



Review Article

How do women with a history of childhood sexual abuse experience the preconception and perinatal period? A qualitative systematic review

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ABSTRACT

Context: Child sexual abuse (CSA) is a public health issue that predominantly affects women and has both short- and long-term consequences. The perinatal period can represent a challenge, but also an opportunity to identify a history of CSA and to provide sensitive care that may help prevent the intergenerational transmission of trauma.

Aim: To describe and understand the experiences and coping strategies of women who are survivors of child sexual abuse and are transitioning to motherhood.

Method: We conducted a systematic review of qualitative studies according to a protocol registered in PROSPERO, following methodological standards and reporting the results according to the ENTREQ guideline. A search was conducted on five databases up to July 2025. Two authors independently selected the articles and assessed their methodological quality. Data were analysed using thematic synthesis and the confidence in the findings was evaluated according to GRADE-CERQual.

Results: We included 21 qualitative studies that resulted in six themes. The findings reveal how women who experienced child sexual abuse and are transitioning to motherhood may experience this stage with ambivalence—ranging from revictimisation to identity reconstruction—where perinatal care emerges as a potential healing vehicle throughout this process.

Conclusions: The perinatal period becomes a window of opportunity to heal deep wounds, with perinatal care playing a key role. The findings support trauma-informed perinatal care, underpinned by reflective practice and a holistic approach. Further work is needed to improve the identification of child sexual abuse, enhance professional training and review current practices to ensure sensitive care.

Introduction

Child sexual abuse (CSA) is a public health issue that affects all sociocultural levels, occurring more frequently among women (Pereda, 2016). According to the WHO, one in five girls and one in thirteen boys experience CSA. Its nature makes disclosure difficult, leading to an underestimation of its magnitude and it often takes place within trusted

environments (Pereda, 2016; WHO, 2024).

Experiences of CSA have both short- and long-term effects, with no single survivor profile (Pereda, 2010). These effects may emerge or intensify with age, impacting physical and mental health, influencing the parental role and increasing the risk of intergenerational transmission (Pereda, 2010). The theory of intergenerational trauma posits that unresolved trauma in adulthood can negatively affect parental

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relationships and have a significant impact on the child (Lange et al., 2020a; Pereda, 2010).

The perinatal period, already considered a stressful time for women (ACOG, 2021; Lombardi et al., 2023), represents a major challenge for those who have experienced CSA. In this context, pregnancy may represent the first contact with the healthcare system, offering a key opportunity to identify a history of CSA and provide multidisciplinary support (Farrow et al., 2018). Recently, recommendations have been proposed to integrate trauma-informed care into perinatal services. These include screening for traumatic experiences, improving access to perinatal mental health services, clear and sensitive communication with women, continuity of care, individualised care that recognises diversity, woman-centred collaborative care, professional training, and supervision and peer support to promote the wellbeing of healthcare professionals (Benton et al., 2024).

Previous research has identified long-term sequelae of CSA in the perinatal period, such as fear of medical examinations (ACOG, 2021), physical changes and symptoms associated with this stage (Aldcroft, 2001) and concerns about their ability to mother (Lange et al., 2020a). This can increase vulnerability among these women. A narrative review conducted twenty years ago identified risk behaviours during pregnancy and disturbance of delivery by sudden memories of sexual abuse (Leeners et al., 2006). Mental health disorders are common during the perinatal period and a history of CSA can exacerbate them during pregnancy (Lombardi et al., 2023). CSA has been associated with postpartum depression (Leeners et al., 2006) and post-traumatic stress disorder during the perinatal period (Frederickson et al., 2023; Wosu et al., 2015).

To our knowledge, no methodologically sound qualitative systematic review has integrated women's experiences from the preconception period through pregnancy, childbirth and the first year postpartum, while also exploring the coping strategies used throughout this transition. Therefore, a comprehensive qualitative synthesis is needed to provide a more holistic understanding of how a history of CSA influences the transition to motherhood.

Based on these reasons and informed by a feminist perspective, we sought to build an integrative and interpretative representation of the impact of CSA on the experience during the perinatal period. To this end, we conducted a qualitative systematic review to describe and understand the experiences of women survivors of CSA during the preconception and perinatal periods, as well as their coping strategies in relation to this phenomenon.

Methods

We conducted a qualitative evidence synthesis following a standardised methodology (Noyes et al., 2018), based on a pre-specified protocol registered in PROSPERO (CRD42020193047) and reported the findings in accordance with the ENTREQ statement (Supplementary material 1) (Tong et al., 2012).

Eligibility criteria

We used the SPIDER framework (Cooke et al., 2012) to define the eligibility criteria. We included studies exploring the experiences and coping strategies (Phenomenon of Interest) of women with a history of CSA during the preconception and/or perinatal period (pregnancy, childbirth, and the first postpartum year) (Sample). Eligible studies employed qualitative methodologies for their design, collection and analysis (Design, Research Type). We excluded studies using quantitative methodologies and those focusing on other forms of childhood trauma (e.g. physical abuse) without specifically addressing CSA.

Search strategy

We searched MEDLINE (via PubMed), CINAHL (via EBSCOHost), and

PsycINFO (via ProQuest) using a combination of free-text and controlled vocabulary terms, without date or language restrictions. We also searched ProQuest Dissertations and Theses (via ProQuest) and Open Access Theses and Dissertations, and conducted citation tracking in Web of Science and Google Scholar. The last search was performed on 17 July 2025. Full search strategies are provided in Supplementary material 2.

Study selection, data extraction and assessment of methodological limitations

Three authors (CRG, MGB, NMH) independently screened titles and abstracts, resolving disagreements by consensus. Full texts for eligible studies were assessed similarly, involving a fourth author (ASO) when necessary. Mendeley (Mendeley Ltd, 2019) and Rayyan (Ouzzani et al., 2016) were used for reference management and screening. Two authors (CRG, ISA) independently extracted data into an Excel spreadsheet and appraised methodological limitations using the Critical Appraisal Skills Programme checklist (CASP) (CASP, 2018).

Data analysis, synthesis and assessment of confidence in the findings

We conducted a thematic synthesis (Thomas and Harden, 2008), iteratively coding textual data from the included studies and integrating them into descriptive themes. Then, these were interpreted to generate findings with greater insight and contextualisation. Through reflexive integration of the themes, we developed a trustworthy interpretation that extended beyond the primary studies (Thorne, 2023). One author (CRG) completed the synthesis and discussed it with the other authors (CRG, ASO, CMB, ISA). Two authors (CRG, ISA) developed and agreed on the interpretative analysis of the review findings and assessed confidence using the GRADE-CERQual approach (Lewin et al., 2018), which considers methodological limitations, coherence, adequacy and relevance.

Reflexivity

We critically reflected on how our characteristics and professional backgrounds may have influenced the review (Dodgson, 2019). Our multidisciplinary team (midwives, sexologists, psychologists, and public health specialists) enabled a pluralistic approach. We advocate for evidence-based care and adopt a post-structuralist feminist perspective (Aranda, 2018), supporting women's agency in decisions about their sexual and reproductive health and their right to voice their experiences (Davis-Floyd, 2001). Although our own experiences may have influenced the interpretation of the phenomenon under study, we regularly discussed our interpretations and considered them in relation to the existing literature throughout the analysis.

Results

Characteristics of included studies

The search yielded 3673 records; we reviewed 115 reports in full and included 24 reports from 21 unique studies (Bellhouse, 2013; Byrne et al., 2017; Canzonieri, 2018; Coles, 2006; Coles and Jones, 2009; Garratt, 2008; Jonsdottir et al., 2021; Knox, 2017; Lasiuk, 2007; Lee, 2001; Mathewson, 2016; Montgomery, 2012; Montgomery and Seng, 2021; Palmer, 2004; Parratt, 1994; Rhodes and Hutchinson, 1994; Richmond, 2005; Roberts et al., 2021; Roller, 2011; Welch, 2013; Wood and Van Esterik, 2010). Two studies reported results in multiple publications: one doctoral thesis (Coles, 2006) was also published as a journal article (Coles, 2009), and another doctoral thesis (Montgomery, 2012) generated two journal articles (Montgomery et al., 2015a, 2015b). Fig. 1 presents the study eligibility flow diagram and Supplementary material 3 provides details of the excluded studies.

