences of sexual violence? [If no, would you liked them to have known? If yes, how did they come to know?]

How do survivors of adulthood sexual violence and abuse experience birth?

- How were you feeling about the birth in the run up to it?
    - What plans had you made for the birth?
- What was the birth like for you?
    - How did you feel about the differences between what you wanted to happen and what actually happened?
    - How did you feel after the birth?
- How, if at all, do you think having experienced sexual violence affected your experience of birth?
- How did you feel about the care you received during labour and birth?
- Did any of the staff looking after you during labour and birth know about your experiences of sexual violence? [If no, would you liked them to have known? If yes, how did they come to know?]
- What helped you during this time? What further support would you have liked?

How do survivors of adulthood sexual violence and abuse experience the postnatal period?

- What were the early weeks like for you?
    - What did you enjoy/find difficult?
    - Did your feelings change over time?
    - What decision did you make about how to feed your baby?
- How, if at all, do you think having experienced sexual violence affected your experience of early motherhood?
- What helped you during this time? What further support would you have liked?
- How did you feel about the postnatal care you received? (e.g. GP appointments, midwife appointments, health visitor appointments)
- Did any of the staff looking after you during this time know about your experiences of sexual violence? [If no, would you liked them to have known? If yes, how did they come to know?]

Is there anything else that you would like to say or I didn't cover?

Appendix H: Example of a Narrative Summary (Survivor Study)

Key:

- Key events
- *Providing context*

Key events (excerpt)
Discovered pregnancy (planned) *The first thing I thought about: how will I cope? How will I survive the birth [psychologically]?* Disclosed SV as a reason for wanting planning C-section *Had several meetings with gatekeeper to planned C-section [clinical psychologist]. Feeling really distressed in those appointments because she was being asked to prove why SV was a valid reason to have an elective c section* *Didn't mind disclosing SV to HCPs, but felt that should be enough for planned C-section* Being passed around, re-telling story to different people *SV not recognised as a valid reason to need extra or different support* *Was clear on the things that would help her i.e. elective C-section, extra person at birth* *Felt she was seen as too difficult, demanding, controlling*
Key people
'gatekeepers' to care – the clinical psychologist who would not accept her fear of birth as a valid reason to have an elective c section as well as all the other maternity care providers and social workers she met that reinforced her fears and shamed and judged her. Social workers that judged her and reinforced her fears that she would not be a good enough mother. Perinatal psychotherapist that reassured her that she would be a good enough mother and built on her confidence and self-worth.
Key themes

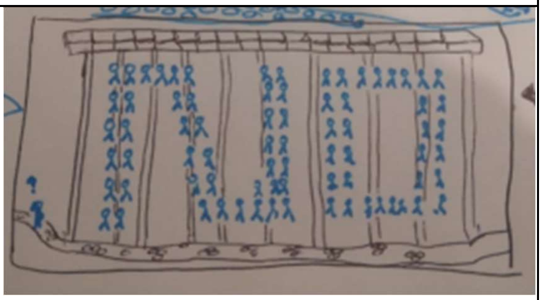
Dehumanisation:

- Being reduced to a diagnosis of borderline personality disorder. All her concerns and worries attributed to that. Not being listened to.
- Providers touching her breasts without her consent

Shaming:

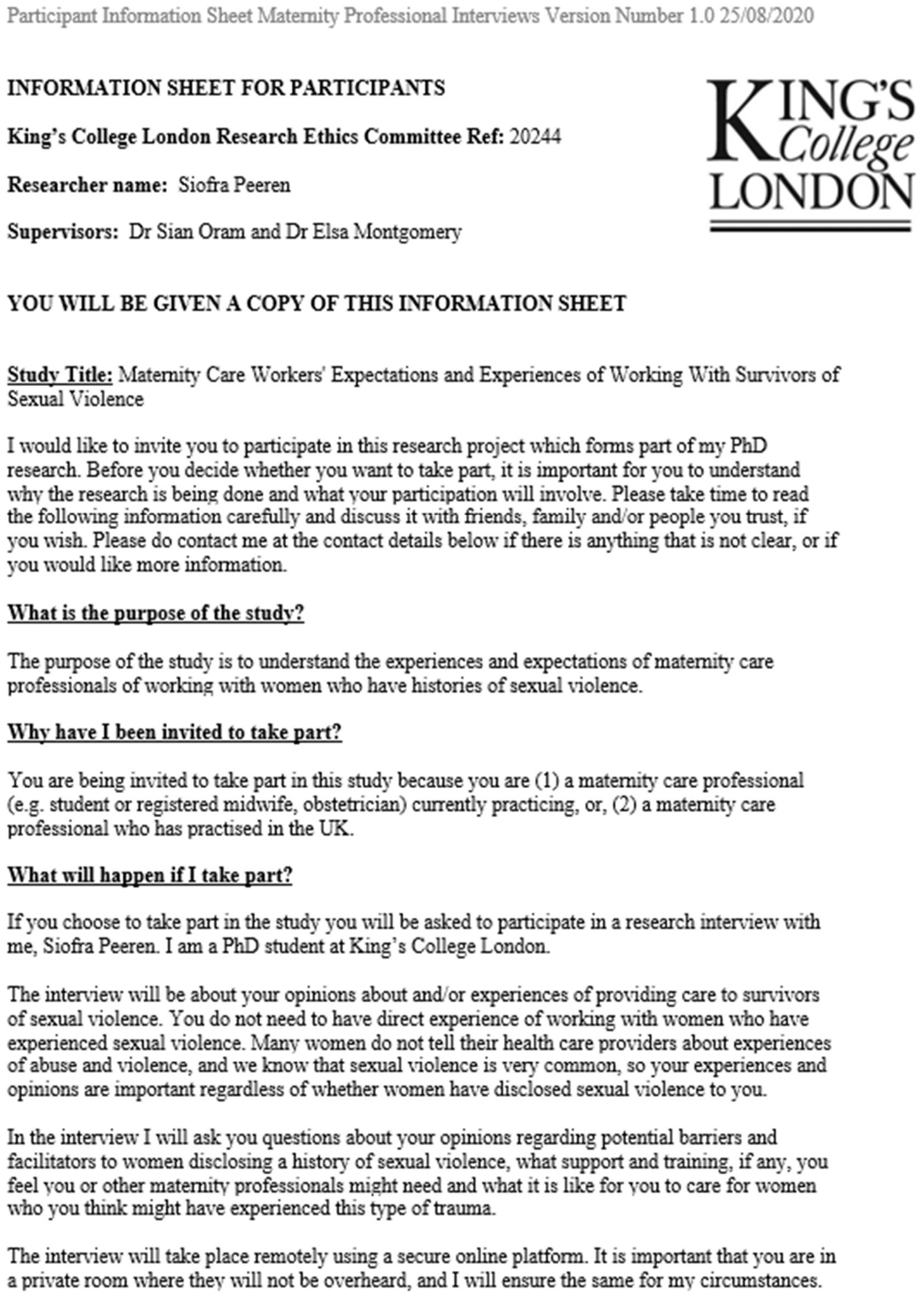
- Fear of not being a good enough mother – fear of being traumatised by the birth and this was reinforced by providers and system preventing her from accessing care.
- Being shamed by providers whose silence and dismissal told her that disclosing SV was wrong and that her reasons for needing an elective c section were not valid.

Illustrations



This image illustrates the gatekeepers to care and how she was silenced and dehumanised on a systemic level. All the providers came together to prevent her from accessing the care she wanted, needed and asked for openly. This wasn't one provider – it was a repeated experience. The 'NO' is spelled out by many providers all stacked on top of each other and they are guarding a gate which she wants to go through to get to the care she needs. The 'NO' is so big and powerful because there are so many providers making it up and only one of her.

Appendix I: Provider Study Participant Information Sheet



Participant Information Sheet Maternity Professional Interviews Version Number 1.0 25/08/2020

INFORMATION SHEET FOR PARTICIPANTS

King's College London Research Ethics Committee Ref: 20244

Researcher name: Siofra Peeren

Supervisors: Dr Sian Oram and Dr Elsa Montgomery

KING'S College LONDON

YOU WILL BE GIVEN A COPY OF THIS INFORMATION SHEET

Study Title: Maternity Care Workers' Expectations and Experiences of Working With Survivors of Sexual Violence

I would like to invite you to participate in this research project which forms part of my PhD research. Before you decide whether you want to take part, it is important for you to understand why the research is being done and what your participation will involve. Please take time to read the following information carefully and discuss it with friends, family and/or people you trust, if you wish. Please do contact me at the contact details below if there is anything that is not clear, or if you would like more information.

What is the purpose of the study?

The purpose of the study is to understand the experiences and expectations of maternity care professionals of working with women who have histories of sexual violence.

Why have I been invited to take part?

You are being invited to take part in this study because you are (1) a maternity care professional (e.g. student or registered midwife, obstetrician) currently practicing, or, (2) a maternity care professional who has practised in the UK.

