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1 **Obstetric Violence against Women in the Portuguese Context: A Qualitative In-**
2 **Depth Approach**

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Abstract

21 Evidence suggests that women worldwide experience mistreatment during institutional
22 childbirth. This qualitative study aimed to explore obstetric violence in Portugal,
23 specifically, its related factors and perceived impact. The inductive thematic analysis of
24 19 semi-structured interviews with women living in Portugal (22-41 years old), who
25 identified themselves as victims, revealed six central themes: (1) obstetric violence, (2)
26 the impact of obstetric violence, (3) victims' awareness, (4) coping strategies, and (5)
27 explanatory factors. This study adds relevant evidence on what (experiences), why
28 (explanatory factors), and how (processes and coping strategies) obstetric violence
29 might occur, as well as its psychological, interpersonal, and physical impacts.

30 **Keywords:** *Obstetric Violence; Coping; Impact; Qualitative Study*

31

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33 **Data Access Statement:** Research data supporting this publication are not available
34 because of confidentiality concerns.

35

Introduction

36 Worldwide, women are threatened when they experience disrespectful, abusive,
37 or negligent treatment during childbirth, including psychological or physical abuse,
38 discrimination, abandonment, and privacy violations (Bohren et al., 2019; Castro &
39 Rates, 2021; Miltenburg et al., 2018; Silveira et al., 2019). Thus, it is important to
40 explore women's perceptions related to pregnancy and childbirth, as they might inform
41 health care policies and clinical practices. The current study aimed to explore women's
42 voices regarding their experiences of obstetric violence. Obstetric violence involves
43 dehumanized care provision, which can involve health professionals' negative conduct
44 affecting the woman's body and reproductive system (e.g., Annborn & Finbogadóttir,
45 2022; Trajano & Barreto, 2021). Similar to other forms of violence, obstetric violence
46 has a range of severity levels, including subtle forms (e.g., the prohibition of a birth
47 partner, restriction of the woman's mobility) and more severe practices (e.g., abdominal
48 pressure [Kristeler Manoeuvre] and threats) (Bohren et al., 2019; Pontes et al., 2021).

49 Obstetric violence is a worldwide public health concern due of its non-negligible
50 prevalence across countries, affecting women of all backgrounds, ages, cultures, and
51 socioeconomic status (Abuya et al., 2015; Carer et al., 2021; Kruk et al., 2014; Limmer
52 et al., 2023; Martínez -Galiano et al. 2020). Global structural factors perpetuating social
53 and gender inequalities, as well as patriarchal structures that reinforce gender
54 stereotypes may facilitate obstetric violence (Bohren et al., 2019; Sadler et al., 2016).
55 Specifically, these social structures and inequalities might allow practices involving the
56 objectification of the women's body, the restriction of their autonomy, and the
57 minimization of their suffering (e.g., "the woman must be a good mother", "must
58 prioritize the baby's well-being over her own" and, "must collaborate during labor")
59 (Bohren et al., 2019; Smith-Oka, Rubin & Dixon, 2021). Furthermore, there are specific

60 cultural and social factors that might influence the experience of obstetric violence, such
61 as social norms regarding motherhood and labor/birth (e.g., physiological or
62 medicalized birth), and health policies of obstetric health (Bohren et al., 2019; Savage &
63 Castro, 2017). For these reasons, countries with underfunded healthcare systems,
64 limited financial and human resources, and few support systems for the most vulnerable
65 population may be more prone to obstetric violence (Savage & Castro, 2017; Smith-Oka
66 et al., 2021). In fact, there is significant evidence focused on obstetric violence in
67 women from low-income countries such as Nigeria, Ghana, Guinea, and Myanmar
68 (Bohren et al., 2019). These studies highlighted a significant number of women who
69 reported experiences of physical and verbal abuse, stigma, discrimination, non-
70 consensual interventions, and inequalities in treatment during labor, suggesting a greater
71 risk among younger women with less education (Bohren et al., 2019).

72 Nevertheless, there is a recent concern related to obstetric violence in middle-
73 and high-income countries, where even though there are more resources in the
74 healthcare system, the prevalence of obstetric violence seems to be non-negligible. In
75 addition to the structural factors previously highlighted, the excessive medicalization of
76 childbirth and rigid high hierarchy in the relationships between health professionals and
77 women might contribute to experiences of obstetric violence (Mena-Tudela et al.,
78 2020b; WHO, 2018). Studies suggest that there is a set of unnecessary medical
79 interventions (such as scheduled cesarean or early inductions or episiotomies), that
80 might undermine women's autonomy in the decision-making processes, with a negative
81 impact on childbirth (Costa et al., 2022; Mena-Tudela et al., 2020b; WHO, 2018).
82 Conversely to the evidence gathered from the low-income countries, some studies
83 developed in middle and high-income countries suggest that women's higher levels of
84 education and their attendance in antenatal classes might increase their awareness about

85 their rights and ability to identify abusive health care practices (Gonzalez-De la Torre et
86 al., 2023; Martínez-Galiano et al., 2021; Mena-Tudela et al., 2020a).