All studies were conducted in high-income countries and were led by

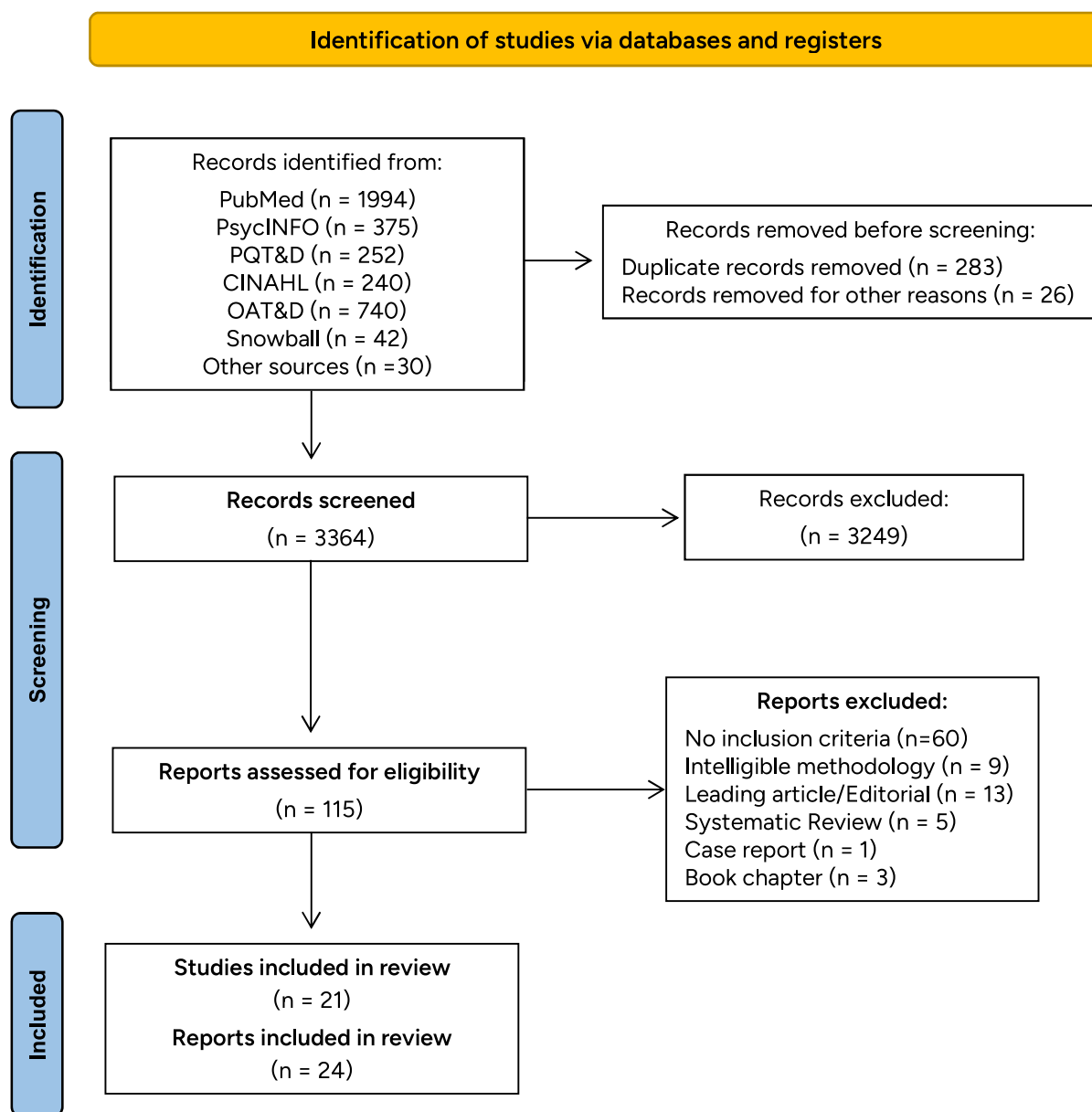


Fig. 1. PRISMA flow diagram.

women. Table 1 presents the main characteristics of the included studies, while the sample of participants is detailed in Supplementary material 4.

The studies gathered the accounts of 303 women; however, the narratives of the 269 women survivors of CSA were analysed. Twelve of these women were healthcare professionals who were also survivors (Garratt, 2008). One study included the narratives of eight healthcare professionals who had not experienced CSA (midwives and nurses) and whose accounts were not separated from those who had (Rhodes and Hutchinson, 1994). Other studies also included additional participants, although only data separately reported for women with a history of CSA were considered in this review (Montgomery, 2012).

Methodological limitations of the included studies

Overall, the included studies did not present considerable methodological limitations. The main limitations concerned reflexivity, which was absent in four studies (Palmer, 2004; Rhodes and Hutchinson, 1994; Roller, 2011; Wood and Van Esterik, 2010) or superficially addressed in

one (Bellhouse, 2013), and ethical considerations, which were not reported in two studies (Roller, 2011; Welch, 2013), or reported imprecisely in four studies (Bellhouse, 2013; Byrne et al., 2017; Lee, 2001; Wood and Van Esterik, 2010). Data analysis was appropriate in most cases, except in one study (Wood and Van Esterik, 2010), and another where it was imprecise (Lee, 2001). Table 2 presents the methodological assessment according to CASP, with additional details provided in Supplementary material 5.

Findings: the impact of history of childhood sexual abuse experience on preconception and perinatal period

We identified six themes (comprising 26 subthemes) from the included studies: trauma reactivation, a transition toward healing, the experience of perinatal care and mothering, the search for a safe environment, the perinatal care, and coping strategies. These themes interact throughout the transition to motherhood (TM), as reflected in a set of interrelated subthemes, and shape a complex experience in which vulnerability and recovery coexist, mediated by relational contexts, care

Table 1
Characteristics of included studies.

Author, Year Country Author's gender Support	Aim	Perinatal Stage	Framework Methodology Method Analysis	Sample	Overall study quality
(Parratt, 1994) Australia Female Journal article	Explore whether and how childbirth can trigger memories of incest, what triggers them, how these memories affect the childbirth experience and what personal or practical mechanisms help some survivors experience childbirth in a positive way.	Childbirth	Not described Phenomenology Interviews (in-depth) Phenomenological analysis described by Patton	6 women between 27 and 43 years old. All victims of CSA by a very close relative.	Valuable
(Rhodes and Hutchinson, 1994) United States of America Female Journal article	Explore and describe the labour experiences of childhood sexual abuse survivors.	Childbirth	Not described Ethnography Interviews ('formal', structured) and participant observation. Spradley's developmental research sequence (DRS)	15 women, of which 7 are victims of CSA, 5 midwives and 3 nurses from the maternity area.	Unclear
(Lee, 2001) United States of America Female Doctoral Dissertation	Explore the ways that being a survivor of sexual abuse interacts with the childbearing experience.	Childbirth	Not described Not described Interviews (semi structured) Not described	7 women victims of chronic CSA by close relatives. Ages between 26 and 38 years, all Caucasian.	Unclear
(Palmer, 2004) Canada Female Doctoral Dissertation	Explore the experience of childbearing for survivors of childhood sexual abuse through listening to and embracing survivors' life stories.	Childbirth	Symbolic interactionism Grounded Theory Interviews (in-depth) Constant comparative analysis	68 participants. 2 women were in the preconception stage. Seven participants refer to a same-sex partner.	Valuable
(Richmond, 2005) United States of America Female Doctoral Dissertation	Explore the experience of being a pregnant survivor with a history of childhood sexual abuse and experiences during perinatal care and services.	Perinatal	Feminist Grounded Theory Interviews (in-depth) Constant comparative analysis	11 women victims of CSA, aged between 26 and 51 years.	Valuable
(Coles, 2006; Coles, 2009) Australia Female Doctoral dissertation	Explore the experience of breastfeeding in mothers with a history of CSA perpetrated by a family member.	Breastfeeding Postpartum	Constructivism Not described Interviews (in-depth) Thematic analysis described by Boyatzis	11 women victims of CSA by relatives. Ages between 18 and 41 years.	Valuable
(Lasiuk, 2007) Canada Female Doctoral dissertation	Explore what is the lived experience of pregnancy and birthing of women with a history of childhood sexual abuse.	Pregnancy, Birthing	Not described, probably Constructivism Phenomenology Interviews (in-depth) Dynamic interplay of six research activities, adapted from Van Manen	7 women victims of CSA of which 2 were Canadian public figures. Ages between 23 and 60 years.	Valuable
(Garrat, 2008) United Kingdom Female Doctoral dissertation	Gain a deep insight into the lived experiences of survivors of sexual abuse during pregnancy, birth and early parenting.	Pregnancy, birth and parenting	Feminist Grounded Theory Interviews (in-depth) Voice-centred relational method	20 women victims of CSA, of which 12 are health professionals (midwives). Ages between 22 and 58 years.	Valuable
(Coles and Jones, 2009) Australia Female Journal article	Explore women's responses to perinatal professional touch and examination of themselves and their babies.	Perinatal	Constructivism Not described Interviews (in-depth) Thematic analysis described by Boyatzis	18 women (11 of which, collected from the previous sample). Ages between 18 and 50.	Valuable
(Roller, 2011) United States of America Female Journal article	Construct a theoretical framework to describe how CSA survivors manage the pain of the intrusive reexperiencing of CSA during the perinatal period.	Perinatal	Symbolic interactionism Grounded Theory Open-ended interviews Constant comparative analysis	12 women victims of CSA. Some gestation fruit of abuse. Ages between 16 and 39 years.	Unclear
(Wood and Van Esterik, 2010) Canada Female Journal article	Explore the effects of childhood sexual abuse on women's breastfeeding and infant feeding decisions and experiences.	Breastfeeding Postpartum	Not described Not described Interviews (semi structured) Not described	6 women victims of CSA.	Unclear
(Montgomery, 2012; Montgomery et al., 2015a, 2015b) United Kingdom Female	Explore the impact that CSA has on the maternity care experiences of adult women.	Perinatal	Feminist Narrative research Interviews (in-depth) and maternity care records	9 women victims of CSA. Ages between 28 and 52 years.	Valuable

(continued on next page)

