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An Exploration of the Psychosocial Impacts of Sexual Violence on Somali Women.

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Dedication

In loving memory of my ayeeyo Amina, my cousin Nagiib, and my cousin Nura, who are missed beyond words can express. May Allah, the most glorified, the most high, reunite us all in Jannatul Firdaus.

Ameen.

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Abstract

Aims: Sexual violence against girls and women is a global human rights issue. It may encompass a range of acts and is associated with detrimental impacts on women's physical and psychosocial wellbeing. The aim of this study was to explore the psychosocial impacts of sexual violence on Somali women from the United Kingdom. This study also explored their perceptions of disclosure and psychological help-seeking.

Method: Five semi-structured interviews were conducted with Somali women who had experienced varying forms of sexual violence. Interview data was analysed using Interpretative Phenomenological Analysis.

Results: Three superordinate themes and seven subordinate themes were identified from the data. Together, the themes described the adverse physical and psychosocial impacts of sexual violence. Moreover, the themes highlighted the negative impact of perceived betrayal, silencing, and institutional harm. Finally, the themes described women's different recovery journeys, focusing on their relationships to religion and their experiences with (psychological) support services.

Discussion: Findings of this study were discussed in relation to the wider literature and relevant frameworks taking into consideration Somali women's intersectional identities. Clinical implications for Trauma Informed Practice were also considered.

Chapter 1: Introduction

Chapter Overview

This thesis concerns sexual violence experienced by Somali women living in the United Kingdom (UK) by a perpetrator known to them. In this chapter, I will first situate my position as a researcher, wherein I will describe my relationship to the research topic followed by my ontological and epistemological position. This chapter then reviews conceptualisations of sexual violence, considering feminist, intersectional, and Somali perspectives. The next part of the chapter considers the psychosocial impacts of sexual violence and psychological help-seeking more generally, followed by a systematic literature review focusing on the evidence base relating to Somali women specifically. The chapter will finally outline the rationale and research questions of this thesis.

1.1 Positioning the Researcher

1.1.1 Relationship to the research topic.

In the summer of 2020, I accessed Twitter, and was taken back by the latest viral Tweets. Using the hashtag “SomaliMeToo”, large numbers of Somali women had taken the difficult step to share their experiences of sexual violence (Ibrahim, 2020). As a Somali woman myself, I felt sad, enraged, and subsequently felt compelled to carry out this research, both for the women who had loudly raised their voices, and for those who had theirs denied. As the Somali poet Warsan Shire

reminds us: “In Somali, when we see injustice we say ‘Dhiiga kuma dhaqaaqo?’, which translates into ‘does your blood not move?’” (Mire, 2017, para. 15).

Similarly, as a Muslim, when we see injustice, we are encouraged to address these to the best of our ability. Indeed, the Prophet Mohamed (peace and blessings of Allah be upon him) has said:

> Whosoever of you sees an evil, let him change it with his hand; and if he is not able to do so, then [let him change it] with his tongue; and if he is not able to do so, then with his heart — and that is the weakest of faith (Muslim, n.d.).

My insider position has therefore influenced my investment in this research (Kanuha, 2000). Yet, at the same time, my close relationship to the research topic has also presented challenges. Since the conception of this topic, I have experienced many doubts (Appendix 1). Doubts over whether I could emotionally manage this topic, given the pain that I would be witnessing, and knowing that many women in my life had been similarly hurt in this way. I also experienced doubts over how the findings of this research could be interpreted and used. I know that sexual violence occurs across cultural groups across the world. And still, I know there might be people who will be eager to use any issues identified in this study as further ammunition to harm, my already marginalised, community (Eltahawy, 2015). Nevertheless, as Audre Lorde (1977, p.41) states, “Your silence will not protect you.” I have therefore had to remind myself that no progress can be made if we continue to perpetuate silence. There is both beauty and pain in all communities. As we address the difficult issues in our community, “then we can embrace the good”, as

one woman reflected at the end of her research interview in this thesis, because "home is where the hurt is, and home is where we must start to heal" (Eltahawy, 2015, p.178).

1.1.2 Ontological and epistemological position.

> Everything in the social world subsists on our love, our creativity, it could not exist for a moment without them. But oppression is real. These are real structures and real systems but we have the capacity to cut their supply lines. It is a difficult thing to do but we can do it. (Bhaskar, 2002, p.318)

When considering the topic of sexual violence, I felt morally and ethically compelled to acknowledge that there is a reality in which oppression, inequality, and violence exist, which have actual consequences on victim's[1] lives, wellbeing, and relationships (Maxwell, 2012; Patel & Pilgrim, 2018; Pilgrim, 2014). Although some methods and theories can help us more closely align to reality than others, the data acquired in this research was not presented as a reflection of reality in itself

[1] Individuals with lived experiences of sexual violence may identify with different terminologies which can have different connotations (Boyle & Rogers, 2020). Two commonly used terms are 'victim' and 'survivor' (Bourke, 2020; Boyle & Rogers, 2020). Whilst the term 'victim' is commonly used in the criminal justice system and may give individuals access to support and reparation within this system, it has also been criticised for the way in which it positions individuals as helpless and powerless (Boyle & Rogers, 2020; Colpitts, 2019). In contrast, the term 'survivor', may have more positive connotations associated with strength and empowerment. In line with neoliberal perspectives of recovery, however, the term survivor may encourage victims to readily shift from victimhood into survivorship, so that they can reassume their positions in society (Colpitts, 2019). It should also be noted that not all victims survive sexual violence, and many of those who do survive, consider themselves to be victims (Bourke, 2020). In recognition of this, this thesis generally used the word 'victim' or 'expert by experience' to describe individuals who have experienced sexual violence, where the focus is on the lived experience and pain of the violence, as opposed to it being a moral judgement or reflection of someone's identity (Bourke, 2020).

(Fletcher, 2017; Pilgrim, 2014). Rather, it represented my interpretation of women's accounts, influenced by my contexts, that could help give insight into the reality of sexual violence and its impacts. As such, this thesis adopted a critical realistic ontological perspective, which supports the existence of reality that exists irrespective of our perceptions or observations of it (Fletcher, 2017; Haigh et al., 2019; Zachariadis et al., 2013). This ontological perspective was integrated with a relativist epistemological stance (de Souza, 2014; Miller & Tsang, 2011; Zachariadis et al., 2013). This suggests that the process of data acquisition can bring us closer to reality, but requires interpretive understanding, is potentially fallible, and is shaped by historical, political, and other contextual factors (McEvoy & Richards, 2003; Price, 2015; Zachariadis et al., 2013). These ontological and epistemological positions have informed my thinking throughout the thesis and influenced my research methods described in Chapter 2.

1.2 Conceptualising Sexual Violence: Feminist, Intersectional, and Somali Perspectives

1.2.1 Defining sexual violence.

Sexual violence is a pervasive human rights concern, prevailing in societies across the world, including the UK (Office for National Statistics, 2021; World Health Organisation, 2002). It has been estimated that approximately one third of women have experienced physical and/or sexual violence during their lives (García-Moreno et al., 2013). This thesis will specifically focus on sexual violence against Somali women. The term 'sexual violence' is often interchangeably used with the terms

'sexual assault' and 'rape', definitions of which have fluctuated across time and contexts (e.g., in research, by communities) and which have varying emotional connotations and linguistic powers (Canan & Levand, 2019). Given the differences in definitions and usage, I used the term 'sexual violence' as an all-encompassing term, which may include both sexual assault (i.e., attempted or completed coerced sexual acts that may or may not involve physical contact and penetration) and rape (i.e., attempted or completed physical sexual contact involving penetration). Thus, all rape is conceptualised as sexual violence in this thesis, but not all acts of sexual violence may constitute rape (Canan & Levand, 2019).

The World Health Organisation (2002) specifically 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."
> (World Health Organisation 2002, p.149)

This definition recognises that, in addition to sexual assault and rape as described above, sexual violence may encompass a wide range of acts, including female genital mutilation, cutting, or circumcision (FGM/C). FGM/C describes a custom involving either the partial or complete removal of a girl's external genitalia or other forms of genital harm (WHO, 2022) and is considered to violate the sexual integrity or autonomy of girls and women (World Health Organisation, 2002). This

perspective is also in line with views from activists with lived experiences of FGM/C. Dr Leyla Sirad Hussein for example, argued that FGM/C, like sexual violence, was motivated by power, not sexual gratification (Batha, 2018). With few exceptions (e.g., Coho et al., 2019; Coho & Parra Sepúlveda, 2021), this view may be less recognised in practice, and could be met with scrutiny by the communities in which it is practised (Appendix 1). Following careful discussions with the research team, including FGM/C activist and expert-by-experience Hoda M. Ali, as well as taking into consideration other activists' views, I adopted the World Health Organisation's definition of sexual violence, which included FGM/C. However, research participants, as well as members of the community more widely, are not expected to share or uphold this view.

1.2.2 Feminist and intersectional perspectives on sexual violence.

Historically, and across the globe, there have been significant variations in the weight given to the two aspects of sexual violence (Bourke, 2020). Some perspectives, both current and historical, primarily emphasise the sexual component of sexual violence. That is, sexually violent crimes cause outrage as it is deemed a violation of female sexual purity, honour, and decency (Bourke, 2020; Canan & Levand, 2019). In line with these perspectives, girls and women may be sexually objectified by perpetrators and communities, where a loss of virginity may correspond with a loss in their worth. Like many other societies, this appears to be a dominant perspective in Somalia, where sexual violence can be interpreted as a matter of honour, public decency, and morality, where the focus appears to be less on the violation of the victim's bodily integrity and more on the crime against the

family, tribe, or community (International Alert/CISP, 2015). However, given the lack of theoretical literature focusing on Somali perspectives on sexual violence, both in Somalia and the wider diaspora, this requires further exploration.

Other perspectives, which have been heavily influenced by predominantly Western feminist frameworks, emphasise the violent aspect of sexual violence. Accordingly, sexual violence is situated within social and political contexts, and framed as a tool to exert power and control rather than being (primarily) motivated by sexual gratification (Canan & Levand, 2019; McPhail, 2016). Whilst feminist frameworks of sexual violence have helped shape our understanding of why and how sexual violence is perpetrated across societies, they can be inappropriately applied to understanding the experiences and perspectives of marginalised groups. For example, whilst Western Feminist frameworks have framed FGM/C as a practice that perpetuates male domination and gender inequalities, African feminists argued against both this rigid binary gender perspective, which separated bodies from their cultural contexts, and criticised the (neo)colonial undertones of Western discourses (e.g., calling the practice “barbaric”) (Diop et al., 2017).

In contrast, prominent African feminist Awa Thiam offered a holistic and culturally nuanced approach to understanding FGM/C utilising local knowledges (Thiam, 1995, as cited in Diop et al., 2017). This view posits the practice is maintained through a complex interaction of contextual, cultural, and structural factors, including: 1) the embeddedness of patriarchal socio-cultural factors (e.g., male domination, female oppression), 2) socially constructed positive attributes associated with the practice (e.g., guarantee of “virginity”, increased marriage prospects), and 3) positive cultural identifications (e.g., FGM/C as a marker of

identity, a sign of womanhood). Those who have not (yet) been circumcised may subsequently be vulnerable to social stigma and ostracism (Perovic et al., 2021). Many families therefore practise FGM/C believing it is in the best interest of their child (Coho et al., 2019).

Many Western theoretical frameworks, including liberal feminism, have also been scrutinised for their single-issue focus (e.g., patriarchy) which diminish the multi-layered experiences of oppression affecting ethnically minoritised women. Somali women in the UK for example, live within racist, Islamophobic, and multiple patriarchal societies (British and Somali). Whilst their female identity increases their risk of sexual violence, their Black and Muslim identities increase their vulnerability to xenophobic abuse (Mohamoud, 2011; Syed, 2022). These varying intersections may subsequently influence Somali women's patterns of disclosure and psychological help-seeking. For example, gendered Islamophobic discourses that portray Muslim women as being sexually repressed, passive, and under the control of their husbands or fathers, can increase their vulnerability to abuse (e.g., the forceful removal of a veil to "liberate" the Muslim woman) and may characterise them as "acceptable" targets for sexual violence (Ahmad, 2018, 2019). Ahmad's (2018) study showed that Islamophobic stereotypes may also be held by the helping professions, such as therapists, which risk minimising the women's experience of sexual violence and may adversely impact on psychological help-seeking.

Similarly, racist stereotypical views about Black women (e.g., justifying the rape of a Black woman due to stereotypes that they are "sexually loose" or because "they enjoy it") can also inappropriately blame the victim and minimise the violence (Tillman et al., 2010; White et al., 1998). Whilst certain stereotypes (the "strong Black

woman") may promote resilience, they may also be met with a culture of silence (Tillman et al., 2010). Moreover, when stereotypes are internalised, women may not perceive their experiences as sexual violence and/or have concerns that they will not be recognised as legitimate victims of sexual violence by systems who may endorse such views (Frasier, 2005; Tillman et al., 2010). The potential fear of embarrassment and rejection may therefore outweigh the potential benefits of disclosure and help-seeking (Tillman et al., 2010).

Building on the long-standing work on the interconnectedness of race and gender by Black female scholars and activists (e.g., Anna J. Cooper, Sojourner Truth), Kimberlé Crenshaw coined the term 'intersectionality' in 1989 (Colpitts, 2019; Crenshaw, 1989). This intersectional lens describes how people hold multiple and concurrent social identities, which intersect together to create a unique experience. Rather than viewing intersectionality as the mere accumulation of different identities, it considers how systems of oppression increase risk of vulnerability and victimisation at intersections of particular identities (Canan & Levand, 2019; Crenshaw, 1989; Nayak, 2021).

It should be noted that further complexities may arise when sexual violence is perpetrated within victims' own communities. Research suggests that sexual violence perpetrated by someone who is known to the victim is the most common form of sexual violence yet is less likely to be reported (e.g., to the police) (Hester & Lilley, 2017; Koss et al., 1988). For victims from marginalised groups specifically, the fear of further victimisation, humiliation, or stigmatisation of their communities may deter victims from disclosing their experiences (Bourke, 2020; Dahir, 2021). This may also explain the popularity of the online #SomaliMeToo movement on Twitter,

which took place in the weeks after the murder of George Floyd by officers of the Minneapolis Police Department. Given that tension and mistrust of the police was on the increase in a community which had already been victimised across the Somali diaspora (Dahir, 2021; Syed, 2022), the #SomaliMeToo movement may have been a means to create alternative forms of justice whilst centring the victims' voices (Dahir, 2021). For example, whilst Twitter was used for victims to (anonymously) share their stories, spaces were also created for perpetrators to take accountability for the abuse (Dahir, 2021). Social media, and the anonymity of Twitter, therefore offered victims a powerful tool to protect themselves, to protect other potential victims from the perpetrators, as well as the community from further harm by policing and judicial systems.

Thus, this thesis conceptualised sexual violence as a wide-ranging concept, which includes FGM/C, and which is perpetrated to exert power over victims rather than being primarily motivated by sexual gratification. Moreover, it was highlighted that most acts of sexual violence are perpetrated by someone who is known to the victim, which may affect patterns of disclosure and help-seeking. Complexities increase when sexual violence is perpetrated within a community or social setting. In her book, Joanna Bourke states that "terror is always local; universalist assumptions insult the specificities of individual histories." (Bourke, 2020, p.149). It is therefore argued that sexual violence should be considered within the distinct sociocultural and political contexts it is profoundly entrenched in.

1.2.3 Somali conceptualisations of sexual violence.

Whilst exact figures are not available, it is estimated there are approximately 100,000-200,000 Somali people in the UK, which represents the largest Somali community in Europe (Hassan et al., 2013). Despite this large group, very little is known about their perspectives and conceptualisations of sexual violence. Where studies have described Somali perspectives of sexual violence, these have often drawn from one key book written by Gardner and El Bushra (2004), which may therefore not adequately reflect the wide range of existing discourses, perspectives, and conceptualisations.

In addition, it is important to consider the different contexts of sexual violence that have been reported in the literature. As seen in Table 1, some forms of sexual violence appeared to be more common in wartime. Whilst sexual violence within and outside of wartime are thought to be similarly situated within wider societal practices, ideologies, and disempowering structures of power, it is also important not to conflate these two contexts (Bourke, 2020). That is, sexual violence in wartimes necessitates a significant systemic level of planning (e.g., training of soldiers, mass dissemination of propaganda). It also both substantially lowers the threshold at which sexual violence takes place at an interpersonal level and substantially changes the nature of that violence. Wartime sexual violence can serve different strategic purposes (e.g., an act of patriotism, an act to humiliate the enemy), and has therefore also been framed as a weapon of war. Furthermore, whilst some forms of forced marriage appeared to be more prevalent in traditional Somali nomadic society, others seemed more common to victims from the Somali diaspora (Gardner & El Bushra, 2004; Parveen, 2018). These concepts of sexual violence should

therefore be interpreted with these considerations in mind, and further highlight the importance of understanding sexual violence within their sociocultural and political contexts (Bourke, 2020).

Table 1: An overview of concepts and types of sexual violence in Somali contexts

Type of sexual violence	Description
"Kufsi"	This term is most similar to the Western definition of rape (Gardner & El Bushra, 2004). It originates from the word "kuf", which means "to fall down". Implicitly, it refers both to the use of force to make the victim fall, as well as to the "reduction" in "value" of the victim's perceived "honour" and "prestige.
"Faro-xumeyn"	This term can be translated to "bad-fingered". This is considered an all-encompassing term consisting of various penetrative and non-penetrative acts of sexual violence.
"Gudniin", "guditaan" or FGM/C	A custom that involves the partial or complete removal of a girl's external genitalia or other forms of genital harm (World Health Organisation, 2022). FGM/C is categorised in four major types, which vary in severity and can involve different methods (National FGM Centre, 2019). Although FGM/C is often attributed to Islam, the practice predates the religion and is practised amongst different religious and secular communities (28 Too Many, 2015; Hayford & Trinitapoli, 2011). Figures suggest at least 200 million girls and women in 31 countries have been affected by FGM/C (Unicef, 2022). It is also commonly practised in Somalia and Somaliland, with reported prevalence rates of 99.2% in women aged 15-49 years (Macfarlane & Dorkenoo, 2015; NHS, 2019). Although no specific figures are available for the Somali diaspora in the UK, approximately 137,000 are believed to be living with the practice, of which a substantial proportion have originated from the Horn of Africa (Macfarlane & Dorkenoo, 2015).
"Laheyste-galmo"	This refers to the act of taking a victim as a "sexual hostage", which typically occurred during inter-clan warfare (Gardner & El Bushra, 2004). During these times, armed men would attack settlements of rival clans where they abducted girls and women. Alternatively, armed men would occupy the settlements and keep women hostage at home. Women were coerced to engage in household chores (e.g., cooking, cleaning), watch their herds, and forced to provide them with sexual services. This form of sexual violence rarely resulted in marriage and children born as a result of this abuse were deemed to belong to the mother. Victims could be held captive for months.
Forced marriage [a] - "Dhabar-garaac"	"Dhabar-garaac" is a coercive, typically nomadic, practice where a victim is abducted and forced to marry one of her captors using abusive methods (e.g., physical violence, starvation) (Gardner & El Bushra, 2004). Victims could return to and contact their families only after they become pregnant and an annulment of the marriage was no longer possible. Despite the gradual disappearance of this practice, it re-emerged as the civil war erupted and an increasing number of women lost their networks of protection. Several incidents of forced marriage have also been reported in refugee camps.

Type of sexual violence	Description
Forced marriage through rape	A victim may also be raped to force a marriage, which is a form of sexual violence that predominantly occurs in nomadic society (Gardner & El Bushra, 2004). Women in Somali pastoral society are traditionally valued for the bride wealth they can bring to their father's house, which can foster financial security for their father. When the demanded amount of bride wealth exceeds what eligible suitors can afford, groups of potential suitors may conspire to rape the daughter whose bridal wealth is considered unaffordable. As the family will be eager to organise a quick marriage, the suitor is able to negotiate a lower amount of bride wealth with the victim's family. Families often act against the victim's will and enforce these marriages in order to protect their honour. Many of these marriages are short-lived and considered traumatising for the victim, although more research is needed to explore this.
Forced marriage through "dhaqan celis"	"Dhaqan celis" describes a concept of reconnecting individuals to their culture through re-education and rehabilitation (Parveen, 2018). This custom is typically practiced by Somali parents in the diaspora who are concerned over their children and teenagers' lack of cultural identity and involvement in antisocial behaviours. Parents may send their children to Somalia under the pretence of a holiday, where they are sent to schools, but which are described by others as detention centres, and kept under strict conditions. Some of the young people who are sent there are told they can only leave if they marry another Somali, therefore through forced marriage. High number of cases were reported to the Forced Marriage Unit in 2017, which doubled from the previous year (Parveen, 2018). Figures from 2020 linked 15 cases of forced marriage to Somalia (including Somaliland), which was consistent with figures in 2019 (GOV.UK, 2021). It should be noted that the Covid-19 pandemic, and resulting restrictions to travel, contributed towards an overall reduction in cases across countries.

Notes: [a] Different forms of forced marriage are recognised, although specific and reliable statistics are scarce, given the typically unofficial and undocumented nature of these practices (Gardner & El Bushra, 2004; Judy & Akinyi, 2019).

1.3 Psychosocial Impacts of Sexual Violence and Psychological Help-seeking

When people are exposed to traumatic events, such as sexual violence, they are faced with intense helplessness and terror, and disconnected from the systems that offer people a sense of meaning, connection, and control (Herman, 2015). The traumatic nature of sexual violence may result in victims questioning their sense of safety of the world, secure view of themselves, and trust in others. Murn and Schultz (2020) likened the traumatic event(s) of sexual violence to a rock thrown into still waters, where the immediate and significant splash represents the acute consequences experienced during and after incidents of sexual violence. As the ripples in the water expand outwardly, these then represented the more enduring

effects of sexual violence, affecting different aspects of women's psychological, social, and physical wellbeing.

Given the nature of sexually violent acts, which can physically, psychologically, and morally violate the victim (Herman, 2015), it may not be unsurprising that post-traumatic stress disorder (PTSD) is one of the most reported mental health problems experienced by victims (Chivers-Wilson, 2006; Walsh et al., 2012). PTSD can be characterised as "a delayed or protracted response to a stressful event or situation (of either brief or long duration) of an exceptionally threatening or catastrophic nature, which is likely to cause pervasive distress in almost anyone" (World Health Organisation, 2016, p.309). Victims may experience different difficulties, such as the repeated reliving of the traumatic experiences (e.g., intrusive memories or "flashbacks"), perceptions of "numbness" and disconnection from others and surroundings, and a state of hyperarousal with hypervigilance (Herman, 2015; World Health Organisation, 2016). In addition, individuals may also experience comorbid low mood and depression, experience fears and anxiety, become vulnerable to substance misuse (e.g., alcohol dependency), and be at increased risk of suicidal thoughts (Herman, 2015; Tomasula et al., 2012; Walsh et al., 2012).

The National Institute for Health and Care Excellence (NICE) recommends individual trauma-focused Cognitive Behavioural Therapy (CBT) and Eye Movement Desensitization and Reprocessing (EMDR) for the psychological treatment of adults with PTSD (NICE, 2018). However, as discussed previously, sexual violence is considered to be located in socio-political structures (Bourke, 2020; Campbell et al., 2009; Herman, 2015), and its psychosocial impacts, including psychological trauma,

are subsequently influenced by these wider contextual factors. Campbell et al.'s (2009) review for example, applied an ecological theoretical lens, based on Bronfenbrenner's (1977) ecological theory of human development, to show how complex interactions of factors across the social ecological system differentially contributed towards victims' mental health (see Figure 1). The review highlighted inconsistencies in findings regarding the impact of individual level factors (e.g., alcohol use), but more consistent findings at higher levels of the ecological model, such as the potential adverse impact of negative social reactions on symptom severity (microlevel).

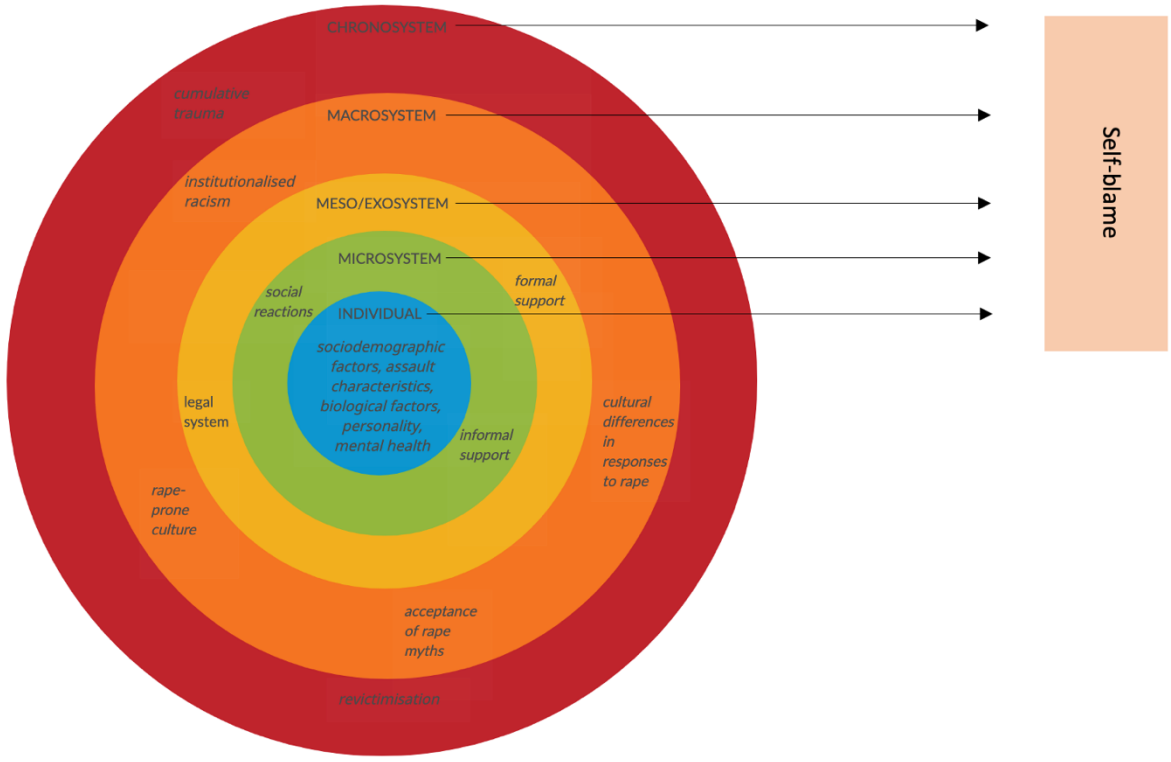

Figure 1: An ecological perspective on the mental health impacts of sexual violence on women adapted from Campbell et al. (2009) *and based on Bronfenbrenner* (1977).

Psychological interventions for individuals with traumatic experiences, such as sexual violence, should therefore move beyond the individual level and consider the victim's social ecological system. For example, as disempowerment and disconnection from others are key features of trauma, Herman's (1998, 2015) staged model of recovery takes into account the psychological and relational sequelae, whilst also considering the wider social and political context. The model outlines three important tasks. First, the therapist focuses on "establishing safety", where they support the victim to regain control over their body (e.g., regulating physiological functioning) as well as control over their environment (e.g., financial security, safe housing). The second task involves "remembrance and mourning", where the victim is supported to tell their full story. The final task is to support the victim's "reconnection with ordinary life" (e.g., restoring connections with the community).

As seen in Figure 1, Campbell et al. (2009) also highlighted the harmful effects of institutional racism and rape myths (macrolevel) which can generate environments that can impede victims' recovery. Keating et al.'s (2002) review explores this issue in detail, by examining the complex relationship between Black communities and mental health services, which were characterised by "circles of fear". To summarise, Black people's adverse experiences in society (e.g., racism) negatively impact on their psychological wellbeing, which in turn affect how they experience and view mental health services (Keating, 2009; Keating et al., 2002). At the same time, society's negative perceptions and stereotypes of Black people may negatively affect how they are treated in mental health services. The interactions in these experiences create circles of fear, where Black people feel unable to trust and fear services, and where mental health professionals are also fearful and suspicious

of Black people, contributing towards poor quality mental health services and reduced engagement on both sides.

Evidence, though limited, has similarly shown how the negative treatment and perceptions of Somali people in society (e.g., discrimination, policing, discourses around radicalisation), which are fuelled by institutional racism and Islamophobia, can exacerbate psychological distress (Byrne et al., 2017; Ellis et al., 2008; Lincoln et al., 2021). Furthermore, Somali people's perceptions of mistrust affect their experiences and engagement with mental health services (Said et al., 2021). Together, this may therefore increase the possibility of circles of fear between Somali people and mental health services (Byrne et al., 2017).

It should finally be noted that Somali cultural expectations around the endurance of pain as a sign of strength and resilience (e.g., during FGM/C), or an accepted part of womanhood (Jacobson et al., 2018; Perovic et al., 2021) may contribute towards perceptions of shame around the experiences or expression of difficulties (Fried et al., 2013; Jacobson et al., 2018; Perovic et al., 2021). In turn, this may create further barriers for Somali women to seek help when support is needed (Fried et al., 2013) and/or potentially negatively affect their ability to vocalise when harm or discomfort is experienced in healthcare encounters (Isman et al., 2013), which may be fuelled by fears about the potential consequences (e.g., fears of deportation due to insecure immigration statuses) (Guerin et al., 2004). This further highlights the importance of considering intersectionality in order to effectively address and remove barriers to support.

1.4 Conclusion

In this chapter so far, I described my relationship to the research topic, which was influenced by my position as an insider researcher. I also discussed the critical realist position I adopted which informed my thinking throughout the thesis. The contentious conceptualisation of sexual violence was also explored, which I defined in accordance with the World Health Organisation. Different perspectives on sexual violence were reviewed, followed by an exploration of the psychosocial impacts of sexual violence. Through these discussions, I highlighted the importance of locating sexual violence in victims' wider socio-political contexts and the different ecological factors that may affect the psychosocial wellbeing of women as well as their patterns of disclosure and psychological help-seeking. The second half of this chapter systematically examines the literature relating to Somali women more specifically.

1.5 Systematic Literature Review

Systematic literature reviews aim to identify, critically examine, and integrate findings across studies to better ascertain the reliability and validity of the evidence-base (Boland et al., 2017; Centre for Reviews and Dissemination, 2009). They are considered the gold standard of literature reviews and have several advantages, including their capacity to coherently synthesise substantial quantities of data and enable cross-study comparisons (Boland et al., 2017; Mulrow, 1994; Smith & Noble, 2016). Whilst the psychosocial impacts of sexual violence have been widely documented, less is known about the evidence base in relation to Somali women. This systematic review aimed to identify and critically evaluate the current state of

knowledge regarding sexual violence against Somali women. Specifically, this review aimed to answer the following question: 'What are the psychosocial impacts of sexual violence on Somali women?' A secondary objective was to examine the literature on Somali women's perceptions of help-seeking and disclosure.

1.5.1 Method.

Information sources and search strategy.

A scoping search focusing on Somali women affected by sexual violence was initially conducted between October and November 2021, which included an examination of studies published in the Cochrane Library and the Centre for Reviews and Dissemination, as well as a brief inspection of Google Scholar. This initial scoping search revealed no extant reviews in this area. Given the paucity of research on people of Somali descent more generally (Palmer, 2007), a thorough search strategy was adopted, which increased the probability of capturing as much of the current evidence base as possible as well as helping to identify gaps in the literature. Evidence from both the published literature and 'grey' literature was considered (see Appendix 2). Search terms were informed by similar reviews and protocols (e.g., Spaducci et al., 2021; Tillman et al., 2010), structured using the 'SPIDER' criteria (Methley et al., 2014) described in Table 2, and modified through research supervision. The specific search strategies were adapted to the different databases as appropriate. The final search was conducted in December 2021. Other search strategies that were employed included screening reference lists and citations.

Table 2: Overview of the search strategy

SPIDER Criteria:		Examples of search terms:
Sample	Somali women	Somal* OR African* OR Black OR Muslim* OR refugee* OR asylum seek* OR immigrant* OR diaspora OR BAME OR BME OR BMER OR PoC OR Wom*n OR Female* OR Girl*
Phenomenon of **I**nterest	Sexual violence	Sexual violence OR sexual abuse OR rape OR penetrat* OR harass* OR intimate partner violence OR domestic violence OR domestic abuse OR incest* OR child* sexual abuse OR female genital mutilation OR cut* OR circumcise* OR FGM OR forced marriage OR human traffick* OR sexual coercion
Design	Qualitative data collection and analysis, Quantitative data collection and analysis, Mixed methods data collection and analysis	Published and grey literature of any design.
Evaluation	Experiences, perceptions, attitudes, impacts, outcomes	Perception OR value* OR perceive* OR perspective* OR view* OR experience OR opinion* OR belie* OR Impact* OR effect* OR psych* impact* OR health* OR recover* OR mental OR stress OR distress OR depress* OR mood*OR anx* OR traum* OR post-traumatic stress OR self-harm OR self-injurious suicid* OR cut* OR substance abuse OR substance misuse OR suicide* OR social OR occupation* OR daily li* OR phys* OR med* OR genital OR sexually transmitted infections OR sexually transmitted diseas* OR pregnan* OR Disclos* OR report* OR talk* OR tell*
Research type	Qualitative method, quantitative method, qualitative method	Qualitative OR quantitative research OR mixed methods

Study selection.

All studies were assessed against the eligibility criteria described in Table 3.