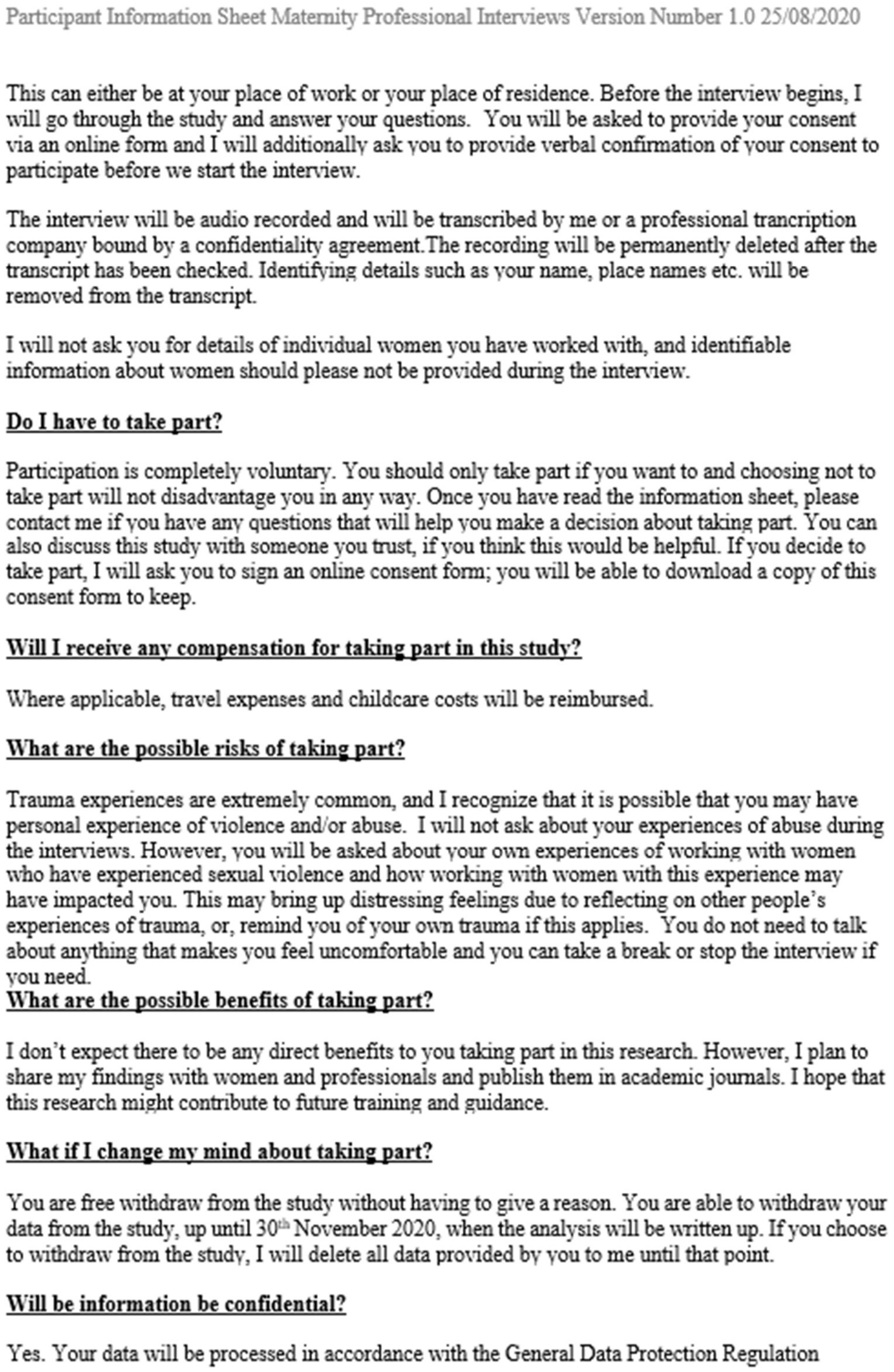
What will happen if I take part?

If you choose to take part in the study you will be asked to participate in a research interview with me, Siofra Peeren. I am a PhD student at King's College London.

The interview will be about your opinions about and/or experiences of providing care to survivors of sexual violence. You do not need to have direct experience of working with women who have experienced sexual violence. Many women do not tell their health care providers about experiences of abuse and violence, and we know that sexual violence is very common, so your experiences and opinions are important regardless of whether women have disclosed sexual violence to you.

In the interview I will ask you questions about your opinions regarding potential barriers and facilitators to women disclosing a history of sexual violence, what support and training, if any, you feel you or other maternity professionals might need and what it is like for you to care for women who you think might have experienced this type of trauma.

The interview will take place remotely using a secure online platform. It is important that you are in a private room where they will not be overheard, and I will ensure the same for my circumstances.



This can either be at your place of work or your place of residence. Before the interview begins, I will go through the study and answer your questions. You will be asked to provide your consent via an online form and I will additionally ask you to provide verbal confirmation of your consent to participate before we start the interview.

The interview will be audio recorded and will be transcribed by me or a professional trancription company bound by a confidentiality agreement.The recording will be permanently deleted after the transcript has been checked. Identifying details such as your name, place names etc. will be removed from the transcript.

I will not ask you for details of individual women you have worked with, and identifiable information about women should please not be provided during the interview.

Do I have to take part?

Participation is completely voluntary. You should only take part if you want to and choosing not to take part will not disadvantage you in any way. Once you have read the information sheet, please contact me if you have any questions that will help you make a decision about taking part. You can also discuss this study with someone you trust, if you think this would be helpful. If you decide to take part, I will ask you to sign an online consent form; you will be able to download a copy of this consent form to keep.

Will I receive any compensation for taking part in this study?

Where applicable, travel expenses and childcare costs will be reimbursed.

What are the possible risks of taking part?

Trauma experiences are extremely common, and I recognize that it is possible that you may have personal experience of violence and/or abuse. I will not ask about your experiences of abuse during the interviews. However, you will be asked about your own experiences of working with women who have experienced sexual violence and how working with women with this experience may have impacted you. This may bring up distressing feelings due to reflecting on other people's experiences of trauma, or, remind you of your own trauma if this applies. You do not need to talk about anything that makes you feel uncomfortable and you can take a break or stop the interview if you need.

What are the possible benefits of taking part?

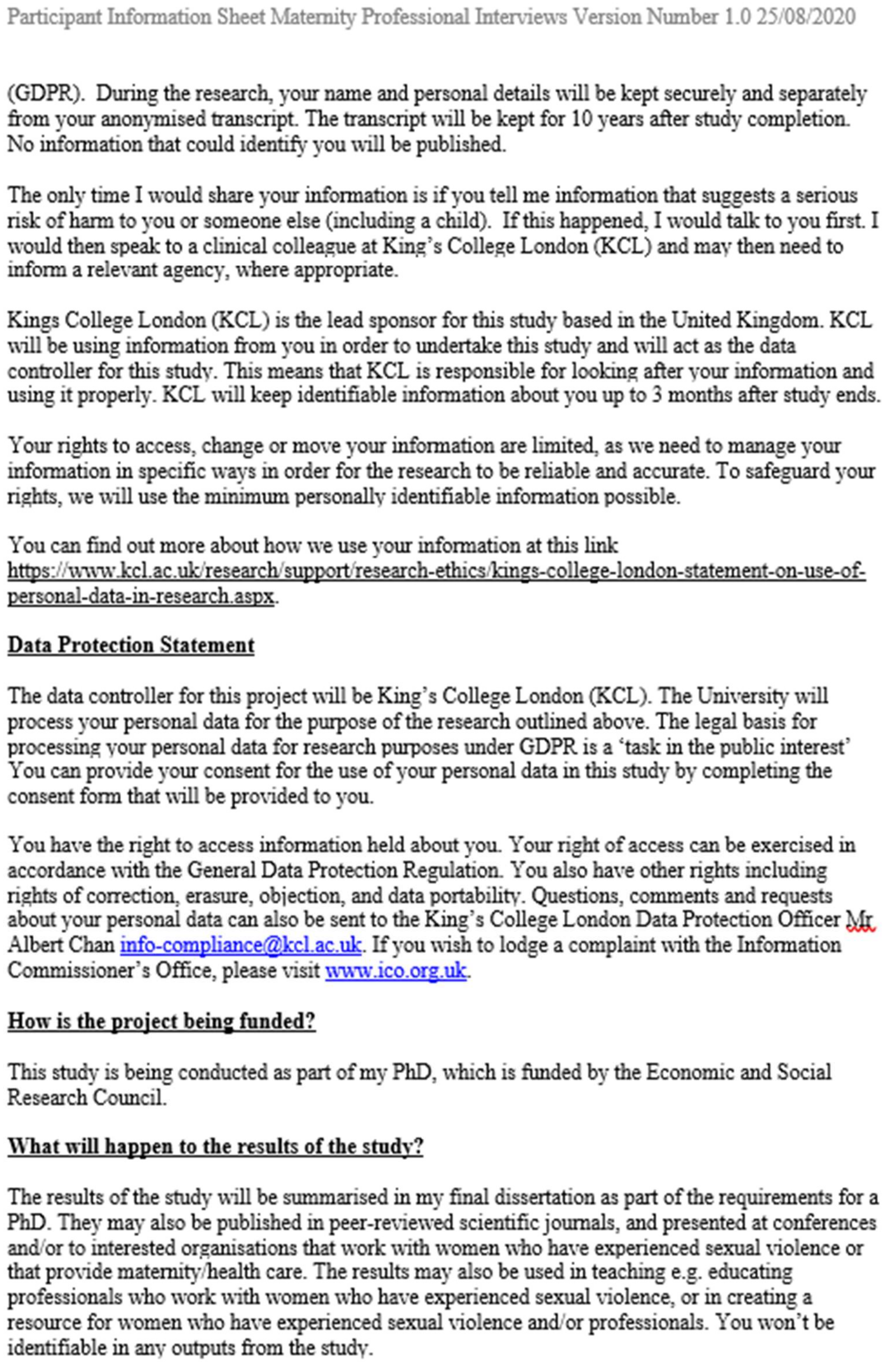
I don't expect there to be any direct benefits to you taking part in this research. However, I plan to share my findings with women and professionals and publish them in academic journals. I hope that this research might contribute to future training and guidance.

What if I change my mind about taking part?

You are free withdraw from the study without having to give a reason. You are able to withdraw your data from the study, up until 30th November 2020, when the analysis will be written up. If you choose to withdraw from the study, I will delete all data provided by you to me until that point.

Will be information be confidential?

Yes. Your data will be processed in accordance with the General Data Protection Regulation



(GDPR). During the research, your name and personal details will be kept securely and separately from your anonymised transcript. The transcript will be kept for 10 years after study completion. No information that could identify you will be published.

The only time I would share your information is if you tell me information that suggests a serious risk of harm to you or someone else (including a child). If this happened, I would talk to you first. I would then speak to a clinical colleague at King's College London (KCL) and may then need to inform a relevant agency, where appropriate.

Kings College London (KCL) is the lead sponsor for this study based in the United Kingdom. KCL will be using information from you in order to undertake this study and will act as the data controller for this study. This means that KCL is responsible for looking after your information and using it properly. KCL will keep identifiable information about you up to 3 months after study ends.

Your rights to access, change or move your information are limited, as we need to manage your information in specific ways in order for the research to be reliable and accurate. To safeguard your rights, we will use the minimum personally identifiable information possible.

You can find out more about how we use your information at this link https://www.kcl.ac.uk/research/support/research-ethics/kings-college-london-statement-on-use-of-personal-data-in-research.aspx.

Data Protection Statement

The data controller for this project will be King's College London (KCL). The University will process your personal data for the purpose of the research outlined above. The legal basis for processing your personal data for research purposes under GDPR is a 'task in the public interest' You can provide your consent for the use of your personal data in this study by completing the consent form that will be provided to you.

