BMJ Open

Trauma has an echo: a mixed methods study exploring barriers to routine healthcare for survivors of sexual violence in a UK higher education setting

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To cite: Hooper L, Meyrick J. Trauma has an echo: a mixed methods study exploring barriers to routine healthcare for survivors of sexual violence in a UK higher education setting. *BMJ Open* 2025;**15**:e102181. doi:10.1136/bmjopen-2025-102181

► Prepublication history and additional supplemental material for this paper are available online. To view these files, please visit the journal online (https://doi.org/10.1136/bmjopen-2025-102181).

Received 13 March 2025
Accepted 11 April 2025

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ABSTRACT

Objectives To explore barriers to healthcare among survivors of sexual violence (SV) and the behavioural pathways behind avoidance, focusing on survivor-led solutions.

Design A mixed methods study collated qualitative interviews/surveys to explore the lived experiences of survivors of SV. Data were analysed using both quantitative descriptors and qualitative thematic analysis to expand the mechanisms/solutions to reported rates.

Setting Higher education setting in the UK.

Participants Forty-two survivors of SV between the ages of 18 and 29 self-identified as female (36), male (4), genderfluid (1) and non-binary transmasculine (1), with 10 describing themselves as being from racially minoritised communities and 32 as White survivors.

Results Analysis found 86% of survivors completely or significantly avoided healthcare, particularly sexual and reproductive services. Three themes were identified: (1) wider societal blame/marginalisation of survivors hindered their ability to access care in what felt like 'a system of oppression'; (2) once past these barriers, direct experiences with professionals replicated trauma, exacerbating avoidance and health disparities through 'healthcare-induced re-traumatisation'**;** (3) survivors identified what they needed to re-engage in healthcare including trauma-informed professionals and compassionate services with 'survivor-centred care'.

Conclusions SV may deepen health inequalities as survivors avoid healthcare. Survivor-led reforms called for survivor-centred practices and encouraged systemic reflection on how healthcare systems may contribute to the broader marginalisation of survivors. Findings echo policy recommendations for co-produced services led by minoritised/marginalised patients and operationalise trauma-informed training for healthcare professionals. Additionally, access-focused psychological support could reduce the impact of sexual trauma on morbidity and mortality.

STRENGTHS AND LIMITATIONS OF THIS STUDY

- ⇒ This study used a trauma-informed approach, prioritising survivor autonomy in data collection.
- ⇒ The work provides unique insights into the barriers survivors of sexual violence face when accessing healthcare services in the UK.
- ⇒ The study's sample was limited to a narrow age range within a higher education setting.
- ⇒ The research did not fully explore barriers faced by racially and sexually minoritised communities due to limited demographic data.
- ⇒ Findings are not generalisable but offer preliminary, survivor-led suggestions for operationalising trauma-informed measures to improve healthcare access.

INTRODUCTION

Sexual violence (SV) is common, and its prevalence reflects patterns of intersectional inequality (women, the young and minoritised communities). Recent UK statistics estimate that 7.9 million people (16.6%) have experienced SV since the age of 16, though underreporting means the true prevalence is likely far higher, with up to 84% of survivors never disclosing their experiences.[1 2] Stigma, shame and societal power dynamics compound barriers to reporting and seeking support.[3 4]

The long-term impacts of SV and the wider prevalence of violence against women and girls (VAWG) are profound, affecting survivors' physical health, mental health and health risk behaviours.[5] Survivors are at increased risk of chronic pain, reproductive health issues and sexually transmitted infections,[6 7] and also one to three more cardiovascular,[5 8] metabolic, haematologic and respiratory diseases.[9] Psychologically, SV can lead to post-traumatic stress disorder, depression and anxiety, often compounded by coping behaviours such as substance misuse or disordered eating.[10 11] Behaviourally, survivors may struggle with boundary-setting or engage in unsafe sexual practices.[12]

Despite greater health needs, survivors are significantly less likely to access healthcare due to systemic barriers. Limited evidence suggests that healthcare-induced retraumatisation, triggered by invasive procedures, interactions or power dynamics[13 14] and limited trauma-informed provider training may increase avoidance of healthcare.[15] Despite the potential scale of this unmet need, little research exists on how survivors experience barriers to healthcare or what they feel they need to overcome them. This study explores the lived experiences of survivors in order to begin to fill the gap in research evidence and find ways to interrupt the trajectory of harm on lifelong health.