Table 1 (continued)

Author, Year Country Author's gender Support	Aim	Perinatal Stage	Framework Methodology Method Analysis	Sample	Overall study quality
Doctoral dissertation (Bellhouse, 2013) Canada Female Master's thesis	Explore attachment and transition to motherhood in survivors of CSA. Secondary data interviews, from a larger study on embodied trauma.	Perinatal	Voice-centred relational method Not described Phenomenology Interviews (semi structured) Six steps described by Creswell	8 women victims of CSA. They are all immigrants, with great ethnic diversity. Three identified themselves as refugees. Ages between 19 and 34 years.	Unclear
(Welch, 2013) Canada Female Master's thesis	Explore and understand the lived experience of first-time pregnant women who have survived childhood sexual abuse and have immigrated to Canada. Secondary data interviews, from a larger study on embodied trauma.	Pregnancy	Not described Phenomenology Interviews (in-depth) Four-step analysis described by Wertz	8 women victims of CSA. They are all immigrants, with great ethnic diversity. Three identified themselves as refugees. Ages between 19 and 34 years.	Unclear
(Mathewson, 2016) Canada Female Master's thesis	Explore how childhood sexual abuse survivors experience childbirth.	Childbirth	Not described, probably Constructivism Phenomenology Interviews (in-depth) Interpretative phenomenological analysis (IPA)	4 women victims of CSA. It does not specify ages, only that they are between their early 20 s and 40 s.	Valuable
(Byrne et al., 2017) United Kingdom Female Journal article	Explore how child sexual abuse influences the pregnancy, childbirth and postpartum experiences of women survivors.	Perinatal	Critical feminist Narrative research Narrative Narrative analysis described by Riessman	3 women victims of CSA. Ages between 27 and 40 years. 1 participant was pregnant at the time of the interview.	Valuable
(Knox, 2017) United States of America Female Doctoral dissertation	Explore the experience of choosing an infant feeding method in mothers with a history of childhood sexual abuse.	Postnatal period (breastfeeding)	Not described, probably constructivism Phenomenology Interviews (semi structured) Transcendental phenomenological research model by Moustakas	13 women victims of CSA. Ages between 23 and 50 years.	Valuable
(Canzonieri, 2018) Canada Female Master's thesis	Explore the thoughts about becoming a mother of survivors of CSA and how their life experiences influenced their perceptions of raising a baby. Secondary data interviews from a larger study on transition to motherhood.	Pregnancy Parenting	Feminist Grounded Theory Interviews (semi structured) Constant comparative analysis using the 6 generic steps of Creswell.	18 women victims of CSA. Ages between 18 and 48 years.	Unclear
(Montgomery and Seng, 2021) United Kingdom Female Journal article	Co-produce an e-resource to help prepare women who have experienced CSA for pregnancy, birth and early parenthood, grounded in their experiences and concerns.	Perinatal	Not described Participatory research Focus groups, telephone interviews and online questionnaires. Thematic analysis through the inductive approach described by Braun and Clarke	37 women victims of CSA. Ages between 20 and 68 years.	Valuable
(Jonsdottir et al., 2021) Iceland Female Journal article	Explore the experiences of women survivors of child sexual abuse (CSA) during pregnancy, childbirth and the impact of abuse on their health during childbearing.	Perinatal	Constructivism Phenomenology Interviews (in-depth) Vancouver school 12-step method of analysis	9 women victims of CSA. Ages between 20 and 60 years.	Valuable
(Roberts et al., 2021) United Kingdom Female Journal article	Explore the pregnancy and childbearing experiences of women survivors of childhood sexual abuse.	Perinatal	Post-positivist Grounded theory Interviews (semi structured) Hybrid, classical grounded theory approach proposed by Silverio	6 women victims of CSA. Ages between 32 and 71 years.	Valuable

experiences, and women's responses to trauma. The themes and their corresponding subthemes are described below, together with assessments of confidence in the findings. Table 3 presents the detailed confidence assessments, with an expanded version including quotations from primary studies provided in Supplementary materials 6 and 7.

Trauma reactivation

Women experienced the preconception period onwards as **trauma triggers**, as they report fear of the childbirth process and concern about the reactivation of memories (high confidence; Byrne et al., 2017;

Garratt, 2008; Knox, 2017; Lasiuk, 2007; Lee, 2001; Mathewson, 2016; Montgomery, 2012; Montgomery and Seng, 2021; Palmer, 2004; Parratt, 1994; Richmond, 2005; Roller, 2011). In that context, many studies report the experience of **obstetric care as an abuse** (high confidence; Byrne et al., 2017; Coles, 2006, 2009; Coles and Jones, 2009; Garratt, 2008; Knox, 2017; Lee, 2001; Mathewson, 2016; Montgomery, 2012; Montgomery and Seng, 2021; Palmer, 2004; Parratt, 1994; Rhodes and Hutchinson, 1994; Roller, 2011; Wood and Van Esterik, 2010). A hostile hospital environment, invasive interventions, dehumanised and body-centred care, exposure, loss of control, and objectification can lead women to perceive care as a new assault. Subtle

Table 2
quality assessment of included studies (CASP).

	are the results valid?					what are the results?				
	Q 1	Q 2	Q 3	Q 4	Q 5	Q 6	Q 7	Q 8	Q 9	Q10
Parratt, 1994	●	●	●	●	●	●	●	●	●	●
Rhodes, 1994	●	●	●	●	●	●	●	●	●	●
Lee, 2001	●	●	●	●	●	●	●	●	●	●
Palmer, 2004	●	●	●	●	●	●	●	●	●	●
Richmond, 2005	●	●	●	●	●	●	●	●	●	●
Coles, 2006	●	●	●	●	●	●	●	●	●	●
Lasiuk, 2007	●	●	●	●	●	●	●	●	●	●
Garrat, 2008	●	●	●	●	●	●	●	●	●	●
Coles, 2009	●	●	●	●	●	●	●	●	●	●
Roller, 2011	●	●	●	●	●	●	●	●	●	●
Wood and Van Esterik, 2010	●	●	●	●	●	●	●	●	●	●
Montgomery, 2012	●	●	●	●	●	●	●	●	●	●
Bellhouse, 2013	●	●	●	●	●	●	●	●	●	●
Welch, 2013	●	●	●	●	●	●	●	●	●	●
Mathewson, 2016	●	●	●	●	●	●	●	●	●	●
Byrne et al, 2017	●	●	●	●	●	●	●	●	●	●
Knox, 2017	●	●	●	●	●	●	●	●	●	●
Canzonieri, 2018	●	●	●	●	●	●	●	●	●	●
Montgomery and Seng, 2021	●	●	●	●	●	●	●	●	●	●
Jonsdottir, 2021	●	●	●	●	●	●	●	●	●	●
Roberts, 2021	●	●	●	●	●	●	●	●	●	●

NOTE CASP Checklist for qualitative research: **Q1** Was there a clear statement of the aims of the research?; **Q2** Is a qualitative methodology appropriate?; **Q3** Was the research design appropriate to address the aims of the research?; **Q4** Was the recruitment strategy appropriate to the aims of the research?; **Q5** Was the data collected in a way that addressed the research issue?; **Q6** Has the relationship between researcher and participants been adequately considered?; **Q7** Have ethical issues been taken into consideration?; **Q8** Was the data analysis sufficiently rigorous?; **Q9** Is there a clear statement of findings?; **Q10** How valuable is the research?.

triggers (e.g., healthcare professional's resemblance to the perpetrator, particular smells, or features of the hospital environment) also play a role as memories of abuse, resulting in flashbacks, similar bodily sensations and reactions, traumatic distress, and difficulties expressing feelings and needs.

At the same time, women emphasize the **bodily exposure** inherent to pregnancy, childbirth and breastfeeding (high confidence; Byrne et al., 2017; Coles, 2006, 2009; Knox, 2017; Montgomery, 2012; Montgomery and Seng, 2021; Palmer, 2004; Richmond, 2005). The

repeated crossing of bodily boundaries during this stage can act again as a trigger, reactivating memories of abuse and intensifying feelings of vulnerability.

Women also described a profound **loss of control** during this stage, which contributes to heightened vulnerability (high confidence; Byrne et al., 2017; Coles, 2006, 2009; Garratt, 2008; Jonsdottir et al., 2021; Knox, 2017; Lasiuk, 2007; Lee, 2001; Mathewson, 2016; Montgomery, 2012; Montgomery and Seng, 2021; Palmer, 2004; Parratt, 1994; Richmond, 2005; Roberts et al., 2021; Welch, 2013). This loss of control

Table 3

Summary of Findings.