87 Therefore, this study focuses on women's perspectives and experiences on
88 obstetric violence in Portugal. Evidence from our country suggests that women report
89 experiencing excessive unnecessary or not-consented medical interventions, lack of
90 information, feelings of objectification, verbal abuse, threats, blaming, and exclusion of
91 birth partners during childbirth (Barata, 2022a; Barata, 2022b). A large-scale study
92 developed during the COVID-19 pandemic among 1845 women, using a self-report
93 questionnaire based on standards of care defined by the World Health Organization
94 (2016), suggested that approximately 23% of women reported emotional, physical, and
95 verbal abuse during childbirth, as well as non-evidence-based practices and unequal
96 access to outstanding maternal health care services across different regions (Costa et al.,
97 2022). However, national research exploring women's perspectives about the impact of
98 obstetric violence on their psychological functioning, as well as the factors that can
99 mitigate or intensify the potential negative impact of this experience remains limited.

100 Some international evidence suggests that disrespectful and abusive practices are
101 associated with a greater likelihood of developing psychological stress (McGarry et al.,
102 2017) or depression (Silveira et al., 2019) in the postpartum period. Moreover, other
103 negative impacts, such as physical injuries to the baby and mother, feelings of mistrust
104 and resentment, weakening of family ties, and impact on the mother-baby relationship
105 have been reported (Elmir et al., 2010; Garcia, 2020; Martinez-Galiano et al., 2020;
106 Silveira et al., 2019; Taghizaden et al., 2021). Long-term impact includes negative
107 memories of childbirth, nightmares, panic, and fear of childbirth (Annborn &
108 Finnogadóttir, 2022; Dias & Pacheco, 2020; Taghizaden et al., 2021; Vedam et al.,
109 2019).

110 In sum, the literature suggests that, on one hand, there are some factors affecting
111 obstetric violence across the world (e.g. gender inequalities) and, on the other hand,
112 there are other specific cultural and social factors that might explain this type of
113 violence (e.g. conditions and policies in the healthcare systems). As such, more cross-
114 cultural research is required to gain a more in-depth understanding of the social
115 specificities that may influence women's expectations, perceptions, and experiences of
116 pregnancy and childbirth (Dias & Pacheco, 2020; Mena-Tudela et al., 2020a; Savage &
117 Castro, 2017; Silveira et al., 2019; Taghizadeh et al., 2021). Therefore, this study aimed
118 to explore women's perceptions related to pregnancy and childbirth in the Portuguese
119 context. Specifically, we aimed to explore (1) women's perceptions of mistreatment
120 experiences during their pregnancy and childbirth (what type of mistreatment
121 experiences they faced, and why do they occur?) (2) the processes and dynamics of
122 abusive experiences in the obstetric context (how do women cope with these
123 experiences?) (3) perceived impact of these experiences on women's psychosocial
124 functioning.

125 Method

126 Participants

127 This study was conducted with 19 women living in Portugal (22-41 years old; M
128 = 33.2; $SD = 1.1$), who identified themselves as victims of obstetric violence. The
129 inclusion criteria considered were: (1) age equal to or greater than 18 years; (2) women
130 residing in Portugal who gave birth in hospitals; (3) birth occurred before the COVID-
131 19 pandemic (March 2020 to March 2022). The period of the COVID-19 pandemic was
132 defined as an exclusion criterion because this time interval presents specificities likely
133 to bias the results of the study (e.g., during the period of the COVID-19 pandemic,
134 health care provision and standards underwent significant changes).

135 Insert Table 1 about here

136 **Instruments**

137 *Sociodemographic Questionnaire*

138 Sociodemographic data (e.g., age, nationality, marital status, and number of
139 children), as well as obstetric and delivery information (e.g., gestational age of the baby
140 at the time of delivery, type of delivery, and delivery plan) were collected through a
141 self-report questionnaire.

142 *Semi-Structured Interview Guide*

143 All authors of this project are Psychologists. Their expertise informed the
144 development of the questions, as well as considered the gaps in the previous literature
145 (i.e., the need to explore the women's perspectives on the impact of obstetric violence
146 on their psychological functioning, as well as the factors that can mitigate or intensify
147 the potential negative impact of this experience). The semi-structured guide included
148 open-ended questions to explore women's perceptions about the following dimensions:
149 (1) their experience of pregnancy and childbirth regarding prenatal care, humanization
150 of care, procedures, and postpartum (e.g., “*How would you describe prenatal care*
151 *considering both positive and negative aspects?*”); (2) the fulfillment of their rights,
152 specifically with regards to choices and options, autonomy and self-determination in
153 decision-making, privacy and confidentiality (e.g. “*In what way do you consider that*
154 *you had an active participation in decision-making on the procedures implemented by*
155 *health professionals?*”) (3) Identification of abusive obstetric clinical practices (e.g.,
156 “*Thinking about your experience, do you identify any practice that you consider*
157 *abusive, that is, that undermined your rights within the scope of hospital obstetric*
158 *care?*”); (4) the perception of the impact of childbirth experience (e.g., “*How did your*
159 *experience in the context of childbirth impact your life in the short and long term?*”).