METHODS

Study design

A mixed methods study collated qualitative interviews/surveys to explore the lived experiences of survivors of SV. Data were analysed using both quantitative descriptors and qualitative thematic analysis to expand the mechanisms/solutions to reported rates.

Participants and recruitment

Self-identified survivors of SV were aged 18 years or older and recruited from a large higher educational institution via convenience sampling using poster advertising and course credit volunteering. Trauma-informed safeguarding ensured that onsite specialist SV support was accessible to both participants and the project researcher.

Patient and public involvement

The semi-structured interview guide and online survey questions were reviewed by an anti-SV advisor to ensure appropriateness. Following ethical approval, the interview and survey guide were piloted with two volunteers. Pilot data were excluded from the analysis. See supplementary files for the interview and survey guide.

Data collection

Data collection occurred between February and May 2024. Semi-structured, online interviews and online surveys were developed based on existing frameworks, including the barriers to help-seeking scale.[16] Participants were given the choice of which method to engage with, resulting in distinct groups for the interviews and the surveys. Interviews lasted around 1 hour and online survey responses were collected using Qualtrics, including self-identified demographic information and consent.

Table 1 Participant demographics based on participants' own labels

			Range			
	N	%	Lowest	Highest	Mean	Median
Age			18	29	20.69	20
Self-identity						
Female	36/42	85.72				
Male	4/42	9.52				
Gender fluid	1/42	2.38				
Non-binary transmasculine	1/42	2.38				
Sexual orientation						
Heterosexual	21/42	50.0				
Bisexual	15/42	35.71				
Pansexual	4/42	9.52				
Queer	2/42	4.76				
Lesbian	1/42	2.38				
Unlabelled	1/42	2.38				
Ethnicity						
White	32/42	76.19				
Mixed	3/42	7.14				
Asian	2/42	4.76				
White and Black Caribbean	1/42	2.38				
Mulatto	1/42	2.38				
Brown	1/42	2.38				
Black North African	1/42	2.38				
Middle eastern	1/42	2.38				

Table 2 Quantitative findings

	N	%
Healthcare avoidance severity		
Fully avoids	17/42	40.48
Significantly avoids (whole categories avoided)	19/42	45.24
Does not avoid	6/42	14.28
Avoided service type group		
Sexual/reproductive health-related care including:	25/42	59.52
Cervical screening	5/25	11.90
Sexually transmitted infection testing	2/25	4.76
Dental care	7/42	16.67
General practices	3/42	7.14
Reason for avoidance other than service type group		
Intimate care/touching	7/42	16.67
Gender of practitioners (male)	4/42	9.52
Avoiding vulnerability	3/42	7.14

Data analysis

Interview transcripts and survey responses were de-identified and quantitative codes for avoidance were generated to rate the data set (3=fully avoid healthcare services, 2=avoid some, 1=no avoidance) plus grouping service or motive-specific information. Data were also analysed using a reflexive thematic approach[17] through familiarisation, generating initial codes, identifying and refining themes, and reporting, all within a critical realist theoretical stance. This was consistent with the researchers' belief in the potential to explore lived experiences in order to uncover causal mechanisms and address social issues while also recognising the researcher's role and subjectivity in the analysis process.

RESULTS

Forty-two participants ranging in age from 18 to 29 completed the study. See table 1 for participant demographics based on participants' own labels. Quantitative insights were explored through qualitative data looking for underlying mechanisms of healthcare avoidance. A large proportion of participants, 86% (36/42), either fully or significantly avoided healthcare services. Among this group, 60% (25/42) avoided sexual/reproductive health services, such as cervical screening and sexually transmitted infection testing. See table 2 for the quantitative findings.

Qualitative findings

The themes are presented in an overview theme map followed by examination of each theme to look at the meaning with supporting quotes from participants. See figure 1 for the overview theme map.

Theme 1: Systems of oppression

Societal attitudes or wider systems of oppression that minimise and discredit experiences of survivors of SV were commonly reported as a key reason to avoid healthcare. Avoidance was often rooted in self-protection and feelings of internalised stigma and self-blame, with many survivors perceiving SV as personal failure.