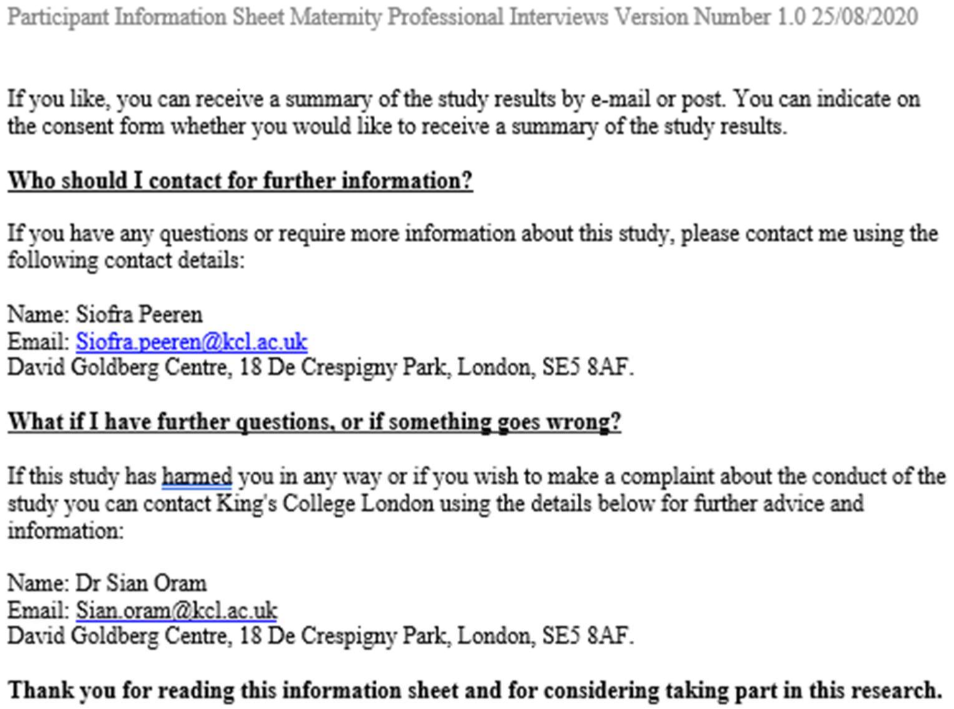
You have the right to access information held about you. Your right of access can be exercised in accordance with the General Data Protection Regulation. You also have other rights including rights of correction, erasure, objection, and data portability. Questions, comments and requests about your personal data can also be sent to the King's College London Data Protection Officer Mr Albert Chan info-compliance@kcl.ac.uk. If you wish to lodge a complaint with the Information Commissioner's Office, please visit www.ico.org.uk.

How is the project being funded?

This study is being conducted as part of my PhD, which is funded by the Economic and Social Research Council.

What will happen to the results of the study?

The results of the study will be summarised in my final dissertation as part of the requirements for a PhD. They may also be published in peer-reviewed scientific journals, and presented at conferences and/or to interested organisations that work with women who have experienced sexual violence or that provide maternity/health care. The results may also be used in teaching e.g. educating professionals who work with women who have experienced sexual violence, or in creating a resource for women who have experienced sexual violence and/or professionals. You won't be identifiable in any outputs from the study.



If you like, you can receive a summary of the study results by e-mail or post. You can indicate on the consent form whether you would like to receive a summary of the study results.

Who should I contact for further information?

If you have any questions or require more information about this study, please contact me using the following contact details:

Name: Siofra Peeren
Email: Siofra.peeren@kcl.ac.uk
David Goldberg Centre, 18 De Crespigny Park, London, SE5 8AF.

What if I have further questions, or if something goes wrong?

If this study has harmed you in any way or if you wish to make a complaint about the conduct of the study you can contact King's College London using the details below for further advice and information:

Name: Dr Sian Oram
Email: Sian.oram@kcl.ac.uk
David Goldberg Centre, 18 De Crespigny Park, London, SE5 8AF.

Thank you for reading this information sheet and for considering taking part in this research.

Appendix J: Provider Study Consent Form

Please complete this form after you have read the Information Sheet and/or listened to an explanation about the research.

Title of Study: Maternity Care Workers' Expectations and Experiences of Working with Survivors of Sexual Violence

King's Research Ethics Committee Reference Number: 20244

Name of researcher: Siofra Peeren

Please initial the boxes that apply to you:

YES

1. I agree to take part in this study. ☐
2. I understand that my information may be reviewed by responsible people at King's College London for monitoring and audit purposes. ☐
3. I confirm that I have read and understood the information sheet, dated 25/08/2020 version 1.0, for the above study. I have had enough time to consider the study, discuss it with anyone I would like, and have questions answered to my satisfaction. ☐
4. I understand that my participation is voluntary and that I am free to withdraw at any time without giving any reason. I understand that I will be able to request to have my data withdrawn up to 30th November 2020, after which the findings will be written up. ☐
5. I consent to the processing of my personal information for the purposes explained to me in the Information Sheet. I understand that such information will be handled in accordance with the terms of the General Data Protection Regulation. ☐
6. I understand that the researcher may be obligated to break confidentiality and provide relevant information to a clinician or other agencies if I disclose a risk of harm to myself or someone else, including a child. ☐
7. I consent to being audio recorded as part of the interview. ☐
8. I confirm that I am a maternity care professional (including students) who is currently or has previously practised in the UK. ☐

Optional:

9. I agree that anonymous verbatim quotes can be used in research reports. ☐
10. I would like to receive a summary of the study results. ☐
11. I am happy to be contacted about future research dissemination events. ☐

________________	________________	________________
Name of Participant	Date	Signature
________________	________________	________________
Name of Researcher	Date	Signature

Appendix K: Provider Study Topic Guide

PREAMBLE AND INTRODUCTORY QUESTIONS

1. What kind of work do you do? (specialist or not, midwife or doctor?)
2. What made you want to participate in this research?

Introduce topic and discussion: This research is about what you think about supporting women who have experienced sexual violence. You may or may not have had direct experience of supporting women who have experienced sexual violence. I won't ask you to share identifiable information about women. If you find any questions distressing or feel upset at any point we can stop the interview and you do not have to answer any questions you don't want to. I also want to point out that many care providers will also be survivors. I won't ask you about this but you are welcome to bring personal experiences into the interview if that feels helpful.

3. Have you had any experience of providing care to women who've experienced sexual violence that you wish to share? Or have you worked with women who did not disclose but you thought they might have experienced sexual violence?*
    a. What made you think they/she had experienced sexual violence?
    b. What did you do, if anything, to respond to your concerns (e.g. talk to/ask advice from another colleague about your concerns, change practice, ask overtly)?
    c. What, if anything, would you have done differently?

1. How, if at all, were you affected by working with this woman/women/person?
    a. How did you feel/what were your feelings when working with her/them?
    b. How did your feelings change, if at all? What made them change?
2. What has helped, or what do you think might help, reduce the impacts of this work on your own well-being?
3. What, if anything, made it difficult to identify if a woman had experienced sexual violence and/or abuse?
4. What could help overcome these challenges to identifying women's experiences of sexual violence and abuse?
5. What, if anything, made it difficult to respond to women's experiences of sexual violence and/or abuse?
6. What could help overcome these challenges to responding to women's experiences of sexual violence and abuse?

Probes for Discussion:

- Working conditions/resources
    - Access to information, time, support from fellow colleagues or more senior colleagues
    - Training (for undergraduate and as a qualified HCP)
- Respect/recognition from management or others
    - Opportunity, achievement, growth (CPD, training, responsibility)
- Management and supervision

Is there anything else that you would like to add?

*If the answer is no to both then ask questions hypothetically i.e. 'what might make you think someone has experienced sexual violence'

Appendix L: Decisions Made Prior to Reflexive Thematic Analysis

Reflective note taken from research diary outlining analytical decisions made prior to beginning reflexive thematic analysis. Based on the questions outlined by Braun and Clarke (2006).

What counts as a theme?

Salience of a theme will be prioritised over prevalence. If it seems important to the experience of maternity professionals and/or explains some sort of mechanism then it should be included.

Rich thematic description of entire dataset or focus on one part?

A rich thematic description of the entire data set so that the reader gets a sense of the predominant or important themes.

Inductive or theoretical thematic analysis?

Inductive analysis is "coding the data without trying to fit it into a pre-existing coding frame or the researcher's analytic preconceptions" (Braun & Clarke, 2006, p. 83). However Braun and Clarke also point out that "data is not coded in an epistemological vacuum" (p. 84). I will therefore take an inductive approach to analysis in the sense that it will be data-driven, while recognising that my own experiences, knowledge and preconceptions will inevitably shape the way I code the data, and that other phases of this research may occur concurrently with analysis of this data set.

Semantic or latent themes?

I will take a semantic approach which means that the analyst is not looking for anything beyond what a participant has said. However, there should still be a "progression from *description*, where the patterns have simply been organised to show patterns in semantic content and summarised, to *interpretation*, where there is an attempt to theorise the significance of the patterns and their broader meanings and implications (Patton, 1990, as cited in Braun and Clarke, 2006, p. 84).

Epistemological approach?

Analysis will be conducted from a critical-realist perspective that assumes the existence of a pursuable reality, whilst acknowledging that knowledge is shaped by factors such as culture, language and political interests.

Appendix M: Distress and Disclosure Protocol

Study title:

Understanding the pregnancy, parenting and maternity care experiences and needs of survivors of adulthood sexual violence

Principal Investigator and Researcher:

Siofra Peeren

Supervisors:

Dr Sian Oram (first supervisor) and Dr Elsa Montgomery (secondary supervisor)

Document title:

Standard Operating Procedures for interviews with survivors

1.0: Scope

This Standard Operating Procedure (SOP) outlines the steps that the researcher (Siofra Peeren) must follow when in contact with survivors of sexual abuse. The document provides specific instructions on methodological procedures associated with conducting qualitative interviews with survivors.

2.0: Researcher mobile telephones

The researcher will have a study mobile phone which should only be used for the study this SOP relates to. When making phone contact with a current or potential research participant, the researcher must confirm they are speaking with the research participant (and not another member of the household for example). Researcher must only discuss the study with the participant and not provide information to others without the consent of the research participant. If the person answering the phone asks who is calling or offers to take a message, researcher should simply state that this is a courtesy call on behalf of a research organisation and that they will call back at another time.

3.0: Risk to participant and others

When speaking to participants for the first time, the researcher should:

- take note of the best contact number for them

- what times suit them to speak
- whether there are any times that the researcher should not contact the participant

Whenever making telephone contact with the participant the researcher should:

- confirm who she is speaking to
- that it is safe to speak
- that the participant cannot be overhead

If the above conditions are not met, the researcher should sensitively end the call and arrange a suitable time to contact the participant.

The researcher will not ask the participant to talk about experiences of abuse during the interviews. However, reflecting on experiences of maternity care may bring up distressing memories and feelings. The potential for this topic to cause participants distress will be clearly outlined in the PIS. Before beginning an interview, the researcher will ask the participant whether there is anyone they would like them to call in case they become distressed, and if so, take a note of their name and number. The researcher will do her best to ensure a safe and non-judgmental environment for participants, so that the participant does not feel under pressure to disclose anything she does not feel comfortable with and feels able to stop the interview or take a break if she needs. In addition, the researcher will signpost participants to free and accessible support services in case they feel distressed following the interview.