160 **Data Collection and Analytical Procedure**

161 This research project was approved by the Ethics Committee of the Lusófona
162 University (Ref. 43/2021). The sampling process was intentional, benefiting from the
163 support of the following partners to disseminate the study and recruit our participants:
164 one association that support women’s rights in pregnancy and childbirth, one
165 organization advocating for victims of obstetric violence, and an activist lawyer who is
166 widely recognized for advocating for birth rights in Portugal. These partners
167 disseminated the study in their mailing lists and social media (e.g., Instagram,
168 Facebook), and women who met the inclusion criteria and agreed to be contacted by the
169 research team were then contacted by the first author. The research objectives and
170 participation conditions (e.g. procedures, audio-recorded interviews, voluntary
171 participation, confidentiality, and anonymity) were provided to the participants, and
172 informed consent was obtained. Face-to-face interviews were conducted in Portuguese,
173 by the first author, between January and May 2022. These interviews lasted an average
174 of 60 minutes and were audio recorded. The participants' privacy and confidentiality
175 were ensured. All participants were debriefed after the interviews and signposted to
176 relevant services or support if required (i.e., team members’ contacts and referral to
177 specialized support if needed). The sample size was determined using theoretical
178 saturation criteria, which means that more interviews would not provide new data.

179 The interviews were transcribed verbatim in Portuguese by the first author and
180 subsequent data processing and respective analyses were performed using the QRS
181 Nvivo10 software. Audio files and transcribed interviews were anonymized and stored
182 electronically with restricted access and password protected. Data were analyzed by the
183 first author using thematic analysis according to the steps defined by Braun and Clarke
184 (2006): (1) familiarization with the data through the transcription of the interviews and

185 their initial exploration; (2) creation of initial codes through the identification of
186 significant patterns in the data; (3) searching for themes and subsequent coding into
187 categories; and (4) review of themes to ensure internal consistency and external
188 heterogeneity. Finally, the themes and subthemes were defined and hierarchized. An
189 inductive and inclusive approach to the data was adopted. To ensure data analysis
190 validity and reliability, the categorization and coding process was systematically
191 discussed among the research team. Feedback from some participants on the results was
192 obtained to check for data accuracy and validity. Trustworthiness was also ensured by
193 providing examples of participants' expressions to illustrate the themes identified. Only
194 in this stage of the research process, the original Portuguese narratives shared by the
195 participants were translated by the first author to English and revised by the other
196 authors.

197 **Results**

198 **Characteristics of Participants**

199 Most of the women who agreed to participate in this study were Portuguese
200 ($n=16$; 84.2%). All women reported living with their children and their parents; most
201 were married at the time of the interview ($n=12$; 63.2%) and had two children ($n=10$;
202 52.6%). Concerning academic qualifications, most participants had completed a
203 bachelor's degree ($n=12$, 63.2%) and were employed ($n=14$, 73.7%). Regarding monthly
204 family income, our participants earned between 800€ and 4500€, and most of them
205 earned between 1500€ and 2500€ ($n=14$; 40%).

206 Among the obstetric and delivery characteristics, the maternal age at the time of
207 delivery ranged from 17 years and 36 years ($M=28.47$; $SD=1.63$). Regarding the
208 gestational age at delivery, most occurred at 39 weeks of gestation (42.1%). Most of the
209 reported deliveries were vaginal (78.9%), involving analgesia before or at the time of

210 delivery (89.5%), and having a birth partner during the labor (78.9%). Most participants
211 mentioned having attended antenatal classes (84.2%), but did not have a birth plan
212 (73.7%) in place. Finally, 13 participants reported that, in the immediate postpartum
213 period, they had skin-to-skin contact with the baby (68.4%) (see Table 1).

214 **Women's Experiences and Meanings**

215 Five main themes emerged in this study: (1) *Obstetric Violence*, which involves
216 a range of abusive or negligent practices of health care professionals; (2) the *Impact of*
217 *Obstetric Violence*, which involves psychological, physical, and interpersonal effects
218 from the experience; (3) *Victims' awareness*, which pertains to the reactions of victims
219 towards mistreatment, encompassing the point at which women came to realize the
220 violent nature of their experience; (4) *Coping Strategies*, which refers to the strategies
221 identified by women to deal with the experience; and (5) *Explanatory Factors of*
222 *Obstetric Violence*, which includes structural factors that are perceived as causing or
223 heightening mistreatment.