Avoidance of help-seeking built often lifelong coping strategies of self-reliance, particularly for survivors of childhood sexual abuse:

> …if I went, they would know that I was kind of broken and dirty – p28, female, late 20s

Many reported that they viewed seeking help as futile:

> Even now when I get ill, I never go to my GP, the pharmacy or anything and rely on myself to make hot drinks and take paracetamol if needed – p39, female, late teens

Early experiences of trauma or the mark of not being believed/heard validated self-protection through self-reliance. For survivors in this study, disclosures had been dismissed and disbelieved by trusted adults:

> I still don't expect to be taken seriously or helped… or…not told it was my fault - p1, non-binary transmasculine, late 20s

Sometimes the simple act of surviving trauma pushed out prioritising physical health:

> The emotional toll of the trauma made it hard for me to prioritise my own healthcare needs – p19, male, early 20s

Additionally, a transgender survivor highlighted the complexities of intersecting barriers when accessing healthcare:

> I don't want to have to be put in a very uncomfortable and invasive position, whilst also being consistently misgendered by the nurses (nervously laughs)…I could deal with one or the other, but put them together and it's like nope – p1, non-binary transmasculine, late 20s

Theme 2: Care that harms: re-traumatisation in health systems

Many survivors in this study reported that healthcare itself had been re-traumatising. The process of examinations or invasive procedures and physical touch often triggered traumatic memories. One survivor of oral assault shared:

> I have not been to the dentist since as I felt uncomfortable and frozen in a position with hands/tools in my mouth – p18, female, early 20s

Being asked personal questions, around sensitive topics like sexual activity or contraceptive use, was often experienced as triggering.

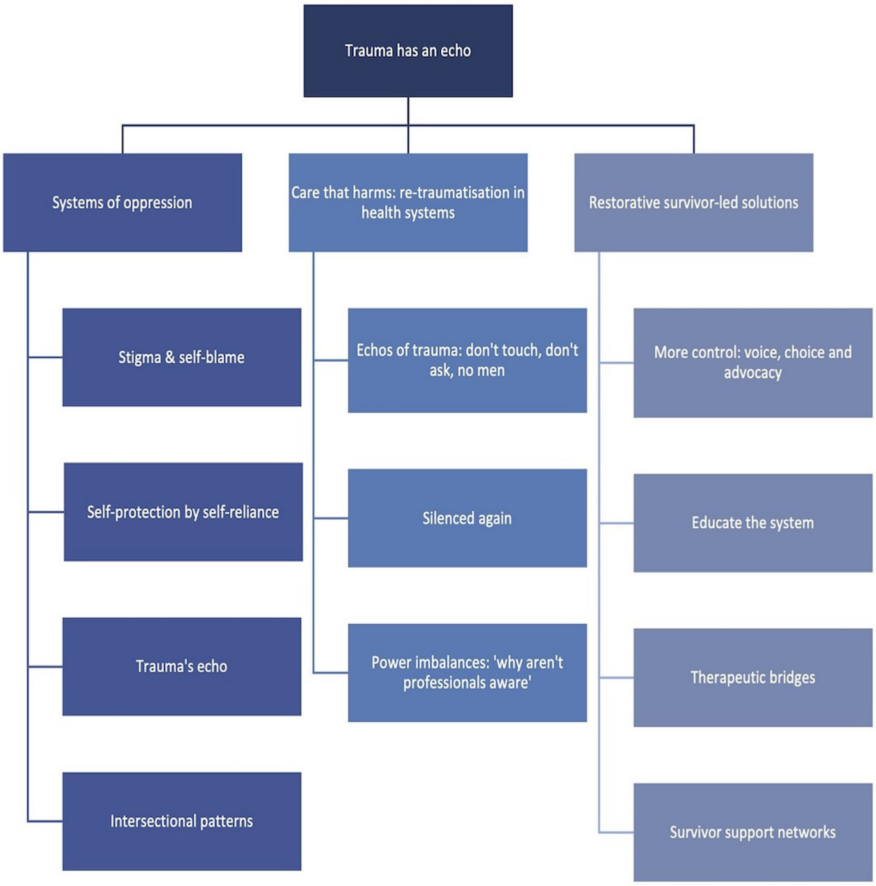

Figure 1 Overview theme map.