TRAUMA REACTIVATION				
Trauma triggers: pregnancy, childbirth, and parenting experiences acting as trauma triggers, generating fear of memory reactivation and awareness of re-victimisation.				
Studies contributing to the review finding: 12 (Byrne, 2017; Garratt, 2008; Knox, 2017; Lasiuk, 2007; Lee, 2001; Mathewson, 2016; Montgomery, 2012; Montgomery and Seng, 2021; Palmer, 2004; Parratt, 1994; Richmond, 2005; Roller, 2011)				
Methodological limitations:	Coherence:	Adequacy:	Relevance:	GRADE-CERQual
No or very minor concerns	No or very minor concerns	No or very minor concerns	No or very minor concerns	High confidence
Obstetric care as an abuse: experienced as abuse through trauma reactivation, dehumanising practices, loss of control, objectification, and environmental triggers associated with past abuse.				
Studies contributing to the review finding: 14 (Byrne, 2017; Coles, 2006, 2009; Coles and Jones, 2009; Garratt, 2008; Knox, 2017; Lee, 2001; Mathewson, 2016; Montgomery, 2012; Montgomery and Seng, 2021; Palmer, 2004; Parratt, 1994; Rhodes and Hutchinson, 1994; Roller, 2011; Wood and Van Esterik, 2010)				
Methodological limitations:	Coherence:	Adequacy:	Relevance:	GRADE-CERQual
No or very minor concerns	No or very minor concerns	No or very minor concerns	No or very minor concerns	High confidence
Bodily exposure: exposed body and crossing of bodily boundaries during pregnancy, childbirth, and breastfeeding triggering traumatic memories and feelings of vulnerability.				
Studies contributing to the review finding: 7 (Byrne, 2017; Coles, 2006, 2009; Knox, 2017; Montgomery, 2012; Montgomery and Seng, 2021; Palmer, 2004; Richmond, 2005)				
Methodological limitations:	Coherence:	Adequacy:	Relevance:	GRADE-CERQual
No or very minor concerns	No or very minor concerns	No or very minor concerns	No or very minor concerns	High confidence
Loss of control: loss of control over emotions, body, coping abilities, and care-related decisions, shaped by power imbalances and contributing to vulnerability.				
Studies contributing to the review finding: 15 (Byrne, 2017; Coles, 2006, 2009; Garratt, 2008; Jonsdottir et al., 2021; Knox, 2017; Lasiuk, 2007; Lee, 2001; Mathewson, 2016; Montgomery, 2012; Montgomery and Seng, 2021; Palmer, 2004; Parratt, 1994; Richmond, 2005; Roberts et al., 2021; Welch, 2013)				
Methodological limitations:	Coherence:	Adequacy:	Relevance:	GRADE-CERQual
No or very minor concerns	No or very minor concerns	No or very minor concerns	No or very minor concerns	High confidence
MOTHERHOOD AS A TRANSITION TOWARD HEALING				
Healing process: transition to motherhood experienced as an empowering process, with reduced guilt, changing roles, strengthened boundaries, and a sense of rebirth.				
Studies contributing to the review finding: 12 (Bellhouse, 2013; Byrne et al., 2017; Canzonieri, 2018; Garratt, 2008; Jonsdottir et al., 2021; Knox, 2017; Lasiuk, 2007; Lee, 2001; Mathewson, 2016; Montgomery, 2012; Montgomery and Seng, 2021; Palmer, 2004)				
Methodological limitations:	Coherence:	Adequacy:	Relevance:	GRADE-CERQual
No or very minor concerns	No or very minor concerns	No or very minor concerns	No or very minor concerns	High confidence
Renewed relationship with the body: renewed through validation, separation from abuse-related meanings, and increased confidence and sense of safety.				
Studies contributing to the review finding: 9 (Byrne et al., 2017; Coles, 2006, 2009; Garratt, 2008; Knox, 2017; Lasiuk, 2007; Lee, 2001; Montgomery, 2012; Palmer, 2004; Wood and Van Esterik, 2010)				
Methodological limitations:	Coherence:	Adequacy:	Relevance:	GRADE-CERQual
No or very minor concerns	No or very minor concerns	No or very minor concerns	No or very minor concerns	High confidence
Transformed past relationships: changes in past relationships, including strengthened connections, modified boundaries, and the ending unsafe relationships.				
Studies contributing to the review finding: 2 (Canzonieri, 2018; Lee, 2001)				
Methodological limitations:	Coherence:	Adequacy:	Relevance:	GRADE-CERQual
Moderate concerns	Serious concerns	Serious concerns	Moderate concerns	Very low confidence · explanation: very low confidence due to methodological limitations, substantial heterogeneity, inadequate reporting, and contextual variability across studies.
MOTHERING				
Ability to mother: trauma influencing motherhood through doubts about parenting ability, fears of repeating patterns, guilt, difficulties with bonding, and polarised perceptions of maternal competence.				
Studies contributing to the review finding: 10 (Byrne, 2017; Coles, 2006, 2009; Garratt, 2008; Jonsdottir et al., 2021; Lasiuk, 2007; Lee, 2001; Montgomery, 2012; Montgomery and Seng, 2021; Palmer, 2004; Welch, 2013)				
Methodological limitations:	Coherence:	Adequacy:	Relevance:	GRADE-CERQual
No or very minor concerns	No or very minor concerns	No or very minor concerns	No or very minor concerns	High confidence
Striving for perfect motherhood: trauma shaping parenting styles and maternal identity, with pursuit of perfect motherhood linked to guilt, shame, and emotional dependence on the child.				
Studies contributing to the review finding: 7 (Bellhouse, 2013; Canzonieri, 2018; Lasiuk, 2007; Montgomery, 2012; Montgomery and Seng, 2021; Palmer, 2004; Welch, 2013)				
Methodological limitations:	Coherence:	Adequacy:	Relevance:	GRADE-CERQual
Minor concerns	No or very minor concerns	No or very minor concerns	No or very minor concerns	Moderate confidence · explanation: moderate confidence due to minor methodological limitations across the contributing studies.
Concern about the child's biological sex: child's biological sex as a trigger for trauma memories and concerns about protection and bonding.				
Studies contributing to the review finding: 11 (Bellhouse, 2013; Byrne et al., 2017; Coles, 2006, 2009; Jonsdottir et al., 2021; Lasiuk, 2007; Lee, 2001; Montgomery, 2012; Montgomery and Seng, 2021; Palmer, 2004; Parratt, 1994; Welch, 2013)				
Methodological limitations:	Coherence:	Adequacy:	Relevance:	GRADE-CERQual
No or very minor concerns	No or very minor concerns	No or very minor concerns	No or very minor concerns	High confidence
Fear of their children might become victims of abuse: fear of children becoming victims of abuse, leading to preventive strategies focused on boundaries, awareness, education, and self-esteem.				
Studies contributing to the review finding: 4 (Bellhouse, 2013; Coles, 2006, 2009; Coles and Jones, 2009; Jonsdottir et al., 2021)				
Methodological limitations:	Coherence:	Adequacy:	Relevance:	GRADE-CERQual
No or very minor concerns	No or very minor concerns	Moderate concerns	No or very minor concerns	Moderate confidence · explanation: we consider the quality to be moderate due to moderate concerns in adequacy.

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Table 3 (continued)