224 Insert Table 2 about here

225 ***Obstetric Violence***

226 All the women identified at least one experience of obstetric violence in the
227 context of pregnancy and childbirth. Specifically, these experiences included poor
228 rapport between women and health care providers, the perceived failure to meet
229 professional standards of care, physical abuse, verbal abuse, secondary victimization,
230 birth partners mistreatment, and prejudice. *Poor rapport between women and health*
231 *care providers* refers to ineffective communication, with partial explanations or
232 incomplete information provided by health professionals, as well as a lack of support
233 and dehumanized care or a loss of autonomy during labor, involving the objectification

234 of their bodies, such as the systematic and intrusive touches by several professionals
235 without consent or explanation:

236 And without saying anything, she introduced the ‘microlax’ [laxative] into my
237 anus, without any explanation, I even jumped. She then said, *Go to the*
238 *bathroom.* (P10, 41 years old)

239 I no longer even know how many (health care providers) have touched me.
240 What’s more, if you ask me if they were doctors, if they were nurses or
241 assistants, and if it was the man from the kitchen, I do not know. They come in,
242 and they do not identify themselves... They do not speak with people and come
243 in and touch. And then they do not say anything, and they turn their backs. (P4,
244 36 years old)

245 Furthermore, obstetric violence was described by the participants as the *failure*
246 *to meet professional standards of health care.* Several women reported lack of
247 informed consent and negative professionals’ attitudes during physical
248 examinations as deviations from professional standards:

249 And it was always speedy: *come on, it must be signed because if not, there is no*
250 *hospitalization.* Okay, I signed it. (P1, 29 years old)

251 It was in our plan that we didn't want that to happen. She went into [the
252 bedroom], placed her fingers in, and performed a membrane sweep. The pain
253 was excruciating. She did not even ask (me) anything. (P19, 30 years old)

254 The participants vividly described their feelings of abandonment, which means that
255 these women felt left behind or dismissed about their concerns and feelings:

256 The whole time I was dilating and then in labor I was absolutely alone. I was so
257 alone that I felt abandoned. They forgot that I was there. (P7, 37 years old)

258 Medical negligence was strongly noted as the failure of professionals to meet the
259 required standards of care, even in the presence of physical symptoms:

260 It was only when the shift changed that I told a new nurse who came to
261 introduce herself: *I'm not feeling well. I have already told your colleagues. I'm*
262 *not feeling well and there's something that's not right.* Only then did she check
263 the temperature, and I had a fever. (P9, 35 years old)

264 Physical and verbal abuse was also mentioned by our participants. Regarding
265 *physical abuse*, women pointed out the use of physical force and the perception of body
266 violation as the most prominent practices:

267 And that's what I felt that I was there with two enemies in front of me. It does
268 not matter what I screamed or how much I screamed, that did absolutely
269 nothing. What I felt in the moment and then over the days, I felt even more was
270 that I was raped. I was saying: no, no, no, and people kept doing things to my
271 body (P13, 26 years old).

272 According to our participants, *verbal abuse* included threats by professionals,
273 allegations, and offensive language. Some participants expressed concerns not solely
274 about the offensive and unkind manner professionals interact, but also regarding the
275 professionals' perceptions of them:

276 I was asking: 'but is everything alright?' -*Yeah, stay quiet for now.* Like, you
277 are there because you have a baby, you are nobody. (P18, 34 years old)

278 *Secondary victimization* was identified by the participants, including minimizing the
279 negative impact of obstetric violence by the informal support network (family and
280 friends), along with the blaming of the victim within the judicial process:

281 Later, during the court proceedings, we presented our side of the story, and the
282 doctor claimed she used a suction cup because I did not cooperate. Did not

283 cooperate!? I was physically unable to, and I should not be blamed for that. (P4,
284 36 years old)

285 Another dimension mentioned by some participants was *birth partners*
286 *mistreatment*, which involves verbal abuse (e.g., harsh and rude language, judgmental
287 comments, threats) and exclusion from the labor and birth process (e.g., refusal to
288 provide information and/or explanations):

289 My husband was pushed out, was pushed away by two people. I do not know if
290 they were nurses or assistants, and he was pushed out without any explanation
291 to the door outside the delivery ward. Even today, he says, I was thinking that
292 you were going to die. I did not understand why suddenly someone came in and
293 expelled me from there. (P4, 36 years old)

294 Finally, although less frequent, experiences of *prejudice* were reported by some
295 participants, namely a set of negative beliefs about these women, including those related
296 to the participants' nationality:

297 Between these moments of pain, one of the nurses said: *But are not you*
298 *Brazilian? Do your people say that they are happy? Where is your joy now?*
299 And that was the point that made me upheaval there. (P1, 29 years old)

300 ***Impact of Obstetric Violence***

301 The perceived impact of obstetric experience by our participants involved
302 psychological, interpersonal, and physical impacts. The *psychological impact* during
303 and after the violence experience includes immediate reactions, such as crying, despair
304 and tremors. Some participants reported panic, and the negative feelings related to
305 childbirth:

306 Always in that mouth chatter of *it's your fault if something happens, you're not*
307 *cooperating; you don't help*. Okay, and of course panic set in there, did not it?
308 (P17, 33 years)