Often this was due to the victim-blaming tone that questions were framed:

> They asked why I would have unprotected sex in a way that felt disapproving. I felt ashamed – p5, female, early 20s
>
> They thought I was wasting time using the service and it was my fault that I was in this position of potentially being pregnant – p5, female, early 20s

Even when survivors disclosed, many found that healthcare providers silenced them again through dismissal:

> I said that I felt really overwhelmed and she replied to me saying something along the lines of 'you're too old to be scared of the dentist' whilst smirking!!! Why aren't healthcare professionals aware of this?? – p6, female, mid 20s

For some survivors, male healthcare providers triggered memories of abuse by male perpetrators, and the prospect of a male healthcare provider heightened their vulnerability:

> I doubt their intentions, thinking they will be inappropriate or perverted – p3, female, late teens

The hierarchical and often gendered structure of healthcare often mirrored the abuse of power that had facilitated victimisation:

> My experience was with a male individual that had authority over me - so never again will I trust a man that I do not know personally – p6, female, mid 20s

Theme 3: Restorative survivor-led solutions

Survivor-led solutions to overcoming barriers included individual ways of restoring the control lost through SV, but survivors emphasised addressing systems that replicate victim-blaming and gender inequality. Survivors in this study expressed a general need for greater autonomy, including specific measures to reduce uncertainty and safe mechanisms to flag their needs, such as services approach to touch and examination, the need to disclose but not necessarily discuss ('don't ask') and minimising feelings of vulnerability:

> If you book online…there's like, never the option to mention it…but yeah I think that would be great if they could actually do that – p4, female, early 20s

This was particularly important for those anticipating potentially triggering appointments:

> I had the coil put in, and it was horrendous, so it would have been nice to let someone know beforehand – p2, female, early 20s

Additionally, there was a strong preference for being able to choose the gender of their provider, as well as access to culturally competent staff:

> An option to choose between a male and female doctor, as well as an option of 'I don't mind' when initially booking an appointment – p31, female, late teens

> Younger (queer trained) female staff have made sexual health treatment feel safer – p1, non-binary transmasculine, late 20s

Many survivors wanted the option to bring a support person with them to their appointment:

> …having someone that you trust in the room just watching and being there in support – P39, female, late teens

Many survivors perceived a lack of trauma awareness among healthcare professionals:

> Healthcare professionals that work in mental health know how to be with me – it's the physical health people that have no idea. They know our brains are connected to our bodies right? Because it doesn't seem like they do – p6, female, mid 20s

Comprehensive training across healthcare needed to go beyond basic, cursory protocols:

> People say we have to do a mandatory half-day safeguarding course once every six months (laughs). It's like, that's not what I fucking mean – p1, non-binary transmasculine, late 20s

Survivors offered ideas about what that training needed to cover, such as information and warnings to better prepare patients for what to expect. For instance:

> Explain what a healthcare professional is going to do. Before doing so, ask for permission and give warning….this would help since I wouldn't be shocked by anything – p39, female, late teens

Survivors also advised that routine questions should be phrased more mindfully around sensitive topics:

> They should be wary of how intrusive their questions are and be less judgemental – p7, female, early 20s

One survivor shared the experience of a clinician getting it right:

> She explained each step of the examination process clearly and made sure I understood what was happening. She asked for my consent before proceeding which made me feel respected and in control of the situation…This positive interaction helped me feel more confident seeking medical care in the future – p31, female, early 20s

Finally, task-focused individual and group-based specialist counselling was suggested as a bridge to access healthcare:

> Counselling to address trauma-related symptoms and develop coping strategies for navigating healthcare settings – p19, male, early 20s

> …it would help to see that other people accessed it and had positive experiences or how to cope with negative ones – p13, female, early 20s

DISCUSSION

Underpinning the widespread avoidance of healthcare services among the survivors in this study, our data describes a cycle of self-protective isolation and self-reliance, stemming from well-evidenced societal silencing and rape myth-informed victim blaming.[18] Surviving trauma made looking after your health seem less important but also less deserved. Providers seemed oblivious that physical touch, triggering questions and gender/power vulnerability, replicated elements of both the original trauma and societal shame/silencing.

Restorative care and co-production of patient pathways could improve survivors' engagement[19] to create supportive healthcare environments.[20 21] Although co-produced services for survivors are not yet widespread, initiatives like the 'My Body Back' project in London and Glasgow[22] and the ASC clinic in Birmingham[23] provide valuable examples of survivor-specific healthcare. However, these should be complemented by system-wide implementation of trauma-informed approaches that ensure all healthcare services are safe and accessible — regardless of an individual's trauma history or whether that history has been disclosed.