Table 3: Overview of the eligibility criteria

Inclusion criteria:	**Exclusion criteria:**
Studies focusing on Somali women.	Conference abstracts.
Studies focusing on any form of sexual violence as defined by the World Health Organisation (2002)	Protocols.
Studies reporting on the psychosocial impacts of sexual violence, including mental, emotional, social, cultural, spiritual, and/or environmental effects (American Psychological Association, 2022; National Institutes of Health: National Cancer Institute, 2022)	Non-primary research (e.g., literature reviews, commentary, book (chapter)).
	Studies published in a non-English language.
Incident(s) of sexual violence may have occurred at any age (i.e., no age limit).	
Any article published in the last 20 years (i.e., January 2001).	Studies focusing on non-sexual violence and/or where data on sexual violence cannot be separated or distinguished.
Qualitative, quantitative, or mixed methods design, including case studies.	Studies focusing on non-Somali samples or samples where data on Somali women cannot be separated or distinguished.
	Studies not describing Somali women's first-hand accounts of psychosocial impacts (e.g., general views on FGM/C) or where accounts of Somali women's psychosocial impacts cannot be separated or distinguished.

Screening procedure.

I independently screened all titles and abstracts against the eligibility criteria. Full text articles were subsequently retrieved for the remaining articles and similarly assessed against the eligibility criteria.

Quality assessment.

Studies included in this review employed a range of designs, including qualitative, quantitative, and mixed-methods research. The all-encompassing Mixed-Methods Appraisal Tool (MMAT; Hong et al., 2018) was initially considered to assess the quality of all included studies due to its capacity to efficiently evaluate and

integrate appraisals of studies with varying methodologies. However, upon further inspection, criteria for both quantitative and qualitative studies were considered to lack the necessary rigour to thoroughly assess their quality. As such, the quality of studies was assessed using methodologically specific tools.

Qualitative studies were evaluated using the Critical Appraisal Skills Programme (CASP) Qualitative Studies Checklist (CASP, 2018). This widely used tool has been endorsed by both the Cochrane Qualitative and Implementation Methods Group and the World Health Organisation, is recommended for novice qualitative researchers, and was designed for health and social care related research, therefore appropriate for the purpose of the current review (Long et al., 2020). The Appraisal Tool for Cross-Sectional Studies (AXIS; Downes et al., 2016) was used to appraise the quality of quantitative research in the current review, which specifically employed cross-sectional designs. Finally, the MMAT was used to assess the quality of mixed methods studies. Whilst not considered sufficiently rigorous for the assessment of qualitative and quantitative studies individually, the MMAT was deemed appropriate to evaluate the quality of included mixed-methods studies. Appendix 3 describes the outcomes for each of the quality assessment tools.

Synthesis method.

There was much heterogeneity across studies. As such, a narrative synthesis was warranted (Popay et al., 2006). The current synthesis was predominantly informed by Popay et al.'s (2006) framework, and supplemented by guidance from

Siddaway et al. (2019) and Baumeister and Leary (1997). The framework can be used flexibly, as opposed to being prescriptive, and can be adapted to a range of reviews. Table 4 outlines three of the four components of Popay et al.'s (2006) framework and the corresponding techniques that I have used. The remaining component, aimed at developing a theory of how, why, and for whom an intervention is effective, was not considered, as it is optional and was not deemed relevant to this current review.

Table 4: Overview of data synthesis method (Popay et al., 2006, pp.11-22)

Component:	Aim:	Corresponding technique used:
1. "Developing a preliminary synthesis."	• To provide an initial description of included studies.	• Tabulation: an overview of study details, such as the methodology, in a tabular form.
2. "Exploring relationships within and between studies."	• To move beyond description by exploring: o Relationships between characteristics of individual studies and their results (i.e., within studies). o Relationships between results across different studies (i.e., between studies).	• Concept mapping: o Connecting the extracted findings across studies to develop a conceptual model, in which the key concepts that are relevant to the review question and relationships between these, are highlighted. o Visually representing the relationships using a flowchart.
3. "Assessing the robustness of the synthesis."	• To assess the overall strength and trustworthiness of the synthesis based on the critical appraisal of the methodological quality of reviewed studies.	• Reflecting critically on the review process (e.g., examining the impact of biases on the outcome of the synthesis) and providing a summary of this appraisal.

1.5.2 Results.

Study selection.

A total of 620 articles were initially identified through database searches and other information sources (e.g., individual journals). Following the removal of duplicates, 516 titles and abstracts were screened against the eligibility criteria, of which 72 articles were selected for full-text review. Nineteen of these articles met the inclusion criteria and were included in the review. Four additional articles were identified through reference and citation checking. Thus, 23 articles were included in this review. Figure 2 displays an overview of the study selection process adapted from Moher et al.'s (2009) 'Preferred Reporting Items for Systematic reviews and Meta-Analyses' (PRISMA) statement. Of note, eleven of the reviewed articles were reporting on five unique studies (e.g., where two articles focused on different outcomes of the same study). In line with best practice guidelines (Boland et al., 2017; Cochrane Information Retrieval Methods Group, 2022), multiple publications relating to the same study were collated and considered as one paper for the purpose of the data extraction form and quality assessment. Therefore, 17 unique studies published across 23 articles were included in the current review.

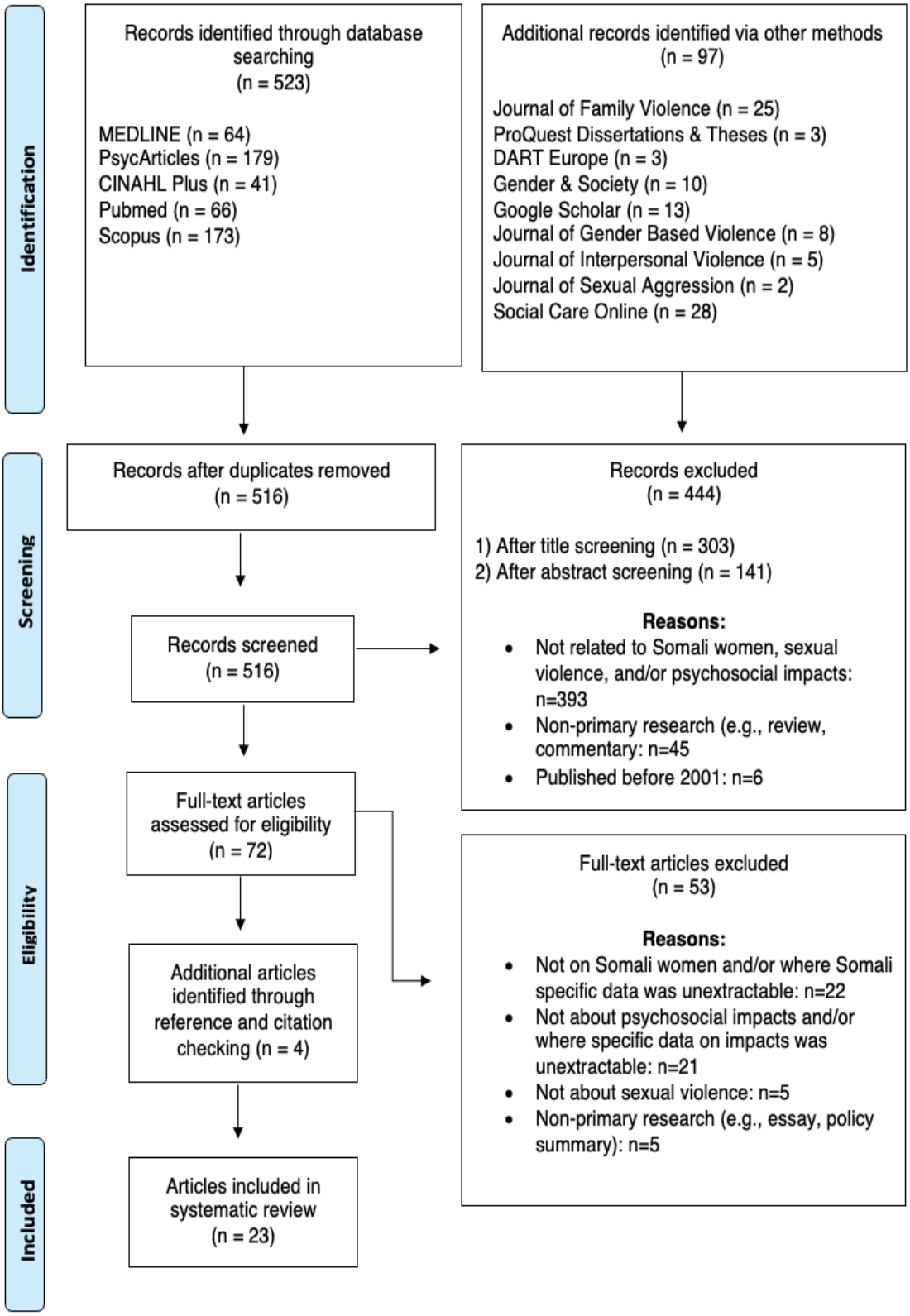

Figure 2: PRISMA flowchart of the study selection process

Study characteristics.

Table 5 provides an overview of the study characteristics and methodology, a summary of the reported psychosocial impacts, as well as the main strengths and limitations. Given the multiple publications of studies, this section will refer to the characteristics of studies as opposed to articles. Most studies were qualitative (n=13), whereas the remainder used mixed methods (n=3) and quantitative methods (n=1). Studies were conducted across different locations, predominantly in the UK (n=4) and Norway (n=3), as well as Sweden (n=2), United States (n=2), Canada (n=1), United States and Canada (n=1), Somalia (n=1), Somaliland (n=1), Turkey (n=1), and the Netherlands (n=1). Sample sizes varied from 7 to 879. FGM/C was the most reported form of sexual violence across studies (n=14), followed by FGM/C and rape (n=2), and rape (n=1). Studies used a variety of sampling strategies, including convenience sampling (n=3), snowball sampling (n=4), purposive sampling (n=3), maximum variation sampling (n=1), or a combination of strategies (n=5). The sampling strategy was not specified in one of the studies. Data collection methods varied depending on the methodology used, including individual interviews (n=9), focus groups (n=1), questionnaires (n=1), or a combination of methods (n=6). Finally, analyses similarly varied depending on the chosen methods and research aims, which included content analysis (n=4), thematic analysis (n=2), systematic analysis (n=1), thematic content analysis (n=1), reflective lifeworld research (n=1), framework approach (n=1), medical anthropological analysis (n=1), logistic analyses (n=1), or a combination of analytical approaches (n=5).

Table 5: Overview of studies included in the systematic literature review

Author (year)	Study aim(s)	Sample characteristics	Methodology	Reported psychosocial impacts of sexual violence	Strengths and limitations
Chavez Karlström et al. (2020)	To explore the lived experiences of young migrant Somali women and their perspectives on medical defibulation.	• Sample size: N=9 • Mean age or age range(s): 19.22 years • Location(s): Sweden • Type(s) of sexual violence reported: FGM/C and rape	• Study design: Qualitative • Sampling strategy: Convenience sampling • Data collection method: Individual interviews • Data analysis: Reflective lifeworld research	• Trauma and fear of reliving painful experiences • Impact of FGM on intimate relationships, including fear of sexual intercourse • Potential medical defibulation increasing risk of shame and stigma	+ The study uniquely highlighted young Somali women's difficulties of reconciling two value systems in relation to FGM and medical defibulation + The analysis was thorough and involved the consultation of a phenomenological research expert + High quality interpreters were employed who had completed training enabling them to manage conversations around sexuality – Limited reflection on the potential risk of bias arising from the first author's employment at one of the participating clinics – Eighteen women declined to participate, possibly suggesting the participants may not be a representative sample
Fried et al. (2013)	To explore Somali women's views on FGM/C related difficulties and their perspectives	• Sample size: N=7 • Mean age or age range(s): 29.43 years	• Study design: Qualitative • Sampling strategy: Convenience sampling • Data collection method: Interviews	• Experience of shame inhibiting women from seeking help for FGM/C related health problems	+ This research offered important insights into attitudes towards FGM/C in Somaliland and its impact on help-seeking as well as the societal

Author (year)	Study aim(s)	Sample characteristics	Methodology	Reported psychosocial impacts of sexual violence	Strengths and limitations
	on information, care, and counselling.	• Location(s): Somaliland • Type(s) of sexual violence reported: FGM/C	• Data analysis: Content analysis		pressures to continue this practice + The authors sensitively reflected on moral authority in research on FGM/C and balanced between relativist and universalist epistemologies – There was a potential risk of selection bias (e.g., all participants found it easy to talk about FGM/C) – Further reflexivity is required regarding the researcher's insider's position
Isman et al. (2013)	To explore perceptions and experiences of FGM/C following immigration to Sweden.	• Sample size: N=8 • Mean age or age range(s): 19-46 years • Location(s): Sweden • Type(s) of sexual violence reported: FGM/C	• Study design: Qualitative • Sampling strategy: Snowball sampling • Data collection method: Interviews • Data analysis: Content analysis	• Experiences of ambivalence regarding cultural values and negative impacts • Impact of pain on intimate relationships and general life • Difficulties in healthcare experiences • Experiences of grief and feelings of betrayal	+ This study highlights the complexities in women's perspectives on FGM/C + Findings offer tangible implications for practice, e.g., the importance of empowering women – Regarding the analysis, a rationale for content analysis was not provided and unclarity around how the researcher arrived at some of the statements regarding the psychosocial impacts (e.g., lack of participant quotes)

Author (year)	Study aim(s)	Sample characteristics	Methodology	Reported psychosocial impacts of sexual violence	Strengths and limitations
					– Initial contact with women through the anti-FGM/C organisation and the exclusion of non-Swedish speaking women may have increased risk of bias
Jacobson et al. (2018) Perovic et al. (2021)	Experiences of everyday life, bodily sensations, and pain in Somali women exposed to FGM/C	• Sample size: N=14 • Mean age or age range(s): 38.3 years • Location(s): Canada • Type(s) of sexual violence reported: FGM/C	• Study design: Mixed methods • Sampling strategy: Purposive sampling • Data collection method: Quantitative sensory testing, questionnaires, and interviews • Data analysis: Quantitative (descriptive analyses); qualitative (thematic analysis and interpretative phenomenological analysis	• Judgement and isolation • Normalcy and othering. • Silence and silencing • Impact of pain on intimate relationships and daily life • Family divisions	+ The researchers demonstrated a strong commitment to involving the community over the course of the study through a community advisory group + The researchers demonstrated reflexivity in terms of languages nuances (e.g., regarding the expression of pain), their own positionality as well as their assumptions – The thematic qualitative analysis in one of the publications required further detail similar to the qualitative analysis in the other publication – The high number of participants who had been deinfibulated and the readiness in which participants shared their stories, suggest there this sample may share characteristics that are different to other FGM/C

Author (year)	Study aim(s)	Sample characteristics	Methodology	Reported psychosocial impacts of sexual violence	Strengths and limitations
					exposed women, thereby demonstrating a potential selection bias – Given what has been reported in the literature regarding FGM/C exposed women's difficulties in healthcare settings and genital examinations, potentially retraumatising victims, as well as the potential barriers to express pain and discomfort, further clarity was needed around the ethical considerations around this research component ensuring the approach was trauma informed and the influence of direct payment on participation
Jelle et al. (2021)	To explore the causes and health impacts of forced evictions on internally displaced individuals.	• Sample size: N=10 • Mean age or age range(s): Not available for female subsample. • Location(s): Somalia • Type(s) of sexual violence reported: Rape	• Study design: Qualitative • Sampling strategy: Maximum variation sampling • Data collection method: Interviews • Data analysis: Framework Approach (thematic analysis)	• Fear of stigma inhibited women from reporting sexual violence to the police or their relatives	+ The researchers took into consideration the perspective of multiple stakeholders, using maximum variation sampling, which helped evidence the significance of the problems associated with forced evictions + The paper presents a comprehensive conceptual framework demonstrating the

Author (year)	Study aim(s)	Sample characteristics	Methodology	Reported psychosocial impacts of sexual violence	Strengths and limitations
					various factors affecting forced eviction and outcomes, including but not limited to, sexual violence – Difficulties maintaining privacy potentially increased the probability of underreporting and inhibited in-depth discussions – Although the authors kept reflective notes, more information on this reflexivity is needed on their positions in relation to those living in camps
Johansen (2002)	To understand Somali women's lived bodily experiences of and reflections on pain resulting from FGM/C.	• Sample size: N= ± 45, including +30 women and 15 men • Mean age or age range(s): 18 – 60 years (women); 25 – 60 years (men) • Location(s): Norway. • Type(s) of sexual violence reported: FGM/C and rape	• Study design: Qualitative • Sampling strategy: Not specified • Data collection method: Participant-observation, interviews, casual communication, home visits, and joint activities • Data analysis: medical anthropological analysis	• Sense of heaviness and darkness • Sense of loss • (Re)traumatisation, fears, and vivid memories • Difficulties expressing experiences • Othering and resentment • Impact on intimate relationships	+ This study offers a rich medical anthropological perspective on Somali women's experiences and perspectives on pain due to FGM/C + Data was collected through a multitude methods, including first-hand accounts and observations, furthering the richness of data – The acquisition of data and process of analysis would benefit from more robust methods (e.g., the exact number of participants was not reported)

Author (year)	Study aim(s)	Sample characteristics	Methodology	Reported psychosocial impacts of sexual violence	Strengths and limitations
					– Participants showed eagerness to share their accounts, therefore raising the possibility of selection bias – More detail is needed regarding the researcher's positionality over the course of their fieldwork and the initial assumptions they alluded to in the article
Karlsen et al. (2019) Karlsen et al. (2020)	To explore the impacts of FGM-safeguarding in healthcare settings on British Somali people from Bristol.	• Sample size: N=30, of which 21 were women • Mean age or age range(s): >18years. No further details were reported • Location(s): UK • Type(s) of sexual violence reported: FGM/C	• Study design: Qualitative • Sampling strategy: Individual contacts & snowball sampling • Data collection method: Semi-structured individual interviews • Data analysis: Content analysis	• FGM/C has had significant physical and psychological consequences and ruptured family relationships, which had required time to repair • FGM/C safeguarding policies, and its implementation by various professionals, neglected and even exacerbated the traumatic experience of FGM/C in itself	+ The study clearly demonstrates the potential retraumatising, harmful, and stigmatising impacts of FGM/C safeguarding polices on the British Somali community + The study was conducted in response to a request from the public by people concerned about FGM-safeguarding in the city, thereby reacting to a need, and involved members of the public at all stages of the research – Although members of the public, specifically those with Somali heritage, were a crucial part of the study, it is unclear whether support was

Author (year)	Study aim(s)	Sample characteristics	Methodology	Reported psychosocial impacts of sexual violence	Strengths and limitations
					offered to enable their involvement, e.g., reimbursement for translation, provision of childcare, etc – There is insufficient information about the conduct of the study (e.g., who interviewed participants) and the details of the analysis process
Kartal and Yazici (2021)	To examine Somali female students' FGM/C related experiences, attitudes, and perceptions.	• Sample size: N=117 • Mean age or age range(s): 20.30 years • Location(s): Turkey • Type(s) of sexual violence reported: FGM/C	• Study design: Qualitative • Sampling strategy: Convenience sampling • Data collection method: Semi-structured focus groups • Data analysis: Descriptive and content analysis	• FGM/C is associated with short-term (psychological trauma) and long-term (depression) psychological impacts	+ The study provides an important understanding of how FGM/C is understood and experienced and what factors may contribute towards the maintenance of this practice + The authors adopted a thorough strategy to strengthen the reliability and validity the data – The link between the study's chosen design (phenomenology) and subsequent analysis is unclear – The mental health impacts of FGM/C required further detail, e.g., use of extracts

Author (year)	Study aim(s)	Sample characteristics	Methodology	Reported psychosocial impacts of sexual violence	Strengths and limitations
Khaja (2004) Khaja et al. (2009) Khaja et al. (2010)	The better understand Somali women's experiences with and perspectives on FGM/C.	• Sample size: N=17 • Mean age or age range(s): 20 -79 years • Location(s): United States of America and Canada • Type(s) of sexual violence reported: FGM/C	• Study design: Qualitative • Sampling strategy: Convenience sample through observations, informal socialising with potential participants • Data collection method: Semi-structured individual interviews • Data analysis: Content analysis using qualitative data analysis software ('ATLAS.ti')	• Painful memories and emotional trauma • Sense of loss • Social stigma and judgement • Trauma and pain during sexual intercourse	+ The ethnography based recruitment approach allowed the researcher to build rapports with participants in their naturalistic environments, in order to help increase safety and comfort during interviews + The researcher committed to engaging in deeply self-reflective processes, through which she critically examined her own assumptions and stereotypes – There is a lack of detail on the research analysis method and process, including the development of themes – This study involved the use of interpreters that were known to the participants, which may have impeded participants' ability to fully share their views

Author (year)	Study aim(s)	Sample characteristics	Methodology	Reported psychosocial impacts of sexual violence	Strengths and limitations
McNeely and Christie-de Jong (2016)	To explore the perspectives of Somali refugees on FGM/C following migration.	• Sample size: N=13, of which 12 were female • Mean age or age range(s): 20 -70 years, female-only mean age or age range not specified. • Location(s): USA • Type(s) of sexual violence reported: FGM/C	• Study design: Qualitative • Sampling strategy: convenience sampling, snowball sampling • Data collection method: Semi-structured individual interviews • Data analysis: Thematic content analysis	• Experiences of anxiety and depression • Experiences of sadness due to constantly thinking about the pain. • Remembering the trauma of the procedure • Negative impact on intimate relationships • Pressure and judgement from the community for their daughters to have FGM/C done	+ The researcher was reflective on their position as an 'outsider', including the impact this may have had on participants' ability to share their perspectives + This study was conducted in rigorous manner, including the conduct of two pilot interview – The dual role of the gatekeepers from the local community who also acted as translators, appeared to have impeded the ability to speak freely for at least one of the participants – More detail was needed on their justification on aspects of the research design (e.g., the rationale for thematic content analysis)
Michlig (2019) Michlig et al. (2021)	Focusing on a sample of Somali women, to quantitatively explore: 1) the association between FGM/C and related	• Sample size: N=879, of which 680 had experienced FGM/C • Mean age or age range(s): 31 years • Location(s): USA	• Study design: Quantitative • Sampling strategy: Respondent-driven and snowball sampling. • Data collection method: Questionnaires	• Experiences of FGM/C related discrimination, affecting perceived quality of care and healthcare usage • Experiences of discrimination were also linked to a higher likelihood of clinically significant distress	+ This study highlights the importance of not treating FGM/C as a binary or singular experience, rather a complex set of experiences with varying contexts of memories that can affect mental health outcomes

Author (year)	Study aim(s)	Sample characteristics	Methodology	Reported psychosocial impacts of sexual violence	Strengths and limitations
	stressors and mental health outcomes; 2) factors related to satisfaction with FGM/C-associated care.	• Type(s) of sexual violence reported: FGM/C	• Data analysis: Bivariate, multivariable, and ordered logistic analyses	• Recall of adverse experiences related to FGM/C were linked to a higher likelihood of clinically significant distress	+ This research adopted a Community Based Participatory Research approach, where the research team worked closely with the community during key stages of the research, e.g., refining the research agenda, questionnaire adaption, research dissemination – The study would have benefited from more robust measures as opposed to the binary outcome variables that were used (e.g., distress), which restricted the degree of depth that could have been derived from the findings – Despite attempts to use respondent-driven sampling and the use of a large sample, the study was unable use randomisation, thereby limiting the generalisability of findings
Morison et al. (2004)	To explore how experiences and attitudes towards FGM/C relate to	• Sample size: N=174 (quantitative) including 94 females and 80	• Study design: Mixed methods • Sampling strategy: Snowball sampling	• Remembering and living in fear of pain and further procedures (e.g., second operation)	+ The qualitative data helped substantiate and illuminate the quantitative data

Author (year)	Study aim(s)	Sample characteristics	Methodology	Reported psychosocial impacts of sexual violence	Strengths and limitations
	age on arrival in Britain in a sample of young and single Somalis in London.	males; N=20 (qualitative), including 10 males and 10 FGM/C affected females • Mean age or age range(s): 16 – 22 years – female only age data not reported • Location(s): UK • Type(s) of sexual violence reported: FGM/C	• Data collection method: Questionnaires and interviews • Data analysis: Quantitative (frequency distributions, cross-tabulations, logistic regression models); qualitative (not specified)	• Experiences of regret and anger • Negative impact on control of sexuality and intimate relationships • Experiencing an implicit lack of trust in their being circumcised	+ The adaptation of questionnaires to the Somali language as well as the employment of male and female Somali researchers helped increase the accessibility of the research to the local community – There is insufficient information on the qualitative component of the study, including the type of analysis used and process of theme development – Despite the researcher's best efforts to recruit a sample with diverse views, there was a potential bias towards participants who were more able or willing to discuss this sensitive research topic. Further information regarding the impact of the researchers' clan affiliation on participants' willingness to participate also required further exploration
Moxey and Jones (2016)	To explore experiences of antenatal and	• Sample size: N=10, of which 8 have been	• Study design: Qualitative • Sampling strategy: Purposive, snowball,	• Accumulation of traumatic experiences	+ This is the first study of its kind, therefore addressing an important gap in the literature

Author (year)	Study aim(s)	Sample characteristics	Methodology	Reported psychosocial impacts of sexual violence	Strengths and limitations
	intrapartum care in England in a sample of Somali women exposed to FGM/C.	exposed to FGM/C • Mean age or age range(s): 20 – 49 years • Location(s): UK • Type(s) of sexual violence reported: FGM/C	and convenience sampling • Data collection method: Interviews • Data analysis: Inductive thematic analysis	• Exacerbation of pre-existing psychological difficulties • Impact on intimate relationships • Experiences of fear, worry, and embarrassment	+ The research reflected on their 'outsider status' and developed a comprehensive recruitment strategy that involving local stakeholders and gatekeepers, although further information is needed on their (cultural) background – Although the use of lay interpreters may have promoted a sense of ease and strengthened rapport, it may have also increased risk of the misinterpretation of questions and responses due to limited training and research experience – The lack of information on response rates and differences between women who participated and did not participate, makes it difficult to assess the risk of potential selection bias
Oguntoye et al. (2009)	The better understand the perception and impacts of FGM/C by women from FGM/C affected	• Sample size: N=18 PEER researchers. Exact number of interviewees unknown (estimated 2 or	• Study design: Qualitative • Sampling strategy: Snowball sampling • Data collection method: Unstructured	• Negative impact on intimate and non-intimate relationships (e.g., resentment)	+ The innovative PEER methodology was promoted trust, connection, empowerment, and was well suited to explore sensitive topics within

Author (year)	Study aim(s)	Sample characteristics	Methodology	Reported psychosocial impacts of sexual violence	Strengths and limitations
	communities using Participatory Ethnographic and Evaluative Research (PEER) methodology.	3 per PEER researcher) • Mean age or age range(s): Not reported • Location(s): UK • Type(s) of sexual violence reported: FGM/C	informal interviews and debriefing meetings. • Data analysis: Peer evaluation workshops using innovative methods (e.g., role plays) and collaborative thematic framework		marginalised communities. + Participants provided tangible and insightful suggestions to improve awareness, and education, support the implementation of policies and legislation, and strategies to end the practice of FGM/C – There is insufficient detail on the methods and methodology, including sample characteristics and data analysis – Further reflection is needed on the potential biases that may arise from the close relationships between PEER researchers and participants
Vangen et al. (2004)	To explore the perinatal care experiences of Somali women exposed to FGM/C and healthcare professionals in Norway.	• Sample size: N=23. Thirty-six healthcare professionals were also interviewed • Mean age or age range(s): 18 – 55 years • Location(s): Norway • Type(s) of sexual violence	• Study design: Qualitative • Sampling strategy: Snowball sampling • Data collection method: Repeated, open, explorative, thematically structured, interviews • Data analysis: Systematic analysis	• Judgment and stigma from healthcare professionals • Fear of inadequate care.= • Revitalisation of embodied pain from FGM/C during pregnancy and childbirth	+ The study highlighted gaps in the knowledge of healthcare professionals, which validated Somali women's concerns, and highlighted the need for further training, empowerment, and culturally sensitive care + The researchers recruited a heterogenous sample, thereby promoting diverse views.

Author (year)	Study aim(s)	Sample characteristics	Methodology	Reported psychosocial impacts of sexual violence	Strengths and limitations
		reported: FGM/C			– Despite this diverse sample, it was highlighted that the sample overrepresented Somali women with higher education levels. This may subsequently have underestimated the reported communication difficulties between Somali women and healthcare professionals – The study lacked important detail regarding the methods (e.g., a lack of information on the analysis process), relationships (e.g., between Somali women and healthcare professionals, interviewers), and ethical considerations (e.g., a lack of information on the duty of care provided to Somali women who were interviewed at the hospital in the days following potential traumatic childbirths)
Vloeberghs et al. (2012)	To explore the mental, psychosocial and relational impacts	• Sample size: N=66, of which 18 women were Somali	• Study design: Mixed methods • Sampling strategy: Purposive sampling	• Difficulties talking about FGM/C. • Reliving the pain and memories	+ The study was conducted in a culturally sensitive manner, including the use of culturally validated

Author (year)	Study aim(s)	Sample characteristics	Methodology	Reported psychosocial impacts of sexual violence	Strengths and limitations
	of FGM/C and women's coping styles.	• Mean age or age range(s): 35.5 years (range: 18-69 years) • Location(s): The Netherlands • Type(s) of sexual violence reported: FGM/C	• Data collection method: Interviews and structured questionnaires • Data analysis: Quantitative (t-tests and one-way analyses of variance) and qualitative (Grounded Theory)	• Shame due to the 'medical gaze' • Coping through physical exercise and engaging in religious activities	questionnaires, the translation of documents, and the involvement of peer researchers from participants' communities and FGM/C exposure + The use of qualitative and quantitative methods strengthened the trustworthiness of the data – Participants' willingness to talk about FGM/C and its impacts suggests there may be a potential selection bias. Women who have more difficulties to talk about FGM/C and who may have other mental health difficulties, views, or experiences, may therefore be underrepresented and could have resulted in different findings – Further detail was needed on the study's Grounded Theory analysis process
Ziyada et al. (2020)	To explore girls and women's intentions to using as well as barriers and facilitators to	• Sample size: N=26. An additional 17 participants were recruited to validate the	• Study design: Qualitative. • Sampling strategy: Purposive sampling. • Data collection method: Interviews,	• Impact on intimate relationships • Negative interactions with healthcare professionals, e.g., feelings of humiliation	+ The data collection process was thorough, in which findings were triangulated through different methods

Author (year)	Study aim(s)	Sample characteristics	Methodology	Reported psychosocial impacts of sexual violence	Strengths and limitations
Ziyada & Johansen (2021)	accessing FGC-related healthcare services.	findings through group discussions • Mean age or age range(s): 16 – 63 years • Location(s): Norway • Type(s) of sexual violence reported: FGM/C	participant observations, and validation group discussions • Data analysis: Thematic analysis		+ The author showed high levels reflexivity, considering the impacts of her outsider and insider positions – Further detail was needed on the chosen methods and its potential impacts, e.g., the justification for not transcribing audio recordings and what the limitations are of this approach – The study indicates participants' forthcomingness to speak about sensitive and culturally stigmatised topics regarding sexuality, which suggests the possibility of selection bias, and the potential underrepresentation of women with other views

Quality assessment.

All studies identified a clear research aim or question. Whilst most studies were able to contextualise their research question in relation to gaps in the wider literature, Johansen et al.'s (2002) anthropological study only briefly comments on their review of the literature. The author also does not critically examine their assumptions around FGM/C that had led them to conduct this study. Although appropriate methodology was used across all studies, some studies (Kartal & Yazici, 2021; McNeely & Christie-de Jong, 2016; Vangen et al., 2004) provided insufficient detail regarding the justification of their study design. For example, whilst Kartal and Yazici's (2021) qualitative approach is appropriate for their aim to research FGM/C in depth, there is a lack of information and reflection regarding the relationship between their study design (phenomenological), their data collection method (focus groups), and data analysis (descriptive analysis and content analysis).

A variety of sampling strategies were used across studies. Whilst some studies (Jelle et al., 2021; Karlsen et al., 2019, 2020; Michlig, 2019; Morison et al., 2004; Vangen et al., 2004) made attempts to increase diversity in their samples (e.g., through maximum variation sampling), all the included studies used a form or combination of non-probability sampling methods to recruit participants. These recruitment strategies are not uncommon in research, particularly qualitative studies (Lyon, 2015). Moreover, given the sensitivity of the research topic and known difficulties surrounding Somali people's involvement in research (Change Institute, 2009; Moxey & Jones, 2016; Safari, 2013), the employed sampling strategies were deemed appropriate for the included studies (Lyon, 2015). Nevertheless, despite the

risk of selection bias this introduced across the studies, only some studies (Chavez Karlström et al., 2020; Fried et al., 2013; Isman et al., 2013; Jacobson et al., 2018; Morison et al., 2004; Perovic et al., 2021; Vangen et al., 2004; Vloeberghs et al., 2012) reflected on who may have been excluded or underrepresented using these methods.

Many of the qualitative studies did not (adequately) consider the relationship between the researcher(s) and participants or provided insufficient detail to be able to assess these relationships (Chavez Karlström et al., 2020; Jelle et al., 2021; Johansen, 2002; Karlsen et al., 2019, 2020; Kartal & Yazici, 2021; Oguntoye et al., 2009; Vangen et al., 2004). For example, whilst Oguntoye et al.'s (2009) participatory research method had many strengths (e.g., improving access to underserved communities, increased trust, increased empowerment), there was no reflection on the potential drawbacks of the close relationships between the peer researchers and interviewees who were reportedly friends and acquaintances. It is questioned whether the proximity of the researchers to the interviewees could have potentially also reduced trust (e.g., due to potential risk of confidentiality breaches within the community (Safari, 2013)). Despite this, many of the studies made efforts to conduct their research in a culturally sensitive manner, such as the use of culturally validated measures, through collaborative work with the community with the involvement of community gatekeepers and stakeholders, and through the employment of and collaboration with peer researchers (e.g., Michlig et al., 2021; Michlig, 2019; Moxey & Jones, 2016; Oguntoye et al., 2009; Vloeberghs et al., 2012).