309 Others emphasized a sense of relief with the birth of the child, which means that
310 instead of experiences of happiness or being delighted by the child, these women felt
311 that their difficult childbirth experience is no longer happening:

312 When people said they felt happiness and joy when they held their babies in
313 their arms...I did not feel any of that. I felt relieved that he had already been
314 out. (P2, 25 years old)

315 Participants highlighted their feelings of fear and thought that they might be in a
316 particularly vulnerable situation if they shared their feelings and needs:

317 So, I really kept quiet. I chose to be a little quieter because I was really afraid of
318 what could happen if I started complaining a lot more. (P1, 29 years old)

319 This feeling of fear tends to last over time and generalize to various situations, such
320 as the perceived lack of security and trust in healthcare services and professionals:

321 Nowadays, I go to a doctor, and I no longer feel the confidence I used to have
322 in doctors. I would go to the office and feel calm and comfortable, and I would
323 go calm. Not now, not with me or my daughter; going alone... terrifying, very
324 afraid of what they might do to her without her parents' consent. (P19, 30 years
325 old)

326 Linked to this experience of fear and the feeling of vulnerability, participants
327 reported feeling helpless guilty, but also a sense of frustration:

328 It was at this moment that I couldn't even say: wait a minute! I could not, words
329 could not come out, and nothing came out. I accepted what was happening. (P3,
330 22 years old)

331 Many women must have the same thought that I had of thinking that it was our
332 fault, that we were insufficient, that we should have spoken up. (P1, 29 years
333 old)

334 Even today, these issues... seven years have passed, and they still disgust me a
335 lot. (P4, 36 years old)

336 The psychological impact of this experience included depressive symptoms and
337 post-traumatic stress such as nightmares, recurrent traumatic memories (flashbacks),
338 and avoidance of thoughts or places related to the experience:

339 I had nightmares about it for, I don't know, one year or more. I remembered
340 screaming in the middle of the night. (P15, 38 years old)

341 Likewise, the interviewees described recurrent feelings of sadness, isolation, and
342 changes in their thought process, as well as some described a formal diagnosis of
343 postpartum depression:

344 I didn't think of throwing myself out of the window, I didn't think of throwing
345 the boy out of the window, but I would see myself falling out of the bedroom
346 window with the child in my arms. Sense of abyss, sense of helplessness, sense
347 of sadness, that's how I was. (P8, 34 years old)

348 I had postpartum depression when 'X' [her baby] was four months old. He was
349 an intense baby; he needed attention as I did. Maybe I also needed attention and
350 affection in that postpartum period (P16, 33 years old).

351 Regarding *interpersonal impact*, such as on intimate relationships, participants
352 reported difficulties in bonding with their partner, especially experiencing changes in
353 individual functioning (e.g., irritability, sadness, isolation) and difficulties in
354 maintaining intimate and sexual relationships:

355 Every time my boyfriend tried to touch me, I always remembered the birth and
356 the way I had been treated, because that was a bit of a violation of my body.

357 That's how I felt. (P9, 35 years old)

358 In addition, the participants described the impact on their interaction with the
359 baby, citing emotional ambivalence in those moments and expressing difficulties and
360 perceived limited confidence regarding their ability to parenting, particularly regarding
361 breastfeeding:

362 About six months after giving birth, I did not feel well. I could not go out with
363 my baby and was happy. It was difficult to interact. (P12, 38 years old)

364 Finally, the *physical impact* (for the woman and the child) described by the participants
365 included immediate harm, such as the postpartum consequences stemming from an
366 episiotomy, together with the irreversible damages resulting from childbirth:

367 And it also changed in the postpartum period, I had a very long cut, very
368 stepped on and I couldn't pee and poop. (P13, 26 years old)

369 This 'beautiful birth' left my daughter with sequelae for the rest of her life. I
370 have also experienced irreversible damage. I have undergone hip replacement
371 surgery, which is something that gets into the elderly. At 36 years of age, I had
372 hip replacement. (P4, 36 years old)

373 *Victims' Awareness*

374 Victims' awareness was mentioned by almost all participants, specifically the
375 mistreatment recognition, the challenging 'normality,' and the recognition of the birth
376 partners mistreatment. *The mistreatment recognition* is associated with the moment
377 women realize their childbirth experience was abusive. This awareness did not
378 consistently occur immediately. Some women reported recognizing the abusive aspects

379 of their childbirth experience while still in the hospital, others needed an extended
380 period to fully integrate this realization:

381 I had much information about childbirth, so I realized, while still in the hospital,
382 that the situation was awful for me. (P12, 38 years)

383 I think I only had a full understanding of it almost two years after childbirth.
384 (P15, 38 years)

385 Some participants reported *challenging the perceived normality* of the experience,
386 recognizing the sense that something had gone wrong without yet identifying the nature
387 of the violence:

388 And I was trying to convince myself that the experience hadn't been that bad.

389 But the truth is, I would just cry every time I talked about the birth. (P13, 26
390 years old)

391 Finally, the victims *recognized the mistreatment of their birth partners* and realized
392 that this experience had also affected them. Specifically, they mentioned depressive
393 symptoms and self-blame associated with the perceived helplessness they felt in falling
394 protecting both the woman and the baby during the process of labor and birth:

395 It was challenging because my husband was very traumatized by the childbirth
396 experience. He thought he was going to lose us, and that he had not done
397 anything. The feeling of guilt after birth was 100 %. (P1, 29 years old)

398 ***Coping Strategies***

399 Findings from this study revealed that the coping strategies used by the
400 participants to deal with the mistreatment experience could be described as primary
401 strategies (i.e., more immediate) or more long-term strategies, such as sharing the
402 experience, seeking formal and informal support, meaning-making, , and making a
403 formal complaint. In this context, the *primary strategies* included passive responses,

404 characterized by acceptance of their reality and experience as mentioned by a
405 participant:

406 I noticed in the hospital a predisposition to accept everything. Okay, I would
407 like to do it that way, but I can't, it doesn't matter, I'll change my idea if
408 necessary. (P13, 26 years old)

409 Others highlighted a more assertive behavior in which the woman managed to
410 impose their views:

411 And I said: *Doctor, I appreciate your opinion, but I don't want an episiotomy.*

412 It's my will. This time, I do not want to. If it goes wrong, I will take over. (P11,
413 27 years old)

414 *Sharing the experience* with others was mentioned by most participants as a strategy
415 of self-validation in this context, getting support from other women and breaking the
416 belief of being a 'unique case':

417 I'll share what I think is important. If I can ever help even one person with one
418 of my shares, I think it's worth it. (P14, 39 years old)

419 Our participants revealed that they *search for formal support*, particularly
420 professional help from mental health staff, such as psychologists or psychiatrists, as a
421 resource to minimize the impact of the victimization experience and to support them
422 managing the emotional burden:

423 At the time I didn't know what I know today, and it was a very traumatic
424 childbirth. I did a lot of psychotherapy after that. (P17, 33 years old)

425 These participants described *informal sources of support*, such as friends or family,
426 as an important resource:

427 My sister is the girl's godmother, and from the beginning, when I needed her,
428 she supported me a lot. However, nowadays I try not to pass on these concerns
429 to her. I rely a lot on my husband, and he relies on me. (P4, 36 years old)

430 Moreover, *meaning-making* coping was adopted by some women to overcome the
431 abusive experience:

432 And that was the beginning of the healing process and accepting what happened
433 and at the same time accepting that I can't change what happened, but I can face
434 what I can do now. And if every woman who passes by me (in my role as a
435 nurse) manages to stop them from doing what they did to me, it will be one
436 woman less. Okay, that gave me focus again (...) I decided to pursue a specialty
437 in maternal health precisely because I started to think that I could try to do
438 something different. (P6, 31 years old)

439 Finally, some participants referred to *filing complaints* as a strategy to cope with
440 their experiences, seek justice, and aim to raise awareness about this type of violence.
441 They hoped to contribute to a more effective identification of such cases, thereby
442 reducing the risk to other women:

443 If I can make a complaint? I will. I have nothing to lose. I do not gain anything
444 from this, but other mothers can gain, because at least it attracts attention. (P9,
445 35 years old)

446 ***Explanatory Factors of Obstetric Violence***

447 This theme refers to participants' perceptions on the factors associated with
448 obstetric violence. Specifically, this theme involves the *social endorsement*, acceptance
449 and normalization of obstetric violence within social and institutional contexts.

450 According to the participants, social legitimization might perpetuate obstetric violence

451 practices, which in turn undermine women capacity to recognize the abusive nature of
452 such behaviors:

453 And they don't feel that it's a childbirth, it's more like: let's get this over with
454 because it's the normal procedure in the hospital. They do not feel the need to
455 explain, because it's just part of their daily routine. (P16, 33 years old)

456 Additionally, participants also considered that a set of *healthcare system constraints*
457 may facilitate these practices, especially the lack of human resources:

458 They said the obstetrician would arrive in the morning. I think during the night,
459 there was no obstetrician, or if there was, they were only on call for
460 emergencies, which was not the case, right? And in the morning, I remember it
461 was already broad daylight. I said, *but no one is coming to see me? I am in a lot*
462 *of pain.* (P7, 37 years old)

463 **Discussion**

464 This study aimed to explore women's perceptions and experiences related to
465 pregnancy and childbirth in the Portuguese context. All women reported at least one
466 experience of obstetric violence during childbirth, such as poor rapport between women
467 and health care providers, failure to meet professional standards of care, physical and
468 verbal abuse, secondary victimization, and prejudice. Data from this research is in line
469 with previous studies completed in Portugal (Barata, 2022a, 2022b; Costa et al., 2022),
470 in which abusive experiences, threats, and blame were reported, but the current research
471 adds to the previous insights by adding evidence about the experiences of stigma and
472 prejudice, secondary victimization, and poor rapport between women and health care
473 providers.