There is some evidence that targeted mental health support, such as short eye movement desensitisation and reprocessing (EMDR) and coping skills interventions, can help survivors prepare for triggering medical appointments, such as dental visits or smear tests.[24] Survivors themselves mentioned the potential role of chaperones and support groups. Expanding existing groups to include sessions focused on healthcare access could offer practical advice, shared experiences and emotional support. However, specialist support agencies are widely underfunded at present with long waiting lists.[25]

Harmful gender power dynamics have been evidenced across the NHS[26] and in organisations across society.[27] These survivors described healthcare that perpetuated wider societal victim-blaming. Caring for survivors of SV requires settings that address their own systemic gender inequalities.

Contextualising both individual behaviour and institutional responses within a wider, rights-based, societal lens helps us connect this work with efforts to address other NHS inequalities[28] as well as the evidence of what works in tackling VAWG.[29] The NHS aims to provide a trauma-informed service,[30] but this study suggests it is falling short and failing survivors of SV.

Strengths and limitations

This study provides unique insight into the barriers survivors of SV face when accessing healthcare services in the UK. A trauma-informed approach to data collection emphasised survivor autonomy to facilitate participation — including offering different data collection methods and avoiding questions about the trauma itself. However, this also limited the collection of detailed demographic or experience-based data. As such, the study is unable to fully explore the nuanced barriers faced by different groups, particularly racially and sexually minoritised communities, whose voices remain underrepresented. In addition, the sample was drawn from a narrow age range within a higher education setting, which further limits the scope of the findings. For example, some participants may not yet qualify for routine cervical screening in the UK, and lower engagement with general practice among younger adults may have influenced reported healthcare experiences.

Findings from this small-scale study are not generalisable but offer transferable, preliminary, survivor-led proposals for improving access to healthcare for survivors.

Conclusion

This smaller scale study is the first to document potentially widespread avoidance of healthcare by survivors of SV. If rates are anywhere near the 86% avoidance for the 7.9 million survivors in the UK, it exposes an alarming and yet invisible unmet need. Survivors described a wider culture of marginalisation, driving self-protective avoidance at the cost of their physical health.

The lives of individuals express wider societal patterns that healthcare systems also seem to echo, amplifying harm. No existing research evidence speaks to the invisible healthcare needs of survivors of SV. Sexual trauma silences, which is reflected in the low rates of sexual crime reporting. Survivors experience isolation which continues to harm through coping strategies of self-reliance and healthcare avoidance. Health systems and staff can compound this harm, contributing to significant health inequalities and poorer health outcomes for survivors.

Ultimately, healthcare institutions should play a role in breaking cycles of victimisation, ensuring survivors receive the tailored care they need and improve the health outcomes among this population. This research operationalises the widely called for 'trauma-informed care' into concrete, survivor-led measures.

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Acknowledgements The authors wish to express their gratitude to the survivors who bravely took part in this research.

Contributors All authors fulfil the ICMJE authorship criteria. LH was responsible for the study design, ethics application, data analysis and manuscript writing. LH had complete access to all the data and takes responsibility for the integrity and accuracy of the data analysis. JM provided supervision, guidance on study design and analysis and assistance with manuscript drafting. LH holds overall responsibility for the content as the guarantor.

Funding The authors have not declared a specific grant for this research from any funding agency in the public, commercial or not-for-profit sectors.

Competing interests None declared.

Patient and public involvement Patients and/or the public were involved in the design, or conduct, or reporting, or dissemination plans of this research. Refer to the Methods section for further details.

Patient consent for publication Not applicable.

Ethics approval This study involves human participants and was approved by the College of Health, Science, and Society Research Ethics Committee at the UWE (ID: CHSS.24.01.091). Participants gave informed consent to participate in the study before taking part.

Provenance and peer review Not commissioned; externally peer reviewed.

Data availability statement Data are available upon reasonable request. Individual participant data that underlie the results reported in this article, after deidentification, is available upon reasonable request immediately following publication and ending 5 years following article publication with anyone who wishes to access the data. Proposals should be directed to https://orcid.org/0009-0007-2980-8061.

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