The researcher has previous experience of conducting research interviews with survivors of domestic violence and other vulnerable populations, and has hands-on experience of supporting survivors of sexual violence within the charity sector. She is therefore well-informed about the dynamics of abuse and experienced in working with issues specific to this group e.g. flashbacks or panic attacks. The researcher will be supervised by senior staff: Dr Sian Oram is experienced in conducting research with survivors of domestic and sexual abuse, including survivors of trafficking, and Dr Elsa Montgomery is experienced in conducting research with survivors of sexual abuse and is an experienced midwife. A lead and a deputy clinical colleague will be available to contact in case safeguarding issues emerge and the researcher needs to contact a clinician to determine whether there is a need to break confidentiality.

If the participant seems distressed the researcher will respond in one of the following ways. Depending on what seems most appropriate at the time, the researcher may suggest:

- taking a break
- continuing the interview at another time
- skipping any questions or topics that are stressful
- stopping the interview

If appropriate, the researcher will stop the recording of the interview and only restart the recording when the participant actively consents to this.

The PIS will clearly outline the circumstances under which the research will need to break confidentiality i.e. any current risk to herself or others. The following actions will be taking if the participant discloses current risk to themselves, or another person, to the researcher:

- The researcher will contact the designated clinical colleague to discuss the concern and determine whether the researcher needs to break confidentiality
- If the team decides that this concern needs to be disclosed, the researcher will speak to the participant, explain her concerns and seek consent to pass on this information to the relevant service or agency. Ideally, this disclosure is made to the service by the participant, or together with the participant.

Before finalising any interview times with participants, the researcher will ensure that a clinical colleague is available to take a call regarding a disclosure or safeguarding concern for the duration of the interview and immediately afterwards. The researcher will confirm the clinician's availability again prior to attending any interview.

4.0: Risk to researcher

Interviews will be conducted in private but preferably in a public facility a consulting/meeting room at either an NHS facility or support organisation which is convenient for the participant. Interviews can be conducted in participant's homes where this is deemed safe after a risk assessment. Before conducting an interview in a participant's home the researcher will speak to the participant's clinical team and/or case worker to obtain information necessary for a risk assessment. Following this, the researcher will discuss the following with the supervisor(s).

- The location of the participant's home
- If any person or animal living in the participant's home may be dangerous
- If the participant or any person living in the participant's home has a history of violence to others, drug or alcohol problems
- If there are any other potential dangers to take into account.
- If there is any doubt about the safety of the participant's home the interview should scheduled in a neutral place, such a room in a service they may be using

In cases where interviews are conducted in participant homes the following steps will be undertaken:

- Before attending an interview, the researcher must ensure that she has her mobile and that it is fully charged.
- The location of the interview will be written on a piece of paper enclosed in a sealed envelope and given to a colleague at the IoPPN. Because confidentiality is extremely important when conducting research with survivors of abuse, identifying information such as their address will always be sealed in an envelope and the envelope only opened when necessary. The aforementioned colleague within the IoPPN will also be told the interview starting and approximate finishing time, and information about who to contact if they don't hear from the researcher at the appointed time. The researcher will ensure this colleague has her contact number.
- The colleague which has this information must be available to answer a call from the researcher when the interview finishes or take action if they do not hear from the researcher.
- If the colleague does not hear from the researcher, they must first ring the researcher to check if she is safe. If they cannot make contact, they should ring the supervisor and pass on the details enclosed in the envelope. If they are worried, they should pass the information to the police.

- If the researcher checks in at the correct time and all is well, the aforementioned colleague will return the envelope containing the participant's details, still sealed, to the researcher. The researcher will then dispose of the envelope using a confidential waste bin.

Other general safety rules are as follows: The researcher should:

- assess the area/house that they are going to. If they feel uncomfortable with the location or the circumstances – even if it is at the last minute or during the interview, the researcher should make their excuses and leave
- make sure that they are dressed appropriately, taking into consideration cultural and gender issues. For women: wear something comfortable and not short skirts/high heels- in case they need to run
- not use the bathroom. It is usually upstairs (not easy access to the front door in case you need to leave the house immediately) or you can be easily trapped in it
- make sure that you conduct the interview in a 'neutral room' such as the living room. Avoid doing the assessments in the bedroom or the kitchen (danger of knives etc)
- make sure you sit next to the door or have easy access to it
- ensure that no written and/or verbal information regarding sources of support are given to participants when they are in the presence of partners, family members, friends or children of comprehending age (there is a risk that an abuser may find out about this information)
- ensure that written information about sources of support are not taken away by participants, unless it is safe for them to do so
- ask participants how they feel after the meeting and whether they would like to discuss anything further with their responsible clinician and/or support worker.

5.0 Risk to Children

This section of the SOP is informed by the *Working Together to Safeguard Children* (2018) guiding framework for the safeguarding of children. This report defines a child as anyone who has not reached their 18th birthday. Safeguarding children is everyone's role, but the researcher's role is not to determine whether abuse of children is or has taken place or to investigate the issue. However, the researcher must discuss any concerns relating to abuse of children with the study clinician, who will decide what the next steps are.

Abuse is defined as “a form of maltreatment of a child” (*Working Together to Safeguard Children*, 2018, p. 103). Abuse can include various forms, such as physical abuse, emotional abuse, sexual abuse, child sexual exploitation, and/or neglect (*Working Together to Safeguard Children*, 2018).

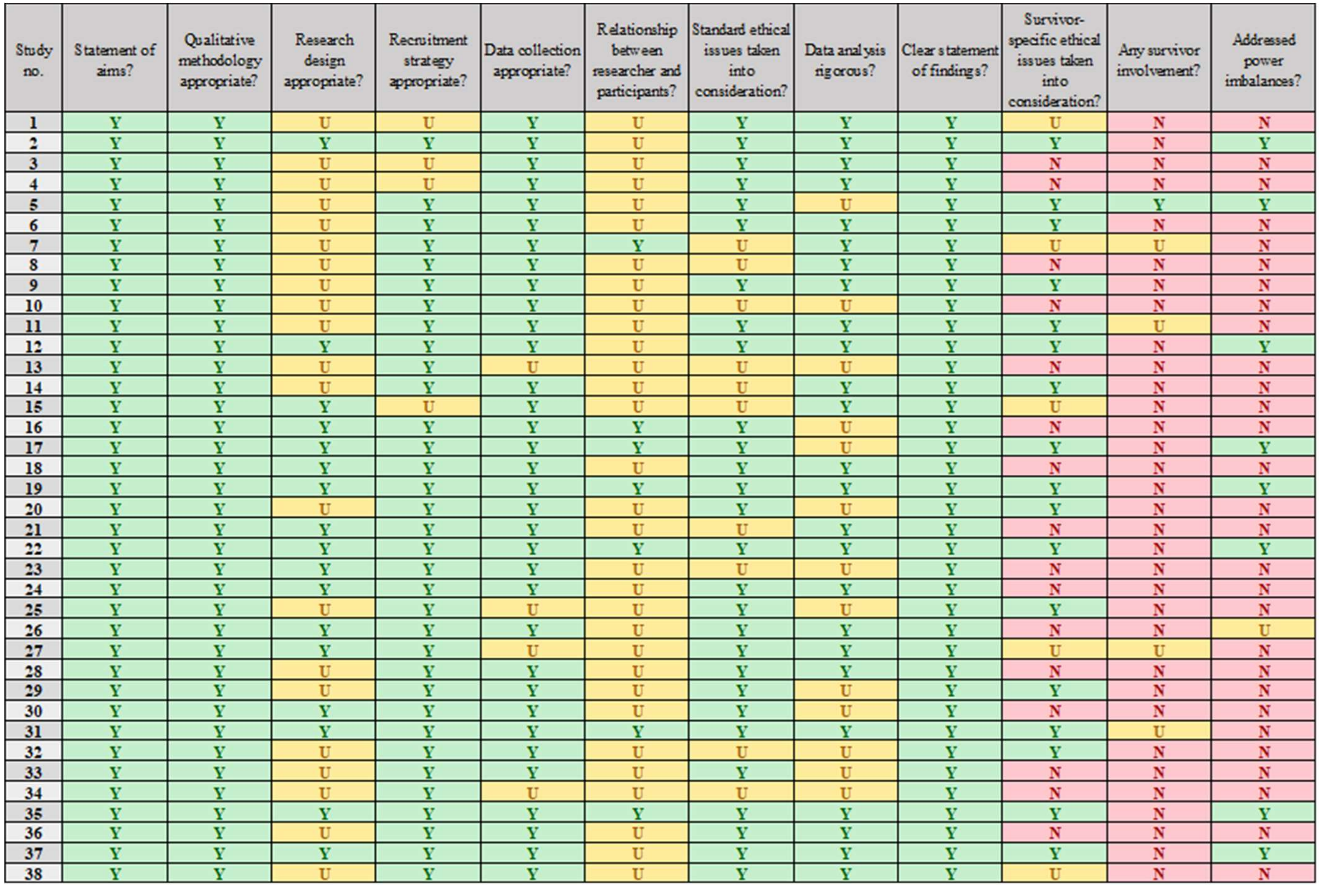
Where a participant makes a disclosure of abuse, harm or neglect of a child, the researcher should:

- believe the participant and take the information seriously
- listen, encourage, but avoid asking leading questions
- tell the participant that they will need to talk to someone else about the next steps
- contact the clinical contact for the study
- if it is deemed necessary by the clinical contact to pass this information on to support services or a relevant agency, seek consent to break confidentiality and disclose this information to the participant’s support worker,responsible clinician and/or relevant agency. If the participant does not consent to the sharing of this information, it will still be necessary to break confidentiality
- check that the participant understands what they are going to do e.g. speak to the clinical contact, break confidentiality
- record their observations and what the participant has said at the earliest opportunity, including dates and times

6.0: Authorisation

- This SOP was written by: Siofra Peeren
- This SOP was reviewed by: Sian Oram and Elsa Montgomery
- This SOP was authorized by: Sian Oram
- Authorisation Date: 26/04/2019

Appendix N: CASP and Additional Trauma-Informed Research Quality Indicators Quality Assessment Outcome