All studies took ethical issues into sufficient consideration. However, whilst some studies such as Johansen (2002) and Oguntoye et al. (2009) made reference to obtaining ethical approval and ethical guidelines, they did not offer much detail on the ethical processes (e.g., how informed consent was acquired). It should finally be noted that the quantitative component in Perovic et al.'s (2021) article describes the genital examination of participants in their investigation of pain. Given the evidence showing FGM/C victims' difficulties in healthcare settings, particularly in relation to genital examinations (Moxey & Jones, 2016), as well as the potential cultural barriers around vocalising pain and discomfort (Fried et al., 2013; Jacobson et al., 2018; Perovic et al., 2021), more detail was needed around this part of their mixed-methods study and how risk of re-traumatisation was minimised.

Many of the studies (Isman et al., 2013; Johansen, 2002; Karlsen et al., 2019, 2020; Khaja, 2004; Khaja et al., 2009, 2010; Oguntoye et al., 2009; Perovic et al., 2021; Vangen et al., 2004; Vloeberghs et al., 2012) provided insufficient detail to assess the robustness of their data analysis process. Whilst researchers often referred to their analytical method (e.g., grounded theory), there was a lack of information on what their analysis entailed, thereby reducing the replicability of their methods. It should be noted that these issues pertained to the qualitative studies, including the qualitative component in mixed methods studies. Some studies described the approaches that were used to increase the credibility of their findings, such as the triangulation of data (e.g., Oguntoye et al., 2009).

Most studies were able to provide a clear statement of findings in relation to their initial research aim, which were often considered in the context of the wider literature. The writing style in the anthropological and ethnographical studies

(Johansen, 2002; Khaja, 2004; Khaja et al., 2009, 2010) however, sometimes made it difficult to discern the study results, given that the discussion and main findings were embedded throughout the papers. Furthermore, articles relating to two studies (Karlsen et al., 2019, 2020; Oguntoye et al., 2009) did not explicitly discuss their findings in relation to their research aim. Overall, while there were some limitations to the quality of studies, the findings nevertheless made a valuable contribution to the wider literature and had important implications for clinical practice. The studies were subsequently deemed of sufficient quality to include in the narrative synthesis.

It should finally be noted that despite the variation in search terms used to capture the broad conceptualisation of sexual violence as defined by the World Health Organisation (2002) and as proposed by some FGM/C activists (Batha, 2018), studies in this review predominantly focused on FGM/C and did not specifically conceptualise FGM/C as a form of sexual violence, as was done by Coho and Parra Sepúlveda (2021). This therefore potentially suggests a discrepancy between conceptualisations of FGM/C in the literature and the perceptions and experiences of those who have been subjected to FGM/C.

Synthesis of findings.

Three main concepts were identified using Popay et al.'s (2006) narrative synthesis framework regarding the psychosocial impacts of sexual violence against Somali women, including: 1) 'a lifetime of pain and trauma'; 2) 'ruptured bonds and identities, and 3) 'stigma and discrimination'. Figure 3 contains a conceptual map describing the three concepts and the relationships between these.

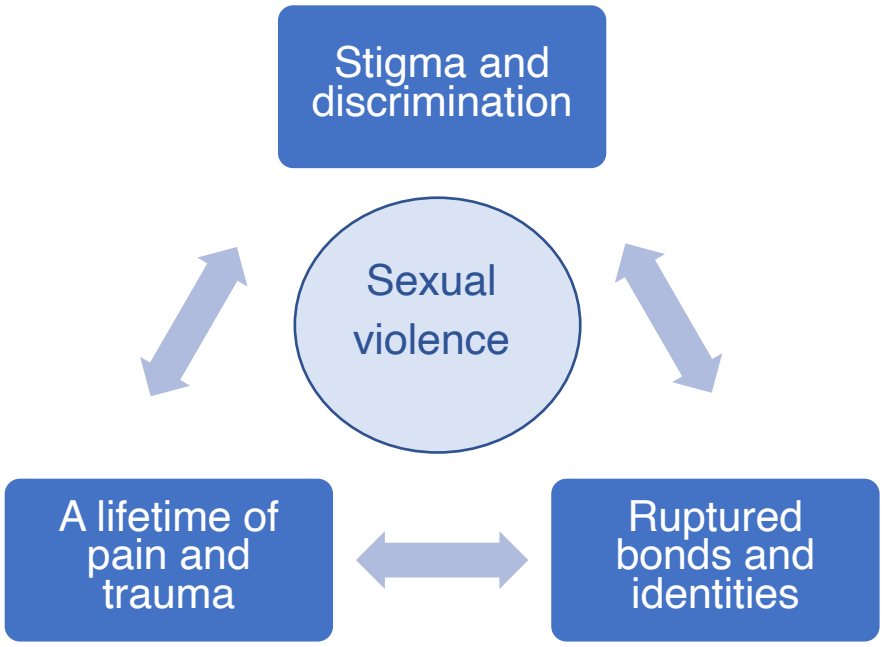

Figure 3: Overview of the main concepts identified in the systematic review.

A lifetime of pain and trauma.

With some reported exceptions (e.g., Moxey & Jones, 2016), FGM/C has been a difficult, life-changing ordeal for many women across studies, which have caused varying psychological difficulties, including anxiety, depression, sadness, and shame (e.g., McNeely & Christie-de Jong, 2016; Moxey & Jones, 2016). In addition to experiencing FGM/C directly, some women also reported witnessing or hearing of the death of girls' due to FGM/C (Kartal & Yazici, 2021; McNeely & Christie-de Jong, 2016), raising the possibility of secondary or additional trauma. A predominant theme underlying many women's difficulties has been the impact of pain. This includes the immediate pain during the procedure (e.g., Chavez Karlström et al., 2020) and the

agonising, often long, recovery periods that followed. One woman in Johansen's (2002) study reflected on the pain and frustration of having to empty a full bladder, a single drop at a time, and indicated she would come back from the toilet having shed *"more tears than urine"* (Johansen, 2002, p. 317).

The pain of FGM/C was frequently relived as women navigated everyday life, marriage, and motherhood (Johansen, 2002). Feeling helpless and ashamed, one woman in Oguntoye et al.'s (2009) study described her adverse experiences as she engaged in sexual intercourse for the first time:

> *When the time came I felt a lot of pains but I could not speak to stop him or do anything, maybe because I was ashamed or I wanted to reach the end to feel relaxed because I know I have no choice and I felt like an injured bird. The only thing I did was cry and I hated everything in my life.* (Oguntoye et al., 2009, p. 1022)

The painful experience of FGM/C also led to some women experiencing an aversion to and/or a loss of a desire or pleasure for sexual intercourse (e.g., Johansen, 2002; Kartal & Yazici, 2021). Two women in Isman et al.'s (2013) study also reported the negative effect on their husbands, who experienced guilt over their desire for sex. Women in Khaja's paper (2004) highlighted the vital role of men in managing the severity of pain during sexual intercourse, and some expressed appreciation for the patience, love, and care shown by their husbands, which helped them cope with these difficult circumstances.

The physiologically painful experiences of FGM/C were also accompanied by ongoing traumatic memories for many women across the reviewed studies. Although

it was an experience that participants would like to forget (Karlsen et al., 2020), this felt impossible for women across studies. Instead, the pain was something women had to live with, as a participant in Johansen's (2002) study explained: "*The pain of circumcision is like a heavy burden I always carry with me. It is like darkness in my life, in my chest. You can never forget it."* (Johansen, 2002, p. 313). Reflecting on her first pregnancy, one Somali woman in Vangen et al.'s (2004) shared:

> *In my dreams, my delivery and my circumcision are sort of mixed up. I am lying there pregnant, but only six years old as I was at my circumcision, and there are people around me with knives cutting me up everywhere. It is just awful.* (Vangen et al., 2004, p. 33)

Despite years of psychological therapy, one woman in Johansen's (2002) study similarly experienced nightmares when she became pregnant with her first child, where memories of her infibulation became mixed with her upcoming delivery. She was fearful that the trauma resulting from her circumcision would be retriggered by childbirth. Pregnancy also appeared to exacerbate long-standing fears in Moxey and Jones's (2016) study, with women fearing how they could deliver a baby given the nature of their infibulation.

Although these memories resurfaced after significant life events, such as childbirth for some women, other women were triggered during more everyday occurrences, such as routine healthcare encounters. For one Somali mother in Vloeberghs et al.'s (2012) study for example, it was difficult to see her GP about her FGM/C complications. In addition to the barrier posed by his gender (i.e., not wanting to show her genital area to a man), she also expressed not wanting to explain

everything all over again, as she did not want to be reminded of the pain. When asked by the interviewer what the pain did to her, she explained: *"I start to tremble all over, and all the memories come flooding back. I cannot do anything for the next few days, and all I want to do is sleep."* (Vloeberghs et al., 2012, p. 686).

The difficulties with painful memories and distress were evident in both qualitative and quantitative studies. Findings from Michlig's (2019) cross-sectional analysis for example, identified a link between trauma, adverse memories, and distress. Despite these significant distressing experiences reported across studies, only Vloeberghs et al. (2012) specifically examined how women coped with the varying impacts, which identified the important role of religion as a means of attaining comfort and strength. In Jacobson et al.'s (2018) study, the authors identified laughter as an important theme and hypothesised whether this was potentially both a coping and defence mechanism.

It should finally be noted that Somali participants in Vloeberghs et al.'s (2012) study reportedly showed more difficulties in talking about FGM/C compared to participants from other cultural backgrounds. There appeared to be variation in women's ability to disclose across studies, with some participants reporting no difficulties (e.g., Fried et al., 2013; Jacobson et al., 2018) and others finding it very difficult (e.g., Johansen, 2002; Vloeberghs et al., 2012). Evidence, though limited, suggested that different factors contributed towards experiences of disclosure. Some women in Johansen's (2002) study for example, questioned why they should talk about it, expressing sentiments such as, "*What is done is done. Talking cannot change that."* (Johansen, 2002, p.325). Other factors included feelings of

embarrassment, silence in the community and being silenced, and the distressing and traumatic nature of FGM/C in itself (Jacobson et al., 2018; Johansen, 2002).

Ruptured bonds and identities.

FGM/C was a difficult experience to process for women across studies. Although the cultural normalisation and religious justification of FGM/C helped some women positively perceive the practice in a Somali context, difficulties arose for participants when they settled in countries where FGM/C deviated from the norm and was negatively perceived (Jacobson et al., 2018). This has led to some women questioning their varying, intersecting identities. For example, whilst some women continued to be supportive of or see the value of the practice (Isman et al., 2013; Kartal & Yazici, 2021), others started to critically evaluate its purpose and relevance following their migration (Jacobson et al., 2018; Johansen, 2002). Cultural identities and values were particularly challenged when several women in Jacobsen et al.'s (2018) study realised the practice was not a religious requirement:

> *Growing up. . .we [were] told it was something to do with the religion. . .but at the end we found out it has nothing to do with religion. . .[it] was just a cultural, traditional. . . After I found out that I was so upset.* (Jacobson et al., 2018, p. 11)

Women in other studies similarly experienced difficulties with the realisation that the practice was not a necessity (e.g., Morison et al., 2004), which contributed towards feelings of anger and resentment towards the culture and towards those

who upheld it. When a participant in Johansen's (2002) study realised none of her peers at school had been circumcised, she experienced a sense of shock and bitterness, wondering why she was put through this ordeal. Similarly, a participant in Oguntoye et al.'s (2009) study reported a sense of resentment: *"I hated our tradition and I hated most my grand mum. But I didn't hate my mother because I know she didn't want to harm me but she could not do anything*." (Oguntoye et al., 2009, p. 1022).

It is important to highlight the participant's mother's powerlessness in this context. Participants' accounts across studies have shown that the decision to perform FGM/C is rarely held with a single individual. For some, the probable risk of social stigma and abuse may influence whether someone is cut or cuts their children. McNeely and Christie-de Jong (2016) for example, described the way in which being cut was associated with positive connotations (e.g., being "good", bringing "glory" to the family), whereas being uncut led to abuse both inside Somalia and in the wider diaspora (e.g., mothers being portrayed as "bad").

In some studies, participants were cut against their parent or parents' wishes. The daughters of a mother in Johansen's (2002) study, for example, were infibulated after visiting their grandfather's house despite the opposition of both her and her husband and struggled witnessing her daughter's pain as she cared for her. Clashes in opinions on the necessity of FGM/C had also caused difficulties in other families. For example, some participants in Jacobsen et al.'s (2018) study expressed their fathers' disapproval and felt angry when the procedure went ahead:

> *[My father] didn't want us to have the circumcision. . .he was so mad! . . .When he heard. . . he was yelling at my mom 'I told you not to touch my girls! I told you not to do that to my girls!'* (Jacobson et al., 2018, p. 8)

Women may finally question their sense of self, their womanhood, and sexual identity, following FGM/C (e.g., Isman et al., 2013). Across studies, women appeared to be grieving what had been taken from them, as though something was missing, which was described as *"a loss, in their body and soul"* (Johansen, 2002, p. 331). When describing feelings in their bodies, participants in Jacobsen et al.'s (2018) study stressed the importance of being able to feel, and the sense of loss that was experienced when they were not able to do so. Whilst not experienced by all participants, the losses that were described by participants in this study included the loss of pleasure and feeling during sexual intercourse.

Whilst the experience of cutting could be perceived as a means to achieving completeness in appearance by some women (Isman et al., 2013), the physical loss of genital parts through FGM/C can also cause a sense of incompleteness for others. One participant in Johansen's (2002) study for example, shared how she used to joke with her sister-in-law about going back to search for the removed parts of their body. However, in a sad tone, she continued: *"Of course that is not possible. They just threw it away. What has been cut away cannot be replaced. A part of my body is missing."* (Johansen, 2002, p. 324). Some women in Khaja's (2004) paper similarly struggled with the missing parts of their body. For one woman, it was too difficult to look at her vagina, believing there was nothing there, and preferred for her vagina to be resealed, so she did not have to be reminded of her loss. She explained, "*I don't have all my natural things there. So when I see my vaginal opening, it's just ugly*

thing. Just to see that I will get more hurt…I would rather not see it." (Khaja, 2004, p. 103)

Shame, stigma, and discrimination.

Participants across studies reported experiences of shame, stigma, and/or discrimination both within and outside of the community following sexual violence. At a community level, significant importance was attached to being infibulated. Thus, when a participant in Chavez Karlström et al.'s (2020) study believed her infibulation was "opened" due to having been raped, this has led to pervasive fears around her potential wedding night, where the relative ease of sexual intercourse, could be misconstrued (i.e., not being perceived as a "virgin"), increasing risk of stigma and divorce. Fear of stigma may also impact on women's ability to report incidents of sexual violence and help-seeking. One participant in Jelle et al.'s (2021) study for example, did not report an incident of gang rape to the police, relatives, or neighbours, due to her fear of being stigmatised.

Isman et al. (2013) reported on the difficulties in expressions of pain, which was connected to shame, both in relation to the pain during the FGM/C procedure and pain throughout their lives (e.g., during childbirth). Thus, when a participant from Sweden was told she did not have to hide her pain during childbirth, this remained a difficulty for her:

> *It felt...you have to endure, put yourself together, you shouldn't show your pain, you just have to be brave, put yourself together and don't say anything...we're made to endure...well you have pieces of fabric in your mouth*

> *so you can't scream, and you bite to it, yes you clench your teeth, you cling tight to your scarf.* (Isman et al., 2013, p. 96)

Outside of the community, Somali women may similarly be shamed, stigmatised, as well as be discriminated against. For example, whilst participants in Khaja et al.'s (2004, 2009, 2010) study were in favour of a ban against the practice, they struggled with the term "FGM", which they described as "*degrading*", "*racist*", and "*insulting*". From their perspective, the term FGM and discourses surrounding this practice had an underlying Western implication of being "*(sexually) flawed*" or "*uncivilised*". Such insensitive discourses increased feelings of mistrust and defensiveness amongst circumcised women. Moreover, compared to women who had not undergone the practice, the term implicitly positioned women as inferior to women who had not undergone the procedure. Women in this study also believed that the laws around the practice overlooked Somali people's love of their children, and portrayed mothers and communities as abusers instead, which felt insulting in multiple respects. Similarly, participants in Karlsen et al.'s (2019, 2020) study, believed that these negative portrayals unfairly targeted and stereotyped Somali people, and increased risk of racial abuse.

Stigma and discriminatory practices from healthcare professionals were commonly experienced by Somali women across different studies. In Ziyada and Johansen's (2021) paper, participants felt humiliated and disrespected by having multiple people examine their genital area, particularly without their consent. One Somali participant shared her experience as follows:

> *I would never forget how small I felt at the time. [The gynaecologist] had students in the room. She did not ask me if it was okay. I never agreed to have them staring at my private parts! It was a very uncomfortable situation. I felt violated [and] disrespected.* (Ziyada & Johansen, 2021, p. 15)

For some women in Vloeberghs et al.'s (2012) study, healthcare professionals' non-verbal responses, including facial expressions, felt judgemental and caused hurt:

> *You can see the facial expressions of the nurse, the doctor, the midwife. You can see their faces, the range of emotions and how they are looking at my body. That hurts… Those people's eyes make you feel sick.* (Vloeberghs et al., 2012, p. 687)

In contrast, other studies such as Jacobson et al. (2018) and Vangen et al. (2004) report on healthcare professionals' offensive and explicit verbal responses that shamed participants about their body. One participant in Jacobson et al.'s (2018) study shared one of her experiences:

> *"This is your ass. What is this? Where is your vagina? . . .Only one hole is over there. Did you get cancer? Did they remove something?" Sahra said, "No I didn't get cancer this is traditional." To which the doctor. . ."touch[ed] his head and. . . said, 'I can't believe it.'"* (Jacobson et al., 2018, p. 10)

Despite varying in severity, Somali women across all focus groups in Karlsen et al.'s (2019, 2020) study discussed how they had been frequently mistreated in different health settings. The repetitive questions about their FGM/C experience for

example, occurring both within and across their encounters with healthcare professionals, felt intrusive, provoked fear, and both neglected and exacerbated the traumatic nature of FGM/C. Healthcare professionals described in other studies also displayed much ignorance, which felt *"insulting"* and made women feel *"embarrassed and attacked"*, whereas women in other studies felt "*frightened"* and *"abandoned"* as a result of this lack of knowledge (e.g., Isman et al., 2013; McNeely & Christie-de Jong, 2016; Vangen et al., 2004). The predominant focus on FGM/C also led to other, potentially serious, health concerns being overshadowed, contributing towards fears and a sense of abandonment for women (Karlsen et al., 2019, 2020).

Where women in Karlsen's et al.'s (2019, 2020) study described more positive encounters, these were characterised as friendly and open, appearing to be in stark contrast with their negative encounters:

> *She wasn't saying it in a kinda aggressive way, she was saying it as if it was a normal chat. She goes, 'I know this is a really silly question to ask' but she's like, 'I've gotta ask it'. She just said, 'There isn't any chance of you having FGM done [while you're on holiday]?' I goes, 'No, there isn't'. She goes, 'That's fine, then." If they were a bit more sensitive and they just kinda said, in a polite way, 'I don't mean to be rude or insensitive but is there any chance that your daughter could be at risk of FGM? No offence to you or anything', and the parent says, 'No', then...there's no need to get the police involved.* (Karlsen et al., 2020, p. 4)

Participants in other studies also reported positive encounters. In Moxey and Jones's (2016) study for example, women reported that midwives showed good

cultural and religious awareness, posed questions in a culturally sensitive way, and offered culturally and religiously appropriate treatment options (e.g., offering the choice of a female midwife).

In addition to healthcare settings, participants in Karlsen et al.'s (2019, 2020) study also reported FGM/C related stigma and discrimination from professionals' involvement in child safeguarding, particularly at school. Whilst parents in this study understood and appreciated the school's responsibility to protect their children, it was believed that their approach undermined their ability to effectively safeguard, achieving the opposite outcome instead (i.e., the stigmatisation and traumatisation of children). Moreover, the hostility displayed by those implementing the safeguarding procedures negatively affected their family relationships. When one participant described her experiences with a social worker and police woman's line of questioning, she said this caused her daughter to feel confused and scared of her, as her mother, therefore creating ruptures from the outside when there did not appear to be any before:

> *'When you come back, we will contact you, we will check your daughter.' It was terrible – coming to my house like I was a criminal. I was frightened. I was so scared, upset, and angry. My daughter was frightened. The way the social services and police told her, it was like, "she's going to take you to Somalia, and they are going to do these things." They made her scared of me.* (Karlsen et al., 2019, p. 25)

Participants in this study described being met with strong suspicion. Safeguarding practises were perceived as tools to cause fear and exert power and

control over a vulnerable marginalised group, particularly in instances where safeguarding professionals did not account for, or took advantage of, limited English language abilities. Families perceived warnings that their children may be examined (e.g., following a holiday) as threatening and unsafe, contributing towards experiences of generalised fear. In addition to straining relationships between children and their parents, it also risked traumatising the children who were subjected to these safeguarding procedures:

> *They say they going to check the children. So, we as parents have to prepare them. We have to say, when we come back from holiday, the GP might need to check your private parts. The girls they don't understand. They say, 'but Mum, you always told us that no one's allowed to see your private parts […] so why do I have to show it?" For us as a parent, to explain, it's so hard. And the girls, they keep worrying about it, when they go to school – is it going to happen today? Tomorrow? And if you say, 'you have to go to the doctor,' they say, 'Mum, is it for my private parts?'".* (Karlsen et al., 2019, p. 42)

To conclude, three main concepts were identified in this systematic review. The first theme was 'a lifetime of pain and trauma', which described women's experiences of psychological and physical health difficulties, where pain and painful memories were relived during both everyday experiences, such as routine examinations and sexual intercourse, and during major life events, including pregnancy and childbirth. The second concept, 'ruptured bonds and identities', described the reported disruptions to women's' relationships (e.g., resentment

towards family members) as well as their identities, some of which appeared exacerbated by their migration experiences. The final concept was ‘stigma and discrimination’, which related to challenges both within and outside of women’s communities. As mentioned in the quality assessment, most studies focused on FGM/C, and the findings reported in this synthesis, were similarly almost exclusively reported in relation to FGM/C. This therefore raises the question on the generalisability of findings to other forms of sexual violence.

1.5.3 Critical reflection on the review process

To the best of my knowledge, this is the first systematic review that critically examined the psychosocial impacts of sexual violence against Somali women, therefore making a valuable contribution to the current evidence base. A comprehensive search strategy was also adopted, incorporating studies from the grey literature, which facilitated access to a range of information sources and potentially reduced the risk of publication bias (Boland et al., 2017). Notwithstanding this, this review was not without its limitations. The nature of this review and subsequent search strategy, may have overrepresented views that highlight adverse views and experiences. Furthermore, the quality assessments also identified selection biases in multiple studies. Evidence derived from participants with a readiness to share their stories for example, may not necessarily be applicable to those who find disclosures more challenging. Due to a lack of time and resources, studies published in a non-English language were excluded from this study. It is therefore possible that my search strategy excluded potentially important literature,

including those published in the Somali language. Despite my best intentions, I was unable to conduct this review in collaboration with others, which could have helped reduce the risk of errors and biases (e.g., through the double screening of articles). The findings from this review should therefore be considered with these limitations in mind.

1.6 Rationale for the Current Study

In this chapter, I introduced conceptualisations of sexual violence, taking into consideration different feminist and Somali perspectives. I also explored the psychosocial impacts of sexual violence as well as factors that may influence disclosure and help-seeking. This was followed by a systematic review of the literature focusing on the evidence base relating to Somali women specifically. The findings offered critical insights into the perceptions and experiences of Somali women, such as experiences of traumatic memories and the impacts of stigma and discrimination.

1.6.1 Gaps in the literature.

The systematic review highlighted important gaps in the literature. First, despite the thorough search strategy, most participants across studies had experienced FGM/C. Yet, this chapter has shown that sexual violence may encompass any sexual act or attempted sexual acts against a person's sexuality or sexual integrity using coercion, which may include, but is not limited to FGM/C

(World Health Organisation, 2002). It is therefore unclear how these findings may apply to Somali women who have experienced other forms of sexual violence.

The review also highlighted the lack of reporting on the nature of the relationship between Somali women and the perpetrators across studies. However, research has shown the influence of the victim-perpetrator relationship on factors such as disclosure and help-seeking behaviours (Hester & Lilley, 2017), as well as the impact of factors across the victim's ecological system (Bronfenbrenner, 1977; Campbell et al., 2009), and this therefore should have been considered across all studies.

Finally, the introduction highlighted that Somali women form part of a large, but marginalised, group in the UK (Hassan et al., 2013), whose intersectional identities and societal experiences may increase their vulnerability to abuse (e.g., Ahmad, 2018), could potentially affect experiences of distress (Byrne et al., 2017), and which may potentially influence patterns of disclosure and help-seeking (Said et al., 2021; Tillman et al., 2010). However, given the predominant focus of research studies on Somali victims' experiences with physical health services, current knowledge on their experiences and perceptions of mental health services are less clear.

The gaps in the literature therefore highlight a need to: 1) explore the impacts of varying types of sexual violence against Somali women; 2) understand these impacts taking into consideration Somali victims' cultural and social contexts as well as the nature of the relationship between the victim and perpetrator, and 3) explore

Somali victims' perceptions of disclosure and their experiences of help-seeking, not limited to physical health services.

1.7 Research Aim and Questions.

The aim of this study was to explore the psychosocial impacts of sexual violence on Somali women. Specifically, this study aimed to answer the following research questions:

1. How do Somali women from the UK perceive the psychosocial impacts of sexual violence when it is perpetrated by someone who is known to them?
2. What are these women's perceptions of facilitators and barriers to disclosure and psychological help-seeking?

Chapter 2: Method

Chapter Overview

This chapter describes the method of this study in order to explore the research aim and questions. In this chapter, I provide a rationale for my chosen qualitative research design. Following this, I describe the involvement of 'Experts by Experience', who played a vital role in this study. I then provide information about the sample, recruitment challenges, and important ethical considerations. In the final part of this chapter, I discuss the data collection and analysis process and assess the quality of this study appropriate to the study methodology.

2.1 Design

The systematic review highlighted the paucity of research exploring Somali women's perceptions of the psychosocial impacts of sexual violence as well as their perceptions of the barriers and facilitators to disclosure and psychological help-seeking. A qualitative research design was deemed the most appropriate approach to address these aims, as it facilitated the rich exploration of complex phenomena, which would have been difficult to capture using a quantitative methodology (McEvoy & Richards, 2006; Sullivan & Sargeant, 2011; Teherani et al., 2015). Second, it is considered particularly suitable to studies that have not been as extensively researched and where understanding is therefore more limited (Barker et al., 2015). Third, it aligns well with the critical realist epistemological stance adopted in this thesis (McEvoy & Richards, 2006), as it allowed me to use my interpretative

understanding, shaped by my intersectional contexts, to get closer to Somali women's reality of sexual violence and the psychosocial sequelae, rather than trying to present findings as a reflection of reality in itself (Fletcher, 2017; Pilgrim, 2014).

2.2 Methodology

2.2.1 Rationale for a phenomenological approach.

Despite the variations and degrees of overlap, qualitative studies can be broadly categorised into constructionist approaches and phenomenological approaches (Barker et al., 2015). Constructionist researchers conceptualise knowledge as a social construction as opposed to offering an insight into an external or objective reality (Barker et al., 2015; Willig, 2008). Constructionist approaches, such as Discourse Analysis, focus on how language is used (e.g., to persuade) to construct different types of social reality which can help attain social objectives (Willig, 2008). Constructionists criticise the idea that language can infer a person's mental state (Barker et al., 2015; Willig, 2008). Whilst this study explored the function of language (see section 2.6), I was primarily interested in making sense of participants' inner world through their use of language (Barker et al., 2015). A phenomenological methodology, which does aim to better understand a person's inner states (e.g., perceptions, experiences), and which posits this can be achieved through language, was therefore considered most suitable for this study.

2.2.2 Rationale for Interpretative Phenomenological Analysis (IPA)

Different phenomenological approaches can be employed to make better sense of an individual's inner world. I considered Reflexive Thematic Analysis to gain a better understanding of Somali women's perceptions (Braun & Clarke, 2021). Though not a methodology, this theoretically flexible method, can be applied to phenomenological studies and enables the researcher to identify patterns of meaning across data. Its lack of idiographic lens, however, would have limited my ability to get closer to participants' inner experiences. I therefore considered IPA as the most appropriate phenomenological approach to address the aims of this study, which allows for the systematic exploration of individuals' experiences, understandings, perceptions, and/or views (Smith et al., 2009). Like Reflexive Thematic Analysis, IPA incorporates a thematic focus, where themes are identified across participants (Braun & Clarke, 2021; Smith et al., 2009). However, IPA also has an idiographic theoretical orientation, where the researcher examines each participants' particular accounts and unique characteristics in much depth before examining patterns of meaning across individuals (Smith et al., 2009). This detailed dual analytic approach therefore enabled me to more closely engage with each woman's perception (Braun & Clarke, 2021; Smith et al., 2009).

In addition to its phenomenological and idiographic theoretical underpinnings, IPA is also influenced by hermeneutics, which is conceptualised as "the theory of interpretation" (Smith et al., 2009, p. 21). IPA posits that humans are sense-making beings. Their accounts are therefore considered to offer insight into their attempts to make sense of their experiences. At the same time, the IPA researcher engages in a "hermeneutic circle", which describes the iterative and dynamic nature of the

analysis process, as they think in different ways about participants' accounts. Thus, there is a "double hermeneutic" (Smith et al., 2009, pp. 27–28), where the researcher is making sense of the way in which participants are making sense of their perceptions and experiences (Smith et al., 2009). This therefore challenges critiques describing IPA as being overly descriptive (Tuffour, 2017) and corresponds with the critical realist epistemological stance, which acknowledges the researcher's reliance on interpretative understanding when acquiring knowledge (Fletcher, 2017).

2.3 Consultation with Experts by Experience

The importance of involving individuals with lived experiences, also referred to as experts by experience, is becoming increasingly recognised in research studies (Beames et al., 2021). For the person with lived experience, involvement in research can potentially help them feel valued, empowered, and increase their sense of confidence and self-esteem (Brett et al., 2014; Minogue et al., 2005). From a researcher's perspective, potential benefits may include a greater understanding of the researched community's needs, improved insight into their barriers to research, as well as the challenging of any preconceived assumptions pertaining to the community under study (Brett et al., 2014). The level of involvement can vary depending on the nature or stage of the research project, such as consultation and dissemination (Minogue et al., 2005). Two Somali women with lived experiences of sexual violence were involved in this study, who shared their expertise and offered input at different stages of the project. Both women were paid for every meeting they attended in acknowledgement of their time and emotional labour. An overview of their involvement is described in Appendix 4.

2.4 Participants

2.4.1 Sampling.

In IPA studies, participants are selected based on their specific perspectives on a certain experience in a particular context (Smith et al., 2009). As such, participants represent a particular perspective as opposed to being representative of a wider population. IPA studies typically also employ a relatively uniform sample for whom the research question would be meaningful yet allows for a level of variation between participants in a study. By aiming for a relatively homogenous sample, degrees of convergence and divergence can be more closely examined. Finally, given the idiographic nature of IPA studies and the detailed, time-consuming level of analysis of each participant's account that is required, sample sizes in this type of research are comparatively small. Smith et al. (2009) recommend a sample size of 4 to 10 interviews for professional doctorate studies.

In line with these guidelines, this study employed a purposive homogeneous sampling strategy to identify participants (Smith et al., 2009). The study eligibility criteria are listed in Table 6. This study included Somali women aged 18 years or over with a lifetime experience of sexual violence. To increase the homogeneity of the sample, the sample was restricted to women who live in the UK, as the perspective of women from other diasporas or those who live in Somalia may be shaped by other contextual factors (e.g., varying levels of access to (psychological) healthcare). Given the importance of the relationship between the perpetrator and victim of violence (Hester & Lilley, 2017), the sample was restricted to women where

the sexual violence was perpetrated by someone who was known to them. Due to the sensitive and potentially distressing nature of the topic, women were not eligible if the incident(s) of sexual violence occurred within the last two years at the time of the interview and if they experienced high levels of psychological distress within the last six months at the time of the interview.

Table 6: An overview of the study's eligibility criteria

Inclusion criteria	Exclusion criteria
Women from the Somali diaspora living in the UK.	Experiences of sexual violence in the last two years.
Lifetime experience of sexual violence perpetrated by someone known to them.	Experience of sexual violence that is restricted to stranger or non-acquaintance sexual violence.
Aged 18 years or over.	Experience of sexual violence that is restricted to politically motivated sexual violence in the context of war.
	Within the past 6 months – any high levels of psychological distress such as self-harming behaviours or thoughts of ending one's life.

2.4.2 Recruitment strategy and challenges.

Participants were recruited between October 2021 and April 2022. The study was advertised on different social media platforms, including Facebook, Instagram, and Twitter. Study information, including the research poster, participant information sheet, and consent form, was made available both in English and Somali (Appendix 5-7). A range of organisations (e.g., Coffee Afrique, Forward UK, Women's Inclusive Team) and community figures were also contacted to advertise the study and share information with potential participants. The research team also supported recruitment

by disseminating the research materials and putting me in contact with community gatekeepers and potential participants. I also joined different events to introduce myself and this area of research, such as the Women Inclusive Team's conference on "Preventing Violence against Women and Girls in the Somali Community" and the 2021 Somali Week Festival where I joined a panel (see Figure 5).