474 Our participants mentioned the loss of autonomy as the primary constraint in
475 their relationship with health professionals, including their exclusion from the decision-

476 making process regarding childbirth, lack of support, and non-personalized care. These
477 dehumanization practices of care and objectification of women's bodies are consistent
478 with international findings and may be framed in the literature on gender differences
479 and inequalities (e.g., Aguiar & d'Oliveira, 2011; Annborn & Finnbogadóttir, 2022;
480 Villarmeia & Kelly, 2020). Gender inequalities have been identified as structural
481 conditions that perpetuate power imbalances, limiting women's autonomy, and
482 contributing to their objectification in the obstetric context (Bohren et al., 2019; Sadler
483 et al., 2016; Smith-Oka et al., 2021). In certain circumstances, the delivery process in
484 the hospital context and, particularly, the medicalization of childbirth, can increase
485 women's feelings of losing their individuality and autonomy given that healthcare
486 providers might follow routine procedures without considering individual needs and
487 more person-centered approach to pregnancy and childbirth (Carer et al., 2021; Diniz et
488 al., 2015; Kruger & Schoombee, 2009; Mena-Tudela et al., 2020b).

489 Ineffective communication with healthcare providers is a cross-cutting
490 dimension, including the lack of information and explanations about procedures as a
491 failure to meet professional standards of care. Lack of prior information or refusal to
492 explain the procedure contributes to an inability for women to make informed decisions
493 (Bezerra et al., 2020; Bohren et al., 2015; Cassiano et al., 2016; Dias & Pacheco, 2020;
494 Elmir et al., 2010), which seems to be particularly critical in the Portuguese context as
495 Barata's studies have also acknowledged (Barata, 2022a, 2022b). Physical and verbal
496 abuse were also reported in this study, including excessive force and physical restraint,
497 as well as threats, judgmental approach, and insults, sometimes directed towards the
498 birth partner, along with their exclusion from the process. While verbal, emotional and
499 physical abuse of women is relatively well documented in national and international
500 literature (e.g., Bohren et al., 2019; Costa et al., 2022; Limmer et al., 2023, Reuther,

501 2021), these behaviors directed at women's birth partners emerged in this study as
502 something novel. Previous findings in the Portuguese context also highlighted the
503 exclusion of the birth partner from the birth experience (Barata, 2022a, 2022b), but not
504 the verbal abuse directed toward these birth partners. Thus, considering the significant
505 role of women's birth partners at this sensitive moment, these results reveal that
506 threatening behaviors might weaken the supportive role of these elements.

507 Social endorsements and healthcare system constraints were reported by our
508 participants as legitimizing obstetric violence, which highlights previous evidence
509 suggesting that normalizing obstetric violence might be due to a lack of awareness
510 among both professionals and women, who do not perceive these practices as abusive
511 (Freedman et al., 2014; Savage & Castro, 2017; Sen et al., 2018). In this study,
512 participants found it challenging to question professionals' behaviors, as they were
513 perceived as established clinicians following clinical policies and procedures. They also
514 noted that abusive practices, such as the restriction of autonomy, were socially accepted.
515 Societal expectations regarding women's behavior in obstetric settings and gender
516 stereotypes increase the normalization of abusive practices (Ayala et al., 2021; Bohren
517 et al., 2016; Hennig, 2016; Leite et al., 2022; Sen et al., 2018), its invisibility and
518 endurance (Freedman et al., 2014; Sen et al., 2018).

519 This is also true for women as some of them easily found themselves to be
520 victims, while others mentioned taking months or even years to having been able to
521 recognize the abusive nature of their experiences, which highlights the lack of
522 consensus regarding the abusive nature of certain practices (Freedman et al., 2017;
523 Lansky et al., 2019; Sen et al., 2018). This finding is particularly relevant as women
524 sometimes felt unsafe to question, seek support, or convey their concerns and share their
525 experiences of pain with health professionals, because of the fear of potential retaliation

526 and escalation of abusive acts (Aguiar & D'Oliveira, 2011; Bezerra et al., 2020; Elmir,
527 2010; Kruger & Schoombee, 2009).

528 By contrast, some women revealed that sharing their experiences and seeking
529 formal support were the most frequent coping strategies. Sharing this abusive
530 experience breaks the 'single case' believe and facilitates the unrestrained expression of
531 emotions, allowing for greater understanding, integration, and validation of the
532 experience (Elmir, 2010, Bezerra et al., 2020; Diamond-Smith et al., 2016; Kruger &
533 Schoombee, 2009). One of the most innovative results of this study is the
534 acknowledgement of the positive role of mental health staff, as well as support from
535 significant others, such as family, friends, and partners, during childbirth and
536 postpartum. This evidence is noteworthy to support women who have experienced
537 obstetric violence, since not only mobilizing mental health professionals is very
538 important for preventing or reducing psychological difficulties, but also informal
539 support can help them overcome such difficulties, by providing them with feelings of
540 comfort, assistance, and security (Bezerra et al., 2020; Diamond-Smith et al., 2016).