MOTHERING				
Physical contact with their children: challenges related to physical contact and intimate caregiving, including concerns about sibling interactions and professional care of children.				
Studies contributing to the review finding: 4 (Coles and Jones, 2009; Palmer, 2004; Parratt, 1994; Wood and Van Esterik, 2010)				
Methodological limitations:	Coherence:	Adequacy:	Relevance:	GRADE-CERQual
No or very minor concerns	Minor concerns	Moderate concerns	No or very minor concerns	Low confidence · explanation: low confidence due to minor concerns regarding coherence and moderate concerns regarding adequacy.
Breastfeeding: breastfeeding shaped by abuse-related experiences, generating guilt, shame, and distress for some women, while fostering bodily validation and mother–infant connection for others.				
Studies contributing to the review finding: 6 (Coles, 2006, 2009; Knox, 2017; Montgomery, 2012; Palmer, 2004; Wood and Van Esterik, 2010)				
Methodological limitations:	Coherence:	Adequacy:	Relevance:	GRADE-CERQual
No or very minor concerns	No or very minor concerns	No or very minor concerns	No or very minor concerns	High confidence
Aspired to an idealised close-knit, ideal family: aspiration to an idealised family model, with paternal involvement shaped by experiences of abusive or dysfunctional relationships.				
Studies contributing to the review finding: 2 (Canzonieri, 2018; Welch, 2013)				
Methodological limitations:	Coherence:	Adequacy:	Relevance:	GRADE-CERQual
Moderate concerns	Serious concerns	Serious concerns	Serious concerns	Very low confidence · explanation: very low confidence, as it is unclear whether the finding adequately represents the phenomenon of interest due to moderate methodological concerns and serious concerns regarding coherence, adequacy, and relevance.
SAFE ENVIRONMENT: A FUNCTIONAL OR DYSFUNCTIONAL SETTING?				
Safe environment? functional or dysfunctional setting: safety and support within intimate, social, and professional relationships shaping the experience of the transition to motherhood.				
Studies contributing to the review finding: 6 (Lasiuk, 2007; Lee, 2001; Mathewson, 2016; Montgomery, 2012; Montgomery and Seng, 2021; Palmer, 2004)				
Methodological limitations:	Coherence:	Adequacy:	Relevance:	GRADE-CERQual
No or very minor concerns	Minor concerns	Minor concerns	No or very minor concerns	Moderate confidence · explanation: moderate confidence due to adequacy as the result has not been expressed with sufficient richness.
PERINATAL CARE AS A SOURCE OF SUPPORT OR DISTRESS				
Perinatal care acting either as a source of support or distress: perinatal care acting as either a source of support and safety or a source of distress, shaped by professional relationships, care practices, and opportunities for disclosure.				
Studies contributing to the review finding: 11 (Coles, 2006, 2009; Coles and Jones, 2009; Garratt, 2008; Jonsdottir et al., 2021; Lee, 2001; Montgomery, 2012; Montgomery and Seng, 2021; Palmer, 2004; Richmond, 2005; Wood and Van Esterik, 2010)				
Methodological limitations:	Coherence:	Adequacy:	Relevance:	GRADE-CERQual
No or very minor concerns	No or very minor concerns	No or very minor concerns	No or very minor concerns	High confidence
Aspects to improve: recommendations for care including recognition of child sexual abuse impact, safe and empathetic communication, explicit consent, respectful treatment, and improved access to services.				
Studies contributing to the review finding: 14 (Coles, 2006, 2009; Coles and Jones, 2009; Garratt, 2008; Jonsdottir et al., 2021; Knox, 2017; Lasiuk, 2007; Lee, 2001; Mathewson, 2016; Montgomery, 2012; Montgomery and Seng, 2021; Palmer, 2004; Parratt, 1994; Richmond, 2005; Roller, 2011)				
Methodological limitations:	Coherence:	Adequacy:	Relevance:	GRADE-CERQual
No or very minor concerns	No or very minor concerns	No or very minor concerns	No or very minor concerns	High confidence
COPING STRATEGIES: ADAPTATIVE VS MALADAPTATIVE				
Maintaining control: control as a coping strategy, achieved through preparation, birth planning, autonomy, and choice regarding care, birth setting, and participants.				
Studies contributing to the review finding: 13 (Coles, 2006, 2009; Coles and Jones, 2009; Garratt, 2008; Lee, 2001; Mathewson, 2016; Montgomery, 2012; Montgomery and Seng, 2021; Palmer, 2004; Parratt, 1994; Rhodes and Hutchinson, 1994; Richmond, 2005; Roberts et al., 2021; Roller, 2011)				
Methodological limitations:	Coherence:	Adequacy:	Relevance:	GRADE-CERQual
No or very minor concerns	No or very minor concerns	No or very minor concerns	No or very minor concerns	High confidence
Women sought support: seeking support as a coping strategy through family, friends, professionals, legal services, therapy, antenatal education, and spiritual practices.				
Studies contributing to the review finding: 10 (Bellhouse, 2013; Canzonieri, 2018; Jonsdottir et al., 2021; Knox, 2017; Lee, 2001; Montgomery, 2012; Palmer, 2004; Richmond, 2005; Roller, 2011; Welch, 2013)				
Methodological limitations:	Coherence:	Adequacy:	Relevance:	GRADE-CERQual
Moderate concerns	No or very minor concerns	No or very minor concerns	No or very minor concerns	Moderate confidence · explanation: moderate confidence, as the finding is likely to represent the phenomenon of interest despite moderate concerns regarding methodological limitations and adequacy.
Skills to manage stressful situations: use of personal coping strategies, including desensitisation, resilience, and dissociation, supported by social, therapeutic, and spiritual resources.				
Studies contributing to the review finding: 4 (Coles and Jones, 2009; Palmer, 2004; Parratt, 1994; Welch, 2013)				
Methodological limitations:	Coherence:	Adequacy:	Relevance:	GRADE-CERQual
Minor concerns	Moderate concerns	Serious concerns	No or very minor concerns	Low confidence · explanation: low confidence due to minor concerns regarding methodological limitations, moderate concerns regarding coherence, and serious concerns regarding adequacy (limited data richness)
Engaging many forms of self-care: engagement in self-care practices and adoption of health-promoting coping strategies, sometimes accompanied by increased vulnerability following the abandonment of previous survival mechanisms.				
Studies contributing to the review finding: 7 (Bellhouse, 2013; Canzonieri, 2018; Lasiuk, 2007; Lee, 2001; Palmer, 2004; Richmond, 2005; Welch, 2013)				
Methodological limitations:	Coherence:	Adequacy:	Relevance:	GRADE-CERQual
Moderate concerns	No or very minor concerns	Moderate concerns	Minor concerns	Moderate confidence · explanation: moderate confidence due to moderate concerns regarding methodological limitations and adequacy, including limited richness of the supporting data.

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Table 3 (continued)

COPING STRATEGIES: ADAPTATIVE VS MALADAPTATIVE				
Mental and bodily disconnection: mental and bodily disconnection as a trauma-related coping strategy during the transition to motherhood.				
Studies contributing to the review finding: 13 (Bellhouse, 2013; Garratt, 2008; Jonsdottir et al., 2021; Lee, 2001; Mathewson, 2016; Montgomery, 2012; Montgomery and Seng, 2021; Palmer, 2004; Parratt, 1994; Rhodes and Hutchinson, 1994; Richmond, 2005; Roberts et al., 2021; Wood and Van Esterik, 2010)				
Methodological limitations: No or very minor concerns	Coherence: No or very minor concerns	Adequacy: No or very minor concerns	Relevance: No or very minor concerns	GRADE-CERQual High confidence
Negligent behaviours: use of maladaptive coping strategies, including substance use, eating disorders, self-harm, suicidality, and avoidance of healthcare or medication.				
Studies contributing to the review finding: 5 (Bellhouse, 2013; Palmer, 2004; Richmond, 2005; Roller, 2011; Welch, 2013)				
Methodological limitations: Moderate concerns	Coherence: No or very minor concerns	Adequacy: Serious concerns	Relevance: Moderate concerns	GRADE-CERQual Low confidence · explanation: low confidence due to serious concerns regarding adequacy and moderate concerns regarding methodological limitations and relevance.
Internal and external struggle: transition to motherhood experienced as an internal and external struggle, involving self-doubt, self-criticism, perfectionism, and defensive or aggressive behaviours.				
Studies contributing to the review finding: 6 (Byrne et al., 2017; Montgomery, 2012; Palmer, 2004; Rhodes and Hutchinson, 1994; Roberts et al., 2021)				
Methodological limitations: Minor concerns	Coherence: No or very minor concerns	Adequacy: Moderate concerns	Relevance: No or very minor concerns	GRADE-CERQual Low confidence · explanation: low confidence due to minor concerns regarding methodological limitations and moderate concerns regarding adequacy.
Tensions between silence and disclosure: tensions between concealment and disclosure of abuse experiences, shaped by guilt, shame, ambivalence, and perceived readiness to discuss past trauma.				
Studies contributing to the review finding: 1 (Montgomery, 2012)				
Methodological limitations: No or very minor concerns	Coherence: Moderate concerns	Adequacy: Serious concerns	Relevance: Minor concerns	GRADE-CERQual Low confidence · explanation: Low confidence due to serious concerns regarding adequacy arising from the paucity of supporting data.
Loss of confidence: Loss of confidence associated with abuse, including distrust in the body and doubts about parenting and protective capacities.				
Studies contributing to the review finding: 12 (Bellhouse, 2013; Byrne et al., 2017; Coles, 2006, 2009; Garratt, 2008; Jonsdottir et al., 2021; Lasiuk, 2007; Lee, 2001; Montgomery, 2012; Montgomery and Seng, 2021; Palmer, 2004; Parratt, 1994; Rhodes and Hutchinson, 1994)				
Methodological limitations: No or very minor concerns	Coherence: No or very minor concerns	Adequacy: No or very minor concerns	Relevance: No or very minor concerns	GRADE-CERQual High confidence
Dysfunctional emotional experiences: experiences including anxiety, overwhelm, ambivalence, panic, depressive symptoms, and post-traumatic stress.				
Studies contributing to the review finding: 7 (Jonsdottir et al., 2021; Knox, 2017; Lasiuk, 2007; Lee, 2001; Mathewson, 2016; Montgomery and Seng, 2021; Palmer, 2004)				
Methodological limitations: No or very minor concerns	Coherence: No or very minor concerns	Adequacy: Moderate concerns	Relevance: No or very minor concerns	GRADE-CERQual Moderate confidence · explanation: moderate confidence due to moderate concerns regarding adequacy.

extends to their emotions, bodies, abilities and internal coping strategies, as well as to the care received, often shaped by power imbalances, limited choice of caregiver, the clinical environment and restricted presence of family members.

Motherhood as a transition toward healing

The TM is described by many women as a **healing process** (high confidence; Bellhouse, 2013; Byrne et al., 2017; Canzonieri, 2018; Garratt, 2008; Jonsdottir et al., 2021; Knox, 2017; Lasiuk, 2007; Lee, 2001; Mathewson, 2016; Montgomery, 2012; Montgomery and Seng, 2021; Palmer, 2004). This stage may bring relief from the lasting effects of trauma, with diminished feelings of guilt, shifts in roles, and the establishment of clearer boundaries with others. Some women experience it as a form of rebirth beginning as early as the preconception stage. For some, this transition also facilitates a **renewed relationship with the body**, allowing it to be validated beyond the history of abuse (high confidence; Byrne et al., 2017; Coles, 2006, 2009; Garratt, 2008; Knox, 2017; Lasiuk, 2007; Lee, 2001; Montgomery, 2012; Palmer, 2004; Wood and Van Esterik, 2010). Motherhood helps to separate the body from its sexualised meaning, normalising it and validating a sense of purpose. Through this process, women report gaining confidence and a greater sense of security.