Figure 4: A Twitter post describing a panel I was a part of

Despite this comprehensive recruitment strategy, recruitment remained challenging. Previous research by Change Institute (2009) has identified difficult barriers that can negatively affect Somali people's engagement in research (e.g., scepticism about the potential agenda of research and destination of findings within the context of systemic scrutiny). Furthermore, the research topic is understandably incredibly sensitive, particularly within the Somali community, and will likely also have contributed towards recruitment challenges (Moxey & Jones, 2016). Following a meeting with the Women's Inclusive Team for example, I was informed that even

the word “sexual” in “sexual violence” could be a deterrent, given that there are cultural taboos around discussing sexual topics. We discussed the possibility of holding an event in collaboration with faith leaders aimed at discussing healthy relationships, following which I could gently introduce the topic of sexual violence and my research. However, this was difficult to arrange due to time restrictions, but may be considered in the study dissemination stage. Initial restrictions on face-to-face contact due to Covid-19 guidelines also posed a barrier, limiting my ability to meet potential participants in person within community settings (e.g., I was invited to join coffee mornings as a way of immersing myself further into community groups). A total of 7 eligible participants were identified in this study, of which five were interviewed (see Figure 5).

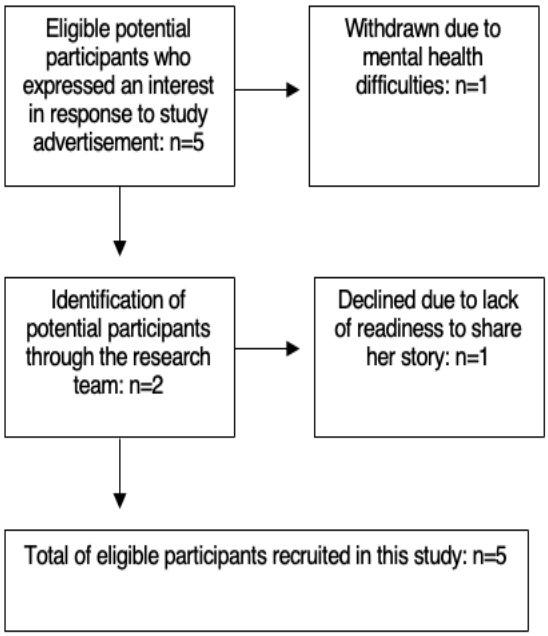

Figure 5: Overview of recruitment process

2.4.3 Participant characteristics.

The sample consisted of five Somali women. All participants reported being first generation women, although had lived in the UK for a significant period of their lives. All participants identified as Muslim. To protect confidentiality and anonymity, all participants' names were changed to a chosen pseudonym (n=3), although a pseudonym was given if one was not provided (n=2). Potentially identifiable data was also reported in a generalised format, including the provision of age ranges rather than specific ages. No "pen portraits" were included to further protect participants' anonymity and confidentiality. An overview of the participants' characteristics is provided in Table 7:

Table 7: Overview of participants' characteristics

Participant pseudonym	Age range	Context of incident(s) of sexual violence
Leyla	18 – 25 years	- Intimate partner sexual violence (IPSV) – rape
Araweelo	26 – 35 years	- FGM/C - Forced marriage - IPSV – rape
Hayat	26 – 35 years	- FGM/C - Non-penetrative child sexual abuse – sexual touching
Edna	36 – 45 years	- IPSV - Rape
Hawa	46 – 55 years	- FGM/C

2.5 Ethical Considerations

2.5.1 Ethical approval.

Ethical approval was sought from and granted by the University of Hertfordshire's Health, Science, Engineering and Technology department (protocol number: LMS/PGR/UH/04648). A copy of this ethical approval is attached in Appendix 8. Three amendments were submitted and accepted to modify the participant signposting materials, including the addition of suitable support services, and to change the length of the study period following the recruitment delays.

2.5.2 Informed consent.

A participant information sheet, containing important information about the study was shared with participants prior to their participation in the study. This included information about the study and research team, the eligibility criteria, their right to withdraw, information about the procedure, information about the potential benefits and risks of taking part, and information about the management of information, including details about confidentiality and plans for dissemination. A screening call was offered to assess participants' suitability for the study. This call offered participants further opportunities to explain the study, go through the eligibility criteria, and answer any questions. However, information was also provided via written communication (e.g., private messaging), where needed. I went through each aspect of the consent form with participants and obtained consent prior to their interview. All consent forms were password protected and stored securely in line with

the University's ethical guidelines, separate from participants' interview data. Participants were reminded of their right to withdraw their data at the end of the interview, including the latest date of withdrawal (two weeks following their interview date). Although all participants were English speakers, Somali translations of the participant information sheet and consent form were available.

2.5.3 Confidentiality, anonymity, and data management.

All participant data was stored securely in line with the University's ethical guidelines. Participants were informed about the confidentiality of data, as well as exceptions to confidentiality, where there was a risk of harm to the participant or others. Identifiable or potentially identifiable data in transcripts was also removed (e.g., references to own or others' names, references to specific services). Full interview audio recordings were accessed by myself and by a professional transcriber, who signed a non-disclosure agreement (Appendix 9). One of the consultants on the project, who is also a native Somali speaker, also accessed parts of the recordings to provide translation checks where Somali terminology was used. Consent forms, demographic data, and audio recordings will be deleted on completion of this research. Pseudo anonymised transcripts will be kept for five years following completion of this study.

2.5.4 Managing participants' wellbeing.

A number of measures were taken to minimise risk of harm to participants. Given the potentially distressing nature of the research interviews, participants were

sent a copy of the interview schedule (Appendix 10) in advance, to help them emotionally prepare for the questions as well as helping them decide whether they still wanted to participate. They were also reminded that they did not have to answer any questions they did not want to.

At the start of the interview, I also conducted a number of checks, including ascertaining whether they were in a safe and confidential place to speak. After sharing a definition of sexual violence, I also checked with participants how they wanted me to refer to what happened to them, to minimise the use of potentially distressing terminology.

As all interviews were conducted remotely there were fewer social cues to help ascertain participants' wellbeing. Check-ins were offered at different points of the interview, to assess their wellbeing and their ability to continue. Participants were offered a chance to debrief and reflect on their experiences of the interview. All participants were offered to complete a relaxation or grounding exercise at the end their interview or were sent a copy to complete it in their own time (Appendix 11). Participants were also provided with a list of organisations with contact details for further support (Appendix 12). One participant requested and was offered support with identifying and contacting a support organisation.

2.5.5 Data collection.

Interview schedule.

A semi-structured interview schedule was developed based on a topic guide (Appendix 13), a review of the literature on sexual violence, and in consultation with the research team, including both of my supervisors and one of the consultants. The interview schedule was semi-structured, which enables greater flexibility in participants' responses, and is deemed most appropriate for novice IPA researchers (Smith et al., 2009).

A pilot interview was conducted with a fellow Trainee Clinical Psychologist on the course. To help this trainee prepare herself for the role, I sent her a video of an online interview conducted with a Somali woman who has lived experiences, which she familiarised herself with prior to the interview. She reported a positive experience and no suggestions for improvements. The transcript was then reviewed in supervision and a minor modification was made where the participant was not specifically asked how I should refer to the perpetrator, as it seemed to cause confusion. The interview schedule was reviewed again in supervision after the first interview. Minor modifications were again made to improve clarity (e.g., in relation to the question about their generation) and suggestions were also made to elicit more depth (e.g., through further follow-up questions). This was particularly key given my insider position, where my shared cultural background limited curiosity at times, due to assumed knowledge (Kanuha, 2000). No further modifications were made to the interview schedule with the remaining participants.

Given the sensitivity of the research topic, introductory information was presented first followed by background demographic questions, to help participants ease into the research and help build report (Ranney et al., 2015), before more sensitive areas were explored. Following this, participants were invited to share the context of the incident(s) of sexual violence to help 'set the scene' (e.g., what life was like at home) and help make better sense of their story as we moved through the interview. Although the interview was organised around three main areas (i.e., perceptions of the psychosocial impacts and coping, perceptions of experiences with disclosure or lack thereof, and perceptions of experiences with support and psychological help-seeking or lack thereof), the participants and I moved through the interview schedule in a flexible, non-linear manner (Smith et al., 2009). The interview schedule included suggestions for prompts and follow-up questions, to elicit further information and thus add more depth. Participants were offered an opportunity to discuss anything that may have been missed at the end of the interview.

2.5.6 Interview procedure.

After consent was obtained, which included consent for the use of audio recordings, the interviews were commenced. Participants were informed of the start and end of audio recordings. All interviews were carried out remotely, in which participants could express their preference for the interview platform. Two interviews were conducted on Zoom and three interviews were completed over the phone. Although research on the effectiveness of remote interviews (e.g., telephone, video conferencing) compared to in-person interviews has produced mixed findings (Gray

et al., 2020; Johnson et al., 2021), studies suggest that remote interviews can be positively perceived, increase accessibility, and can be conducted productively without substantially compromising on content or depth, particularly when opportunities for in-person interviews are limited (Gray et al., 2020; Irani, 2019; Sturges & Hanrahan, 2004). All interviews were conducted in English, although some Somali and Arabic terminology were occasionally used. No participant requested or required an interpreter. Interviews lasted between 44 and 112 minutes (average= 72 minutes). I checked in on all participants at the end of the interview and offered them a debrief, as well as the option of completing a relaxation or grounding exercise. All participants were given a £20 voucher of their choice. However, in order to minimise potential risk of undue inducement (Vinay & Bauer, 2022), the value of the voucher was not mentioned beforehand.

2.6 Data Analysis

The analysis was completed using Smith et al.'s (2009) framework, which outlines a set of processes and techniques that can be applied flexibly and iteratively. I first bracketed my recollections of the interview experience, in line with Smith et al.'s (2009) recommendations. I then immersed myself with the original data, by listening and relistening to the interview recordings, as I read through the transcripts, making corrections where necessary. This helped me actively engage with the data and enter participants' phenomenological world. As I moved through to the next phases of analysis, I returned to the audio recordings and re-read the transcripts as necessary, thereby increasing my engagement with the data.

In the next phase, I further familiarised myself with the transcript, by making initial notes, which helped identify the way in which each participant described, perceived, and thought about their experience (Smith et al., 2009). These initial notes included descriptive comments (i.e., key words, phrases, or explanations used by the participant), linguistic comments (i.e., a focus on how language was used and content was presented by the participant, such as pauses, laughter, metaphor), and conceptual comments (i.e., approaching data at a more interpretative level, which may include personal reflections).

I then developed emergent themes, which can be described as concise statements based on the initial descriptive, linguistic, and conceptual notes, which reflect the "psychological essence of the piece and contain enough particularity to be grounded and enough abstraction to be conceptual" (Smith et al., 2009, p. 92). As seen in Appendix 14, three separate columns were created, as suggested by Smith et al. (2009). The original transcript was recorded in the first column, the initial notes were recorded in the second column, and the emergent themes were recorded in the third column. As IPA typically produces a large number of emergent themes, I also recorded the emergent themes in *NVivo*, which were linked to the original transcript, and where I completed the rest of the analysis.

In the next phase of the analysis, I looked for connections across the emergent themes using NVivo, primarily using abstraction (i.e., finding patterns between themes and grouping connected themes together to create a 'super-ordinate theme) and polarisation (i.e., identifying oppositional relationships by looking for differences) (Smith et al. 2009). This process led to a list of super-ordinate themes and subordinate themes for one participant. This process was

repeated for each participant, ensuring I created a new Word document and new NVivo document as I completed the process, to protect the idiographic nature of the analysis. When this process was completed for all participants, I identified patterns and connections by looking across all the themes for participants and identifying areas of convergence and divergence (Smith et al. 2009). Using a similar process of abstraction and polarisation used in the analysis of individual transcripts, this process eventually led to the development of three superordinate themes and seven subordinate themes, which are presented in the Results chapter. Appendix 15 describes examples of the theme development. All themes and the analysis process were reviewed in supervision, and subsequently checked by a participant as way of contributing towards a more complete understanding of the participants' perceptions (McEvoy & Richards, 2003). This participant believed the themes reflected her experiences well and offered further context and clarification to her specific data extracts (Carlson, 2010).

2.7 Quality Assurance

Although the CASP (2018) was used to assess the methodological quality of qualitative studies in the systematic review, in line with Smith et al.'s (2009) recommendation, I specifically applied Yardley's (2000) four broad principles to appraise the quality of this IPA study, which are outlined below.

2.7.1 Sensitivity to context.

The first principle refers to the importance of demonstrating sensitivity to context. Smith et al. (2009) argue that sensitivity to context is shown at the initial phases of the IPA research process. That is, the decision to adopt an IPA methodology in itself, will be based on the perceived need to show sensitivity to context, by closely engaging with the idiographic (Smith et al., 2009). By drawing upon the lived experiences and expertise of the Somali consultants in my research team, my own cultural understandings and experiences, as well as drawing upon the intersectional and African feminist frameworks described in the Introduction chapter, I demonstrated further sensitivity to theoretical context and acknowledged the socio-cultural contexts in which this study and women's experiences were situated. The way in which I sensitively conducted interviews (e.g., showing empathy, trying to make the participants feel at ease), as well as the immersive nature of the analysis process which aimed to get closer to each participants' inner world whilst remaining grounded in verbatim extracts from original transcripts, further increased the sensitivity that was shown to context (Smith et al., 2009).

2.7.2 Commitment and rigour.

The second principle refers to the demonstration of commitment and rigour (Smith et al., 2009; Yardley, 2000). Commitment can be evidenced in different ways and shares overlap with Yardley's (2000) principle of demonstrating sensitivity to context. In this study, commitment was shown to participants during the interview stage, where I paid close attention to their individual accounts as well as by

monitoring their wellbeing, sense of comfort, and safety, in which I additionally drew upon my clinical skills. Commitment was also demonstrated through my close engagement with the data, taking care to pay specific attention to the particular, before addressing commonalities and divergences in experiences across individuals (Smith et al., 2009). Rigour, which describes the completeness of the research, was shown through my careful selection of participants to establish a reasonable level of homogeneity, as well as through my systematic, idiographically engaged, and thorough analysis informed by Smith et al.'s (2009) guidance. The thoroughness was also reflected in the writing of the Results chapter, where extracts from transcripts were drawn upon to support the superordinate and subordinate themes.

2.7.3 Transparency and coherence.

The description of the research process, from recruitment to analysis, described in this chapter and in Appendix 14 and 15, demonstrated the study's transparency. Furthermore, the transparency of the study was enhanced by the inclusion of extracts from my research diary in Appendix 1, through which I demonstrated how I may have influenced the direction, gathering, and interpretation of findings (Tufford & Newman, 2012). The principle of coherence describes the finished write-up of the thesis. With support from my supervisors, I have carefully written and re-written drafts of the thesis, making amendments where needed, to increase the cohesiveness of the information that was presented within and across chapters. I also demonstrated coherence by conducting this study in line with Smith

et al.'s (2009) IPA framework and paying close attention to its theoretical underpinnings.

2.7.4 Impact and importance.

According to Yardley (2000) and Smith et al. (2009), all qualitative research should be evaluated based on its usefulness and ability to create an impact. This study's focus on the experiences of Somali women in itself has addressed an important gap in the literature. The Discussion chapter careful considered the value of this research and described the impacts of the findings. I also aim to work in collaboration with the research team to consider effective dissemination strategies, that is accessible to both academic and non-academic audiences.

Chapter 3: Results

Chapter overview

In this chapter, I present the findings derived using the IPA methodology. In line with a critical realist epistemology, I present these results as my interpretation of participants' accounts which was influenced by my interacting personal and professional contexts. I present a summary of themes in Table 8, which outline three superordinate and seven subordinate themes. Findings will then be described in more detail, where I aimed to share my interpretative understanding, whilst remaining grounded within participants' accounts[2]. Finally, the recurrences of themes across participants are described in Appendix 16.

Table 8: Summary of themes

Superordinate theme	Subordinate theme
"The beginning of a nightmare" - The (in)visible wounds of sexual violence	The many faces of pain
	"Chaos" and disruption
"Getting away from one evil and running into another evil" - (Re)traumatising systems	The ultimate betrayal
	Silence and silencing
	When helpers harm
"You go forward a few steps, and then you go back again a few steps" - The winding path to recovery	"A spiritual awakening"
	Carving your own path

[2] Direct quotes pertaining to participants accounts are presented within quotation marks and in italics. Where participants emphasised words or phrases, these are described in bold. Ellipses (…) are used to mark pauses. Where words have been omitted to improve the flow and clarity of accounts, this is indicated using the following symbol: […] Participants' preferred terminology is used within their respective interviews and terminology within quotes has been retained to protect their voices.

Superordinate Theme 1: *"The Beginning of a Nightmare"* - The (In)visible Wounds of Sexual Violence.

Sexual violence has had a significant impact on various aspects of women's lives, which Hawa described as "*the beginning of a nightmare*". This theme outlines the various sequelae of sexual violence across the women, including FGM/C, intimate partner sexual violence (IPSV), forced marriage, and non-penetrative child sexual abuse. It describes the wounds that were both visible (e.g., the physical complications associated with FGM/C) and those that were less or invisible (e.g., the difficult thoughts and feelings that were unspoken). This superordinate theme consists of two subthemes, including 'the many faces of pain' and '"chaos" and disruption', which are described in further detail below.

Subordinate theme 1.1: The many faces of pain.

When describing the impacts of sexual violence, it was evident that all events of sexual violence left the women with an unimaginable pain, including physical and emotional agony. Leyla, who described being subjected to IPSV, reported that life was "*just really horrible at the time*" and shared she was feeling "*very, very down*". When reflecting on her experiences of anxiety and depression, many of her difficulties appeared to have manifested themselves physiologically. This, in turn, seemed to have exacerbated her experiences of distress. That is, in addition to the frequent stomach aches, lack of appetite, and weight gain, Leyla noted:

> *…and then I had a really bad like … um … eczema outbreak as well … […] … and I've never had an eczema outbreak in my life … but that one time I had*

> *an eczema outbreak […] … that added to my stress because for 7 days, I thought I had sunburn but my skin was … I felt like my skin was peeling off … - Leyla*

For other women, the short- and long-term physical pain and health problems following incidents of sexual violence, particularly FGM/C, were perceived as a difficult ordeal to live with. Araweelo, who shared she was subjected to FGM/C as a child, remembered a "***horrible***" pain. In addition to this immediate pain, Araweelo also described experiencing chronic issues with tearing and pain since she started menstruating, as "*the period had nowhere to come out from.* ***Absolutely nowhere!***". Further difficulties were experienced when she was forced into a marriage, during which she was raped repeatedly. Araweelo believed that her virginity combined with the small opening from the circumcision aggravated the impacts of rape, where it felt she was *"being torn… apart"*. Despite the significant pain she was experiencing, however, Araweelo shared not receiving medical attention at the time:

> *Ehm, but so much force was used for so many days, that it caused internal ehm, ehm trauma and damage. And* ***again****, because we don't talk about the effects of* ***FGM*** *and* ***sex****, ehm, I didn't know… like how my body reacted to that particular trauma, like I didn't know, like I knew it was painful, I couldn't pee properly for three months… Ehm, I had a really bad infection, ehm and they refused ehm, for me to get medical attention…Even though I couldn't urinate [light chuckle], I I* ***really*** *could not urinate and the days that I did it was the most painful experience, I would sit on the floor. - Araweelo*

Following FGM/C, Hayat, described being "*scared to go to the toilet because it would hurt me"*, so tried to hold it in instead. Hawa, also described difficulties with using the toilet following FGM/C, which she felt served as a painful reminder of what had happened to her:

> *"… the pain was always there … nobody to talk to … um … it just eats you away … you go to the toilet … you are constantly reminded of what's happened to you because you can't urinate properly. It was just a nightmare. It really was a nightmare." – Hawa*

Human bodily functions, such as menstruation and urination, cannot be avoided, meaning the physical and subsequent emotional pain could not be avoided. These constant reminders and potential chronic difficulties therefore made it feel impossible to escape the severe abuses they had experienced whilst navigating their everyday lives. Understandably then, women clearly described psychological difficulties as one of the faces of pain. The perceived psychological impacts varied both in type (e.g., low mood, night terrors) and severity (e.g., suicidal ideation, hospitalisation), and a common thread that appeared to cut across some women's experiences was a sense of overwhelm with what had happened to them, contributing towards a sense of disconnect from the here-and-now. Hayat's reports of ongoing *"flashbacks"* of being sexually touched as a child and experiences of *"dissociations"* during sexual intercourse for example, may reflect a difficulty with processing what happened to her across childhood. Edna, whose former husband severely abused both her and their child, describing living a life of fear, where resistance was perceived as futile, and instead, "*you're just getting on with it*", and described a dream-like state, which similarly may reflect a sense of overwhelm:

[…] it's like you're living in a dream innit? (Laughs) … it is the case, isn't it? Do you know what I mean? You're floating … you're walking but you're not walking … does that make sense? You know. […] You're walking but you're floating – do you know what I mean? - Edna

Subordinate theme 1.2: "Chaos" and disruption.

Sexual violence appeared to have disrupted the women's lives, relationships, and sense of selves in profound and unimaginable ways. For Hawa, life was *"literally wiped out by that razor"* following FGM/C where everything around her became *"chaos"*. She described herself as a talkative, curious, "*happy chappy"* child before she was cut. However, her personality significantly changed following FGM/C. For example, whilst she used to enjoy school and learning, and credited her high performance to her strong curiosity, she indicated that, *"after cutting, I just changed. I just couldn't be bothered"*.

Leyla similarly compared her life and personality before and after being subjected to IPSV. Before the incident, Leyla was studying at college and had a job as well. She said she *"was enjoying college. I was doing college every day. I was doing well with my exams."* Leyla also had *"a really good social life"*, including *"quite a few friends"* and was generally *"very sociable and happy"*. After the incident, however, Leyla perceived her life as having gone *"downhill really fast"*, and described an inability to work, socialise, and having to take a year out of college. Worrying about the permanence of these changes, Leyla indicated: *"I just feel like it*

was a completely different era of my life that I was going into. I was just worried about never being the same again."

Both Leyla and Hawa also described difficulties with the enormity and variability of their affective experiences. Hawa indicated feeling "*so many things"* after she was circumcised, where her moods changed rapidly: "…*every five second - one minute you are happy, then the next minute, you are not. And, then afterwards, you feel anxiety … it's like too much going on."* Leyla continues to struggle with the significance of what happened, where the "*heaviness of everything [is] starting to add up in my life"*. She indicated lacking control both in her ability to disclose due to the negative reactions from others, and a lack of control over her mood and mental state, which may potentially interlink:

> *… just how I feel … I feel like I've lost control in other ways like I just … I just get up and down quite a lot … I'll be … one day I'll be like I just want to change my life like for a good week or two then […] …like, say another month, I'll just be down […]… really upset, like really hurt…- Leyla*

One unexpected impact for Leyla was the effect on the relationship with her partner. Despite the love they have for one another, her partner has picked up on certain difficulties (e.g., her not wanting to *"be too close"* to him). Given the negative reactions she experienced from her community, she was concerned her Somali partner would potentially share similar views and feared he would abandon her. Also taking into consideration the infancy of the relationship, Leyla has therefore felt unable to share what had happened with her partner.

Hayat similarly reflected on the impact of sexual violence on her relationship and reported her marriage was the most affected area of her life. She explained how her expectations of marriage contrasted with her lived experiences, which led to her internalising her difficulties:

> *…But I would definitely say marriage, for sure […] had a huge impact obviously from [...] like I said there were times with sexual intercourse [...] not knowing at the time [...] yeah [...] it was dissociation [...] I would black out or I would [...] you know [...] fake things and then [...] it was a bit confusing [...] and pain – I was actually in pain [...] and then I kept thinking "There's something wrong with ME." Because … probably... [...] when you just think of … [...] … marriage is … is all the hap… … happiness and that lovely experience that you've sort of … there's that … naïve I guess … until you get into it you … you sort of realise "No, actually this is … this is … hard times …*
>
> *- Hayat*

Although Hayat indicated she did not recognise or was able to express the effects at first, she gradually started to identify the difficulties and communicated her experiences to her husband. Whilst she thought her husband *"never really understood"* her experiences, she described his approach as *"very patient", "very supportive",* and *"caring"*.

For Araweelo, fear of judgement of FGM/C appeared to have affected her ability to start new relationships. She described her experiences of getting to know a potential partner as follows:

…And he looked at me and he was like 'What is that?' And I explained what it was and he goes, 'So, that means you don't feel anything then?' … and I'm like … he goes 'You're completely shut, like nothing there.' Like it's things like that, and I'm thinking 'Oh my God!' Like you hear the word 'mutilated' and you obviously think of the worst thing possible. […] And our vaginas are not the worst thing possible. […] The procedure is but our vaginas are not the worst thing possible, so you can't call it female genital mutilation – that's my genitals. […] My genital is not mutilated. - Araweelo

These experiences and perceptions of stigma and negative judgments also appeared to have contributed towards shame for Araweelo. She shared her experience of attending a sex education class at school not long after her arrival in the UK. Whilst the normalisation of circumcision in her community led her to feel *"it was right, we are right, and everyone else's opinion of it is wrong"*, Araweelo struggled with the realisation that her genitals were different compared to girls who had not been subjected to FGM/C:

…so I sat in that classroom and they show, you know, female genitals and male genitals and explain what it is. And in in my mind, I'm thinking that's impossible. Like that's not. That's not what mine looks like because mine is completely shut. But I couldn't say anything. To anyone. Because… can you imagine saying but mine doesn't look like that? […] Like it's completely shut! So even though I, I couldn't speak English very well. I knew, I felt shame. I, I knew that I was different. – Arawaeelo

In addition to the impact on Araweelo's body image, the circumcision also appeared to have disrupted her identity as a woman. Referring to the loss of her removed genital parts, Araweelo described feeling incomplete, which seemed to have affected her sense of womanhood: *"I felt sadly less of a woman…because I didn't have all the **parts** of a woman…"* FGM/C similarly affected Hawa's identity as a woman. Despite trying to achieve this completeness by changing her appearance on the outside, this did not appear to have translated into an internal change for her when she was younger:

> *… I never thought I was … you know … a complete person. I always thought something was missing with me … I'm not … you know … a complete woman … I'm incomplete … stuff like that … I did dress up, but I just didn't feel, from inside. – Hawa*

Superordinate Theme 2: "Getting Away From One Evil and Running into another Evil" - (Re)traumatising Systems

This theme describes women's perceptions of victimisation and harm across different systems, including by family, the community, and/or various institutions. For Hawa, there appeared to be no place of safety from adults as a child, who described feeling as though she was *"getting away from one evil and running into another evil".* Although there were exceptions to the rule, participants unfortunately reported experiencing betrayal, being silenced, and being harmed by those they thought were meant to help/protect them. Thus, the women's accounts described the harms by the violence initially, which appeared to be compounded by perceptions of negative

reactions and treatment afterwards. This theme consists of three subordinate themes, including: 'the ultimate betrayal', 'silence and silencing', and 'when helpers harm'.

Subordinate theme 2.1: The ultimate betrayal.

On the night Hayat was circumcised, she reported being made to believe there was going to be a sleepover party at her house. Being an only child, she believed this was an *"amazing idea"*, and was looking forward to the fun she was going to have with the other girls, including her younger cousin and one of her best friends. The first part of the night was indeed perceived as enjoyable. However, when a man showed up at her house, the atmosphere *"changed from us having fun…um…enjoying ourselves…having a laugh to…you know, being picked one by one…"*. Feeling unsure of why she was being subjected to FGM/C, Hayat described her perplexity and feelings of betrayal at the time:

> *I was like almost fighting everyone, trying to get out … um … wasn't sure why this man … you know … was in a position where I had to lie there and my legs were being opened. So, it … it was just confusing … I think that's the word to use. It was very confusing at the time. I felt like these were the people that were meant to protect me … so, it was a sense of sort of betrayal.*
>
> *– Hayat*

Hayat's feelings of confusion and betrayal re-emerged after she was inappropriately touched as a child, particularly given that a relative, who she believed

was her best friend, was also one of the perpetrators: *"...I just felt confused … again that confusion's come back of … 'I thought you were close to me. I thought we're family. I thought you were my best friend. What are you doing?'"*

The experiences of confusion and betrayal therefore appeared to be located in the disturbing juxtaposition of the abusive events, in which the infliction of harm was framed in a positive light, leaving her feeling disconcerted, fearful, and traumatised, as well as appearing to have ruptured her sense of belonging and safe sense of community. This also appeared to be the case for Araweelo and Hawa, who struggled both with the celebration and cultural justification of FGM/C. Despite *"being oblivious to what it really meant"*, Araweelo described cutting as something she had heard about throughout childhood and indicated this was a *"celebrated"* as opposed to a *"feared"* custom. However, upon experiencing the reality of FGM/C, Araweelo described feeling resentful towards her family for even considering putting her through this. Not only was she confused by what had happened, she also felt vulnerable without her mother, and feared for her life, believing she was unable to trust her family:

> *"Yeah, because the **pain**…and the way that it happened… was **horrible**. And then everyone was smiling and it just didn't make sense that it was confusion. And a sense of [...] betrayal and from that moment I genuinely thought my family were going to kill me (chuckles). […] Like I know it's weird. […] But because my mother wasn't there. [...] and it was my grandma who was raising us. It was… like it was just. It felt as if it was me and my sister against everyone else. My, and my little sister died as well, mysteriously... […] So it was kind of like, am I next? (light chuckle) And when that happened it was like*

'Oh my God, like what else are they going to do?' Then like the trust in terms of family flew out of the window…- Araweelo

Similarly, Hawa struggled, and continues to have difficulties with making sense of the FGM/C celebrations and apparent adultification of children. She wondered why people were saying she was going to be a *"naag quruxley"* [beautiful woman] and questioned: *"What does a six-year-old know about 'naag' at all really?"* Her bewilderment with this is also reflected in this extract below, where she appears to be struggling to formulate her thoughts around the practice:

And … um … I (sighs) … you know, you become a grown woman, and you look back and you start to question everything … things like "How did they make you have that kind of party … and then go and do this? How do they think these two things go together? ***How?****" […] "Was it to make you … you know … um … you know, you have dresses to look forward to … you're going to be OK … what was …?" … Still, I don't get it. I still … even today … I don't get it. How the concept of … you know … giving you this party … it's celebrating you … knowing that what awaits you … I just … it … it … it's still something that I struggle with to understand … the concept.*

– Hawa

Like Araweelo, Hawa reported feeling vulnerable and unsafe around her family and, by extension, her community. She explained how *"you really are loved as a child"* in the Somali community. Thus, when everybody around her behaved *"like nothing has happened"*, this contrasted with her perceptions of her family and community, and which made her feel uncared for. It became difficult for Hawa to trust

other people and their intentions, who described a state of hypervigilance, and questioned her sense of safety at every turn:

> *It was just constant. I just couldn't stop that thought … if I came back home, and I saw many people at home … you know … there was a festive mood, and people were celebrating something … I automatically assumed something bad is going to happen, so … anything that was … except from death and wedding … if I saw anything else, I just assumed something bad is going to take place. I hated parties … I hated any celebrations because I thought the minute I hear the word 'woman' it signifies something evil is about to take place. – Hawa*

At the same time, Hawa also recognised the various pressures on Somali parents to cut their children, who may lack power to go against the norms of the community. Hawa said she knew that if she stayed and had a daughter in Somalia, that it did not matter *"whether I wanted it or not, family members would just take them… […] and do that to them anyway"*. Wanting to *"get away from that life so desperately"*, she described feeling *"grateful to Allah"* when *"it happened because of the war"*. Hawa's sense of belonging and feelings for her family and community were therefore complex and seemed difficult to disentangle from her challenging early life experiences.

Similar sentiments were shared by Leyla, who struggled with her relationship to the Somali community after being subjected to IPSV. For Leyla, multiple experiences of being treated poorly and with disdain by people from her community, contributed towards her challenging relationship with them and difficulties with trust:

Yeah, I just felt like I couldn't trust any people ever again … just like I was being treated … you know … just being treated different to everyone else because of what I had been through … it felt like I was being looked down on so I went through a phase of actually feeling insecure around Somalis. […] It was like if I ever spoke out or spoke to them, they were the first people dragging me … it wasn't even people from other backgrounds, it was them. […] And I just didn't want to be around that...– Leyla

Leyla's focus on the negative responses from Somali people, as opposed to other cultural groups, suggested a sense of disappointment, which may be further indicative of the betrayal that was experienced. Moreover, her experiences of insecurity also suggest her identity as a Somali might have been threatened by the community's responses to her.

Subordinate theme 2.2: Silence and silencing.