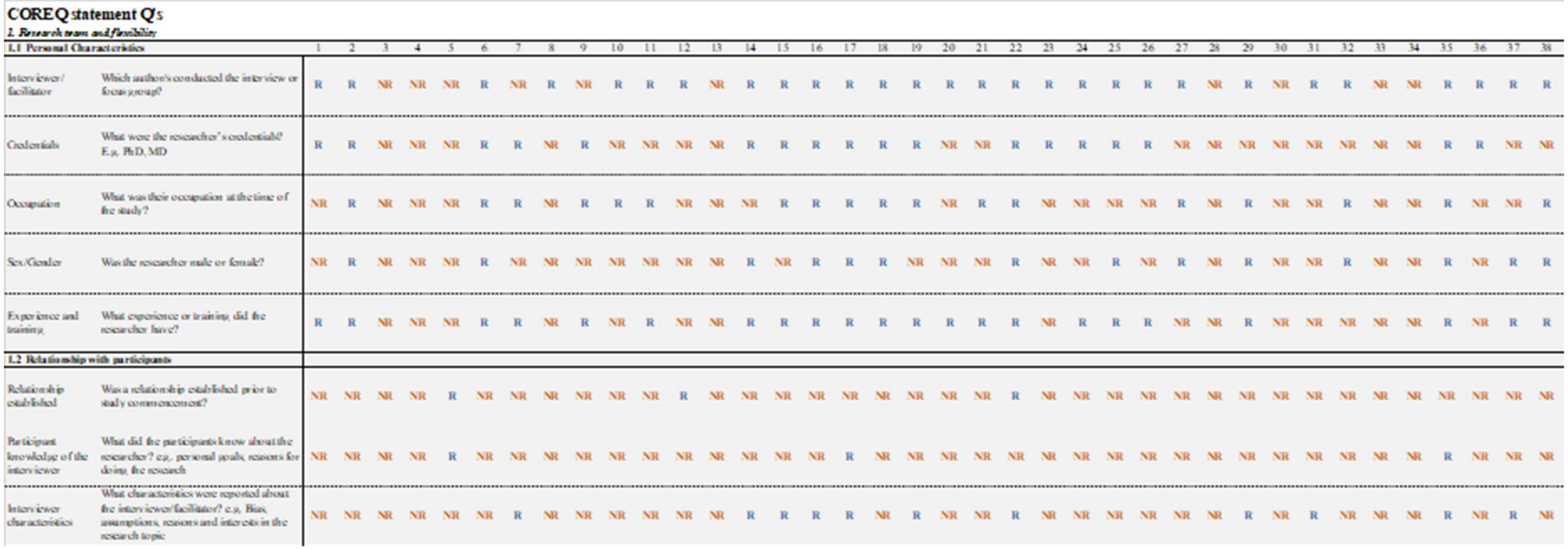


Study no.	Statement of aims?	Qualitative methodology appropriate?	Research design appropriate?	Recruitment strategy appropriate?	Data collection appropriate?	Relationship between researcher and participants?	Standard ethical issues taken into consideration?	Data analysis rigorous?	Clear statement of findings?	Survivor-specific ethical issues taken into consideration?	Any survivor involvement?	Addressed power imbalances?
1	Y	Y	U	U	Y	U	Y	Y	Y	U	N	N
2	Y	Y	Y	Y	Y	U	Y	Y	Y	Y	N	Y
3	Y	Y	U	U	Y	U	Y	Y	Y	N	N	N
4	Y	Y	U	U	Y	U	Y	Y	Y	N	N	N
5	Y	Y	U	Y	Y	U	Y	U	Y	Y	Y	Y
6	Y	Y	U	Y	Y	U	Y	Y	Y	Y	N	N
7	Y	Y	U	Y	Y	Y	U	Y	Y	U	U	N
8	Y	Y	U	Y	Y	U	U	Y	Y	N	N	N
9	Y	Y	U	Y	Y	U	Y	Y	Y	Y	N	N
10	Y	Y	U	Y	Y	U	U	U	Y	N	N	N
11	Y	Y	U	Y	Y	U	Y	Y	Y	Y	U	N
12	Y	Y	Y	Y	Y	U	Y	Y	Y	Y	N	Y
13	Y	Y	U	Y	U	U	U	U	Y	N	N	N
14	Y	Y	U	Y	Y	U	U	Y	Y	Y	N	N
15	Y	Y	Y	U	Y	U	U	Y	Y	U	N	N
16	Y	Y	Y	Y	Y	Y	Y	U	Y	N	N	N
17	Y	Y	Y	Y	Y	Y	Y	U	Y	Y	N	Y
18	Y	Y	Y	Y	Y	U	Y	Y	Y	N	N	N
19	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	N	Y
20	Y	Y	U	Y	Y	U	Y	U	Y	Y	N	N
21	Y	Y	Y	Y	Y	U	U	Y	Y	N	N	N
22	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	N	Y
23	Y	Y	Y	Y	Y	U	U	U	Y	N	N	N
24	Y	Y	Y	Y	Y	U	Y	Y	Y	N	N	N
25	Y	Y	U	Y	U	U	Y	U	Y	Y	N	N
26	Y	Y	Y	Y	Y	U	Y	Y	Y	N	N	U
27	Y	Y	Y	Y	U	U	Y	Y	Y	U	U	N
28	Y	Y	U	Y	Y	U	Y	Y	Y	N	N	N
29	Y	Y	U	Y	Y	U	Y	U	Y	Y	N	N
30	Y	Y	Y	Y	Y	U	Y	U	Y	N	N	N
31	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	U	N
32	Y	Y	U	Y	Y	U	U	U	Y	Y	N	N
33	Y	Y	U	Y	Y	U	Y	U	Y	N	N	N
34	Y	Y	U	Y	U	U	U	U	Y	N	N	N
35	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	N	Y
36	Y	Y	U	Y	Y	U	Y	Y	Y	N	N	N
37	Y	Y	Y	Y	Y	U	Y	Y	Y	Y	N	Y
38	Y	Y	U	Y	Y	U	Y	Y	Y	U	N	N

Appendix O: COREQ Quality Assessment Outcome

Key:

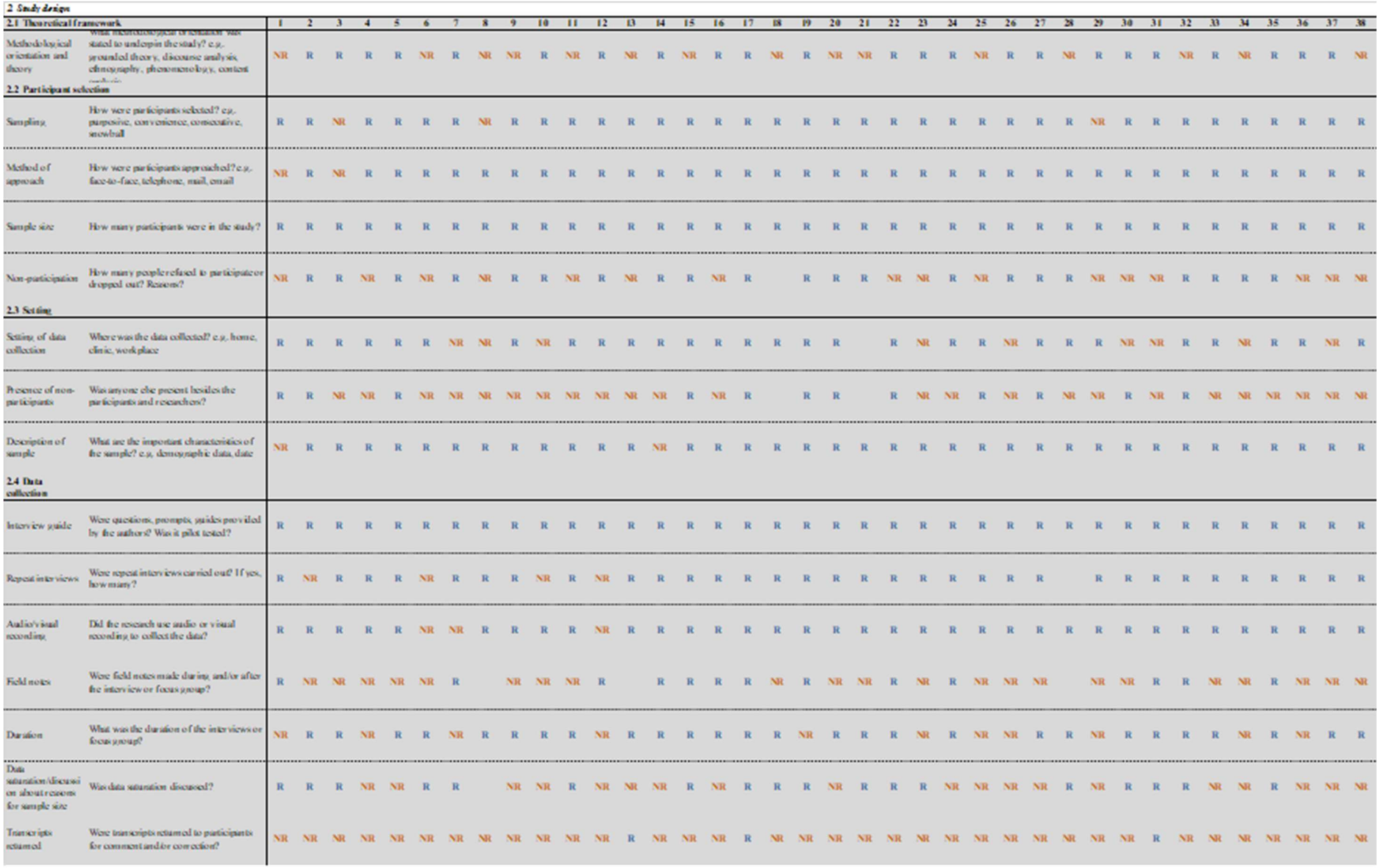
NR = Not Reported
R = Reported
Y = Yes
N = No