For some women, the TM **transformed past relationships** (very low confidence; Canzonieri, 2018; Lee, 2001), leading them to strengthen certain ties, redefine boundaries, or end relationships to create safer environments.

Mothering

The effects of childhood sexual trauma and the distress it generates influence women's experiences of motherhood. For some, the TM raises doubts about their **ability to mother** (high confidence; Byrne et al., 2017; Coles, 2006, 2009; Garratt, 2008; Jonsdottir et al., 2021; Lasiuk, 2007; Lee, 2001; Montgomery, 2012; Montgomery and Seng, 2021; Palmer, 2004; Welch, 2013), sometimes leading to delayed motherhood, interrupted pregnancies or adoption decisions. Many describe disbelief at becoming a mother to their own child, fear of repeating harmful patterns, vulnerability to external demands and a sense of losing themselves. Feelings of guilt were common, particularly when women felt unable to meet expectations of bonding, to remain present in difficult circumstances, or to protect themselves and their children, and in some cases when children were removed from their custody amid internal struggles. Some also feared disclosing their abuse due to concerns that they would be judged as unfit mothers. Internal narratives were often polarised, ranging from self-sabotage to confidence in their capacity to mother and achieve their goals.

Women's TM also shapes the parenting approaches they adopt. Many describe how their history of abuse and birth experiences influence the way they relate to their children and construct their maternal roles, often in reference to their own relationships with their mothers. Parenting styles vary, ranging from overprotective to authoritarian or permissive. For some, mothering involves **striving for perfect motherhood** (moderate confidence; Bellhouse, 2013; Canzonieri, 2018; Lasiuk, 2007; Montgomery, 2012; Montgomery and Seng, 2021; Palmer, 2004; Welch, 2013), linked to the desire to be the "perfect daughter" in

response to past abuse, often accompanied by guilt and shame. Some women also report emotional dependence on their child, using this bond to meet their own unmet needs.

Women repeatedly expressed **concerns about the biological sex** of their children (high confidence; Bellhouse, 2013; Byrne et al., 2017; Coles, 2006, 2009; Jonsdottir et al., 2021; Lasiuk, 2007; Lee, 2001; Montgomery, 2012; Montgomery and Seng, 2021; Palmer, 2004; Parratt, 1994; Welch, 2013), as it could trigger memories of abuse and influence their perceived ability to protect and mother. Some feared girls might be at greater risk of victimisation and felt reassured when expecting a boy, while others viewed boys as potential perpetrators and reported difficulties bonding with them.

Some women **feared their children might become victims of abuse**, particularly in trusted environments, and described preventive strategies such as educating them about appropriate boundaries, adapting guidance to their child's maturity, monitoring their environment and fostering self-esteem (moderate confidence; Bellhouse, 2013; Coles, 2006, 2009; Coles and Jones, 2009; Jonsdottir et al., 2021). Intimate aspects of mothering could be challenging for some women. In some cases, their abuse history influenced how they experienced **physical contact with their children** (low confidence; Coles and Jones, 2009; Palmer, 2004; Parratt, 1994; Wood and Van Esterik, 2010), generating conflicts around sibling interactions or discomfort when professionals attended to their children.

Breastfeeding was one context in which these tensions impacted the most (high confidence; Coles, 2006, 2009; Knox, 2017; Montgomery, 2012; Palmer, 2004; Wood and Van Esterik, 2010). For some women, their abuse history shaped how they experienced their breasts and bodily exposure, sometimes associating them with pain and influencing their decision to breastfeed. Feelings of guilt were common (choosing formula feeding, fearing that breastfeeding might expose their child to harm, or struggling with the physical and emotional reactions it provoked). Shame about their bodies, difficulty meeting social expectations or breastfeeding in public, and a sense of failure when problems arose were also reported, often accompanied by feelings of objectification and limited ability to express their needs. However, validation from professionals or shared decision-making with partners could bring relief. For some women, breastfeeding also became a positive experience, allowing them to validate their bodies and feel connection and joy with their child.

Some women expressed concern about the expectations they placed on their children, particularly regarding their health, education, and emotional and economic wellbeing. Many also **aspired to an idealised close-knit, ideal family** (very low confidence; Canzonieri, 2018; Welch, 2013) with a committed father figure. However, this ideal was often challenged when relationships with partners were abusive or dysfunctional, leading women to question paternal involvement.

Safe environment: A functional or dysfunctional setting?

Close relationships, particularly with a partner, are crucial (moderate confidence; Lasiuk, 2007; Lee, 2001; Mathewson, 2016; Montgomery, 2012; Montgomery and Seng, 2021; Palmer, 2004). Changes in relationships with others and with partners form part of the recovery process. The TM tends to be experienced more positively when accompanied by adequate emotional or practical support. Some women perceived pregnancy as a safe period and described it as a time to receive care and attention. Others sought support from professionals or support groups (although experiences were not always positive), particularly when close support was lacking. Even when partnered, some women still turned to professional support. In contrast, the transition was experienced more negatively when women felt a lack of safety or support in their relationships. In some cases, feelings reminiscent of their abuse history also resurfaced.

Perinatal care as a source of support or distress

Perinatal care played a significant role in shaping women's experiences during the TM, **acting either as a source of support or distress** (high confidence; Coles, 2006, 2009; Coles and Jones, 2009; Garratt, 2008; Jonsdottir et al., 2021; Lee, 2001; Montgomery, 2012; Montgomery and Seng, 2021; Palmer, 2004; Richmond, 2005; Wood and Van Esterik, 2010). Positive experiences were associated with professionals who showed understanding, trust, sensitivity and emotional support, as well as continuity of care and attention to women's emotional wellbeing. Opportunities to disclose past abuse, express feelings related to pregnancy and childbirth and receive clear and consistent information contributed to feelings of safety and reassurance. Some women also sought specific models of care based on previous experiences.

However, not all women experienced care positively. For some, the clinical environment and institutionalised care—often marked by power imbalances—were perceived as threatening and evoked memories of past abuse. Women described feelings of distrust and disconnection from professionals, together with a lack of understanding of the impact of childhood sexual abuse during this stage, leading to experiences of loneliness, abandonment, helplessness and vulnerability.

Women identified some **aspects to improve** and expressed the need for professionals to understand the impact of CSA (high confidence; Coles, 2006, 2009; Coles and Jones, 2009; Garratt, 2008; Jonsdottir et al., 2021; Knox, 2017; Lasiuk, 2007; Lee, 2001; Mathewson, 2016; Montgomery, 2012; Montgomery and Seng, 2021; Palmer, 2004; Parratt, 1994; Richmond, 2005; Roller, 2011). Some chose to disclose their history and valued having it documented to prevent recurrence. They called for a safe environment with relationships grounded in empathetic communication. They suggested that consent should not be assumed and that professionals should introduce themselves, explain each action, and respect both the women and their children. They also highlighted the need to improve access to health services to address the impacts of childhood sexual abuse on their well-being.

Coping strategies: adaptive vs maladaptive

Maintaining control acted as a key coping strategy during the TM (high confidence; Coles, 2006, 2009; Coles and Jones, 2009; Garratt, 2008; Lee, 2001; Mathewson, 2016; Montgomery, 2012; Montgomery and Seng, 2021; Palmer, 2004; Parratt, 1994; Rhodes and Hutchinson, 1994; Richmond, 2005; Roberts et al., 2021; Roller, 2011). Women described preparing in advance, choosing the place of birth, deciding who would be present (often expressing concern about male professionals) and asserting autonomy through boundaries, birth plans and independent decision-making. This sense of control helped them to manage vulnerability. Many **women sought support** as a coping strategy (moderate confidence; Bellhouse, 2013; Canzonieri, 2018; Jonsdottir et al., 2021; Knox, 2017; Lee, 2001; Montgomery, 2012; Palmer, 2004; Richmond, 2005; Roller, 2011; Welch, 2013), doing so at different stages: after the abuse, once able to act independently, or even before conception. They turned to family and friends, healthcare professionals, the legal system, group therapy, antenatal classes or spiritual practices.

Some women **developed skills to manage stressful situations** and, together with their support networks (partners, family, therapy, community and spirituality), faced the TM with greater resources (low confidence; Coles and Jones, 2009; Palmer, 2004; Parratt, 1994; Welch, 2013). Some practised desensitisation, others developed resilience, and some identified dissociation as a coping strategy.

Women described **engaging many forms of self-care** throughout their lives, such as exercise, reading, writing, journaling, or music. For some, pregnancy fostered an orientation to health-promoting and protective behaviours, prompting them to abandon maladaptive coping mechanisms and seek professional support (moderate confidence;

Bellhouse, 2013; Canzonieri, 2018; Lasiuk, 2007; Lee, 2001; Palmer, 2004; Richmond, 2005; Welch, 2013). However, for others, discontinuing these coping strategies contributed to a heightened sense of vulnerability.