Participants' perceptions of silence and silencing referred both to the absence of discussion, the explicit forbiddance to disclose, and to the negative consequences of disclosure. When Leyla disclosed her abuse, she was initially encouraged by a friend's supportive response. However, experiences of betrayal of trust by others, as well as her perceptions of being silenced by different members from her community, contributed towards her difficulties with disclosure:

They said my face … they said my face would be all over the news … my whole family would find out … my boyfriend would split up with me … um …

you know, if I should report it to the police no one would believe me. And then I said 'Right, if I don't go to the police, I'll go to a counsellor or a therapist … and see how they could support me and if I need to report it. I would want at least to speak to a professional, and he said the same. He said 'The professional won't support you. The professional will walk away from you and not believe you. – Leyla

Fears around disclosure also related to the potential impact on a parent:

… obviously we were told not to tell anyone outside home, especially school, especially … um … 'gaalo', as they would all say at the time which is the … you know … the other non-Muslim or White British or whatever it is … so, yeah … I assumed that was school, at the time, I made … I kind of convinced myself I wasn't allowed to talk … um … and even if I did … wanted to talk, how could I explain […] without getting my mum into trouble, or getting … so, it was that guilt as well if I did speak out, who's going to get in trouble … (clears throat) … you know … all that stuff, yeah. (Coughs) … so, yeah … that was … I think a bit of both was there. – Hayat

Hawa also reflected on the complexities of disclosure. She shared she was both forbidden to discuss what happened to her, something she believed functioned to perpetuate the silences, and also believed the traumatic nature of FGM/C in itself acted as a barrier to disclosure. She also described perceptions of labels around disclosure, which did not appear to match with how she was feeling at the time:

And girls are made … they're all programmed to make … "It's a good thing … […]… it's a brave thing … it's a great thing." So, they … I don't think whoever

> *had … was having a pain was in a position to talk about their pain because the deception about it is they say "You're going to be brave! You're going to be this!" … It's like 'brave' is attached to it … […]… and I think if you … if anyone really talks about it, it's like you're not brave, you're a traitor … you're this and that … labels just fly off the self. – Hawa*

Looking back on her first experience of disclosure, which was in a work setting, Hawa was concerned about potential judgements from her colleagues and the risk of being perceived differently by them. Contrary to her concerns, however, *"it was the most amazing response ever"*. Like Leyla, the supportive reception was encouraging, and gave her *"confidence in … in talking about that and sharing…"* And, despite encountering some challenging, critical feedback in response to discussing FGM/C in certain spaces (e.g., *"you are a traitor"*, *"you are Westernised"*, *"you're bringing shame to us"*), she realised that *"when negativity comes actually you are hitting … you are touching a nerve… […] and you are making a difference",* which is how she learnt to cope with any negativity that arose.

The desire to help others and make a difference also seemed to have influenced the other women to share their stories. Both Leyla and Araweelo reflected on the criticism they received on social media. Despite the backlash Leyla experienced when sharing her story on social media, she *"just wanted people to feel like they've got a voice"*, something which she felt was taken away from her, as well as for others to not feel hindered by concerns about the community's perceptions. When Araweelo experienced negativity in her social activism, she said this affected her mentally, as she was *"trying to do such good … you know … something good …"* However, like Hawa, Araweelo framed the negativity as a means to create change,

and laughingly stated, *"bring it on!"* Finally, although Edna has applied her lived experiences of domestic abuse in her work to support and create change for those who have been affected by this, she indicated to have never specifically spoken about the sexual violence that was experienced within her former marriage, other than during a police interview. Understandably, this is not a topic Edna likes to *"freely disclose as such"* and wants to *"move on"* from. However, as she tried to decide whether to partake in this current study, Edna shared that both the anonymity of the study and its potential to help others, enabled her to come forward in this research, as *"that's always the end goal".*

Subordinate theme 2.3: When helpers harm.

The women's experiences of silencing and betrayal by their family and community were difficult to navigate, and for some, contributed towards feelings of confusion and pain. For Araweelo, Edna, and Hayat, experiences of distress appeared to have been compounded by harmful responses perpetrated at institutional levels. Araweelo, for example, had described the difficulties of living with chronic menstrual pain and genital tearing resulting from FGM/C. Her perceived experiences of medical neglect that followed, further contributed towards her distress. She explained that, despite the agony she was in, that nobody took the time to explore why she was experiencing these difficulties or how these may be ameliorated (e.g., through medical deinfibulation):

"I went to a doctor. Every single month…Because of how painful it was.

*Not **one time** was I checked…To see **why**…I was in so much pain when I was on my period. Not one time! And I ended up in the emergency room 100 times!" – Araweelo*

Whilst in some ways, it seemed Araweelo wanted reassurance that she was normal, seemingly experiencing shame or self-judgement in doing so, at the same time, her accounts suggested a need for her unique pain and story to be acknowledged. Whilst Araweelo's experiences of healthcare services abroad made her feel *"noticed",* this was reportedly not her experience of healthcare services in the UK, who she felt did not meet her needs, and which left her feeling unseen:

*There was **never** a conversation about it, not even **once**. Did a doctor ask… Like when did it happen? Or… ehm, does it cause any pain? Or… **nothing**! There's a cyst? OK, let's remove the cyst. […] (light chuckle) Until I had a surgery in [European country]… because of a cyst, as soon as they saw, you know my private parts. They were like, 'if you've had this done, right?' And I said, yeah. They asked, 'was it a long time ago?' I said 'yeah'. And I was like 'they noticed!'... Right? So then I'm thinking, 'why didn't they notice?' Why is it that the ones, the doctors in the UK that I have seen, in [name city], in [name county], why haven't they not noticed? And then I had a second operation in in [name county] here and then again. [...]. Even then I asked, (chuckle) do I look normal? (laugh) I don't know, I had this really bad habit of asking, but I said I just needed someone to give me an honest answer. And they didn't look genuine in any of their answers 'cause they didn't even know I had it done."*

- Araweelo

Both Araweelo and Edna also shared their experiences of encountering systems that lacked sensitivity to their difficult experiences and the harmful impact this had on them. For Araweelo, this related to her experiences with an FGM/C safeguarding professional:

> *No one **ever** offered me help of **any kind** when it comes to FGM, and dealing with it mentally, right? And then there was a woman in my home telling me that **she** feared or the government or don't know who it was that had this fear, that I would do it to my child, **subject** it, that, back to my child.' So I simply asked her and I started shaking from head to toe and I said, 'you come to **my** (light chuckle) house and you suspect that I would do something that traumatised me to my child'. I said, 'why don't you not just **ask** me and I could tell you yes or no.'"*
>
> *[…] She was the **first person**. […] For me to… like, who wasn't from my culture, for, to physically tell her (inaudible), but in a way that was I'm, I suspect you're gonna do it, so tell me, what happened to you? So I couldn't get through the story without, br.., I completely broke down. But it's like asking a rape victim… it's like saying a rape victim, I I have a suspicion that you're going to rape your child…So I'm gonna come… to **your** house… yeah? And check everything… and you tell me what happened, tell me how you got raped.*
>
> ***No** professional would **ever** do that! […] But with FGM… it's not seen as eh sexual violence, so therefore they think that it's OK ethically to ask such a question, 'tell me what happened'.*

Detail by detail. Whilst I sat there in tears. – Araweelo

For Edna, the lack of sensitivity was in relation to several types of professionals. Reflecting on her hospital admission due to severe, potentially life threatening, injuries after being raped by her former husband, she noted:

…I think when it came to the professionals, it was very unprofessional, and [...] it wasn't as … as sensitive process as one would like. […] And I don't think it … I don't think it was … I don't think it was managed well. I think it was very inappropriate. […] It was a thing of [...] Right. Let's just … you know what I mean … sort you out. Thank you very much. Take care. On your way. - Edna

This experience created a barrier to disclose, because *"What's there to discuss after that really? There's nothing to discuss. That's it … I got stitched up and … err …that's it…"* Edna also reflected on her encounters with the Family Court, which she described as her most traumatic experience:

*The Family Courts were the absolute worse than **everything** I've gone through. […] The Judge will tell you … do you know that rapists see their children … he has to have contact, and if you don't have contact – yeah – right? […] So, basically, you've been raped … you've got all the evidence – yeah – you've got all the medical reports there – right? Yeah? […] You've gone through all this stuff only to be traumatised … I was re- … I had to go back to my partner because the Family Courts allowed access, to have contact with my child. […] And this is the thing … so, now you're being re-*

abused again because now you're forced to have interaction with the person that you left. - Edna

It was incredibly difficult for Edna to leave her relationship. In addition to dealing with her fear of repercussions from her husband, she described how *"the system makes it very hard for you to leave …"*. Comparing the different traumatic experiences, Edna wondered what was worse, "*the fact that you know, you're going through the abuse, or the fact that … you know, now … now you're being re-abused again … within a system of family courts."* And, whilst Edna felt empowered in her ability to challenge other institutions such as social services and the police, the structures of Family Court proceedings, did not allow her to do so. Having to accept the Court's arrangements for contact at risk of negative repercussions, Edna's account described perceptions of feeling disempowered, trapped, and invalidated by the Family Courts system.

Finally, Hayat shared how her mental health deteriorated after giving birth to her children, in which labour was perceived as having triggered the traumas of sexual violence. Whilst she shared multiple examples of positive healthcare encounters after the deterioration in her mental health, harm was experienced when she and her family sought help from a Raqi (an Islamic spiritual healer). She indicated how different factors, including a lack of trust and lack of awareness, influenced her and her family's decision to visit the Raqi. Unfortunately, Hayat reported this Raqi engaged in ways that were harmful to her and contributed towards an exacerbation in her symptoms:

*Um … at one point everyone sort of left the room – it was just me and him. […] And out of nowhere, he hits me on my head. (Slight pause) … so, obviously, I fall. And when people came back, he was like "Yeah, I read a few verses and you know, she really needs Koran kind of thing." So, it was almost like … I was confused because I was like … 'I did not fall… he was… **he** hit me'… and no one was listening at the time … -Hayat*

Superordinate theme 3: "You Go Forward a Few Steps, and Then You Go Back Again A Few Steps"- The Winding Path to Recovery

This final theme describes participants' paths to recovery, which was not always perceived as a linear journey and for many, will remain an ongoing journey. As Hayat shared*, "you go forward a few steps, and then you go back again a few steps".* This theme consists of two subthemes, including '"a spiritual awakening"' and 'carving your own path'.

Subordinate theme 3.1: "A spiritual awakening".

Life in the UK was difficult to navigate for the women in this study, who expressed challenges with reconciling their Somali, Muslim, and British identities. Discrepancies in cultural and religious norms created feelings of internal conflict and injuries to different parts of the self for the women. Araweelo for example, *"contemplated suicide three times"* when she was a teenager. She attributed this to

the challenges of having to balance the different societal expectations, where she felt she *"couldn't be Western. I had to be Somalian…but then I can't be Somalian".* Despite her best efforts (e.g., trying to wear a hijab), Araweelo felt unable to meet these different expectations, as *"nothing I did was being accepted",* which left her feeling overwhelmed and *"**so** isolated"*

What seemed particularly challenging for many of the women was the apparent religious justification of sexual violence. That is, all the women, except for Leyla, shared how they had been incorrectly taught that the violence they had been subjected to, was either Islamically justifiable or permissible, thereby normalising their difficult experience. Edna, for example, reflected on her upbringing, where she had to navigate both *"cultural laws"* and *"English laws"*. She described how the lack of discussion around domestic abuse and healthy relationships, meant she did not recognise the abuse during her former marriage:

> *… nobody's aware that you don't need to have sex with your husband, if you don't want to have sex with your husband. […] He's your husband, you've got rights at home [...], it's like culture forces you, but religion is like, actually no, … you've got rights as a woman. […] - Edna*

The realisation that what they had experienced was not a religious requirement contributed towards challenging family perceptions and dynamics for some of the women. Hawa, whose father was a cleric, believed for many years that FGM/C was a part of Islam. She disagreed with this religious portrayal and expressed internal conflict about her father's role and responsibilities as a parent:

> *...but for many years I … I thought this was part of religion because that's how they portrayed it …[…] … and … um … once I've learned that it's got nothing to do with religion, I've just learned about so many things that they said was religion … […] … it was their way of disguising it … the cultural and the tradition things they disguised as part of religion. – Hawa*

Both Hayat and Araweelo reported confronting their families on the religious justifications. Hayat described this came from a place of anger. When she directly asked her religious uncle to give her *"a verse, or evidence from the Quran and Sunna that says to do FGM"*, her uncle was reported to have been shocked by this request. As her uncle *"went round in circles"* and started *"talking about hygiene and all of that stuff"*, Hayat felt unhappy with the response, telling her uncle*, 'I don't want to hear it. This is patriarchal rubbish. (Laughs) … It's men trying to control women.'"* This experience made Hayat feel as though *"no one was again listening"*. When Araweelo confronted her family, this similarly led to challenging conversations. Feeling undeterred by her family's response, Araweelo described how her decision to stop idolising her parents enabled her to challenge her family about FGM/C and marital rape, and said she demanded that they would see and hear her.

The women's accounts suggested a need to separate culture from religion, to make better sense of what happened to them. As religion played an important role in women's upbringing and lives, it was also important for them to hold onto or (re)turn to their religion, even if this was difficult at times. For example, whilst Leyla did not report on experiences of sexual violence being justified in particular ways, her difficult relationship with the Somali community did appear to have negatively affected her religious beliefs. Not wanting to be around Somali people at the time,

who she felt were *"so toxic"* to her, Leyla expressed initially wanting to *"let go of everything"*, but then reminded herself that she could not *"let one experience just change my beliefs for me"*.

Edna and Hayat perceived the increase in their religiosity as a silver lining to their challenging life experiences. Edna for example, indicated she was not a person who prayed and described herself as having been *"very far away from the Deen* [Islamic religion]*"* However, as she started praying and became more involved in her religion, she described this as the main thing that helped her. Edna perceived that this was the *"benefit"* to her circumstances, as without it, she believed she would not be where she is currently. Although what happened to her was experienced as traumatic, Edna believed everything worked out how it was meant to, giving credit to Allah [God] as the One who *"took this man away from me"*.

Hayat similarly reflected on her *"journey to Allah",* which she described as tempestuous. Her adverse life experiences, such as the spiritual abuse, created *"a lot of internal conflict"*, questioning *"Where was Allah? […] when I most needed Him?"* and *"Am I being punished?"* In the member-checking meeting, Hayat further contextualised this journey. She described a long period of going through difficult emotions (e.g., anger, confusion), which she attributed to stigma, including self-stigma. At the time, she also experienced frequent flashbacks of the spiritual abuse she had been subjected to. Whilst Hayat did not perceive this turmoil positively at the time, she now feels grateful for the experience, as with time, she learnt to build her relationship with Allah, talk to Him, and ask Him to ease her pain. She believed faith helped ease this pain and that dua [prayer] also helped to externalise her difficulties.

In addition to helping her reframe her experience, and learning to connect to the lovingness of Allah, this journey also helped her connect to her true self:

> *… because I think, looking back at it now … at the time I didn't feel it … but now I see it as a gift …[…]… it was a gift … to … He almost **shifted** me to get to know my true authentic self … um … which I was **never** connected to. I was always used to doing things for others because of what others have said … um … never really asking "What do I want?" (Slight pause) … um … and through that experience, almost like … Allah was like "Right. Time to sort of wake up now from a coma" … so, I call it a spiritual awakening … - Hayat*

Subordinate theme 3.2: Carving your own path.

Given the women's difficult experiences with their communities and various institutions, finding the right support was often challenging. Araweelo, for example, expressed a desire for therapy, but has not been able to access this. She described the negative impact of long-waiting lists, which made her feel uncared for:

> *...it's still a year later, and I haven't heard anything back and it's kind of exhausting having to … what am I supposed to do? Beg? […] Am I going to beg – please? Give me … err … err … what am I supposed to … like … I have this, I have this, I have this, I have this … like are … are you going to help me now? Like do I have to tell you everything beforehand? How traumatised I am? I don't understand how are you supposed to seek help when you do, you don't get the help that you're seeking. – Araweelo*

Leyla also had not been able to access psychological support. Having experienced several breaches of trust in her personal life, Leyla expressed feeling conflicted on whether to attend therapy, as the risk of being betrayed again by someone from her community seemed too high, and subsequently needed *"some reassurance"* from therapists:

> *… I don't know … about that … part of me wants to speak, and part of me doesn't … part of me just is paranoid, but I feel it's it the right thing to do … is to speak to them? […] and also I feel like I can't trust them … like what if it's someone's cousin? – Leyla*

Despite this, both Hayat and Hawa were able to access therapy and reported to have found this useful for their recovery. Hayat for example, appreciated how therapy helped her make connections between both her early life adversities and the spiritual abuse she experienced in adulthood:

> *… it kind of all links together … um … and I remember my therapist helping me sort of draw up the dots of even in the spiritual abuse … how it was like in the environment at the time … I feel like no one was hearing me again, my voice wasn't heard … even in the adult like … no one was sort of respecting that I'm the expert of me … - Hayat*

Across the women, irrespective of their experiences of both disclosure and help-seeking, there appeared to be common factors that potentially hindered and facilitated their experiences. Hawa and Edna's accounts, for example, suggested how perceptions of control and empowerment may differentially influence experiences of therapy. Hawa for example, initially found it difficult to trust her

therapist and was silent in her session. She believed her therapist's empowering approach allowed her to feel in charge and felt this was particularly key given the lack of power she experienced when she was subjected to FGM/C. This therefore positively influenced her experiences:

> *I think I used to go there and she was telling me "This is your session. You can do what you want. You can sit there and don't say a word. Or you can sit there and talk about anything you want. I will just literally let you guide me." … that's what she said. "And I will not ask you anything that you don't want to disclose. You will be in charge of your disclosures … everything about you're going to say … it will be* ***you****." So, for me, for her to say that kind of felt like I can … I gained trust. […] I felt like I can trust her because she was telling me everything is in my terms … because that is so important … because of what has happened. It wasn't anything that you gave consent to … so, I felt like I was in … in charge of my own talking and what I want to disclose and … because I thought therapy … they made you disclose things, so …[…]… I … I had so many assumptions about it that … that we all have …[…]… so, she removed all those assumptions for me … and it was, afterwards, just me talking about me, piece by piece. – Hawa*

For Edna, the benefits of therapy were less clear. In contrast to Hawa, it appeared Edna did not feel in control, but was *"forced into it"*, as a result of the domestic abuse incidents. The lack of choice in her engagement with therapy, combined with feelings of uncertainty around disclosure, seemed to have contributed towards her initial approach to therapy:

> *… um … I was also in therapy … um … and (slight pause) … um … yeah, it was alright. I mean … you know … it was … it was … it was good … I mean … initially, you know, I was very resistant towards it … […]… um … then, you know, you kind of open up after some time because … you know … it's just being thrown in a room with a whole … stranger … "Let's have a chat!" "Well, I don't know if I want to talk to you!" You know (laughs) – Edna*

Experiences of group support also contributed to positive experiences of disclosure and help-seeking. Both Hawa and Leyla appreciated having people they could relate to, which for Hawa felt as if *"you all had one blanket"* and which made Leyla feel like she "*was in a safe environment".* It is worth noting that Leyla's group was accessed online and anonymously, which further contributed towards her feelings of safety, as there was "*no one was there to twist stories or to use my story to spread it or there was no judgements in there … it was just confidential … no one could see that group chat".*

Perceptions of sensitivity and compassion from informal support systems, contributed towards Edna and Araweelo's experiences, both of whom had shared adverse encounters with institutions. For example, whilst Edna perceived previous encounters with professionals as insensitive and intrusive, her experiences with her child's Headteacher's seemed to be in sharp contrast with that:

> *… I think she just really was … she really was mother hen. And that's sometimes what you need … that mother hen. […] Without somebody asking you "Oh, so did you get raped today? Oh [...] what's that … what's that bruise on your face? Oh … what's that … Oh, why are you limping?" … you know …*

> *[…] … you know … with the problems I had … asking directly "Why is the police car outside your house?" You know … it's the thing of … "Are you OK? How are you? Would you like to sit down and have a cup of tea? Would you like to …? – Edna*

Araweelo discussed her experiences of sharing her stories with colleagues she met through an agency. As this work meant she would not see her colleagues again, this presented an opportunity to share her experiences. Her colleagues' interest in her wellbeing, led Araweelo to *"break down and talk to them",* whilst also wondering why her community could not respond in a similar way. Araweelo believed this experience *"fixed"* and *"actually helped"* her. Seeming to shed the shame through disclosure, she explained *"it wasn't my dirty little secret anymore".*

Both Hayat and Araweelo expressed having benefited from using their lived experiences to help others, through which they helped themselves in the process. Araweelo, for example, described that although many people have told her that she *"can't pour out of an empty glass"*, she believes *"re-pouring into their glass will help my glass become full"*.

Finally, Hayat expressed finding it helpful learning to adopt a holistic perspective on her mental health difficulties. The incorporation of both religion and mental health made "complete sense" to her, but which she had not encountered in previous mental health settings before, and which she therefore found less helpful.

Chapter 4: Discussion

Chapter Overview

In this chapter, I provide a summary and synthesis of the main findings in relation to the research aim and questions, which will be situated within the wider literature and frameworks regarding the psychosocial impacts of sexual violence. I will then describe the strengths and limitations of this research, followed by a consideration of the potential implications, and suggestions for future research. I will conclude the chapter with my reflections on the project.

4.1 Summary of Main Findings

The overall aim of this thesis was to explore the psychosocial impacts of sexual violence when it is perpetrated by someone who is known to them. Specifically, this thesis aimed to answer the following research questions:

1) How do Somali women from the UK perceive the psychosocial impacts of sexual violence when it is perpetrated by someone who is known to them?
2) What are these women's perceptions of facilitators and barriers to disclosure and psychological help-seeking?

Five Somali women were interviewed in this study, who had been subjected to different forms of sexual violence. In each case the perpetrator was known by the participant. Interview data was analysed using IPA through which I identified three

superordinate themes and seven subordinate themes. Together, these themes described the substantial impacts of sexual violence on the Somali women's wellbeing, lives, their various identities, and their relationships. These impacts appeared to interact with or be influenced by sociocultural and systemic factors. As such, in the next section, I will be discussing the findings in relation to the wider literature, which will be structured around the Bronfenbrenner (1977) based ecological framework adapted by Campbell et al. (2009). I intend to honour the idiographic nature of IPA by making references to some of the identified themes, whilst also demonstrating sensitivity to intersectional and African feminist theoretical contexts (Smith et al., 2009; Yardley, 2000).

4.1.1 Perceptions and factors at the individual level.

The subordinate theme "the many faces of pain" highlighted how, despite the varying contexts and types of abuse the women in this study have had to live through, all women described being left with physical and psychological wounds that have been difficult to heal. This subordinate theme corresponded with findings from the systematic review (e.g., McNeely & Christie-de Jong, 2016; Moxey & Jones, 2016). Several women in this study shared experiences of physical complications after being subjected to sexually violent acts, including FGM/C and rape, which varied in type (e.g., infection) and duration (shorter term and chronic). Women's accounts in the current study and in the systematic review (e.g., Johansen, 2002), suggested these painful injuries contributed towards psychosocial difficulties (e.g., impact on distress, impact on everyday functioning). For one of the women, for

example, the difficulties with urination following FGM/C reminded her of what had happened to her. This intensity and recurrence of pain could therefore be interpreted as the embodiment of pain, where it has become a part of their “lived and living” experience (Johansen, 2002, p.319)

It was noted that the severity of the trauma appeared to be overwhelming for some women to bear, which seemed to result in a variability of psychological and affective experiences. For example, some of the women described what could be interpreted as intrusion symptoms, which can be characterised as the reliving of the traumatic event(s) as if it was happening in the moment and may be triggered by seemingly innocuous or insignificant reminders (Herman, 2015). Whilst one woman experienced these as “flashbacks” whilst awake, another reported being affected by traumatic nightmares, including night terrors. Two women in this study also described difficulties that may be reflective of dissociative experiences. Herman (2015) described these as a state of surrender, where a victim may disconnect from what is happening to them. As these dissociative states are thought to prevent the traumatic experience from reaching ordinary consciousness, this may potentially inhibit the integration that facilitates healing.

These findings are also consistent with Campbell et al.’s (2009) findings, which showed a link between the sustainment of injuries relating to sexual violence and mental health difficulties, such as PTSD symptoms, anxiety, and depression. Whilst for most, physical problems appeared to directly stem from the physiological trauma to the body, it may be worth noting that for one participant in the current study, the psychological difficulties appeared to have manifested themselves physiologically (e.g., skin problems), which subsequently appeared to have

contributed towards her distress. Research focusing on both adult and younger populations have similarly documented correlations between sexual violence and the development of somatic symptoms, which can potentially be attributed to stress-related mechanisms in the body (Casanovas et al., 2022).

The subordinate theme “the ultimate betrayal” also requires further exploration. This theme described the women’s perceptions of the betrayal they had experienced by looking at these through a family and community lens. Although previous studies have reported mixed findings on the impact of the familiarity between victims and perpetrators (Campbell, et al. 2009), this appeared to be particularly pertinent to the experiences of women subjected to childhood sexual violence, which was predominantly characterised by FGM/C, in this study. What appeared evident from these women’s accounts in the current study, was the sense of betrayal that was felt. The women questioned how the people they loved and who they believed were meant to protect them, were responsible for or contributed towards the harm they were subjected to. This experience of betrayal, which has also been conceptualised as betrayal trauma (Newton & Glover, 2022), has been documented both in relation to childhood sexual abuse more generally (Finkelhor & Browne, 1985) and FGM/C specifically (Newton & Glover, 2022).

Different theoretical models, including Bowlby’s theory of attachment (Bowlby, 2012), emphasise the importance of early life relationships, through which we acquire a sense of safety in the world, or basic trust, and through which we can also develop a secure and positive sense of the self (Bowlby, 2012; Herman, 2015; Mikulincer & Shaver, 2012). These experiences are thought to form a foundation for relationships across the lifespan and foster a sense of belonging to the world around

us (Herman, 2015). The impacts may be particularly damaging when the caregiver from whom the child would seek comfort during distress, is also the source of the hurt or is perceived to have colluded with the perpetrator (Coho et al., 2019). In addition to being left with overwhelming and complex feelings that are difficult to resolve, such adverse experiences are also believed to disrupt concepts of the self that were formed in relation to others as well as undermining their belief systems that helped give them meaning (Coho et al., 2019; Herman, 2015). Victims who have been exposed to such traumatic experiences may subsequently feel abandoned and isolated with their experiences and may feel disconnected from the close relationships (e.g., family) and affiliations (e.g., religious, community) which had formed such an important part of their lives (Herman, 2015). These experiences are further complicated by variables at the higher levels of the ecological systems model, which are considered in further detail below.

4.1.2 Perceptions and factors at the micro level.

The themes “the ultimate betrayal” and “silence and silencing” highlighted how positive social reactions (e.g., encouragement and compassion) and negative social reactions (incl. breaches of trust and experiences of being silenced), coming from within women’s immediate environments (e.g., friends, family), differentially influenced the psychosocial wellbeing of women in this study, as well as their likelihood of disclosure. Evidence has highlighted the potential deteriorating effects of negative social reactions on victims’ mental health, which may be more pronounced compared to the potential strengthening impact of any positive social

reactions (Campbell et al., 2001, 2009; Littleton, 2010). Victims of sexual violence typically tend to make their first disclosures to those who are closest to them and likely expect a compassionate response (Campbell et al., 2009). Thus, when they receive unexpected negative responses from these close relations, this may be particularly difficult to contend with, and may increase barriers to further disclosures and help-seeking (Ahrens et al., 2007; Campbell et al., 2009).

4.1.3 Perceptions and factors at the meso/exosystem level.

The theme “when helpers harm” described the harms caused by health and social services, Family Courts, and religious institutions that were meant to safeguard, help, and/or protect, but were perceived to have achieved the opposite. The experiences reported in this theme suggested difficulties with mistrust and further pain. Studies have suggested that victims of sexual violence are more likely to experience negative reactions from more formal support providers and institutions than from people in their immediate environments (Ahrens et al., 2007; Campbell et al., 2009). Whilst such responses may be interpreted in the context of wider organisational pressures on such providers and institutions (e.g., limited resources), findings from the current study and systematic review suggested that perceptions of negativity from different professionals contributed towards experiences of harm, invalidation, and retraumatisation of victims. As reported by studies included in the systematic review (e.g., Jacobson et al., 2018), one woman in this study reflected on the lack of sensitivity shown by healthcare professionals, which she believed impeded her ability to make further disclosures.

This same woman also shared the detrimental impacts of her engagement with the Family Courts, which she believed had been more harmful to her than any of the abuses she had experienced within her former marriage. Similar experiences of harm were identified in a report by SafeLives (2021), which conducted a report on victims' experiences of court-related domestic abuse support, on behalf of the Domestic Abuse Commissioner. In response to these issues, various stakeholders including lawyers, commissioners, and charities, have called for changes to the Domestic Abuse Bill, including an end to the "pro-contact culture" that have prevailed in family courts (London Assembly, 2021).

Another woman in this study also reflected on the harmful impact of FGM/C safeguarding practices, where she felt a lack of sensitivity was shown to her distress in the moment and the traumatic nature of FGM/C was considered to have been minimised. Despite guidelines promoting sensitivity, integrity, and respect for the dignity of girls and women, such values appeared to not always be upheld in practice (Karlsen et al., 2020). Findings from this study and previous research highlighted both the risk of psychological distress and the risk of relational ruptures within families following FGM/C safeguarding practices (Johnsdotter, 2019; Karlsen et al., 2019, 2020). Whilst women often understand the importance of safeguarding policies to protect children from harm, current approaches risk traumatising families, and may also retraumatise women who had been subjected to FGM/C in childhood (Karlsen et al., 2019, 2020). Despite their positive intentions, these policies may therefore be potentially ineffective and possibly destabilise the relationships between families, care providers, and other institutions (e.g., schools).

It is also worth noting that aspects of support or care services may unintentionally exacerbate risk of harm. One of the women in this study, for example, indicated that the experiences of labour in itself triggered her childhood memories of FGM/C and sexual touching, which contributed towards her psychological distress. Studies in the systematic review, also reported on women's traumatic memories of FGM/C resurfacing during pregnancy and childbirth (e.g., Vangen et al., 2004). Navigating maternity care, which is inherently intimate, can indeed be particularly difficult for women who have been subjected to sexual violence, including childhood sexual abuse. Montgomery et al. (2015) conducted a study on the maternity care experiences of women subjected to childhood sexual abuse for example, highlighting how the physical aspects of childbirth (vaginal examinations and pain) and psychological aspects of both pregnancy and childbirth (e.g., loss of control over their bodies) paralleled and re-enacted their experiences of childhood sexual abuse, which was not necessarily related to perceptions of positive or empathic care. It is questioned whether the loss of autonomy over one's body in childhood abuse more generally, as well as the experiences of genital pain related to FGM/C more specifically, may help make sense of this participant's experiences as well as the women's accounts reported in the systematic review. These experiences at the meso/exosystem level therefore highlight the importance of trauma informed care (Ardino, 2014; Elliott et al., 2005).

The theme "carving your own path" highlighted the facilitators and barriers to formal psychological help-seeking. One of the women expressed a desire to access therapy, but was not able to, due to long waiting lists, which has been a widespread and longstanding issue in the UK (Punton et al., 2022). Consistent with Keating et

al.'s (2002) "circles of fear" formulation and previous research on the barriers to access for minoritised groups, several women also expressed the impact of fear and mistrust on their ability to access or engage with services. For one of the women, there was a fear that confidentiality may be breached, particularly if the therapist was related to someone from her community. This subsequently raises questions about the notion of racial or ethnic matching in therapy, which, despite its potential benefits (e.g., increased shared understandings and connections), could increase risk of intra-ethnic transference within the therapeutic dyad, which may include concerns about proximity to the therapist from the same cultural or racial group (Comas-Díaz & Jacobsen, 1991).

Another woman's feelings of fears and mistrust, as well as a lack of awareness of available support services, led her to access support from a Raqi with her mental health problems following childbirth. It is not uncommon for Muslims to put their trust in spiritual healers when experiencing ailments or seeking protection from harm (Guerin et al., 2004). However, participants may be at risk of different forms of harm (Chowdhury et al., 2022), as experienced by this participant. Both the incidents of abuse inflicted by the Raqi and the subsequent delayed access to appropriate mental health support contributed towards her retraumatisation and the deterioration in her mental health. This therefore further highlights the importance of addressing these barriers to accessing mental health services for individuals from marginalised backgrounds.

Despite the shared experiences of fears and mistrust around accessing psychological support, some of the women's accounts suggested certain factors could potentially ameliorate some of their concerns. For example, one of the women in this study, who similarly expressed ambivalence around her ability to trust her therapist, attributed her improvement in trust to her therapist's sensitive and empowering approach. This was believed to have fostered a sense of safety and control, something which she felt was particularly important given the loss of self-agency she experienced when she was subjected to FGM/C. This participant also shared her perceptions of group therapy. Whilst individual therapy enabled her to address her traumatic experiences in more depth, she appreciated the support from other women in group therapy who had similar experiences and who she felt she could identify with. The value of sharing spaces with peers who have experienced similar difficulties in life was also shared by other women in this study, which was believed to foster a sense of connection and psychological safety. These qualities may therefore represent important considerations or targets for therapy, and which are also in line with Herman's (2015) staged model of recovery.

4.1.3 Perceptions and factors at the macrolevel.

The theme "a spiritual awakening" discussed the women's varying relationships and (re)connections to the religion, which had been affected by incorrect discourses around the justification of sexual violence (e.g., that marital rape was Islamically allowed) and negative experiences with the community. Studies, though limited, have highlighted the potential detrimental impacts of macro level

factors (e.g., institutionalised racism, rape myths) on the societal acceptance of sexual violence, which risk negatively affecting victims' recoveries (Campbell et al., 2009). What appeared to be more pertinent to women's wellbeing in the current study, however, was the perceived cultural acceptance of sexual violence which they believed had been incorrectly attributed to religion by their family and wider community. For example, two of the women, who had been raped by their ex-husbands, reported how sexual violence had been incorrectly justified in the name of religion. One of these women subsequently believed that her lack of understanding of the abuse in her previous marriage could be attributed to this justification and normalisation of sexual violence.