COREQ statement Q's

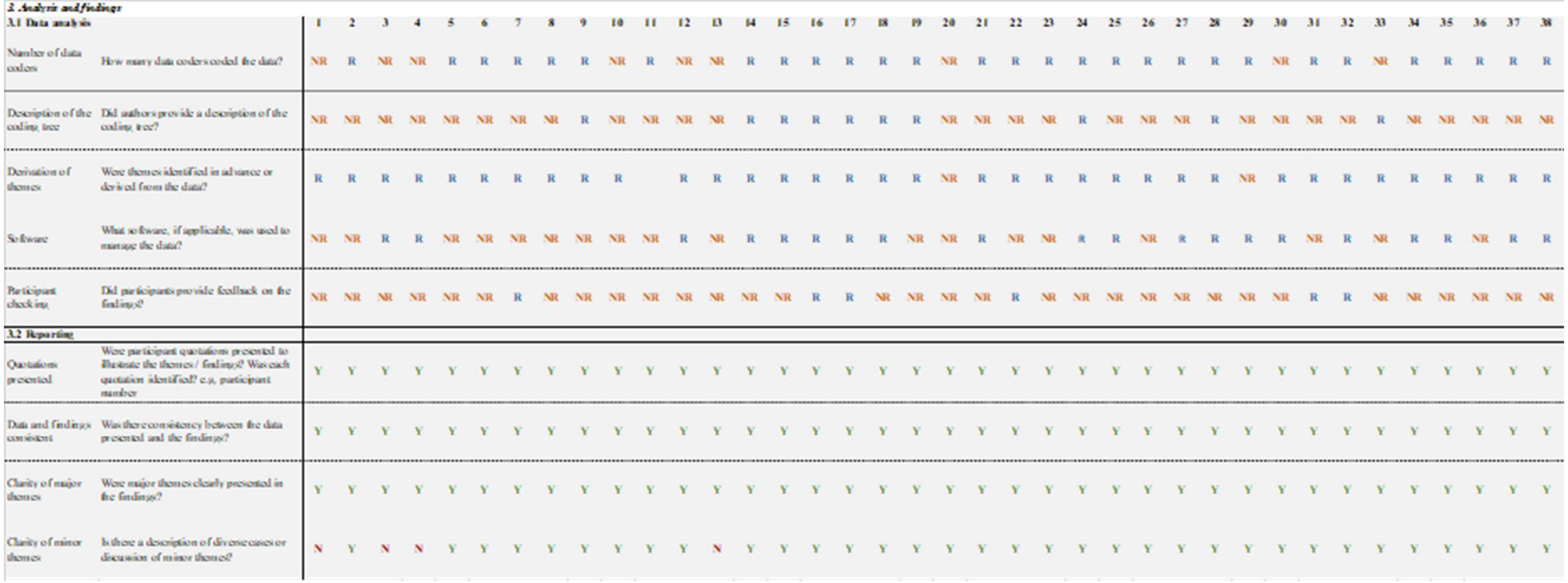
1. Research team and reflexivity

1.1 Personal Characteristics		1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31	32	33	34	35	36	37	38
Interviewer/ facilitator	Which author/s conducted the interview or focus group?	R	R	NR	NR	NR	R	NR	R	NR	R	R	R	NR	R	R	R	R	R	R	R	R	R	R	R	R	R	R	NR	R	NR	R	R	NR	NR	R	R	R	R
Credentials	What were the researcher's credentials? E.g. PhD, MD	R	R	NR	NR	NR	R	R	NR	R	NR	NR	NR	NR	R	R	R	R	R	R	NR	NR	R	R	R	R	R	NR	NR	NR	NR	NR	NR	NR	NR	R	R	NR	NR
Occupation	What was their occupation at the time of the study?	NR	R	NR	NR	NR	R	R	NR	R	R	R	NR	NR	NR	R	R	R	R	R	NR	R	R	NR	NR	NR	NR	R	NR	R	NR	NR	R	NR	NR	R	NR	NR	R
Sex/Gender	Was the researcher male or female?	NR	R	NR	NR	NR	R	NR	NR	NR	NR	NR	NR	NR	R	NR	R	R	R	NR	NR	NR	R	NR	NR	R	NR	R	NR	R	NR	NR	R	NR	NR	R	NR	R	R
Experience and training	What experience or training did the researcher have?	R	R	NR	NR	NR	R	R	NR	R	NR	R	NR	NR	R	R	R	R	R	R	R	R	R	NR	R	R	R	NR	NR	R	NR	NR	NR	NR	NR	R	NR	R	R
1.2 Relationship with participants																																							
Relationship established	Was a relationship established prior to study commencement?	NR	NR	NR	NR	R	NR	NR	NR	NR	NR	NR	R	NR	NR	NR	NR	NR	NR	NR	NR	NR	R	NR	NR	NR	NR	NR	NR	NR	NR	NR	NR	NR	NR	NR	NR	NR	NR
Participant knowledge of the interviewer	What did the participants know about the researcher? e.g. personal goals, reasons for doing the research	NR	NR	NR	NR	R	NR	NR	NR	NR	NR	NR	NR	NR	NR	NR	NR	R	NR	NR	NR	NR	NR	NR	NR	NR	NR	NR	NR	NR	NR	NR	NR	NR	NR	R	NR	NR	NR
Interviewer characteristics	What characteristics were reported about the interviewer/facilitator? e.g. Bias, assumptions, reasons and interests in the research topic	NR	NR	NR	NR	NR	NR	R	NR	NR	NR	NR	NR	NR	R	R	R	R	NR	R	NR	NR	R	NR	NR	NR	NR	NR	NR	R	NR	R	NR	NR	NR	R	NR	R	NR



2 Study design

2.1 Theoretical framework		1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31	32	33	34	35	36	37	38
Methodological orientation and theory	What methodological orientation was stated to underpin the study? e.g., grounded theory, discourse analysis, ethnography, phenomenology, content analysis	NR	R	R	R	R	NR	R	NR	NR	R	NR	R	NR	R	NR	R	R	NR	R	NR	NR	R	R	R	NR	R	R	NR	R	R	R	NR	R	NR	R	R	R	NR
2.2 Participant selection																																							
Sampling	How were participants selected? e.g., purposive, convenience, consecutive, snowball	R	R	NR	R	R	R	R	NR	R	R	R	R	R	R	R	R	R	R	R	R	R	R	R	R	R	R	R	R	NR	R	R	R	R	R	R	R	R	R
Method of approach	How were participants approached? e.g., face-to-face, telephone, mail, email	NR	R	NR	R	R	R	R	R	R	R	R	R	R	R	R	R	R	R	R	R	R	R	R	R	R	R	R	R	R	R	R	R	R	R	R	R	R	R
Sample size	How many participants were in the study?	R	R	R	R	R	R	R	R	R	R	R	R	R	R	R	R	R	R	R	R	R	R	R	R	R	R	R	R	R	R	R	R	R	R	R	R	R	R
Non-participation	How many people refused to participate or dropped out? Reasons?	NR	R	R	NR	R	NR	R	NR	R	R	NR	R	NR	R	R	NR	R		R	R	R	NR	NR	R	NR	R	R	R	NR	NR	NR	R	R	R	R	NR	NR	NR
2.3 Setting																																							
Setting of data collection	Where was the data collected? e.g., home, clinic, workplace	R	R	R	R	R	R	NR	NR	R	NR	R	R	R	R	R	R	R	R	R	R		R	NR	R	R	NR	R	R	R	NR	NR	R	R	NR	R	R	NR	R
Presence of non-participants	Was anyone else present besides the participants and researchers?	R	R	NR	NR	R	NR	NR	NR	NR	NR	NR	NR	NR	NR	R	NR	R		R	R		R	NR	NR	R	NR	R	NR	NR	R	NR	R	NR	NR	NR	NR	NR	NR
Description of sample	What are the important characteristics of the sample? e.g., demographic data, date	NR	R	R	R	R	R	R	R	R	R	R	R	R	NR	R	R	R	R	R	R	R	R	R	R	R	R	R	R	R	R	R	R	R	R	R	R	R	R
2.4 Data collection																																							
Interview guide	Were questions, prompts, guides provided by the authors? Was it pilot tested?	R	R	R	R	R	R	R	R	R	R	R	R	R	R	R	R	R	R	R	R	R	R	R	R	R	R	R	R	R	R	R	R	R	R	R	R	R	R
Repeat interviews	Were repeat interviews carried out? If yes, how many?	R	NR	R	R	R	NR	R	R	R	NR	R	NR	R	R	R	R	R	R	R	R	R	R	R	R	R	R	R		R	R	R	R	R	R	R	R	R	R
Audio/visual recording	Did the research use audio or visual recording to collect the data?	R	R	R	R	R	NR	NR	R	R	R	R	NR	R	R	R	R	R	R	R	R	R	R	R	R	R	R	R	R	R	R	R	R	R	R	R	R	R	R
Field notes	Were field notes made during and/or after the interview or focus group?	R	NR	NR	NR	NR	NR	R		NR	NR	NR	R		R	R	R	R	NR	R	NR	NR	R	NR	R	NR	NR	NR		NR	NR	R	R	NR	NR	R	NR	NR	NR
Duration	What was the duration of the interviews or focus group?	NR	R	R	NR	R	R	NR	R	R	R	R	NR	R	R	R	R	R	R	NR	R	R	R	NR	R	NR	NR	R	R	NR	R	R	R	R	NR	R	NR	R	R
Data saturation/discussion about reasons for sample size	Was data saturation discussed?	R	R	R	NR	NR	R	R		NR	NR	R	NR	NR	NR	R	NR	R	R	R	NR	R	R	R	NR	NR	NR	NR	R	NR	R	R	R	NR	NR	R	NR	NR	NR
Transcripts returned	Were transcripts returned to participants for comment and/or correction?	NR	NR	NR	NR	NR	NR	NR	NR	NR	NR	NR	NR	R	NR	NR	NR	R	NR	NR	NR	NR	NR	NR	NR	NR	NR	NR	NR	NR	NR	R	NR	NR	NR	NR	NR	NR	NR



3. Analysis and findings

3.1 Data analysis		**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**	**11**	**12**	**13**	**14**	**15**	**16**	**17**	**18**	**19**	**20**	**21**	**22**	**23**	**24**	**25**	**26**	**27**	**28**	**29**	**30**	**31**	**32**	**33**	**34**	**35**	**36**	**37**	**38**
Number of data coders	How many data coders coded the data?	NR	R	NR	NR	R	R	R	R	R	NR	R	NR	NR	R	R	R	R	R	R	NR	R	R	R	R	R	R	R	R	R	NR	R	R	NR	R	R	R	R	R
Description of the coding tree	Did authors provide a description of the coding tree?	NR	NR	NR	NR	NR	NR	NR	NR	R	NR	NR	NR	NR	R	R	R	R	R	R	NR	NR	NR	NR	R	NR	NR	NR	R	NR	NR	NR	NR	R	NR	NR	NR	NR	NR
Derivation of themes	Were themes identified in advance or derived from the data?	R	R	R	R	R	R	R	R	R	R		R	R	R	R	R	R	R	R	NR	R	R	R	R	R	R	R	R	NR	R	R	R	R	R	R	R	R	R
Software	What software, if applicable, was used to manage the data?	NR	NR	R	R	NR	NR	NR	NR	NR	NR	NR	R	NR	R	R	R	R	R	NR	NR	R	NR	NR	R	R	NR	R	R	R	R	NR	R	NR	R	R	NR	R	R
Participant checking	Did participants provide feedback on the findings?	NR	NR	NR	NR	NR	NR	R	NR	NR	NR	NR	NR	NR	NR	NR	R	R	NR	NR	NR	NR	R	NR	NR	NR	NR	NR	NR	NR	NR	R	R	NR	NR	NR	NR	NR	NR
3.2 Reporting																																							
Quotations presented	Were participant quotations presented to illustrate the themes / findings? Was each quotation identified? e.g. participant number	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
Data and findings consistent	Was there consistency between the data presented and the findings?	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
Clarity of major themes	Were major themes clearly presented in the findings?	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
Clarity of minor themes	Is there a description of diverse cases or discussion of minor themes?	N	Y	N	N	Y	Y	Y	Y	Y	Y	Y	Y	N	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y

Appendix P: Support Resource Discussed with Survivors

The London Survivors Gateway:

All the information below is based on the London Survivors Gateway website. This is a new service which is run by the Women and Girls Network and allows survivors in London to have one source of information for all the support available to them.