On the other hand, **mental and bodily disconnection** during the TM was one of the most frequently reported maladaptive strategies (high confidence; Bellhouse, 2013; Garratt, 2008; Jonsdottir et al., 2021; Lee, 2001; Mathewson, 2016; Montgomery, 2012; Montgomery and Seng, 2021; Palmer, 2004; Parratt, 1994; Rhodes and Hutchinson, 1994; Richmond, 2005; Roberts et al., 2021; Wood and Van Esterik, 2010). It could occur during pregnancy, childbirth, breastfeeding and parenting, sometimes described as a mechanistic approach or associated with postpartum depression. During childbirth, dissociation could arise from the process itself or from procedures that acted as memory triggers. For some women, this experience was distressing, characterised by numbness, emotional detachment or feeling trapped within themselves. Others viewed it as a protective response developed from childhood. In some cases, dissociation hindered bonding with their child or led to emotional denial of the pregnancy as a way of coping with overwhelming emotions.

Some women reported **negligent behaviours** (low confidence; Bellhouse, 2013; Palmer, 2004; Richmond, 2005; Roller, 2011; Welch, 2013), including substance use, eating disorders, self-harm and suicide attempts. For some, pregnancy prompted the abandonment or modification of substance use, while others replaced suicidal ideation with self-harming behaviours. Some also avoided medical care or medication during pregnancy to maintain control and prevent feelings of insecurity or the reactivation of abuse memories.

Some women adopted hostile behaviours toward others (such as angry or violent reactions toward obstetric staff or physical aggression toward their children) as a way of coping with childbirth and motherhood. The TM was experienced as both an **internal struggle** (negative self-judgements, doubts about their capacity to mother and perfectionism) and an **external struggle** (overprotective behaviours, self-defence and similar responses) (low confidence; Byrne et al., 2017; Montgomery, 2012; Palmer, 2004; Rhodes and Hutchinson, 1994; Roberts et al., 2021). **Tensions between silence and disclosure** are intrinsic to the dynamics of abuse (low confidence; Montgomery, 2012), and abuse histories are often concealed due to guilt and shame associated with victimisation. During the TM, some women found it difficult to express themselves, as it elicited emotional and physical responses reminiscent of the abuse. While some valued discussing their experiences with professionals and viewed this period as an opportunity to confront them, others felt it was not the right time and expressed ambivalence or fear that disclosure might negatively affect their experience.

Loss of confidence associated with abuse was frequently observed (high confidence; Bellhouse, 2013; Byrne et al., 2017; Coles, 2006, 2009; Garratt, 2008; Jonsdottir et al., 2021; Lasiuk, 2007; Lee, 2001; Montgomery, 2012; Montgomery and Seng, 2021; Palmer, 2004; Parratt, 1994; Rhodes and Hutchinson, 1994). Women expressed distrust in their bodies, fear of causing harm to their child, doubts about their protective capacity and a perceived lack of knowledge.

Some women reported a range of **dysfunctional emotional experiences** (moderate confidence; Jonsdottir et al., 2021; Knox, 2017; Lasiuk, 2007; Lee, 2001; Mathewson, 2016; Montgomery and Seng, 2021; Palmer, 2004), including anticipatory anxiety, feelings of being overwhelmed, ambivalence, panic attacks, depressive states, and post-traumatic stress disorder (PTSD).

Integration of the findings

We sought to undertake a reflexive integration of the identified themes to provide a richer level of interpretation of the findings. The experience of women with a history of childhood sexual abuse during the TM is markedly polarised. On one hand, some experiences contribute

to revictimization and are associated with maladaptive cognitive and behavioural coping patterns, often accompanied by altered self-perception and diminished confidence in their abilities. On the other hand, certain experiences enable more positive cognitive constructions and adaptive coping strategies. Alongside survivors' resilience and sense of agency, these processes contribute to the development of a renewed life trajectory. Agency, their perception of control and capacity for self-directed action, is fostered through reconnection with the body (bodily agency), active involvement in decision-making, and the establishment of secure, functional bonds with their children.

For many women, this stage is characterised by heightened vulnerability and fragility; however, for some, it represents a form of rebirth and a catalyst for meaningful life change. The presence of supportive relationships, including partners and healthcare professionals, is central to more positive experiences of the TM. Conversely, the absence of a safe and supportive environment may exacerbate vulnerability and feelings of guilt.

Perinatal care plays a pivotal role in shaping women's experiences. Some women report the reactivation of abuse-related memories triggered by bodily sensations inherent to this stage or by obstetric care perceived as invasive or dehumanising. In contrast, individualised and compassionate care (grounded in effective communication and professionals' understanding of trauma) can foster a more positive transition by offering alternatives to standard practices and enhancing women's sense of safety.

Overall, motherhood, with its biopsychosocial implications, constitutes a turning point in identity. During this transition, identity is reconstructed through processes of internal validation (e.g. emotions, capacities, decision-making) and external validation (e.g. relational, social, and professional support). Fig. 2 reflects how coping strategies shape the continuum of experiences across the transition to motherhood.

DISCUSSION

We conducted a qualitative systematic review to understand the experiences of women who are survivors of childhood sexual abuse during the transition to motherhood. While the transition to motherhood is generally considered a positive process (Torres Zambrano, 2020), the analysis of 269 accounts revealed that experiences and coping strategies do not follow a single trajectory. From 21 studies, we identified six main themes comprising 26 subthemes—most of which had a high or moderate level of confidence—which enabled us to describe and interpret these experiences in an integrated and conceptual manner.

Findings in the context of current knowledge and theoretical perspectives

Our review highlights how bodily sensations and bodily exposure constitute a central dimension of the traumatic experience throughout the perinatal period. This finding is consistent with previous reviews demonstrating that bodily sensations during pregnancy, labour, and the postpartum period are closely linked to a history of abuse, shaping women's overall experience (Chamberlain et al., 2019; Frederickson et al., 2023; Leeners et al., 2006; Montgomery, 2013). Similarly, childhood sexual abuse affects perinatal dissociation and emotional adaptation to motherhood (Brenner et al., 2024). The literature suggests that these experiences may contribute to feelings of vulnerability, dissociation, and loss of control, particularly when the body is perceived as invaded or alien. This phenomenon is better understood within the sociocultural context of the female body, which is often rendered invisible, yet becomes more publicly visible and materially salient during the transition to motherhood (Aranda, 2018; Kurz et al., 2022). In this regard, although other reviews highlight the vulnerability associated with the loss of bodily autonomy and medical care (Frederickson et al., 2023; Leeners et al., 2006; Montgomery, 2013), they do not explore in depth the expository nature of this stage. One review also highlighted that

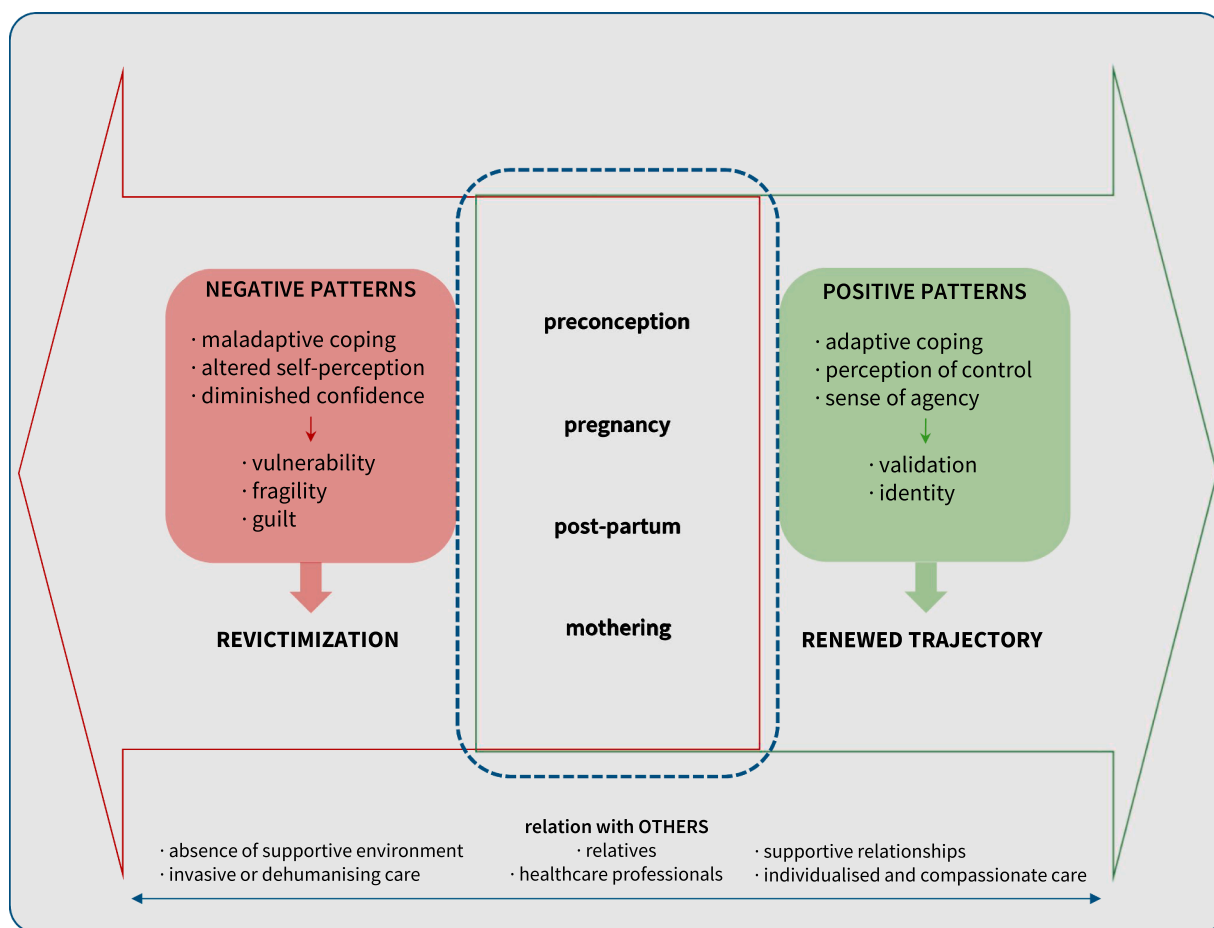


Fig. 2. (Interpretative integration of findings).

some women perceived the use of analgesia as a loss of control, similar to our findings; however, others viewed it as a means of alleviating the accumulated pain of their lives (Leeners et al., 2006).