Women who had (also) been subjected to FGM/C, similarly commented on the apparent religious justification of this practice. In line with African feminist perspectives on FGM/C (Diop et al., 2017) , women also reported on the positive connotations that were attached to the practice (e.g., braveness), as well as the negative connotations and repercussions for those who showed resistance during the procedure (e.g., being labelled as stubborn), those who considered disclosing or had disclosed their experiences (e.g., being labelled as a traitor), or those who have not (yet) undergone the procedure (e.g., ostracisation). This was similarly shared by Somali women in the systematic review, both within Somalia and more widely across the diaspora (e.g., Perovic et al., 2021). Some of the women continued to struggle to make sense of these connotations, justifications, as well as the apparent celebrations, which neither corresponded with nor ameliorated the anguish and confusion that was experienced by the women. Instead, some of the women's accounts suggested ruptures to their intersecting Muslim and Somali identities,

sense of belonging, and sense of safety within the community. This paradox was also highlighted by Coho et al. (2019), who highlighted that these may increase victims' use of avoidance related coping strategies or suppression of feelings. These can then affect the victims' perceptions of themselves, the world, and their relationships, and which are exacerbated by any FGM/C related physical difficulties and the developmental of mental health problems (Coho et al., 2019).

It is also important to consider victims' experiences in the context of migration. That is, findings from this study and systematic review, highlighted the difficulties women may encounter when moving to countries where FGM/C is not the norm (e.g., Jacobson et al., 2018). Women may subsequently have to contend with the negative views about the practice as well as managing their own internal difficulties with their body image. One of the women in this study, who had been subjected to FGM/C, described the negative impact of the label "mutilated" and the difficulties of stereotypes about women's lack of sexual feeling as a result of the practice. She expressed the negative impact of these perceptions on her mental health, intimate relationships, and which she believed could potentially impede other victims from disclosing their experiences. This therefore supports the importance of considering both the wider societal, and more culturally specific macro system factors, when working with victims from marginalised groups.

4.1.4 Chronosystem factors.

All but one of the women in this study reported multiple experiences of sexual violence and/or other forms of abuse, which were experienced at different points in

their lives, some of which was experienced concurrently. Campbell et al. (2009) identified lifetime victimisation as the main chronosystem factor that can negatively affect victims' recovery. Evidence suggests it is common for women to be subjected to multiple incidents of sexual violence, which may potentially have a cumulative impact on women's mental health (Campbell et al., 2009; Im et al., 2020). Social reactions may similarly be cumulative, therefore further increasing vulnerability to psychological distress (Campbell et al., 2009). Whilst this study did not specifically explore pathways of women's mental health outcomes, some of the accounts suggested potential connections between multiple events of sexual violence and mental health, relationships, and/or patterns of disclosure. One of the women in this study, for example, was able to make sense of her mental health difficulties after making connections between the multiple incidents of abuse she had been subjected to through therapy. These findings therefore further highlight the importance of trauma informed practices when supporting victims of sexual violence (Elliott et al., 2005).

4.2 Strengths and limitations

This appears to be the first study focusing on the psychosocial impacts of sexual violence against Somali women when it is perpetrated by someone who is known to them. The broad conceptualisation of sexual violence, which included a wider range of acts, enabled me to support findings previously reported on FGM/C (e.g., experiences of psychological and physical pain) and identify newer insights (e.g., psychosomatic impacts of sexual violence, possible impact of cumulative

traumas or revictimisation on mental health). The study also helped increase insight into the potential barriers and facilitators of disclosure and psychological help-seeking. For example, whilst perceptions of mistrust and concerns around confidentiality breaches may impede someone from disclosing their experiences or seeking mental health support, factors such as sensitive reactions, holistic approaches to mental health, and client empowerment may have positive and encouraging impacts.

In line with Yardley's (2000) criteria, this study therefore made a valuable contribution to the literature, the implications of which will be considered in the section below. I also demonstrated sensitivity to women's contexts by taking a sociocultural and systemic perspective, demonstrated commitment and rigour through my IPA approach, and was transparent in the process (Smith et al., 2009; Yardley, 2000). The involvement of Somali women with lived experiences of sexual violence was another strength (see Appendix 4), which helped improve my insight into issues affecting Somali victims of sexual violence and through which the integrity of findings was increased. My insider position in this research, through which I was able to draw from my cultural experiences and which strengthened my commitment to the conduct and eventual dissemination of this research, also strengthened this study.

This study is also subject to some limitations. First, despite some of the variability in the sample (e.g., age), all the women in this study spoke English at a high level and had settled in the UK for many years. Although the study was advertised across a range of settings, in both the English and Somali language, no participants were identified who have more limited English language abilities and/or

who may have been vulnerable to additional forms of stressors (e.g., insecure migration statuses). Whilst IPA studies aim to recruit relatively homogenous samples, it is questioned whose voices may have been excluded through my recruitment approach.

Relating to this, whilst it was not feasible to systematically record reasons for non-participation, there were two women who were unable to participate due to difficulties with their mental health and readiness for disclosure. Despite participants' experiences of psychological difficulties and their reported complexities of disclosure, it is possible that this study may have been biased towards women with more stable levels of mental health and who were more able to talk about their experiences.

Finally, similar to previous studies (e.g., Newton & Glover, 2022), this study was also potentially biased towards women with negative views on FGM/C. Women who may have more positive or neutral perspectives on the practice, and/or who do not view their experience as a form of sexual violence, may potentially present with different psychological experiences and relational dynamics (Newton & Glover, 2022). Whilst this requires further consideration, such views may be more difficult to capture given women's risk of legal and safeguarding repercussions in the UK (Karlsen et al., 2019, 2020; Newton & Glover, 2022), and thus remain underrepresented in the current study and wider literature.

4.3 Implications of findings

The findings of this study support the importance of integrating trauma informed practice across the different levels of the ecological system. Trauma informed care describes a holistic approach to understanding the role of trauma in victims' lives, which should be embedded in policy, and considers the way in which service systems may respond in ways that minimise harm and risk of retraumatisation (Ardino, 2014; Elliott et al., 2005). Given their relevant training, transferable skills, and positions of leadership across different levels of the system, Clinical Psychologists are considered to be in a particularly good position to promote and sustain trauma informed care (e.g., through consultations, staff supervision, and team formulations) (Jackson, 2017). Table 9 outlines an adaptation of Elliot et al.'s (2005) trauma informed principles for services and the corresponding implications of this study. Some of the main implications are considered in further detail below.

Table 9: Implications of the current study in correspondence with Elliot et al.'s (2005) trauma informed principles

Trauma informed services:	Corresponding study implication(s):
1) Recognise the long term and pervasive impact of sexual violence on the service user's development and commonly used coping strategies.	• E.g., meeting professional FGM/C safeguarding duties in a non-shaming, sensitive manner, which recognises the service user may be a victim as well and the potential impacts FGM/C may have had on them.
2) Identify recovery from trauma as a primary target.	• E.g., increasing access to psychological support, including close collaborations with physical health services.
3) Promote the empowerment of service users.	• E.g., facilitating group support networks to establish connections, thereby increasing their resources.
4) Amplify service users' choices and control over their recoveries.	• E.g., to work collaboratively with the service user and strengthen their sense of control.
5) Are situated in a relational partnership.	• E.g., addressing assumptions about therapy, which may improve trust and control.

Trauma informed services:	Corresponding study implication(s):
6) Create safe environments.	• E.g., be clear about confidentiality policies.
7) Highlight strengths, adaptation, and resilience, and avoid pathologising service users.	• E.g., being mindful of the impacts of potentially stigmatising labels such as “FGM”.
8) Minimise risk of retraumatisation.	• E.g., making a universal assumption of trauma.
9) Strive towards understanding the service users’ cultural context.	• E.g., developing holistic approaches in collaboration with communities, faith leaders, etc.
10) Promote service user involvement.	• E.g., supporting service users with using their lived experiences in ways that feel helpful or meaningful to them.
.	

The women in both the current study and systematic review attributed some of their experiences of harm to the lack of sensitivity to and recognition of their trauma. Trauma informed services stress the importance of recognising the enduring impacts of sexual violence on individual development and coping strategies (Elliott et al., 2005). In doing so, women can feel more validated, which may subsequently increase safety and hope (Elliott et al., 2005; Levenson, 2020). For example, whilst there may be occasions where a professional has to make service users aware of FGM/C safeguarding issues in order to protect minors from potential harm, it is important that this is done in a way that is sensitive, non-shaming, and recognises the person may have been subjected to and traumatised by FGM/C themselves thus minimising risk of retraumatisation (Coho et al., 2019; Karlsen et al., 2019, 2020).

The findings from this study also highlighted the importance of increasing access to psychological support to help women cope with the difficult psychosocial impacts. Elliot et al. (2005) advocate for either the provision of specialist support that specifically focus on trauma recovery or for this support to be integrated with other forms of care. For example, this study showed how women may require care for both

their physical and mental health, which may interlink with each other. Paediatric and adult health services may work in close alignment with corresponding child and adult mental health services to provide holistic care that appropriately addresses trauma whilst attending to other important needs (Casanovas et al., 2022).

Increased access to holistic support is also in line with NHS England's Strategic Direction for Sexual Assault and Abuse Services published in 2018 (NHS England, 2018a, 2018b). In their five-year strategy, NHS England outlines their approach based on six core priorities (e.g., introducing consistent quality standards, ensuring a workforce that is adequately trained) to enhance victims' pathway of care (NHS England, 2018a). Through this strategy, NHS England aims to improve access to treatment addressing both physical and mental health and commits to the provision of life-long trauma care (NHS England, 2018a, 2018b). Moreover, the strategy offers guidance to facilitate collaboration between community organisations to reduce the risk of victims falling through the gaps between services. The strategy finally aims to increase the public's access to information on available services, provide guidance on accessing support, and facilitate understanding regarding the long-term consequences of trauma.

The women's accounts in this study also highlighted difficulties with trust which may affect service users' ability to access or engage with services. Elliot et al.'s (2005) principles recognise the inherent power imbalances in the therapeutic dyad, and encourages professionals to reduce these, particularly given the role of disempowerment in the development of trauma. The findings suggested victims may have certain assumptions about therapy (e.g., wondering how much they should disclose), which if addressed, may help increase trust and control (e.g., by explicitly

letting someone know they are in charge of what they share). A “RICH” relationship, which is characterised as a therapeutic relationship that offers Respect, Information, Connection, and Hope, may also help ameliorate issues with trust and increase perceptions of safety, and can potentially promote relational healing (Harris & Fallot, 2001).

Trauma informed services also create environments that aim to feel safe and welcoming, and which recognise, and attempt to minimise, risk of retraumatisation (Elliott et al., 2005). This may be achieved in different ways. For example, one of the women in this study attributed her concerns about confidentiality breaches to her difficulty with accessing services. To promote feelings of safety, trauma informed services adhere to and clearly explain confidentiality, as well as limits to confidentiality, to help increase transparency and trust. Another participant described how she struggled with the direct, intrusive, nature of professionals, and said she would have valued a holistic and nurturing approach (e.g., offering a cup of tea). Services therefore need to consider how their approach and environments may be adapted to help victims feel at ease (Elliott et al., 2005). As mentioned previously, sometimes traumatic memories are triggered inadvertently and exacerbate distress (e.g., in maternity care services). As professionals may not always be aware of a person’s trauma history, it is finally important for services to adopt a universal assumption of inclusion, assuming all service users may have lived experiences of traumatic events, such as sexual violence (Harris & Fallot, 2001; Reeves, 2015). This may be particularly relevant to women from communities in which FGM/C is widely practised (e.g., Somali, Guinean) whose trauma following sexual violence may be compounded by their exposure to FGM/C (Unicef, 2022).

The final principle that will be considered here is the importance of services to understand service users' cultural contexts. The current study highlighted the complexities and interactions between women's religious and cultural identities and the perceived impacts of psychosocial distress. The findings showed how Somali women's cultural and/or religious backgrounds may influence where they seek support from, how they make sense of their experiences, and how they may heal from their traumas. Studies focusing on other communities who share similar cultural and/or religious characteristics (e.g., other African communities (e.g., Sudanese), South Asian Muslim communities), have similarly highlighted the impacts of cultural and religious perspectives (e.g., around the importance of upholding female virginity and sexual purity) on disclosure and help-seeking (Lim et al., 2022; Tankink, 2013). Therefore, trauma informed services ought to incorporate culture, religion, and any other important factors that have shaped their identities, to promote recovery in meaningful ways (Ardino, 2014; Elliott et al., 2005). They require the professional to educate themselves on service users' cultural backgrounds to help make sense of their experiences, whilst recognising their limitations in understanding, i.e., cultural competence and humility (Ardino, 2014; Danso, 2018; Elliott et al., 2005).

They may also recognise the limitations of current recommendations for the treatment of trauma. NICE guidelines on the treatment of PTSD for example, recommend individual therapies such as EMDR and CBT (National Institute for Health and Care Excellence, 2018). However, this may be less suitable for women whose mental health is socially situated and where group or community-based interventions may be more suitable, to help establish and restore the community bonds that may have been ruptured by the traumatic incidents (Newton & Glover,

2022). They may also require collaborative partnerships with and support to community groups and faith leaders, which can help identify and reduce barriers to care, increase trust and safety, and help adapt interventions that are more responsive and relevant to the person's needs (Byrne et al., 2017; Mustafa, 2021).

Promising examples of culturally competent and holistic therapeutic practices have been identified in the literature. Based on Ncube's (2006) Narrative Therapy based Tree of Life method, Byrne et al. (2017) developed the Tree of Life/Faith in Recovery approach. This intervention incorporated faith and religion and was developed in response to feedback from Muslim communities who highlighted a need for more religiously inclusive services. The intervention was developed in collaboration with a local mental health charity, co-produced with participants, and involved contributions from an Imam which were greatly appreciated by participants.

In addition to Narrative Therapy based approaches, mental health practitioners may also draw on the Power Threat Meaning Framework (PTMF) to make sense of women's experiences (Johnstone & Boyle, 2018). In contrast to mainstream approaches (e.g., biomedical models), where service users may not be specifically asked about their adverse life experiences and social contexts, the PTMF recognises the impacts of psychosocial adversities and inequalities, including racism, and interprets experiences of distress as an understandable response to these systemic issues (Johnstone & Boyle, 2018; Read & Harper, 2022). This may subsequently help increase self-understanding and improve experiences for individuals who engage with mental health services (Read & Harper, 2022). This further supports the importance of promoting holistic and collaborative approaches,

which may reduce the circles of fear that have negatively affected Black and Muslim communities (Byrne et al., 2017; Keating, 2009; Keating et al., 2002).

4.4 Suggestions for future research

Despite the varying experiences of sexual violence in the current sample, many of the women's accounts appeared to be dominated by experiences of FGM/C. It is unclear whether this was related to the complex nature of this practice, which negatively affected victims' identities, relationships, physical health, and mental health. Given that two of the women who had been subjected to FGM/C also reported other incidents of sexual violence, it is also questioned how revictimisation and retraumatisation may have influenced psychosocial difficulties. In light of the widespread prevalence of FGM/C amongst Somali women and its roots within similar structures of power as other forms of sexual violence (Batha, 2018; Macfarlane & Dorkenoo, 2015), future studies may therefore wish to further explore the relationships between multiple types of sexual violence and psychosocial outcomes, e.g., through large cross-sectional designs (Im et al., 2020).

It should also be noted this study focused on first generation adults' experiences of sexual violence in childhood and/or adulthood. It is possible that Somali girls, who may be less likely to have been subjected to FGM/C, and who are potentially second or third generation citizens, may have different relationships to community, culture, and religion, which can differentially impact their perceptions and experiences. Finally, given the sociocultural patriarchal influences on the risks and perpetuation of sexual violence, and Somali men's varying roles and responsibilities within the Somali community specifically (e.g., Jacobson et al., 2018), future

research may also wish to further explore Somali men's perceptions of sexual violence, something which was also suggested by one of the women in this study.

4.5 Conclusion

Sexual violence against girls and women is a pervasive health and social problem, affecting societies across the world. In this study, sexual violence was conceptualised as a wide-ranging term, that may include, but is not restricted to, FGM/C. The aim of this study was to explore the psychosocial impacts of sexual violence on Somali women from the UK, where the violence was perpetrated by someone who is known to them. This study also aimed to investigate Somali women's facilitators and barriers to disclosure and psychological help-seeking. The findings from this study showed that sexual violence is associated with adverse psychosocial impacts, which may be experienced by both women affected by FGM/C and those affected by other forms of sexual violence. Findings suggested that these difficult experiences and perceptions may affect Somali women's relationships with their partners, families, and communities. Consistent with previous research, this study has shown the negative impact of adverse reactions and interactions in both close relationships and with wider organisations or institutions. This study also highlighted the potential barriers and facilitators to psychological help-seeking for Somali female victims of sexual violence. This research demonstrated the importance of incorporating trauma informed principles across settings, including psychological services, to help meet the needs of Somali victims of sexual violence.

4.6 Final reflections

In the first chapter I wrote about my doubts regarding this research and as I write these final reflections, I am still not sure how I feel. Of course, I feel lots of positive emotions such as gratitude, happiness, and a sense of achievement for making it this far. However, whilst my previous research experiences before training have allowed me to keep some distance from topics, this topic hits much closer to home, where it almost quite literally feels like I am wearing my heart on my sleeve, ready for others to pick it apart, as soon as I press “send”. I also do not think I was fully prepared for the emotional labour I would be taking on. This research took me on a professional journey, stretching my mind, in ways I could not have imagined. However, as I went through the various stages of the study, I realise I also went on a personal journey, wondering how the themes in the study apply to my life, and to my family and wider community. I started to reflect on notions around silence and pain in my upbringing and culture, which I had never really questioned, until I examined the literature. My aim for this research was always community focused, and I therefore never even considered how it would apply to my own life. Perhaps the findings from this research will facilitate further conversations and action not just for the wider community, but for myself and my family as well.

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Appendix 1: Reflective Accounts

It was the day before my MRP presentation. [...] I felt this resistance, [...] I also felt quite emotional, particularly re-reading some of the older Tweets, and wasn't quite sure why. I had already been exposed to this before in my work and have read about this quite extensively. Perhaps this topic was hitting closer to home than I expected. Given that I haven't spent much time talking about this, there were still a lot of unprocessed emotions, unanswered questions, and conflicting thoughts. Part of me questioned whether this perhaps wasn't the best topic for me to pursue and investigate for the next two years. However, reading through the tweets also reminded me of the bravery of so many Somali women. Hearing that some of these women had been silenced, criticised, and threatened re-highlighted the importance of this topic for me. I did not want to partake in this culture of silence. It also further motivated me to ensure my project does justice to my community. [....]

My first interview – yay! [...] I also realised I had entered this project with assumptions around the severity or impact of trauma around different types of sexual violence. I expected that FGM/C would have less of an impact than other forms of sexual violence, when this person expressed the opposite through her accounts. Because FGM/C is not really spoken about in my family and described as just something that they had done to them a long time ago, with little overt emotional connotations, I think I somehow and subconsciously even normalised it? I'm not sure if normalising is not quite the right word, but I must have, at some level, to make those assumptions. I wonder what other assumptions I subconsciously hold and how I can minimise its impact on the remaining interviews and data analysis.

I was given a contact person of a man who would potentially be able to help with my recruitment. When he contacted me after I sent through my research materials, I was pleased. Perhaps he had a few good suggestions in mind to help facilitate recruitment. He did, which I appreciate. However, he also was critical of my inclusion of FGM under the 'sexual violence' umbrella. He believed that I was misconceptualising FGM and that this is not how it is perceived by the Somali community. I explained how I had come to this position (including survivor's stories and information from the wider literature). I also showed empathy and validation that opinions may differ with regard to this definition. I accept, and anticipated, such responses. I even address it in the interview schedule. But there was something about this conversation that really frustrated me. Was it because he was a man that was making these assertion? Perhaps it was his "advice" that insinuated that I should connect more with the Somali culture. Does me choosing this definition or perhaps subject as a whole alienate me from the community? It was the opposite of what I have intended. I am doing this *for* the community. I decided not to get into a debate with him and disengaged.

I have completed interview two. I feel so privileged she was able to share her account with me. Sadly, her story resonates with so many Somali victims, and possibly other communities. Something that struck me was her reflection on the interview. Understandably she was nervous at the beginning. Although the interview appeared to have been a positive experience for her, she said she had to prepare herself for any possible experience, including negative experiences, given what she has been through with people in her life. It makes total sense. But it saddened me that this was a worry. I also realised I should be mindful, not just as a researcher, but also a clinician, that I may not represent a person or space of safety. Who knows what a person has been through and what responses they've had before they were able to take that step to participate in the research or get a referral for that appointment.

I have been in the analysis stage for a while now and despite remembering each interview so clearly, I'm amazed at how much else you learn upon re-listening, and re-reading participants' words, how much is conveyed in the non-verbal, and thinking hard on how to capture the different nuances. I also underestimated the emotional impact of listening and reading through participants' accounts over and over again and have to encourage myself to take sufficient breaks, to help me cope with the emotional impact of their stories. As I have been coding and developing themes, I have also found myself feeling quite conflicted on what to include and not include, not wanting these important messages to be lost. [...]

Analysis update: As I've gone through this interview, I noticed she drew a lot upon her professional knowledge and experience, whereas needed more encouragement to reflect on her lived experience. Did drawing on professional experience feel safer/more manageable? Given her mixed feelings on therapy, I also wonder how my position as a trainee hindered her ability to vocalise her experience of therapy and therapists.

As I am reading through the transcript and taking my notes, I notice some of questions are quite value laden and presumptuous. Thinking back to the other transcripts I have analysed, this is not the first time this has happened. Looking into it more specifically, it seems to have occurred at times, where the participants' experiences seemed familiar. Either through direct similarities in experiences or indirect when I have observed it or have known it to happen to someone else. Whilst these assumptions were not necessarily incorrect and driven by what the participants had said, I think there was an element of me overidentifying with what had been said. I wonder if this influenced some of the participants' responses; whether it increased their agreeability at all or whether what I asked or assumed correctly captured their experiences. This also makes me wonder about the strengths of insider positions in research, but also its limitations.

Appendix 2: Overview of Information Sources

Table 10: Overview of the information sources

Information source	Details:
Bibliographic databases	'MEDLINE'; 'PsycArticles'; 'Embase'; 'CINAHL (Plus)'; 'Pubmed'; 'Scopus'; 'Social Care Online', and 'Sage Journals'.
Individual journals	'Gender & Society'; 'Journal of Gender Based Violence'; 'Journal of Interpersonal Violence'; 'Violence against Women'; 'Trauma, Violence & Abuse'; 'Sexual Abuse; Journal of Sexual Aggression'; 'Violence and Victims'; 'Journal of Family Violence'; 'Psychology of Women Quarterly', and 'Journal of Aggression, Maltreatment & Trauma'.
Unpublished/grey literature	'DART Europe E Theses Portal'; 'ETHOS'; 'Proquest dissertations and theses global'; 'King's Fund', and 'OpenGrey'.
Websites	'Google Scholar'; 'IMKAAN', 'Centre for Mental Health'; 'UN Women Global Database on Violence against Women'; 'Justice.gov'; 'World Health Organisation'; 'Fawcett Society'; 'Women's Aid', and 'Rape Crisis England and Wales'.

Appendix 3: Quality Assessment Outcomes

Summaries of the CASP (qualitative research), MMAT (mixed method research), and the AXIS (cross-sectional research) outcomes are described in tables 7, 8, and 9 below.

Table 11: Outcomes of the CASP assessment

	1) Was there a clear statement of the aims of the research?	2) Is a qualitative methodology appropriate?	3) Was the research design appropriate to address the aims of the research?	4) Was the recruitment strategy appropriate to the aims of the research?	5) Was the data collected in a way that addressed the research issue?	6) Has the relationship between the researcher and participants been adequately considered?	7) Have ethical issues been taken into consideration?	8) Was the data analysis sufficiently rigorous?	9) Is there a clear statement of findings?	10) How valuable is the research?
Karlström et al. (2020)	Yes	Yes	Yes	Yes	Yes	Can't tell	Yes	Yes	Yes	Emphasises the importance of giving women space to process traumatic experiences relating to FGM and to sensitively consider their cultural contexts.
Fried et al. (2013)	Yes	Yes	Yes	Yes	Yes	No	Yes	Yes	Yes	Findings demonstrate changing attitudes towards the practice of FGM yet the continuous stigmatisation of women who have not undergone FGM.
Isman et al. (2013)	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Can't tell	Yes	This study demonstrated the need for further research on the value of FGM/C and

	1) Was there a clear statement of the aims of the research?	2) Is a qualitative methodology appropriate?	3) Was the research design appropriate to address the aims of the research?	4) Was the recruitment strategy appropriate to the aims of the research?	5) Was the data collected in a way that addressed the research issue?	6) Has the relationship between the researcher and participants been adequately considered?	7) Have ethical issues been taken into consideration?	8) Was the data analysis sufficiently rigorous?	9) Is there a clear statement of findings?	10) How valuable is the research?
										offers suggestions on strategies to discontinue FGM/C (e.g., the involvement of religious leader in public health work).
Jelle et al. (2021)	Yes	Yes	Yes	Yes	Yes	No	Yes	Yes	Yes	The study demonstrates the significant problems associated with forced evictions of internally displaced individuals and highlights priorities for short- and long-term responses.
Johansen (2002)	Yes	Yes	Yes	Yes	Yes	No	Can’t tell	Can’t tell	Can’t tell	This research adopts a unique medical anthropological approach to understanding the lived bodily

	1) Was there a clear statement of the aims of the research?	2) Is a qualitative methodology appropriate?	3) Was the research design appropriate to address the aims of the research?	4) Was the recruitment strategy appropriate to the aims of the research?	5) Was the data collected in a way that addressed the research issue?	6) Has the relationship between the researcher and participants been adequately considered?	7) Have ethical issues been taken into consideration?	8) Was the data analysis sufficiently rigorous?	9) Is there a clear statement of findings?	10) How valuable is the research?
										experiences relating to FGM/C induced pain amongst Somali women.
Karlsen et al. (2019) Karlsen et al. (2020)	Yes	Yes	Yes	Yes	Yes	No	Yes	Can't tell	Can't tell	The study provides an important contribution on the negative and potentially retraumatising impacts of FGM safeguarding policies on British Somali communities.
Kartal and Yazici (2021)	Yes	Yes	Can't tell	Yes	No	No	Yes	Yes	Yes	This research raises awareness on attitudes towards and impacts of FGM and the values that contribute toward its maintenance.
Khaja (2004)	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Can't tell	Can't tell	This research highlights the importance of

	1) Was there a clear statement of the aims of the research?	2) Is a qualitative methodology appropriate?	3) Was the research design appropriate to address the aims of the research?	4) Was the recruitment strategy appropriate to the aims of the research?	5) Was the data collected in a way that addressed the research issue?	6) Has the relationship between the researcher and participants been adequately considered?	7) Have ethical issues been taken into consideration?	8) Was the data analysis sufficiently rigorous?	9) Is there a clear statement of findings?	10) How valuable is the research?
Khaja et al. (2009) Khaja et al. (2010)										culturally sensitive language in research and discussions and collaborative work with marginalised communities who are negatively and disproportionally affected by policies and practices.
McNeely and Christie-de Jong (2016)	Yes	Yes	Can't tell	Yes	Yes	Yes	Yes	Yes	Yes	Findings from this study illustrated both the impacts of FGM/C as well as the changes in perspectives regarding this practice following migration.
Moxey and Jones (2016)	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	This appeared to be the first qualitative study that explored experiences of

	1) Was there a clear statement of the aims of the research?	2) Is a qualitative methodology appropriate?	3) Was the research design appropriate to address the aims of the research?	4) Was the recruitment strategy appropriate to the aims of the research?	5) Was the data collected in a way that addressed the research issue?	6) Has the relationship between the researcher and participants been adequately considered?	7) Have ethical issues been taken into consideration?	8) Was the data analysis sufficiently rigorous?	9) Is there a clear statement of findings?	10) How valuable is the research?
										antenatal and intrapartum care in England in a sample of Somali women exposed to FGM/C.
Oguntoye et al. (2009)	Yes	Yes	Yes	Yes	Yes	No	Can't tell	Can't tell	Can't tell	This research used a novel and innovative participatory research method to help illuminate the perspectives and lived experiences of Somali women in the UK.
Vangen et al. (2004)	Yes	Yes	Can't tell	Yes	Yes	No	Yes	Can't tell	Yes	This study highlights current gaps and concerns regarding the perinatal healthcare of Somali women exposed to FGM/C and the need for empowering Somali

	1) Was there a clear statement of the aims of the research?	2) Is a qualitative methodology appropriate?	3) Was the research design appropriate to address the aims of the research?	4) Was the recruitment strategy appropriate to the aims of the research?	5) Was the data collected in a way that addressed the research issue?	6) Has the relationship between the researcher and participants been adequately considered?	7) Have ethical issues been taken into consideration?	8) Was the data analysis sufficiently rigorous?	9) Is there a clear statement of findings?	10) How valuable is the research?
										women and healthcare professionals.
Ziyada et al. (2020) Ziyada et al. (2021)	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Can't tell	Findings offered an important insight into inter and intra-cultural variations in attitudes towards and experiences of FGM/C and FGM/C related services as well as current gaps in policies and clinical care management affecting women's accessibility to services.

Table 12: Outcomes of the MMAT assessment

	Are there clear research questions?	Do the collected data allow to address the research questions?	Is there an adequate rationale for using a mixed methods design to address the research question?	Are the different components of the study effectively integrated to answer the research question?	Are the outputs of the integration of qualitative and quantitative components adequately interpreted?	Are divergences and inconsistencies between quantitative and qualitative results adequately addressed?	Do the different components of the study adhere to the quality criteria of each tradition of the methods involved?
Jacobson et al. (2018) and Perovic et al. (2021)	Yes	Yes	Yes	Yes	Yes	Yes	Can't tell
Morison et al. (2004)	Yes	Yes	Yes	Yes	Yes	Yes	Can't tell
Vloeberghs et al. (2012)	Yes	Yes	Yes	Yes	Yes	Yes	No

Table 13: Outcomes from the AXIS assessment relating to Michlig (2019) and Michlig et al. (2019)

Question:	Yes	No	Don't know/Comment
1. Were the aims/objectives of the study clear?	X		
2. Was the study design appropriate for the stated aim(s)?	X		
3. Was the sample size justified?		X	
4. Was the target/reference population clearly defined? (Is it clear who the research was about?)	X		
5. Was the sample frame taken from an appropriate population base so that it closely represented the Yes target/reference population under investigation?			X
6. Was the selection process likely to select subjects/participants that were representative of the target/reference population under investigation?			X
7. Were measures undertaken to address and categorise nonresponders?		X	
8. Were the risk factor and outcome variables measured appropriate to the aims of the study?	X		
9. Were the risk factor and outcome variables measured correctly using instruments/ measurements that had been trialled, piloted or published previously?			X
10. Is it clear what was used to determined statistical significance and/or precision estimates? (e.g., p values, CIs)	X		
11. Were the methods (including statistical methods) sufficiently described to enable them to be repeated?	X		
12. Were the basic data adequately described?	X		
13. Does the response rate raise concerns about non-response bias?		X	
14. If appropriate, was information about non- responders described?		X	
15. Were the results internally consistent?	X		
16. Were the results for the analyses described in the methods, presented?	X		
17. Were the authors' discussions and conclusions justified by the results?	X		

Question:	Yes	No	Don't know/Comment
18. Were the limitations of the study discussed?	X		
19. Were there any funding sources or conflicts of interest that may affect the authors' interpretation of the results?		X	
20. Was ethical approval or consent of participants attained?	X		

Appendix 4: Involvement of Experts by Experience

Table 14: Overview of involvement of Experts by Experience

Stage	Issue/question	Consultation input	Outcome/action point
Refinement of research topic	• Given the stigma around sexual violence and the expected difficulties in recruitment, should this research be pursued or broadened to gender-based violence? • Should FGM/C be conceptualised as a form of sexual violence? • How does sexual violence intersect with other forms of violence?	• An emphasis on the need for research on this topic and the importance of not getting discouraged, even in the face of potential negativity. • Conceptualisation of FGM/C as a form of sexual violence. It was questioned why else people would be interested in little girls' genitals. • Highlighting the intersections between sexual violence and other common forms of abuse.	• Despite being rooted in similar the systemic gender inequalities and oppression, the topic was narrowed down from gender-based violence to sexual violence, following further discussions and supervision, as it risked being potentially too broad as a research topic. • After engaging in further discussions, reflections, and reviewing views shared online by other people with lived experiences of FGM/C (Batha, 2018), it was decided to consider FGM/C as a form of sexual violence for the purpose of this thesis, in line with the WHO definition of sexual violence. • Keeping in mind the intersections of violence at all stages of the research.
Development of interview schedule	• Feedback on interview schedule: what else should be considered or changed?	• To keep in mind the different views on the conceptualisation of FGM/C as a form of sexual violence.	• Highlighting in the interview schedule that FGM/C can be conceptualised as sexual violence, but that not everyone sees it that way.
Data collection	• Support with advertising the study.	• Supporting the advertisement of the study by sharing the study information with potential participants and sharing contact details to those who agreed.	• One participant was recruited into this study through one of the consultants. This participant highlighted the importance of trusting the consultant in helping her decide to take part.

Stage	Issue/question	Consultation input	Outcome/action point
Data analysis	• Review of the findings – reflections, translations, and credibility.	• Upon expressing concerns on the sensitivity of some of the quotes, the consultant validly questioned: "sensitive to who?" and the importance of sharing the stories as they are, even if they are hard to read or hear. • Support with translating some Somali words/phrases.	• To keep the quotes as they are as a way of honouring participants' voices and sense of agency to disclose. • To update translations whilst recognising the difficulties to translate from Somali to English.
Dissemination	• What might be the most suitable avenues for and forms of dissemination?	• Initial discussions around dissemination have been had with one of the consultants, who expressed interest in supporting the dissemination of findings.	• To meet with the consultant and plan and/or gather ideas on dissemination, depending on her capacity.