If you are aged 13 or above, have experienced sexual violence or abuse at any time in your life and live, work or study in London, the survivors gateway can help you to:

- access sexual violence support services in London
- make decisions about what support is right for you
- consider your own safety and support needs
- find self-support guides and resources

They work with all survivors aged 13 or above regardless of gender, sexuality, disability, chosen language, ethnicity or immigration status.

The Gateway is staffed by workers called ‘Navigators’ who understand sexual violence and abuse and they work from the following values (taken directly from their website: https://survivorsgateway.london/)

- believe you
- never judge or blame you
- let you be in control of what you tell us
- provide a safe and confidential space
- respect your choices and be led by you
- work against oppression and prejudice
- not assume to know what you need
- understand your coping mechanisms
- never pressure you to report to the police
- be honest about our limitations
- invite your feedback to improve our work
- offer spaces for your voice to be heard
- recognise your strength, courage and resilience

You can call the Survivors Gateway on 0808 801 0860 or refer yourself online at: https://www.dpmscloud.com/external/referralformselfwgn.

Resources:

A really useful self help guide created by Somerset and Avon Rape & Sexual Abuse Centre. It goes through how trauma affects people, and how to manage key reactions to trauma such as flashbacks. It includes practical tools that anyone can use to help cope with the aftermath of trauma.
https://www.sarsas.org.uk/wp-content/uploads/2017/06/SARSAS-Self-Help-Guide2.pdf

The courage to be me: A story of courage, self-compassion and hope after sexual abuse by Dr Nina Burrowes

The courage to be me combines science, storytelling and illustration to send a message of hope to the millions of people who are living with the impact of rape or sexual abuse. Written by psychologist and researcher Dr Nina Burrowes. You can access it for free at:
https://ninaburrowes.com/books/the-courage-to-be-me/preface/

This page outlines different strategies to manage mental health and well-being, including grounding techniques
https://www.annafreud.org/on-my-mind/self-care/

Six booklets for survivors and those who support them written by The National Association for People Abused in Childhood. They are free to download from the following link:
https://napac.org.uk/project_category/booklets/

Rights of Women
Rights of Women aims to achieve equality, justice and respect for all women. Rights of Women advises, educates and empowers women by (1) providing women with free, confidential legal advice by specialist women solicitors and barristers, (2) enabling women to understand and benefit from their legal rights through accessible and timely publications and training, (3) campaigning to ensure that women's voices are heard and law and policy meets all women's needs.
To find out more about their advice lines and legal information for women visit www.rightsofwomen.org.uk or call 020 7521 6575.

Services:

1. **The Havens**

The Havens have three centres in London that cover the whole of the city. You can make an appointment at the Haven you think is best for you:

- Camberwell Haven, near to King's College Hospital (south)
- Whitechapel Haven, near to Royal London Hospital (east)
- Paddington Haven, near to St Mary's Hospital (west)

Services Offered: The Havens are specialist centres in London for people who have been raped or sexually assaulted in the last 12 months. Services include urgent advice, emergency contraception, specialist support and practical advice and forensic medical examinations (FME). Also offer follow-up care including counselling, tests and treatments.
Service Criteria: Anyone assaulted in the last 12 months regardless of age, ethnicity, religion, gender or sexual orientation.
Website: https://www.thehavens.org.uk/
Contact:
Urgent help, appointments or advice via 020 3299 6900 (24/7). Please note that this number is answered by the London Survivors Gateway 10am-4pm Monday to Friday.

2. **Women and Girls Network**

Services Offered: Ascent Counselling; Advice Line; 1-2-1 casework support; Young Women's Advocacy; Young Womens Prevention Work; Indigo Service (for women with 'complex needs').
Service Criteria: Women and girls who have experience gender based violence. Young Women's Team work aged 11 and above.
Website: http://www.wgn.org.uk

3. **West London Rape Crisis Centre**

Services Offered: Counselling; Independent Sexual Violence Advocate (ISVA) Service; Sexual Violence Helpline; Body Therapy; Group Work.
Service Criteria: Women and girls aged 13+ who have experienced sexual violence at any time in their lives.
Website: http://www.wgn.org.uk
Contact:
Sexual Violence Helpline: 0808 801 0770
Office: 020 8567 7347

4. **GALOP (for LGBT+ survivors)**

Services Offered: Helpline; Practical Advice and Support; Independent Sexual Violence Advocates
Service Criteria: Support for lesbian, gay, bisexual and trans people who have experienced sexual assault, abuse or violence at any time in their lives.
Website: http://www.galop.org.uk/sexualviolence/
Contact:
Office telephone: 0207 7046767
Email: referrals@galop.org.uk.

5. **North London Rape Crisis**

Services Offered: Helpline; Counselling; Independent Sexual Violence Advocates; Group Work; Body Therapies
Service Criteria: Women and girls 13+ who have experienced any form of sexual violence at any time in their lives.
Website: https://www.solacewomensaid.org/solace-rape-crisis
Contact:
Helpline and appointments: 0808 801 0305

6. **East London Rape Crisis**

Services Offered: Helpline; Counselling; Independent Sexual Violence Advocates (ISVA), Group Work
Service Criteria: Women and girls aged 14+ who have experienced sexual violence at any time in their lives.
Website: http://www.niaendingviolence.org.uk/rape/

7. **South London Rape Crisis**

Services Offered: Helpline; Counselling; Independent Sexual Violence Advocates (ISVA), Outreach Support, Training.
Service Criteria: Women aged 13 and above who live or work in any South London Borough
Website: http://www.rasasc.org.uk
Contact:
Helpline: 08088029999 open daily 12:00 – 14:30 & 19:00 – 21:30
Counselling and Advocacy: 0208 683 3311 between 10am and 6pm, Monday to Friday.

National Helplines
The National Association for People Abused in Childhood (NAPAC)
Call 0808 801 0331 **free from all landlines and mobiles**
Monday – Thursday 10:00-21:00 and Friday 10:00-18:00

NAPAC provides a national freephone support line for adults who have suffered any type of abuse in childhood.
Website: **www.napac.org.uk**

SurvivorsUK Helpline Web Chat
Web Chat
(Monday – Friday 10.30 – 21:00; Saturday – Sunday 10:00 – 18:00)
National Web Chat for adult male survivors of rape or sexual
Text: 020 3322 1860
Whatsapp: 07491 816 064
Website: **www.survivorsuk.org**

MOSAC (Mothers of Sexually Abused Children)
Freephone: 0800 980 1958
Supporting all non-abusing parents and carers whose children have been sexually abused. We provide various types of support services and information for parents, carers and professionals dealing with child sexual abuse.
Website: **www.mosac.org.uk**

SupportLine
Helpline: 01708 765200
Confidential emotional support to children, young adults and adults by telephone, email and post.
Website: **www.supportline.org.uk**

CISters (Surviving Rape and/or Sexual Abuse)
Telephone: 02380 338080
Answerphone 023 80 338080 is usually monitored daily during the week and callers can choose to leave their name and phone number, and we will call them back and will take care when doing so. Or can email admin@cisters.org.uk
The helpline is available to female adult survivors of childhood rape/sexual abuse, and others can call if they have a concern about such issues. In the case of the latter we will seek to signpost them to appropriate services.

PODS: Positive Outcomes for Dissociative Survivors
A project of Survivors Trauma and Abuse Recovery Trust (START)
Helpline: 0800 181 4420
PODS works to make recovery from dissociative disorders a reality through training, informing and supporting.
Tuesdays 6-8pm or appointments at other times by contacting the office
Email: mail@start-online.org.uk (for START) or info@pods-online.org.uk (for PODS)
Website: **www.start-online.org.uk** and **www.pods-online.org.uk**

Rape Crisis England and Wales
Freephone 0808 802 9999
12 noon – 2.30pm and 7 – 9.30pm every day of the year
Rape Crisis England & Wales is a feminist organisation that exists to promote the needs and rights of women and girls who have experienced sexual violence, to improve services to them and to work towards the elimination of sexual violence.
Website: www.rapecrisis.org.uk

Safeline
General Helpline: 0808 800 5008
Text Helpline and Online Advisors: 07860 027573
Monday **10am – 4pm|**Tuesday **8am – 8pm|**Wednesday **10am – 4pm|**Thursday **8am – 8pm|**Friday **10am – 4pm|**Saturday **10am – 12 noon**
Safeline is a specialised charity working to prevent sexual abuse and to support those affected in their recovery.
Website: www.safeline.org.uk