Similarly, we observed how the transition to motherhood may represent a process of healing and identity reconstruction. This finding is consistent with other reviews indicating that the transition to motherhood can constitute a turning point in women's relationships and identities (Chamberlain et al., 2019; Montgomery, 2013). This can be related to the concept of matrescence, understood as a biopsychosocial process and a rite of passage in which childbirth constitutes a key moment (Kurz et al., 2022). However, the way care is provided, or matrescent care, may significantly influence the lived experience, suggesting divergent trajectories depending on the care context (Kurz et al., 2022). Similarly, while our findings show that for some women pregnancy constituted a safe period, one review reported cases of intimate partner violence, highlighting the diversity of experiences during this period (Chamberlain et al., 2019).

In relation to motherhood, aligned with our findings, the literature suggests that women with a history of CSA may present greater heterogeneity in parenting styles, higher levels of stress, and a lower sense of competence, coexisting with processes of empowerment and help-seeking aimed at breaking the intergenerational transmission of trauma (Lange et al., 2020a, 2020b; MacIntosh and Ménard, 2021).

Regarding breastfeeding, and in line with our findings, the literature also shows that women may experience ambivalent feelings, where physical contact, bodily exposure, and pressure to breastfeed may reactivate trauma, leading to dissociation, distress, or feelings of guilt (Elfgen et al., 2017; Kendall-Tackett, 1997; Olza et al., 2017). This has been criticised from feminist perspectives, as the promotion of

breastfeeding often focuses exclusively on its benefits, reinforcing the dichotomy of the "good" versus "bad" mother and fostering a disconnection between the body and the maternal experience (Olza et al., 2017). Some women may choose not to breastfeed or experience physical and emotional difficulties during breastfeeding (Elfgen et al., 2017; Kendall-Tackett, 1997).

Our findings also highlight the importance of support during labour from trusted individuals, which has been associated with a greater sense of control, improved communication, and more effective coping strategies (Bohren et al., 2019; Dahlen, 2020). However, difficulties in partner and support relationships may influence this experience among women with a history of CSA (MacIntosh and Ménard, 2021), reinforcing the need for approaches that are sensitive to psychosocial vulnerabilities (Dahlen, 2020).

As we have observed, perinatal care can be both a source of support and distress. In line with other reviews, obstetric care may trigger PTSD symptoms, whereas positive perinatal care may mitigate them (Frederickson et al., 2023). This phenomenon is framed within a medicalised obstetric model that reinforces clinical control and the loss of bodily autonomy (Aranda, 2018; Davis-Floyd, 2001). The literature has criticised the objectification of the female body and its conceptualisation as inferior or uncontrollable (Aranda, 2018). In this context, some obstetric experiences may be perceived as traumatic, associated with professional actions or omissions (Olza, 2014), with accounts of betrayal or even obstetric violence (Kitzinger, 2006). Despite feminist advances, a technocratic model persists that conceptualises childbirth as a production process (Davis-Floyd, 2001). Consequently, the impact of perinatal care is polarised, ranging from sensitive and respectful care that protects wellbeing to institutionalised models that may intensify trauma

(Benton et al., 2024; Kurz et al., 2022; Olza, 2014).

Finally, coping strategies also show a certain degree of polarisation. The literature demonstrates that perceptions of childbirth vary between a high-risk view associated with the hospital setting and a physiological view linked to bodily autonomy and non-medicalised environments (Carlsson, 2016; Lupton and Schmied, 2013). In both cases, loss of control may facilitate experiences of dissociation as a protective response or coping strategy in the face of trauma (Montgomery, 2013). In addition, these women may present greater insecurity regarding their caregiving abilities (Leeners et al., 2006) and a higher prevalence of PTSD symptoms during pregnancy and the postpartum period (Frederickson et al., 2023; Wosu et al., 2015).

Implications for practice and research

Our contribution to practice and research arises from the analysis of our findings alongside existing literature with a similar focus. The findings of our review, as described above, highlight the need for individualised and compassionate care that goes beyond the biomedical approach, integrating trauma-informed care into midwifery practice (Benton et al., 2024). From a feminist perspective, our findings highlight the need to move towards approaches of maternity care that recognise women's agency and their lived experiences. This requires addressing the structural inequalities that shape reproductive experiences, incorporating an intersectional lens into policy and practice, and placing dignity, participation, and relational care at the centre of maternity services (Aranda, 2018).

In this sense, our review fills the gap between theory and practice by providing concrete evidence, based on women's experiences, of how trauma influences their experience during the transition to motherhood. This work will enable midwives not only to understand the phenomenon in greater depth, but also to acquire the competencies described in the EMPATHY framework, which provides guidance for midwives to address trauma sensitively during clinical care (Cull et al., 2025). In this way, it equips midwives to create an environment of trust and safety in routine conversations about trauma and its impact on the transition to motherhood. All of this will allow midwives to anticipate needs, minimise the risk of re-traumatisation, and provide individualised and trauma-sensitive care.

In light of these findings, the importance of the midwife's active role throughout the perinatal period (preconception and the first postnatal year) becomes evident, with implications for both service organisation and the provision of care across different levels of healthcare, particularly within primary care (Generalitat de Catalunya, 2007, 2019; Roberts et al., 2018).

From a public health perspective, we need to design perinatal care that is high-quality and integrative, with a focus not only on addressing the problem but also on its underlying causes. Policies and practices in obstetrics must go further in providing care for complex situations, such as those affecting our population of interest. Recent evidence on trauma-informed care highlights the importance of systematic strategies, including screening, sensitive communication, continuity of care, cultural adaptation, and staff training (Benton et al., 2024), as well as the need to apply trauma-sensitive universal precautions (Owens et al., 2022), recognising that individualised and sensitive care should be provided consistently. Critical reflective engagement and practice, both in research and with vulnerable populations, are urgently needed. This represents an opportunity to rethink discussions on dignity and care in the perinatal context (Aranda and Jones, 2010).

Limitations

Despite a rigorous review process and comprehensive search strategy, some relevant studies may not have been identified due to the recognised impact of dissemination bias in qualitative research (Booth et al., 2018; Weber et al., 2025). Furthermore, the appraisal of the

included studies revealed that some had unclear methodological quality. However, the use of GRADE-CERQual allowed us to transparently assess confidence in the review findings, thereby supporting their interpretation and use in informed decision-making. The nature of the phenomenon under investigation also presents several challenges. Although recall bias is possible, memories of traumatic episodes are generally considered accurate (Simkin, 1992). The impact of traumatic experiences during the preconception period remains underexplored, partly because recruitment at this stage is challenging (SEGO, 2010). In addition, the findings are based primarily on accounts from women living in high-income countries without a clear representation of sociodemographic diversity and limited consideration of intersectionality (for example, regarding the experiences of LGBTQI+ individuals), which may restrict transferability (Aranda, 2018). Finally, we consider it essential to centre women's voices in order to highlight the profound implications of these experiences for their lives, but the absence of evidence regarding other pregnancy-capable individuals (including transgender men and non-binary people) highlights an important gap for future research.

Conclusions

This review explores the experiences and coping strategies of women with a history of child sexual abuse during the transition to motherhood. This stage offers an opportunity to heal deep-seated wounds, consolidate emotional foundations and prevent intergenerational transmission of trauma. Perinatal care is crucial for recognising the impact of trauma and providing personalised support. This analysis gives visibility to women's voices and encourages improvements in research and health policy.

CRedit authorship contribution statement

Claudia Ramírez-Gil: Writing – original draft, Project administration, Methodology, Investigation, Funding acquisition, Formal analysis, Data curation, Conceptualization. **Anna Selva:** Writing – review & editing, Validation, Supervision, Methodology, Conceptualization. **Marta Gallego Barrero:** Writing – review & editing, Visualization, Investigation. **Natalia Muñoz Hidalgo:** Writing – review & editing, Investigation. **Cristina Martínez-Bueno:** Writing – review & editing, Validation, Supervision, Conceptualization. **Ivan Solà:** Writing – review & editing, Validation, Supervision, Methodology, Investigation, Funding acquisition, Conceptualization.

Declaration of competing interest

The authors declare that they have no known competing financial interests or personal relationships that could have appeared to influence the work reported in this paper.

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Supplementary materials

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