Appendix 5: Study Research Posters

Figure 6: Somali version of the research poster

Figure 7: English version of the research poster

Appendix 6: Participant Information Sheets

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WARQADA KU QORAN TAHAY XOGTA MUHIIMKA U AH KA QAYBGALAHA

Waxaa lagugu casuumayaa inaad ka qaybqaadato daraasad cilmi baaris ah. Kahor intaadan go'aansanin haddii aad rabto inaad ka qaybqaadato, waxaa muhiim ah inaad fahanto waxa daraasaddu ku saabsan tahay, sababta daraasadda loo samaynayo, iyo waxa dhici doona markaad ka qaybqaadato. Fadlan wakhti qaado si aad u akhriso warqada ku qoran tahay xogta muhiimka ah si aad taxadar uleh oo kala hadal dadka kale, haddii aad jeceshahay. Haddii wax kasta uusan kuu caddayn ama haddii aad jeceshahay macluumaad dheeraad ah, fadlan ha ka waabanin inaad ila soo xiriirto adigoo isticmaalaya faahfaahinta xiriirka ee ku qoran dhammaadka xaashida.

Tumaan ahay?
Magacaygu waa Muna Dubad oo waxaan ahay tabobarre Soomaaliyeed oo ku takhasusay cilminafsiga oo wax ka barta Jaamacadda Hertfordshire. Sida qayb ka mid ah tababarkayga, waxaan qabani daraasad aan ku eegayo saamaynta xadgudubyada galmada haweenka ka soo jeeda qurba joogta soomaaliyeed oo uu fuliyay qof ay yaqaaniin. Waxaan sidoo kale xiiseynayaa waaya aragnimada haweenkanoo ah inay dadka u sheegaan wax kusaabsan wixii ku dhacay iyo waaya aragnimadooda caawimaad raadinta. Sidoo kale qayb ka mid ah kooxda cilmibaarista waxaa kujira Hoda M Ali (Kalkaaliso Soomaaliyeed, u halganto gudniinka Fircooniga iyo badbaadiso, iyo la taliyaha mashruuca/ cilmibaarto), Ayan Hussein (Shaqaale Sare oo Soomaali ah, Daaweeyso Iskudhafan oo Tababar ah, iyo la taliyaha mashruuca/cilmibaarto), Dr. Jacqui Gratton (Kutakhususe Cilminafsiga, Macallin ah, iyo Kormeeraha Gudaha), iyo Dr Angela Byrne (Kutakhususe Cilminafsiga iyo kormeeraha dibadda).

Waa maxay sababta cilmibaaristan loo sameeynayo?
Xadgudubka galmadu waa dhibaato baahsan oo saamaysa dadka aduunka oo dhan, taas oo keeni karta cawaaqib jidheed, maskaxeed iyo bulsho oo qoto dheer. In kasta oo aan ognahay in xadgudubyada galmadu ay sidoo kale saamayso bulshada Soomaaliyeed, ma aha wax inta badan laga doodo oo la fahmi karo ayna adag tahay in laga hadlo. Sababtaas awgeed, ma cadda sida ay ugu badan tahay bulshada Soomaaliyeed, sida ay u saamayso haweenka Soomaaliyeed, iyo waa maxay arrimaha keenaya in la fududeeyo ama ay si aada u adkaato in wixii dhacay laga hadlo oo taageero loo raadiyo. Sidaa darteed, waxaan u fulinaynaa daraasaddan si aan si fiican u fahamno arrintan oo waxaan rajeyneynaa inaan baran doono waxa taageera, haddii ay jiraan, in loo baahan yahay.

Qofkee lagu casuumayaa inuu ka qaybqaato?
Waxaan jeclaan lahaa inaan casuumo haweenka Soomaaliyeed ee da'doodu tahay 18 sano jir ama ka weyn kuwaas oo sida joogtada ah ugu nool UK oo ay la kulmeen xadgudub galmo oo u geystay qof ay garanayaan. Tani waxa laga yaabaa inuu kujiro Gudniinka/Goynta xubinta taranka haweenka ama noocyada kale ee xadgudubka galmada. Marka la eego wakhtiga go'an, waayo aragnimadani waxa laga yaabaa inay dhacday carruurnimada, baaluqidda iyo/ama qaangaarnimada. Si kastaba ha ahaatee, waa in ay dhacday in ka badan laba sano ka hor oo ayna ku jirin xadgudubka galmada lala kulmay qayb ka mid ah dagaalka. Sababo la xiriira suurtagalnimada xaaladaha murugada leh ee daraasadda, sidoo kale ma awoodi doono in aan ku daro haweenka la kulmay murugo nafsiyeed oo daran (tusaale ahaan, dabeecadaha is waxyeeleeya ama fikradaha soo afjarida nolasha qofka) lixdii bilood ee la soo dhaafay si loo yareeyo khatarta waxyeellada.

Miyeey tahay inaad ka qayb qaadato?
Maya, adiga ayay ku xiran tahay inaad ka qaybqaadanayso iyo haddii kale. Waxaa lagaa codsan doonaa inaad saxiixdo foomka oggolaanshaha si aad u sheegto inaad ku faraxsan tahay ka qaybqaadashada. Si kastaba ha ahaatee, weli waad bedeli kartaa niyadaada oo waad joojin kartaa ka qaybgalka mar kasta inta lagu kudo jiro daraasadda. Haddii tani dhacdo, fadlan ogow inaan lagaaga baahneen inaad bixiso

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wax sabab ah oo aad u joojinayso daraasadda. Haddii aad bedesho niyadaada daraasadda ka dib, taasi sidoo kale waa OKAY. Kaliya aqbal qof ka tirsan kooxda cilmibaarista inuu ogaado. Fadlan ogow inaad xogtaada kala bixi karto laba toddobaad gudahooda marka waraysiga la dhammeeyo (markaas ka dib waxaa bilaabmaya falanqaynta xogta, oo ka bixitaankuna macquulgal ma noqon doono).

Maxaa dhici doona inta lagu kudo jiro daraasadda?
Haddii aad xiisaynayso inaad ka qaybqaadato daraasaddan, fadlan iimayl ii soo dir. Ka dib waxaan kula yeelan doonaa wicitaan si aan u dulmaro daraasadda si faahfaahsan, u hubiyo inaad buuxisay shuruudaha ka mid noqoshada daraasadda, oo aan ka jawaabo su'aalaha aad qabtid. Waxaan ku tusi doonaa su'aalaha wareysiga. **Lagaama** codsan doono inaad ka hadasho wax kusaabsan faahfaahinta xadguddubka galmada taas oo adiga kugu dhacday, taa badalkeeda, diirada waxaa la saaraya saamaynta ay kugu yeelatay iyo caawin raadin kasta.

Marka aad ogolaato inaad ka qayb qaadato daraasadda, waxaan kugu casuumi doonaa inaan waraysi kula yeesho. Waxaan hiigsanayaa inaan waraysigan ku qaado habka Fogaan araga, kaasoo la filayo inuu qaato ku dhawaad 60-90 daqiiqo. Codka laga duubo waraysigan waa la kaydin doonaa. In kasta oo aan haysan doono kamarad inta lagu kudo jiro waraysiga, kaama filayo inaad sidaas oo kale samayso. Haddii aadan ku qanacsanayn isticmaalka madasha sida habka Fogaan araga, waxaan ka wada hadli karnaa ikhtiyaaro kale. Intaa waxaa dheer, iyada oo ay kuxidhantahay tallooyinka dawladda iyo Jaamacadda, goobta, iyo dookhyadaada, waxaan sidoo kale samayni karnaa waraysi fool ka fool ah. Kadib markuu dhamaado waraysiga, waxa lagu siin doonaa calaamad muujinaysa wakhtiga lagu qaatay ka qaybgalka daraasadda iyo shaqada niyadeed oo imaan karta ee la xidhiidha ka hawlgalkaada. Haddii aad jeceshahay, waxaan sidoo kale kula wadaagi karaa natiijadayda dhamaadka daraasadda.

Waa maxay dheefaha macquulka ah ee ka qaybqaadashada?
In kasta oo ka qaybgalka daraasaddan laga yaabo in aanay kuu lahayn dheefooyin toos ah hadda , Ka qaybgalkaaagu wuxu noo suurta galinayaa inaan si wanagsan u fahanno saamaynta xadgudubyada galmo ee haweenka Soomaaliyeed iyo sida ugu wanaagsan ee loo caawin karo.

Waa maxay qasaaraha macquulka ah ee ka qaybqaadashada?
Ka qaybqaadashada daraasaddan, waxa laga yaabaa inay si la fahmi karo ay kuu keento Dareen kugu adag. Waxaan isku dayi doonaa intii karaankayga ah inaan kaadhigo mid qanacsan sida ugu macquulsan inta lagu kudo jiro daraasadda oo aan qaado dhammaan tillaabooyinka suurtagalka ah si aan u yareeyo waxyeelada. Fadlan sidoo kale ogow inaadan u baahnayn inaad ka jawaabto su'aal kasta oo aadan rabin ka jawaabisteeda oo aad xor u tahay inaad joojiso wakhti kasta inta lagu kudo jiro daraasadda adoon bixinin sabab. Haddii aad murugooto ama aad dareento qanac la'aan daraasadda ka dib, fadlan ii soo sheeg. Waxaa sidoo kale laga yaabaa inaad rajaynayso ood xiriir la samaysato adeegyada bixiya taageerada kuwaas oo ku siin kara caawimaad. Liis ay ku jiraan ururada ayaa lagu lifaaqay dhamaadka warqada xogtu ku qoran tahay.

Maxaa ku dhici doona macluumaadka aad bixiso?
Dhammaan doodaha inta lagu kudo jiro wareysiga waa la qarin doonaa oo waxaa loo illaalini si qarsoodi ah. Waxa kaliya ee ka reeban tani waa haddii ay caddaato in ay jirto degdeg, hadda, mustaqbalka, iyo/ama khatar waxyeelo halis ah kuu geysata adiga ama qof kale iyo ka dibna mas'uuliyaddayda xirfadeed waa inaan kugu calaamadeeyo adeegyada ku siin kara macluumaad iyo taageero dheeraad ah. Xaalado aad u adag, waxaan sidoo kale u baahan doonaa inaan gargaar ka raadsado kooxda cilmibaarista (kor lagu qeexay) si aan dadka u badbaadiyo. Waxaan isku dayi doonaa inaan ku ogeysiiyo haddii ay tahay inaan sameeyo tan. Dhammaan xogta waxa si sugan loogu kaydin doonaa erayga sirta ah ee serfarka la ilaaliyo. In kasta oo xogta waraysiga laga yaabo in dibadda loo qoro iyadoo la istimaalayo adeegga qoraalka xirfadda, qoraaladan sidoo kale waxay noqon doonaan kuwo qarsoodi ah.

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Haddii aad dooratid in uu joogo fasire fadhiga, markaas fasire xirfadle ah ayaa la isticmaali doonaa. Fasiraha waxaa laga codsan doonaa inuu ku illaaliyo dhammaan macluumaadka meel gaar ah. Ka dib marka daraasadda la dhammeeyo, macluumaadkaaga waxaa laguu illaalin doonaa si sugan muddo 5 sano ah, taas oo ah sharuudo Jaamacadda. Xogta waa la burburin doonaa tani ka dib. Ugu dambeyntii, waxaan sidoo kale wax ka qori doonaa natiijooyinka ku jira qoraalkayga Jaamacadda iyo sidoo kale inaan usii daayo natiijooyinka kormeerayaashayda (tusaale ahaan, joornaalada cilmibaarista, bandhigyada shirarka, kooxaha bulshada, warbaahinta bulshada). Wax kasta oo aan wax ka qorno ama aan soo bandhigno waxay noqon doonaan kuwo qarsoodi ah.

Qofkee dib u eegay daraasaddan?
Daraasaddan waxaa dib u eegay:

- Jaamacadda Caafimaadka ee Hertfordshire, Sayniska, Enjineernimada iyo Guddiga Anshaxa Tignoolajiyada oo leh Awood loo Wakiishay
- Nambarka borotokoolka UH waa: **LMS/PGR/UH/04648**

In kasta oo aanu rajaynayno in aanay arrintu sidaas ahayn, haddii aad qabto wax cabasho ah ama walaac ah oo ku saabsan qaab kasta oo laguu wajahay ama laguula dhaqmay intii lagu kudo jiray daraasaddan, fadlan u qor Xoghayaha Jaamacadda iyo Diiwaan-hayaha ciwaanka soo socda:

Xoghayaha iyo Diiwaan-hayaha
Jaamacadda Hertfordshire
College Lane
Hatfield
Herts
AL10 9AB

Sideen ku heli karaa wax badan oo ku saabsan daraasadda?
Wixii su'aalo ah ama walaac dheeraad ah, fadlan kala xiriir midkood Muna (m.dubad@herts.ac.uk), Dr Jacqui Gratton (j.gratton@herts.ac.uk) ama Dr Angela Byrne (angela.byrne7@nhs.net) adiga oo adeegsanayo iimayl.

Aad baad ugu mahadsantahay akhrinta macluumaadkan iyo tixgelinta aad siisay ka qaybqaadashada daraasaddan.

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PARTICIPANT INFORMATION SHEET

You are being invited to take part in a research study. Before you decide if you want take part, it is important for you to understand what the study is about, why the study is being done, and what will happen when you take part. Please take time to read this information sheet very carefully and talk about it with others, if you would like to. If anything is not clear or if you would like more information, please do not hesitate to contact me using the contact details at the end of the sheet.

Who am I?
My name is Muna Dubad and I am a Somali Trainee Clinical Psychologist studying at the University of Hertfordshire. As part of my training, I am conducting a study exploring the impacts of sexual violence on women from the Somali diaspora carried out by someone who is known to them. I am also interested in these women's experiences of telling people about what happened to them and their experiences of help-seeking. Also part of the research team are Hoda M Ali (Somali Nurse, FGM activist and survivor, and project consultant/co-researcher), Ayan Hussein (Somali Senior Peer Worker, Trainee Integrative Therapist, and project consultant/co-researcher), Dr Jacqui Gratton (Clinical Psychologist, Lecturer, and Internal Supervisor), and Dr Angela Byrne (Clinical Psychologist and External Supervisor).

Why is this research being done?
Sexual violence is a widespread problem affecting people across the world, which can have profound physical, psychological, and social consequences. Although we know that sexual violence is also experienced in the Somali community, it is not something that is often discussed and understandably difficult to talk about. Because of this, it is not clear how common it is in the Somali community, how it affects Somali women, and what factors make it easier or more difficult to talk about what happened and seek support. Therefore, we are carrying out this study to understand this issue better and we hope we will learn what support, if any, is needed.

Who is being invited to take part?
I would like to invite Somali women aged 18 years or over who permanently live in the UK and have experienced sexual violence by someone who is known to them. This may include Female Genital Mutilation/Cutting or other forms of sexual violence. With regard to the timeframe, this experience may have occurred during childhood, adolescence and/or adulthood. However, it must have happened more than two years ago and does not include sexual violence experienced as part of a war. Due to the potentially distressing nature of the study, I will also not be able to include women who have experienced severe psychological distress (e.g., self-harming behaviours or thoughts of ending one's life) in the last six months to reduce the risk of harm.

Do you have to take part?
No, it is up to you whether you take part or not. You will be asked to sign a consent form to say that you are happy to take part. However, you can still change your mind and stop participating at any point during the study. If this happens, please know that you do not have to give any reasons for stopping the study. If you change your mind after the study, that is OK too. Just let someone from the research team know. Please note that you can withdraw your data within two weeks of the interview completion (after which point the data analysis will begin, and withdrawal will not be possible).

What will happen during the study?
If you are interested in taking part in this study, please email me. I will then arrange a call with you to go through the study in more detail, check whether you meet the inclusion criteria for the study, and answer any questions you may have. I will show you the interview questions. You will **not** be asked to talk about

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the detail of the sexual violence that has happened to you, instead, the focus is on the impact it has had on you and any help-seeking.

Once you have consented to taking part in the study, I will invite you to an interview. I aim to conduct this interview on Zoom, which is expected to take approximately 60-90 minutes. An audio recording of this interview will be saved. Although I will have the camera on during the interview, you are not expected to do the same. If you do not feel comfortable with using a platform such as Zoom, we can discuss alternative options. Moreover, depending on government and University guidelines, your location, and preferences, we can also arrange a face-to-face interview. After the interview finishes, you will be provided with a token in recognition of the time spent participating in the study and the potential emotional labour associated with your involvement. If you would like, I can also share my findings with you at the end of the study.

What are the possible benefits of taking part?
Although participating in this study may not have direct benefits for you right now, your participation will enable us to better understand the impact of sexual violence on Somali women and how to best help them.

What are the possible disadvantages of taking part?
Taking part in this study, may understandably bring up difficult feelings for you. I will try my best to make you as comfortable as possible throughout the study and take all reasonable steps to minimise harm. Please also know that you do not have to answer any question you do not want to and are free to stop at any time during the study without giving a reason. If you become distressed or feel uncomfortable after the study, please let me know. You may also wish to make contact with support services who could offer help. A list with organisations has been attached at the end of this information sheet.

What will happen to the information you provide?
All discussions during the interview will be anonymised and kept confidential. The only exception to this is if it becomes clear that there is immediate, current, future, and/or serious risk of harm to you or someone else and then my professional responsibility is to signpost you to services that can provide you with information and further support. In more complex cases, I will also need to seek assistance from the research team (described above) in order to keep people safe. I will try to let you know if I have to do this. All data will be securely stored on a password protected server. Although the interview data may be externally transcribed using a professional transcription service, these transcriptions will also be anonymous. If you choose to have an interpreter present in the session, then a professional interpreter will be used. The interpreter will be asked to keep all the information private. After the study has been completed, your information will be kept securely for 5 years, which is a requirement of the University. Data will be destroyed after this. Finally, I will also write about the findings in my thesis for the University as well as disseminate the findings with my supervisors (e.g., research journals, conference presentations, community groups, social media). Everything we write about or present will be anonymous.

Who has reviewed this study?
This study has been reviewed by:

- The University of Hertfordshire Health, Science, Engineering and Technology Ethics Committee with Delegated Authority
- The UH protocol number is: **LMS/PGR/UH/04648**

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Although we hope it is not the case, if you have any complaints or concerns about any aspect of the way you have been approached or treated during the course of this study, please write to the University's Secretary and Registrar at the following address:

Secretary and Registrar
University of Hertfordshire
College Lane
Hatfield
Herts
AL10 9AB

How can I find out more about the study?
For any further questions or concerns, please contact either Muna (m.dubad@herts.ac.uk), Dr Jacqui Gratton (j.gratton@herts.ac.uk) or Dr Angela Byrne (angela.byrne7@nhs.net) via email.

Thank you very much for reading this information and giving consideration to taking part in this study.

Appendix 7: Consent Forms

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Lambarka Aqoonsiga Kaqaybgalaha:

Foomka Oggolaanshaha:

Ciwaanka mashruuca:
Fahmidda saamaynta xadgudubka galmo ee haweenka qurba joogta Soomaalida ee kayimid UK oo uu kula kacay qof ay garanayaan iyo caqabadaha ka hortaagan raadinta caawimaad nafsiga ah.

Magaca Baaraha Maamulaha: Muna Dubad

1. Waxaan xaqiijinayaa inaan akhriyay warqada ku qoran tahay xogta muhiimka ah (nooca 2) ee daraasaddan kor kuxusan. Waxaan fursad u helay inaan tixgeliyo macluumaadka, weydiiyo su'aalo oo waxaan ka helay jawaabahaas si lagu qanco. ☐

2. Waxaan fahamsanahay in kaqaybgalkeygu uu yahay mid ikhtiyaari ah oo aan xor u ahay inaan ka baxo wakhti kasta inta lagu kudo jiro daraasadda iyo illaa laba toddobaad ka dib wareysiga anigoon wax sabab ah sheegin. ☐

3. Waxaan fahamsanahay in macluumaadkayga loo ilaalin doono si adag oo qarsoodi ah. Waxa kaliya ee ka reeban tani waxay ahaan lahayd haddii ay jiraan walaac ku saabsan badbaadadayda ama badbaadada dadka kale. Xaaladdan oo kale, waxaa laga yaabaa inay lagama maarmaan noqoto in la wadaago macluumaadka oo tani waxaa la samayn doonaa iyadoo lala tashanayo kooxda cilmibaarista (oo lagu qeexay xaashida macluumaadka kujira). ☐

4. Bixinta ogolaanshahayga si aan uga kaqaybgalo daraasaddan, Waxaan fahamsanahay in cod duubitaan ay dhici doonto. Waxaa la igu wargeliyay cidda heli doonta duubistan, oo ay ku jiraan kooxda cilmibaarista, adeegga qoraalka (haddii ay khusayso), iyo fasire (haddii ay khusayso). Waxaan fahamsanahay in duubista lagu keydin doono serferka wax lagu illaaliyo ee erayga sirta ah, oo waa la burburin doonaa ka dib marka daraasadda la dhammeeyo. ☐

5. Waxaan fahamsanahay in xogta la uruuriyo inta lagu kudo jiro daraasadda aan la qarin doonin. Waxaa laga yaabaa in ay eegaan shakhsiyaadka ka socda Jaamacadda Hertfordshire iyo adeegyada khuseeya (tusaale ahaan, adeegga qoraalka xirfadda ah), ☐

University of Hertfordshire UH Ethics Committee

halka ay khusayso ka qayb qaadashadayda cilmibaaristani. Waxaan u fasaxay shaqsiyaadkan inay helaan xogtan.

6. Waxaan fahamsanahay in qorista laga yaabo inay kujirto xigashooyin toos ah kuwaas oo aan la qarin doonin. ☐

7. Waxaan aqbalay in la ila soo xiriiro daraasadda ka dib si loo helo soo koobida natiijooyinka. ☐

8. Waxaan aqbalay inaan ka qaybqaato daraasaddan kor ku xusan. ☐

Magaca Kaqaybgalaha	Taariikhda	Saxiixa
Magaca Qofka Oggolaanshaha Qaadanaya	Taariikhda	Saxiixa

University of Hertfordshire UH Ethics Committee

Participant Identification Number:

CONSENT FORM:

Title of project:
Understanding the impacts of sexual violence on women from the UK Somali diaspora perpetrated by someone known to them and barriers to psychological help-seeking.

Name of Principal Investigator: Muna Dubad

1. I confirm that I have read the information sheet (version 2) for the above study. I have had the opportunity to consider the information, ask questions and have had these answered satisfactorily. ☐
2. I understand that my participation is voluntary and that I am free to withdraw at any time during the study and up to two weeks after the interview without giving any reason. ☐
3. I understand that my information will be kept strictly confidential. The only exception to this would be if there are concerns about my safety or the safety of others. In this case, it may be necessary to share information and this would be done in consultation with the research team (described in the information sheet). ☐
4. In giving my consent to participate in this study, I understand that voice recording will take place. I have been informed who will have access to this recording, including the research team, the transcription service (if applicable), and interpreter (if applicable). I understand that the recording will be saved on a password protected server, and will be destroyed after the study has been completed. ☐
5. I understand that data collected during the study will be anonymised. It may be looked at by individuals from the University of Hertfordshire and relevant services (e.g., a professional transcription service), where it is relevant to my taking part in this research. I give permission for these individuals to have access to this data. ☐
6. I understand that the write-up may include direct quotes which will be anonymised. ☐

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7. I agree to be contacted after the study to get a summary of the findings. ☐

8. I agree to take part in the above study. ☐

Name of Participant	Date	Signature
Name of Person Taking Consent	Date	Signature

Appendix 8: Copy of Ethics Approval Notification

University of Hertfordshire UH

HEALTH, SCIENCE, ENGINEERING AND TECHNOLOGY ECDA

ETHICS APPROVAL NOTIFICATION

TO Muna Dubad

CC Dr Jacqueline Gratton

FROM Dr Simon Trainis, Health, Science, Engineering & Technology ECDA Chair

DATE 02/08/2021

Protocol number: **LMS/PGR/UH/04648**

Title of study: Understanding the impacts of non-stranger sexual violence on women from the UK Somali diaspora and barriers to psychological help-seeking.

Your application for ethics approval has been accepted and approved with the following conditions by the ECDA for your School and includes work undertaken for this study by the named additional workers below:

Dr Angela Byrne (external supervisor)
Ayan Hussein (consultant/co-researcher)
Hoda M. Ali (consultant/co-researcher)

General conditions of approval:

Ethics approval has been granted subject to the standard conditions below:

Permissions: Any necessary permissions for the use of premises/location and accessing participants for your study must be obtained in writing prior to any data collection commencing. Failure to obtain adequate permissions may be considered a breach of this protocol.

External communications: Ensure you quote the UH protocol number and the name of the approving Committee on all paperwork, including recruitment advertisements/online requests, for this study.

Invasive procedures: If your research involves invasive procedures you are required to complete and submit an EC7 Protocol Monitoring Form, and copies of your completed consent paperwork to this ECDA once your study is complete.

Submission: Students must include this Approval Notification with their submission.

Validity:

This approval is valid:

From: 02/08/2021

To: 10/02/2022

Appendix 9: Transcriber Confidentiality Agreement

Non-Disclosure Agreement with Transcription Company

This non-disclosure agreement is in reference to the following parties:

Muna Dubad (discloser)

and

Kate MacFarlane (transcriber)

- The recipient agrees to not divulge any information to a third party with regards to the transcription of audio recordings, as recorded by the discloser. The information shared will therefore remain confidential.
- If the recipient is able to identify and knows the participant in the recording, the recipient agrees to cease transcription, inform the disclosure and destroy any copies of the recording.
- The recipient also agrees to destroy the transcripts as soon as they have been provided to the discloser.
- The recipient agrees to return and/or destroy any copies of the recordings they were able to access provided by the discloser.

TRANSCRIBER TO COMPLETE:

SIGNED: Kate MacFar

NAME: KATE MACFARLANE

DATE: 3/4/2022

University of Hertfordshire UH Ethics Committee

This is an official notification by student of the University of Hertfordshire in respect of a study involving human participants.

Title of study: Understanding the impacts of non-stranger sexual violence on women from the UK Somali diaspora and barriers to psychological help-seeking.
Protocol Number: aLMS/PGR/UH/04648(3).
Approving Committee: Health, Science, Engineering & Technology ECDA

The University of Hertfordshire Health, Science, Engineering and Technology Ethics Committee with Delegated Authority

If you have any queries concerning this document, please contact me Muna Dubad, Trainee Clinical Psychologist, m.dubad@herts.ac.uk or my supervisors Dr Jacqui Gratton (j.gratton@herts.ac.uk) and Dr Angela Byrne (angela.byrne7@nhs.net).

Appendix 10: Interview Schedule

Introduction:

Thank you for meeting me today. The interview should take about 1hr-1.5hrs. You can say if you do not want to answer a question. We can take as many breaks as needed and you can stop altogether, without having to give me a reason.

Some people might put their hand up or tell me when they need to stop or take a break. How would you like to let me know when you need to stop or take a break? Just to let you know, I will keep checking how you are doing during this interview.

As mentioned in the information sheet, I will keep my camera on. But you may keep yours off, if you prefer to.

Although the interview will be recorded, you may also notice me taking some notes during the interview, to help me remember and come back to some points, as needed. I would like you to know that I will still be listening to you as I do this.

I also wanted to remind you that all discussions during the interview will be anonymised and kept confidential. The only exception to this is if it becomes clear that there is immediate, current, future, and/or serious risk of harm to you or someone else and then my professional responsibility is to signpost you to services that can provide you with information and further support. In more complex cases, I will also need to seek assistance from the research team (described in the information sheet) in order to keep people safe. I will try to let you know if I have to do this.

Is that still OK with you?

Before I make a start, can I check you are in a safe and comfortable space? Is there anything that you would like to have with you or I can do to keep safe and comfortable? Is there anyone who may be able to overhear the conversation today?

- Management plan: e.g., headphones, move rooms.

What would be the best way to contact you or for you to contact me if there is a sudden interruption?

- Management plan: back-up contact - e.g., email, text message.

Background information:

If it is OK with you, we will start off with some general questions about yourself. You may share as much or as little as you feel comfortable with now and throughout the interview.

- Firstly, could you tell me how old you are?
- Can you also tell me what your religious belief is, if any?
- Finally, this is not about immigration, but I would like to ask what generation you're from. For example, were you and your parents born here, or born elsewhere, like Somalia?

Defining sexual violence:

As you know, the interview will be focusing on Somali women and the impacts of sexual violence when it is done by someone known to them. I would also like to talk to you about your experiences with telling others and help-seeking, if you have any. I wanted to mention again that you will not be asked to speak about the sexual violence in itself.

Sexual violence is a term that is used to describe many types of sexual acts or attempts against someone without their consent. This can be done by any person in any place at any time. It can include anything with clothes and without clothes. Sexually violent acts can range from non-contact acts, such as making unwanted sexual comments, sharing intimate images, and making someone watch sexual activities. It also covers all kinds of sexual acts that do involve contact or touching.

The term sexual violence can also include female circumcision or cutting, but we know not everyone sees it that way.

These are the terms that sexual violence can cover. What names would you like me to use to talk about any events of sexual violence that happened to you?

Life around the time of the event(s):

As mentioned, sexual violence can happen to anyone at any place and at any time. If it is OK with you, I would like to get an understanding of what life was like around the time(s) you experienced [insert interviewee's term]. I would like to emphasise that I am not asking you to describe the actual event(s), but would like to know what life was like for you, where you were at, and what was going on for you at the time. It is useful to know so we can follow what you're telling us and better understand the impact on you. Is that OK?

- What was life like at the(se) time(s):
  - Prompts:
    - These things can happen at any age in life. Can I ask you whether you were child, teenager, adult, middle aged, older adult, when these things happened to you?
    - Home life, occupation/education, intimate or non-intimate relationships.

Life after the event(s):

Impacts:

Thank you for sharing this with me. If you're OK to carry on, I would now like to focus on the time after the event(s). You can share as much or as little as you like and stop at any time.

- How have you/how has your life been impacted by the [use interviewee's terminology]?
- What has been the biggest impact on your life?
    - Prompts: Wellbeing, day-to-day life, relationships, home life, occupation/education, impact of knowing the perpetrator, influences of culture and/or religion.
- Coping strategies: what has been helpful? What has been less helpful?

Telling people:

How are you doing at the moment? Are you OK to continue? If you are OK to continue, I would now like to move on to the next part of the interview, where I would like to know more about your experiences of telling people, if any, such as friends or family, about what happened to you. Again, you may share as much or as little as you feel comfortable with and can stop at any time.

- Have you been able to tell someone about what happened to you?
    - No:
        - Prompt:
            - Explore what has made it difficult.
            - Influence of culture and/or religion in relation to the difficulties to disclose.
            - What has led them to feel more able to today.
    - Yes:
        - Could you tell me about the time you first talked about the [insert terminology]?
            - Prompts: reason for disclosure, experience of talking about the event(s), reactions, what made it easier and/or more difficult, informal and formal disclosures/reporting, impact of knowing the perpetrator, outside support/influence/discouragement to disclose/report.
            - Prompt: How do you think culture and/or religion has influenced your experience(s) of disclosure?

Support and help-seeking:

How are you doing at the moment? Are you OK to continue? If you are OK to continue, I would now like to move on to the final part of the interview, where I would like to know more about your experiences and views on support and help-seeking.

As before, you may share as much or as little as you feel comfortable with and can stop at any time.

- Was there anyone around you who you could turn to for support? What support do you feel was available?
- Did you seek help after what happened to you?
    - Prompts: reasons for seeking or not seeking help, what type of help (e.g., counselling/ talking therapy), what helped or made it difficult to seek help, what made the person ready to seek help, impact of knowing the perpetrator, outside support/influence/discouragement to seek help.
- If help was sought: what was your experience with seeking help?
    - Prompts: experiences of contacting the services, experiences of the process, anything that was useful or less useful/would change about the process.
    - Prompt: How do you think culture and/or religion has influenced your experience(s) of support and help-seeking?

Ending:

We have come to the end of the interview. Before we finish up is there anything you would like to mention? Is there anything you feel we didn't talk about and you feel we should have talked about? Are there any other areas you feel would be worthwhile talking about in this interview?

Thank you so much for taking part in this interview. How are you? How did you find the interview? What have you got planned now that the interview has finished? Is there anything you can do to keep yourself safe and comfortable?

If you find it helpful, we could do a relaxation or grounding exercise together or I can share a copy with you, so you can complete it in your own time?

As mentioned, our discussions will be anonymised and be kept confidential. If at any point you no longer wish your data to be used for this interview, please let me know within the next two weeks (give exact date), as it will be very difficult to withdraw your data afterwards due to the analysis process. Is that still OK?

Please let me know if you feel distressed or uncomfortable after this interview. I have also attached a list of organisations with the information sheet, which you may find helpful to contact for further support.

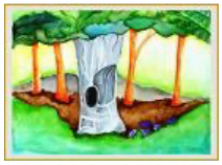
Please take this voucher as a small acknowledgement of your time spent taking part in this study and the emotional efforts associated with your participation.

Thank you. You may now leave the call when you are ready.

Appendix 11: Relaxation Exercises

Relaxing 'Safe Place' Imagery

All visualisations can be strengthened by ensuring you engage all your senses in building the picture in your mind's eye - it's more than just "seeing"!



If you notice any negative links or images entering your positive imagery, then discard that image and think of something else. Avoid using your home (or bed) as a 'safe place'. You can create a new 'safe place' in your imagination.

Start by getting comfortable in a quiet place where you won't be disturbed, and take a couple of minutes to focus on your breathing, close your eyes, become aware of any tension in your body, and let that tension go with each out-breath.