Appendix Q: CERQual Assessment Evidence Profile

Theme	Summary of review finding	Studies contributing to the review finding	Methodological limitations	Coherence	Adequacy	Relevance	CERQUAL assessment of confidence in the evidence	Explanation of CERQUAL assessment
Acknowledgement: shifting shame and blame (6.3.1) Societal perceptions which positioned women as responsible for sexual violence shaped how women made sense of their experiences and how they were treated by providers. When presenting to healthcare women expected to be blamed and not be believed (n = 24 studies; 2, 7, 8, 9, 11, 12, 14, 15, 16, 18, 19, 20, 22, 26, 28, 29, 30, 31, 33, 34, 35, 36, 37, 38).	**Alienation and shame.** Shame alienated survivors from their bodies as well as other people. Fear of being blamed prevented disclosure. Blaming responses to disclosures re-enforced shame.	18 studies (2, 7, 8, 9, 11, 15, 16, 18, 19, 26, 28, 29, 30, 31, 33, 35, 36, 37)	14 (78%) minor or no concerns (2, 7, 9, 11, 16, 18, 19, 26, 28, 30, 31, 35, 36, 37) and 4 (22%) moderate concerns (8, 15, 29, 33).	No or very minor concerns about coherence. The data reflected that survivors felt shame and blame which prevented disclosure, and that blaming responses to disclosures exacerbated shame and self-blame.	No or very minor concerns about adequacy: 16 studies described shame and blame (either from the self, perpetrators or society); 7 studies reported responses to disclosure that blamed survivors and thus reinforced self-blame; 6 studies explored how fear of further blame prevented disclosure.	Minor or no concerns about relevance (18 studies). The topic of six studies (2, 7, 16, 26, 35, 27) was not directly relevant to the review question and therefore only relevant data were extracted.	This finding was graded as high confidence.	It is likely that the finding is a reasonable representation of women's experiences and expectations of healthcare after experiencing sexual violence in adulthood. Twenty-seven studies with minor or no methodological limitations. No or very minor concerns about coherence and adequacy.
	Acknowledging sexual violence. Providers gently naming the experience(s) as sexual violence could shift shame and self-blame. Societal misconceptions about 'real rape' prevented women from having the language to name experiences as sexual violence.	17 studies (9, 11, 12, 14, 18, 19, 20, 22, 26, 30, 31, 33, 34, 35, 36, 37, 38)	13 (76%) minor or no concerns (9, 11, 12, 18, 19, 22, 26, 30, 31, 35, 36, 37, 38) and 4 (24%) moderate concerns (14, 20, 33, 34)	No or very minor concerns about coherence. The data reflected that acknowledgement was central to healing, that providers' acknowledgement was powerful, but that women faced many barriers to acknowledgement.	No or very minor concerns about adequacy: 7 studies described acknowledgement taking a long time or not being a linear process; 6 studies described that women did not have the language to label their experiences, or that misconceptions about 'real rape' prevented them from labelling the experience as sexual violence; 3 studies described that responses to disclosure that named the violence shifted shame.	Minor or no concerns about relevance (17 studies). The topic of five studies (12, 14, 22, 26, 35, 37) was not directly relevant to the review question and therefore only relevant data were extracted.		

Theme	Summary of review finding	Studies contributing to the review finding	Methodological limitations	Coherence	Adequacy	Relevance	CERQUAL assessment of confidence in the evidence	Explanation of CERQUAL assessment
Being Seen: Respect, validation and responsiveness (6.3.2) Survivors felt that both they and their experiences of sexual violence were invisible. This was counteracted by providers and services that acknowledged sexual violence, respected their feelings, validated their experiences, and responded to their health care and emotional needs (n = 26 studies; 1, 2, 4, 5, 6, 8, 10, 11, 14, 15, 17, 18, 19, 20, 22, 24, 25, 26, 28, 29, 30, 31, 33, 34, 35, 36).	**Invisibility and disconnection.** Survivors felt that both they and their experiences of sexual violence were invisible in healthcare. When services and providers did not understand or did not want to know this led to disconnection and silence.	17 studies (2, 5, 8, 11, 14, 15, 17, 19, 20, 22, 24, 25, 26, 29, 33, 35, 36)	10 (59%) minor or no concerns (2, 5, 11, 17, 19, 22, 24, 26, 35, 36) and 7 (41%) moderate concerns (8, 14, 15, 20, 25, 29, 33)	No or very minor concerns about coherence. The data reflected that sexual violence was not recognised by providers or in the health system and that women felt dehumanised by approaches to care.	No or very minor concerns about adequacy: 9 studies described women not feeling safe to disclose either due to ungrounding health care environments or disinterested or rushed healthcare providers; 4 studies described that impersonal treatment by staff led women to feel invisible and not important; 13 studies described instances of women's needs being dismissed and overlooked, leading women to feel silenced (including disclosures).	Minor or no concerns about relevance (17 studies). The topic of 5 studies (5, 14, 25, 26, 35) was not directly relevant to the review question and therefore only relevant data were extracted.	This finding was graded as high confidence.	It is likely that the finding is a reasonable representation of women's experiences and expectations of healthcare after experiencing sexual violence in adulthood. 25 studies with minor or no methodological limitations. No or very minor concerns about coherence and adequacy. The finding 'shining a light on sexual violence' had a smaller number of studies contributing to it compared to other findings, but 75% were of high methodological quality and directly relevant to the review topic.
	Shining a light on sexual violence. The invisibility of sexual violence could be counteracted by providers and services that wanted to know about sexual violence and treated it as an unacceptable violation of human rights that was within their remit to respond to.	8 studies (8, 18, 19, 22, 28, 31, 34, 35)	6 (75%) minor or no concerns (18, 19, 22, 28, 31, 35) and 2 (25%) moderate concerns (8, 34)	No or very minor concerns about coherence. The data reflected that acknowledgement of the seriousness of sexual violence by providers through asking sensitively, other communication such as posters, and welcoming expressions of distress validated women's experiences irrespective of whether they were ready to disclose.	No or very minor concerns about adequacy: 4 studies described that women wanted to be asked about sexual violence in a sensitive way, even if they were not ready to disclose, because asking sensitively communicated caring. 4 studies described the importance of allowing and welcoming feelings and distress.	Minor or no concerns about relevance (8 studies). The topic of two studies (22, 35) was not directly relevant to the review question and therefore only relevant data were extracted.		
	Facilitating human connection. Providers who helped women to feel seen and heard as whole people facilitated connection. Thid involved respecting women's feelings, validating their experiences and responding to their individual health and emotional needs.	16 studies (1, 2, 4, 6, 8, 10, 11, 17, 18, 19, 20, 29, 30, 33, 35, 36)	9 (56%) minor or no concerns (2, 6, 11, 17, 18, 19, 30, 35, 36) and 7 (44%) moderate concerns (1, 4, 8, 10, 20, 29, 33).	No or very minor concerns about coherence. The data reflected that human connection could be facilitated by actions as much as words, and that connection helped women to feel seen and important.	No or very minor concerns about adequacy: 4 studies described that women needed kindness and warmth, and 11 studies described the importance of attunement to women's needs and feelings. 4 studies noted the importance of companionship and 4 studies highlighted the harmful impact of being left alone on women's sense of safety.	Minor or no concerns about relevance (16 studies). The topic of three studies (2, 6, 35) was not directly relevant to the review question and therefore only relevant data were extracted.		

Theme	Summary of review finding	Studies contributing to the review finding	Methodological limitations	Coherence	Adequacy	Relevance	CERQUAL assessment of confidence in the evidence	Explanation of CERQUAL assessment
Being Heard: Choices, empowerment, and shared decision-making (6.3.3) - 29 studies Survivors needed to reclaim their bodies and their lives after sexual violence. Provider behaviours and service delivery influenced women's ability to connect with their needs and either amplified or dampened their voice when women tried to communicate these needs. Experiences captured in this theme were largely negative, although women suggested ways to improve care through ensuring full, ongoing, active and informed consent and having continuity of care (n = 29 studies; 1, 2, 3, 4, 5, 6, 8, 9, 10, 11, 12, 13, 15, 16, 17, 18, 19, 20, 21, 23, 27, 29, 30, 31, 32, 33, 35, 36, 37).	**Intersecting power imbalances.** Providers had power and authority and the power imbalance was widened by inequalities due to gender and race. Survivors felt safer with women and racially minoritised survivors felt safer with racially minoritised providers.	20 studies (2, 4, 5, 9, 10, 11, 12, 13, 15, 16, 17, 19, 20, 21, 23, 29, 33, 35, 36, 37)	12 (60%) with no or minor concerns (2, 5, 9, 11, 12, 16, 17, 19 ,21, 35, 36, 37) 7 (35%) with moderate concerns (4, 10, 15, 0, 23, 29, 33), and 1 (5%) with serious concerns (13)	No or very minor concerns about coherence. The data reflected that health care providers had power, and that this power interacted with gender. There was less data that this power interacted with race, although 3 studies still addressed this.	No or very minor concerns about adequacy: 10 studies described providers being in a position of power and authority, 4 studies described clinical touch as authoritarian, 12 studies noted that women's sense of safety was gendered. 3 studies described that race impacted women's experiences.	Minor or no concerns about relevance (20 studies). The topic of seven studies (2, 5, 12, 13, 16, 35, 37) was not directly relevant to the review question and therefore only relevant data were extracted.	This finding was graded as high confidence.	It is likely that the finding is a reasonable representation of women's experiences and expectations of healthcare after experiencing sexual violence in adulthood. 30 studies with minor or no methodological limitations. No or very minor concerns about coherence and adequacy.
	Healthcare mirroring abuse. Healthcare could mirror the coercion and silencing of sexual violence through unconsented touch and examinations and/or dismissing or ignoring women's needs. Women could re-experience traumatic memories in response to procedures and examinations, but the same procedure could be experienced differently depending on how in control a woman felt.	16 studies (1, 2, 3, 4, 5, 6, 9, 10, 11, 12, 15, 18, 20, 27, 32, 35)	9 (56%) with no or minor concerns (2, 5, 6, 9, 11, 12, 18, 27, 35) and 7 (44%) with moderate concerns (1, 3, 4, 10, 15, 20, 32).	Minor concerns about coherence. The data clearly reflected that healthcare could be re-traumatising, but some authors focused on individualistic accounts. The data as a whole indicated that provider interactions and healthcare environments were significant factors in explaining re-traumatisation. This importance is therefore reflected in the sub-theme names.	No or very minor concerns about adequacy: 5 studies described aspects of healthcare as another violation, 7 studies described that choice and control were critical to avoiding re-traumatisation. 7 studies described that healthcare environments added to women's distress or re-traumatised women, and 5 studies noted re-experiencing of trauma.	Minor or no concerns about relevance (16 studies). The topic of six studies (1, 2, 5, 12, 27, 35) was not directly relevant to the review question and therefore only relevant data were extracted.		
	Silence and silencing. Women were silenced when their efforts to disclose and seek support for sexual violence were repeatedly dismissed, misunderstood or overlooked. Biomedical dominance and standardisation of care contributed to this silencing. For instance, mental health diagnoses were used to dismiss women's concerns and ignored the role of trauma in their distress.	13 studies (2, 5, 8, 11, 17, 18, 19, 23, 30, 31, 32, 33, 36)	9 (69%) with no or minor concerns (2, 5, 11, 17, 18, 19, 30, 31, 36) and 4 (31%) with moderate concerns (8, 23, 32, 33)	No or very minor concerns about coherence. The data reflected that women experienced both silence and silencing from providers, because repeated attempts to seek support got no response or their request for support for their trauma was dismissed (in favour of a mental health diagnosis, for example).	No or very minor concerns about adequacy. 6 studies described that women's attempts to seek support for trauma were dimissed, 5 studies described harms from women having to repeatedly disclose their trauma without a response, 2 studies described having a named health care provider helped women to access support, 4 studies described fragmented and inconsistent access to care that prevented women from accessing support.	Minor or no concerns about relevance (13 studies). The topic of two studies (2, 5) was not directly relevant to the review question and therefore only relevant data were extracted.		