- Imagine a place where you can feel calm, peaceful and safe. It may be a place you've been to before, somewhere you've dreamed about going to, somewhere you've seen a picture of, or just a peaceful place you can create in your mind's eye.
- Look around you in that place, notice the colours and shapes. What else do you notice?
- Now notice the sounds that are around you, or perhaps the silence. Sounds far away and those nearer to you. Those that are more noticeable, and those that are more subtle.
- Think about any smells you notice there.
- Then focus on any skin sensations - the earth beneath you or whatever is supporting you in that place, the temperature, any movement of air, anything else you can touch.
- Notice the pleasant physical sensations in your body whilst you enjoy this safe place.
- Now whilst you're in your peaceful and safe place, you might choose to give it a name, whether one word or a phrase that you can use to bring that image back, anytime you need to.
- You can choose to linger there a while, just enjoying the peacefulness and serenity. You can leave whenever you want to, just by opening your eyes and being aware of where you are now, and bringing yourself back to alertness in the 'here and now'.

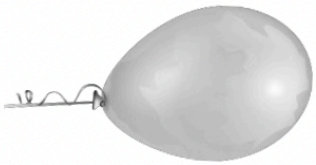
www.getselfhelp.co.uk/imagery.htm ***www.get.gg***

Mindful Breathing

The primary goal of mindful breathing is simply a calm, non-judging awareness, allowing thoughts and feelings to come and go without getting caught up in them.

- Sit comfortably, with your eyes closed and your spine reasonably straight.
- Bring your attention to your breathing.
- Imagine that you have a balloon in your tummy. Every time you breathe in, the balloon inflates. Each time you breathe out, the balloon deflates. Notice the sensations in your abdomen as the balloon inflates and deflates. Your abdomen rising with the in-breath, and falling with the out-breath.
- Thoughts will come into your mind, and that's okay, because that's just what the human mind does. Simply notice those thoughts, then bring your attention back to your breathing.
- Likewise, you can notice sounds, physical feelings, and emotions, and again, just bring your attention back to your breathing.
- You don't have to follow those thoughts or feelings, don't judge yourself for having them, or analyse them in any way. It's okay for the thoughts to be there. Just notice those thoughts, and let them drift on by, bringing your attention back to your breathing.
- Whenever you notice that your attention has drifted off and is becoming caught up in thoughts or feelings, simply note that the attention has drifted, and then gently bring the attention back to your breathing.

It's okay and natural for thoughts to enter into your awareness, and for your attention to follow them. No matter how many times this happens, just keep bringing your attention back to your breathing.



Appendix 12: Sign-posting services

List of resources/services for further support in the UK

Support for women from Muslim and/or ethnic minoritised backgrounds

- Imkaan:
  - This is the only UK-based, umbrella women's organisation dedicated to addressing violence against Black and Minoritised women and girls.
  - The website offers an extensive list of contact details for (specialist) support services: https://www.imkaan.org.uk/get-help
- Dahlia Project:
  - This organisation aims to provide free to access therapeutic support groups and individual counselling for women who have undergone FGM.
  - Visit: https://www.dahliaproject.org/
  - Email: dahlia@manorgardenscentre.org
- Safe Spaces for Black Women:
  - This organisation aims to offer a safe space for Black women affected by COVID-19, the current political system, racism, patriarchy and mental health where Black women can express and explore their experience in the world through virtual meet-ups with a qualified therapist providing support.
  - Visit: https://www.safespacesforblackwomen.com/contact-us
- Muslim Women's helpline:
  - Will provide listening support, help women (regardless of their religion) in a crisis situation as well as providing information about legal rights.
  - Telephone: 0800 999 5786
  - Email: info@mwnhelpline.co.uk
- Nafsiyat:
  - A pioneering charity offering intercultural therapy in over 20 languages to people from diverse cultural communities.
  - Telephone number: 020 7263 6947
  - Email: admin@nafsiyat.org.uk
- Muslim Counsellor and Psychotherapist Network (MCAPN).
  - The MCAPN provide an online directory of private, qualified and registered professional Muslim counsellors, psychotherapists and psychologists. There is a choice of face to face or online counselling via Skype/Telephone/Email.
  - Website: http://www.mcapn.co.uk/

Sexual and domestic violence support

- Refuge:
  - Refuge provides specialist support to women, children and some men escaping domestic violence and other forms of violence.
  - Their National Domestic Abuse Helpline team is accessible at any time, day or night: 0808 2000 247
- The Domestic and Sexual Abuse helpline:
  - For anyone affected by domestic or sexual violence.
  - The helpline is free and open 24 hours a day, 365 days a year.
  - Telephone number: 0808 802 1414 (number does not appear on a landline telephone bill)
  - Email: info@dsahelpline.org (confidential email service and doesn't record your email address).
- Safeline:
  - Safeline is a specialised charity working to prevent sexual abuse and to support those affected in their recovery.
  - General helpline: 0808 800 5008
  - Text helpline and online advisors: 07860027573
  - Opening hours: Monday (10am-4pm), Tuesday (8am – 8pm), Wednesday (10am-4pm), Thursday (8am – 8pm), Friday (10am-4pm), Saturday (10am – 12 noon).
- The National Association for people abused in childhood (NAPAC):
  - NAPAC provides a national freephone support line for adults who have suffered any type of abuse in childhood.
  - Telephone number: 0808 801 0331
  - Opening hours: Monday – Thursday (10am – 9pm) and Friday (10am – 6pm).
- The Survivors Trust:
  - Lists local specialist services for survivors of sexual violence, including advocates and Independent Sexual Violence Advisors (ISVAs).
  - Telephone number: 08088 010 818
- Rape Crisis England & Wales:
  - Support for women and girls affected by rape, sexual abuse or any form of sexual violence. Provides details of local centres.
  - Website: www.rapecrisis.org.uk

General mental health support

- Urgent mental health support:
  - Visit this website to find out what support is available if you need urgent mental health support: https://www.nhs.uk/mental-health/advice-for-life-situations-and-events/where-to-get-urgent-help-for-mental-health/
    - Emergency support:
      - Call **999** for support in an emergency.
    - NHS 111
      - NHS **111** will tell you the right place to get help if you need to see someone. You may be able to speak to a nurse, or mental health nurse, over the phone. A GP can advise you about helpful treatments and also help you access mental health services.
      - Use the NHS **111** online service or call **111**.
    - GP:
      - You may find it helpful to contact your GP if you experience psychological distress or discomfort. They may be able to advise you for further sources of support, such as a referral to a Clinical Psychologist.
- Samaritans
  - The Samaritans provide emotional support to anyone in emotional distress, struggling to cope, or at risk of suicide throughout the United Kingdom and Ireland
  - Telephone number: 116 123 (24 hours, any day of the year)
  - Email: jo@samaritans.org (response time: 24 hours)

International resources/services for further support

Please visit the following websites, which contain contact information for mental health support resources/services outside of the United Kingdom. If your country does not have a national helpline please seek professional and community support from trained and experienced carers:

- Mental health Europe: https://www.mhe-sme.org/library/helplines/?location=at
- United for Global Mental Health: https://unitedgmh.org/mental-health-support

List of resources/services for support if you are worried about someone else (UK):

- If you are worried about a child or young person at risk of abuse or neglect, you can:
  - Contact the children's social care team at their or your local council: https://www.gov.uk/report-child-abuse-to-local-council
  - Contact the NSPCC:
    - https://www.nspcc.org.uk/keeping-children-safe/reporting-abuse/report/
    - Telephone: 0808 800 5000
  - Visit the NHS UK website for furher information and contact details for other organisations: https://www.nhs.uk/conditions/social-care-and-support-guide/caring-for-children-and-young-people/children-and-young-peoples-services/

- If you are worried about a (vulnerable) adult, you can:
  - Download the NHS England Safeguarding app to obtain information and contact details of your/their local council.
  - Contact your/their local Authority Adult Social Care Services: https://www.nhs.uk/service-search/other-services/Local-Authority-Adult-Social-Care/LocationSearch/1918

- If you are worried about an older adult, you can also contact:
  - Age UK:
    - Advice line: 0800 678 1602
    - Find your local Age UK: https://www.ageuk.org.uk/services/in-your-area/
  - Hourglass:
    - https://wearehourglass.org/hourglass-services
    - Free text: 078 6005 2906
    - Helpline: 0808 808 8141

- Other organisations:
  - Women's Aid - A charity that aims to end domestic violence against women and children:
    - Website: https://www.womensaid.org.uk/
    - Email: helpline@womensaid.org.uk

    - Chat (10:00am – 6:00pm): https://chat.womensaid.org.uk/
  - Support for human trafficking– the Citizens Advice website offers information on human trafficking and contact details for organisations that give further support: https://www.citizensadvice.org.uk/immigration/report-human-trafficking
  - Support for FGM – the Citizens Advice website offers information on FGM and contact details for organisations that can give further support: https://www.citizensadvice.org.uk/family/gender-violence/female-genital-mutilation-fgm/
  - Support for forced marriage - this government website offers information and contact details if you are trying to stop a forced marriage or need help leaving a forced marriage: https://www.gov.uk/stop-forced-marriage

Appendix 13: Topic Guide

- Psychological impacts:
    - Types of psychological impacts
    - Use of resources and coping strategies
    - Role of culture, gender, and religion
- Social impacts:
    - Intimate and non-intimate Interpersonal relationships
    - Relationship with community
    - Occupational functioning (employment, education)
    - Role of culture, gender, and religion
- Disclosure:
    - Experiences of disclosure
    - Facilitators and barriers to disclosure
    - Role of culture, gender, and religion
- Help-seeking:
    - Experiences of help-seeking
    - Relationship to help-seeking
    - Facilitators and barriers to help-seeking
    - Role of culture, gender, and religion

Appendix 14: IPA Process

The following pages contain extracts of my analysis process, describing my exploratory notes and emergent themes. To minimise risk of identification, the extracts below have been taken from different parts of a participant's interview, some of which was described in the Results chapter.

Original transcript	Exploratory comments	Emergent themes
Because… can you imagine saying but mine doesn't look like that?	*Highlighting it would have been an impossible question to ask? Seeking reassurance/confirmation from me perhaps?*	
I: No.		Silenced.
P: Like it's completely shut!	*Stressing the severity of the cutting, as well as the difference from other, typical genitalia.*	
So even though I I couldn't speak English very well.	Not knowing the language well.	
I *knew,* I felt shame.	*A strong awareness.* Feeling shame.	Shame.
I I *knew* that I was different.	Knowing she was different.	
And then I didn't get to know the name FGM until I was in high school.	Learning about FGM.	
But even during primary school times, and knowing that I was different, I still viewed it because I lived within a Somali community.	Knowing she was different. Impact of living in a Somali community.	Cultural perceptions of FGM/C.
I still viewed it as it was right, we are right, and everyone else's opinion of it is wrong.	Viewing what is right and wrong.	
I: Uh-hmm.		
P: Like this is how it should be done.	The way it should be.	
So I was judging everyone else for not having it.	Judging others without FGM/C.	Social comparisons – FGM/C practice.
Thinking, you know, it's weird, like why don't you like, well, you know.		
Why don't you have it and I have it. It's a bit weird.	Comparing experiences. Finding it weird. <u>Questioning self vs others.</u>	
And then when I got know, I think I watched Desert Flower, eh, the movie.	Watching the Desert Flower movie.	

Original transcript	Exploratory comments	Emergent themes
	Difficulty holding different view. Potentially unconscious and conscious elements to this?	
Because EVERYONE has the same view, so I don't think I've met anyone who didn't have their views to kind of base my feelings on.	*The use of 'everyone' further stressing the difficulty of diverging from the norm.* Nobody with other views.	
It was like even even though it was traumatic for me and I hated it and I kind of resented ehm my grandma and my auntie and my uncles for even CONSIDERING it.	Traumatic experience. Hating what happened. Feeling resentment towards family members for considering it. *Potentially some hesitation about expressing resentment initially through the use of 'kind of'. Her stressing the word 'considering' then emphasising the severity of the act, letting me know it should have never have been a consideration, let alone, something they had gone through with.*	FGM/C as a traumatic experience. Hatred.
It were the ones that were in control.		Resentment of family.
Of your [inaudible, poor connection]		
[break, poor connection]		
I: So you just you were speaking about feeling resentful for your family even considering putting you through this.		
P: Yeah, because the PAIN…and the way that it happened… was HORRIBLE.	A sense of resentfulness due to the pain, the way it happened, and the horribleness. *An emphasis was put the pain and the horribleness of what happened, potentially further bewilderment as to how her family could have put her through this ordeal.*	
And then everyone was smiling and it just didn't make sense that it was confusion.	Everyone was smiling. It did not make sense. Feeling confused. The paradox here is highlighted again between her pain and others' joy, resulting in confusion.	Confusion.
And a sense of ehm betrayal and from that moment I genuinely thought my family were going to kill me [chuckle].	A sense of betrayal. Thinking she will be killed. *The chuckle may indicate a sense of absurdity at the thought your family may kill you yet this being a genuine concern.*	Betrayal. Fear of family.

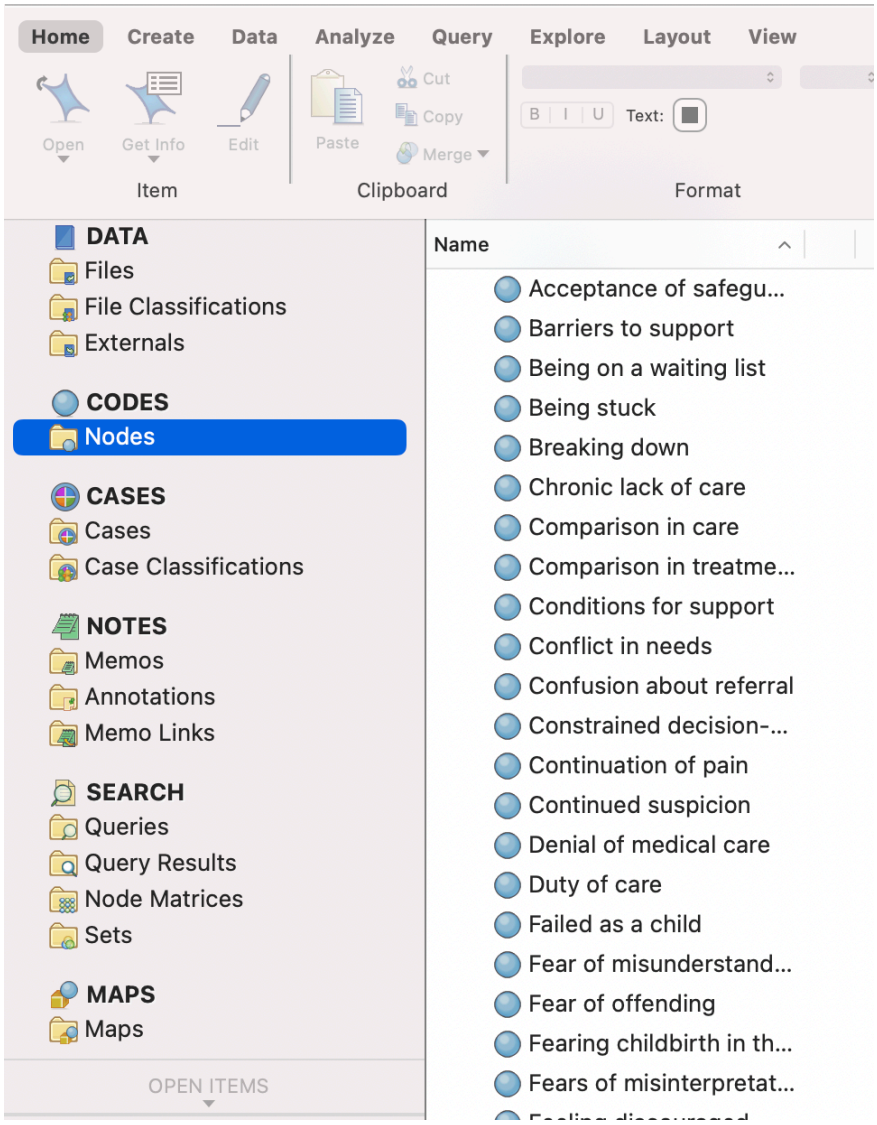
Original transcript	Exploratory comments	Emergent themes
I: Uh-hmm.		
P: Right? And I believe that religion is manipulated… to… such a degree that… it also plays a part in your trauma.	Manipulation of religion contributing towards trauma.	Manipulation of religion.
	Playing a part in her trauma.	
It did in mine [chuckle] because being told that what happened to me was was by the will of God.	The will of God.	
Like, what can you? [light chuckle] say, well, can you say to that?	Not knowing how to respond.	
But they're within the same sentence they say, you know God is perfect, and and you know He makes no mistakes. But I was born this way, why change it?	Wonder why she should change. *A paradox between God being positioned as perfect and her being changed.* A sense of internal dilemma or existential crisis?	Religious paradox.
So it's very contradicting what they say. It's very confusing so…	Contradicting message. Feeling confused.	Confusion.
It's it's they both give such like various mixed signals [light chuckle] and people don't know.	Receiving mixed signals.	
Uh especially, uh, migrants that come from war torn countries.		
It's very, very difficult for them to adjust as you know, as quickly as everyone wants them to…	Migrants' adjustment difficulties. Expectations of adjustment.	Expectations of adjustment.
I: Yeah.		
P: It's not going to happen so quickly	Not happening quickly.	
I: No.		
P: Because it's a learning curve.	Adjustment being a learning curve.	Adjustment as a learning curve.
And that's what FGM was for me, it was such a learning curve when I came here.	FGM being a learning curve.	FGM as a learning curve.

Original transcript	Exploratory comments	Emergent themes
come… to YOUR house… yeah? And check everything… and you tell me what happened, tell me how you got raped.	Someone coming the house of a rape victim, checking everything, and asking what happened.	
NO professional would EVER do that!	A professional never doing that. *The emphasised words highlighting the contrast in experience between victims of rape compared to FGM/C, demonstrating the perplexity regarding this difference.*	
I: No.		
P: But with FGM… it's not seen as eh sexual violence, so therefore they think that it's OK ethically to ask such a question, "tell me *what* happened".	FGM not seen as sexual violence thereby ethically justifying such questions.	Minimisation of FGM/C.
Detail by detail.	Being asked detail by detail. *The level of detail demonstrating the intrusiveness.*	Intrusive questioning.
Whilst I sat there in tears.	Sitting in tears. <u>The questions, and detail, while she sat in tears – she was clearly in distress, yet this was not noticed or responded to. What does that communicate to her?</u>	Insensitivity to distress.
I: How did that feel that that little regard for the trauma?		
P: It felt horrible.	It felt horrible.	
I: Horrible.		
P: And not only that, once I finished telling my story, they were still they STILL, she wasn't convinced.	Finishing my story. Still not convinced. *Further bewilderment after her painful story was shared and she was still not believed.* <u>Her pain and vulnerability was not seen. Is there a racialised element to this?</u>	Not being believed.
And I told her "LOOK at me and the way that I am right now".	Look at me. *Notice me.* <u>See my pain.</u>	Wanting to be seen.
"Do you think I would ever subject my child to such a thing?"	Asking whether she would subject her child to this.	
And she said "I don't know…it could be a possibility…".	Social services saying it was a possibility.	Continued suspicion.

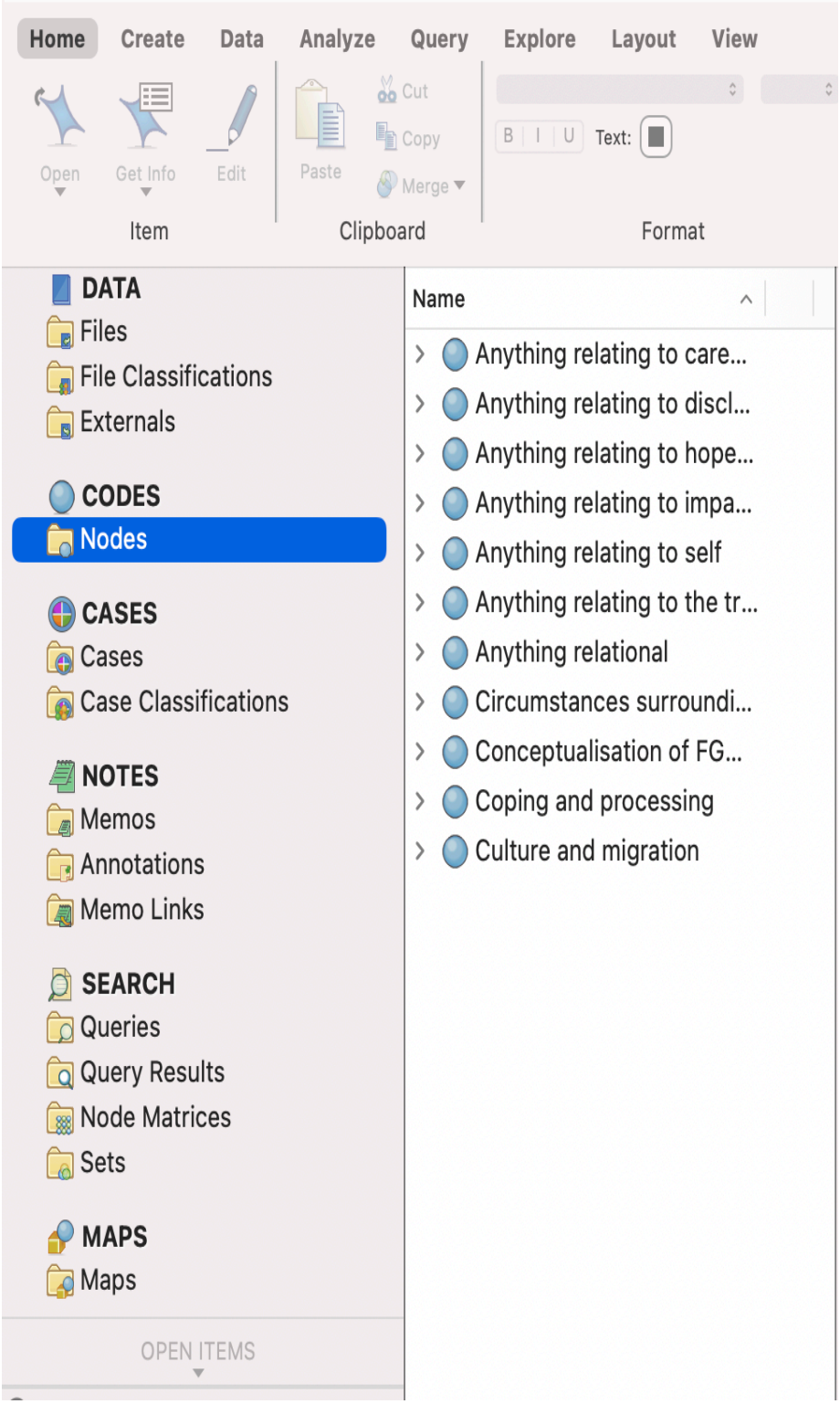
Original transcript	Exploratory comments	Emergent themes
They'll be like "this is wasted goods" …	Being told it's wasted goods.	
All of this, these events made me feel so worthless... as a woman and I felt sadly less of a woman…because I didn't have all the PARTS of a woman…	Being made to feel worthless as a woman. Sadly feeling less of a woman. Not having all the parts of a woman. Questioning her identity as a woman. A sense of loss at the 'missing parts'?	Feeling worthless. Loss of womanhood.
And, I think, I didn't even, I never even knew that it was a possibility to have your whole private part reconstructed…	Not knowing about vaginal reconstruction.	
I didn't know that a clitoris was longer than it actually is, that some of it can actually be brought out. I didn't know all of that.	Not knowing about the clitoris length. Not knowing parts of the clitoris could be brought out. Not knowing all of that.	Lack of FGM/C awareness.
I was so undereducated in FGM but when you go through trauma like that and then you have the society views to deal with and the expectations of religion and your family and every other institution… but you have expectations of yourself as well, and then mine, for ME, my child has expectations of me, and those are already hard things to, you know, to deal with…	Being undereducated in FGM. Going through the trauma. Dealing with society's views. Religious expectations. Family's expectations. Institutions' expectations. Own expectations. Child's expectations. Finding it hard to deal with. It seems she has to spin many plates, on top of dealing with the trauma. How does one cope?	Managing competing demands.
But on top of that, no support... No help... no outlet to SPEAK! No sense of EVEN consideration for the way that you speak to, speak about FGM when you are speaking, like, when you refer to, referring to victims or whether they feel or not or, that's not a debate for anyone to be having… I mean, that's, it's victims themselves or survivors themselves… because THEY know whether you feel or you don't… But I feel like no one has ever sat anyone down and said, "what is your experience?"	No support, no help, no outlet. Isolation, abandonment? Lack of consideration when speaking about or referring to FGM. Victims' sense of feeling not up for debate. For victims and survivors to debate. Victims and survivors knowing about presence or absence of feeling. *The emphasis on they highlighting they are the expect of their experiences.* Dealing with assumptions. Not being asked about your experience.	Lack of support. Insensitivity of assumptions.
Do you, like, how do you view sex? … How do you view your body? How do, like I get them to express themselves so that they may actually HEAL.	Not being asked about views on sex. Not being asked about views on body. Not being asked about self-expression for healing.	Lack of interest/curiosity.

Appendix 15: Theme Development Process

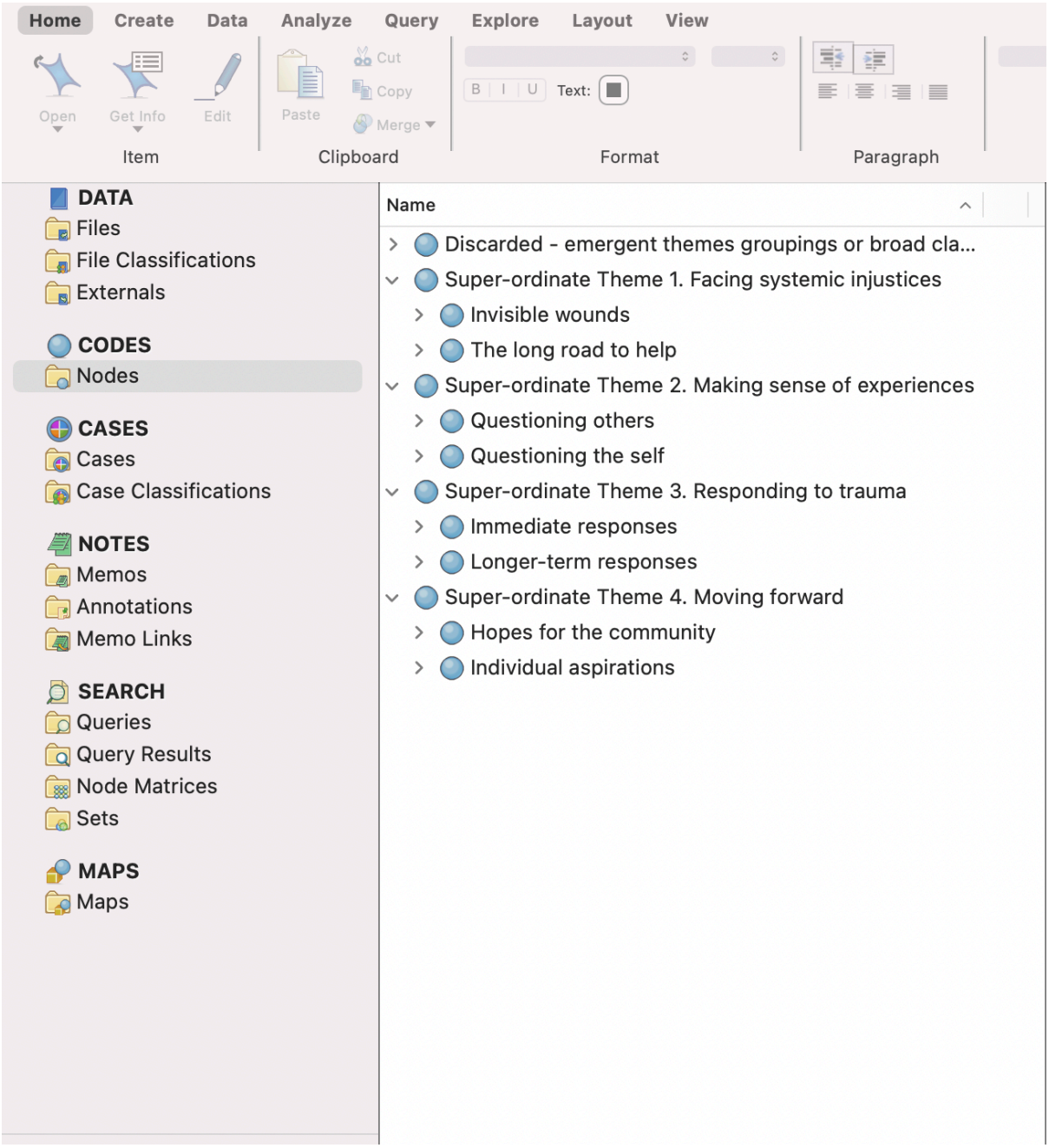
1. List of emergent themes in NVivo



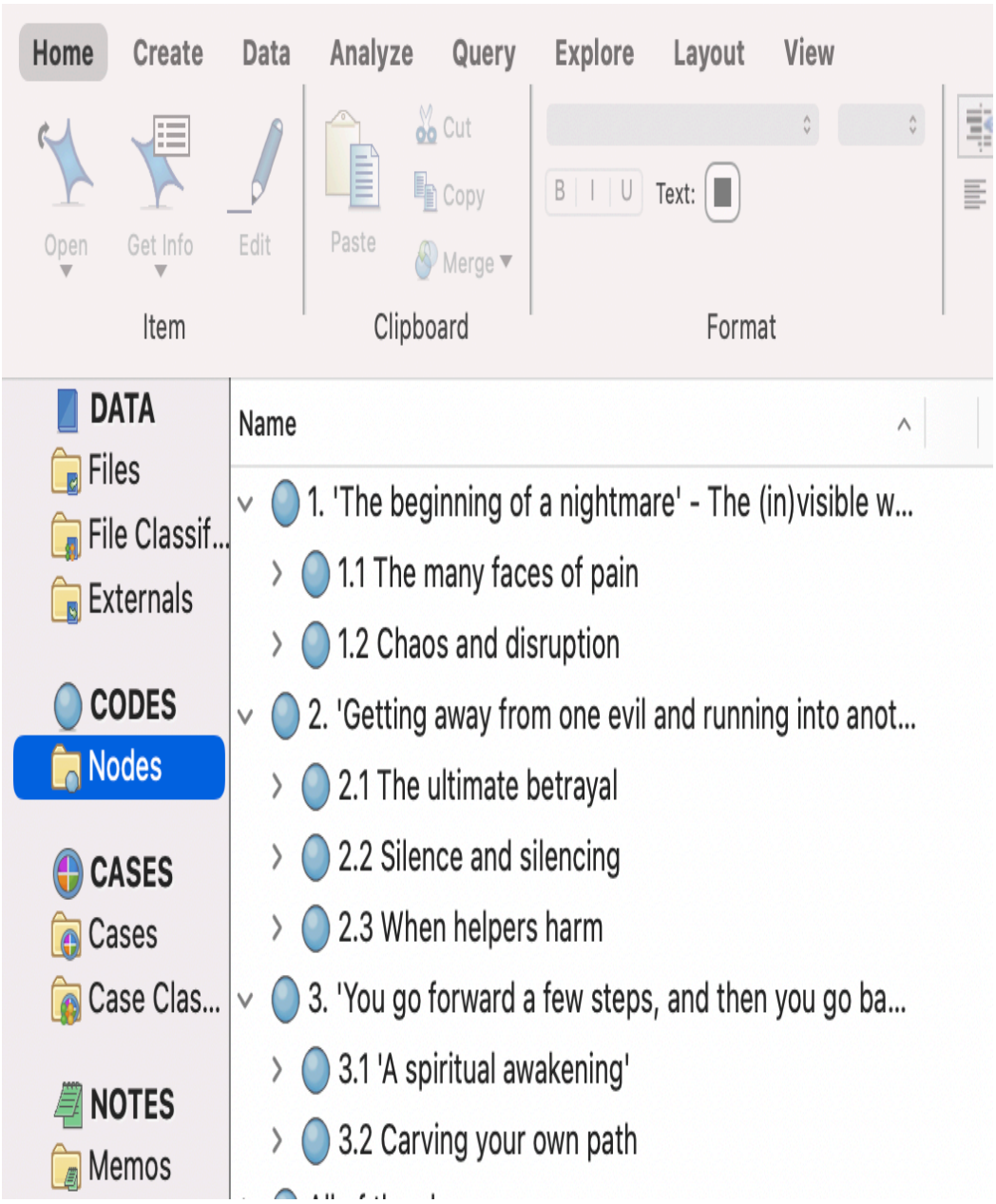
2. Grouping emergent themes/finding connections



3. Development of superordinate themes and subthemes for a participant.



4. Final themes after merging and reviewing connections across participants' superordinate themes.



Appendix 16: Recurrent Themes

Table 15: Identification of recurrent themes.

Superordinate theme	Subordinate theme	Araweelo	Edna	Hayat	Hawa	Leyla
"The beginning of a nightmare" - The (in)visible wounds of sexual violence	The many faces of pain	X	X	X	X	X
	"Chaos" and disruption	X		X	X	X
"Getting away from one evil and running into another evil" - (Re)traumatising systems	The ultimate betrayal	X		X	X	X
	Silence and silencing	X	X	X	X	X
	When helpers harm	X	X	X		
"You go forward a few steps, and then you go back again a few steps" - The winding path to recovery	"A spiritual awakening"	X	X	X	X	X
	Carving your own path	X	X	X	X	X