541 This support seems to be critical as our findings stress that obstetric violence is
542 particularly detrimental to women's psychological functioning, but it also entails
543 interpersonal and physical impacts (e.g., such as severe vaginal hematoma resulting
544 from episiotomy and labral rupture). While the impact on women's psychological
545 functioning is acknowledged in the literature (e.g., Ayers et al., 2016; Annborn &
546 Finnogadóttir, 2022; Martinez-Vázquez et al., 2021; Martinez-Vázquez et al., 2022;
547 Silveira et al., 2019; Paiz et al., 2022), and documented in this study, an innovative
548 result from the current work is the perceived interpersonal impact of obstetric violence.
549 As such, intimate relationships and mother-baby quality relationships were weakened
550 by this abusive experience, as women reported increased detachment from their intimate

551 partners and significant challenges in restarting sexual relationships because of the
552 violence they endured. Specifically, some women perceived the violence during
553 childbirth as a form of 'violation,' which in turn negatively impacted their sexual
554 relations, leading to heightened avoidance and discomfort (Elmir et al., 2010;
555 Taghizadeh et al., 2021). The mother-baby relationship also seems to be impaired,
556 including difficulties in breastfeeding, challenges in establishing a bond, or displaying
557 hypervigilant behaviors toward the baby (Elmir, 2010; Taghizadeh et al., 2021).

558 Overall, these findings are innovative as they suggest that obstetric violence is
559 more than an individual (woman-centered experience) or cultural (patriarchal social
560 structure) matter. This study adds an intermediate ecological level to better understand
561 obstetric violence, which refers to women's close interpersonal relationships (formal
562 and informal). First, these relationships can also be affected by abusive experiences (e.g.
563 when the birth partner is also the target of abusive behaviors). Second, interpersonal
564 relationships, such as supportive relations, are important protective factors to mobilize.
565 Third, the impact of obstetric violence might also involve dyadic relations with both the
566 baby and partner.

567 **Limitations and Implications for Research and Practice**

568 Despite the innovative findings described above, several limitations should be
569 considered. First, the characteristics of the sample are acknowledged and discussed.
570 Based on national statistics for Portugal (PORDATA, 2022), it is important to be careful
571 when discussing the current findings. It is worth highlighting the higher level of
572 education of our participants compared to the average in the Portuguese population.
573 Nevertheless, they earn a similar average monthly income (2063€) to the national
574 average monthly income (i.e., 39177€ per year/14 months= around 2700€). The sample
575 in this study had a lower average age of mothers at the birth of their children (28.4

576 years) compared to the Portuguese national average (31.6 years). Regarding marital
577 status, it is worth noting that less than half of Portuguese women (41%) are in a married
578 relationship, in contrast to the sample, where all women are married or live in a civil
579 partnership. As such, our sample is dissimilar in these demographics when compared
580 with the national population, and it also lacks diversity, given that it is composed mostly
581 of Caucasian women. Ethnicity and socioeconomic status are important markers of the
582 incidence of obstetric violence and the severity of abuse (Dwekat et al., 2020; Sen et al.,
583 2018), which should be further explored in future studies, including more diverse
584 community-based samples. Nevertheless, the intentional selection of the current
585 sample— that is, women who recognize themselves as victims of obstetric violence— may
586 justify these differences, as the characteristics of our participants might have made them
587 more prone to identifying obstetric violence experiences, providing a deeper and more
588 comprehensive understanding of this topic. Second, we did not explore any differences
589 or similarities among the narratives of the women considering their background
590 characteristics, which would be further explored in future studies. Finally, in this study
591 we only included the women’s voices, which require further studies that include the
592 perspective of health professionals to gain a more comprehensive understanding of
593 obstetric violence.

594 Despite these limitations, this study adds relevant data on what (experiences),
595 why (explanatory factors), and how (processes and coping strategies) obstetric violence
596 might occur in Portugal, which enables us to identify a set of recommendations for
597 practice and policy making at different levels. First, considering that the social
598 endorsement, normalization, and devaluation of these experiences seem to legitimize
599 obstetric violence and heighten its negative impact, it is essential to raise social
600 awareness about this specific type of violence. Not only can health providers may

601 endorse beliefs that justify abusive practices, but also women do not always recognize
602 themselves as victims. Second, healthcare systems must provide effective mechanisms
603 to safeguard women's and children's rights and implement policies, guidelines,
604 regulations, and care protocols that ensure person-centered, safe and respectful birth and
605 post-birth care. One of the key findings of this study was that interpersonal relationships
606 surrounding women serve as a significant protective factor for those who have
607 experienced obstetric violence. Moreover, it is essential to provide appropriate
608 responses to the psychological and physical needs of these women (e.g., psychological
609 support from mental health staff to address their emotional difficulties). Finally,
610 ensuring continuous training for healthcare providers is critical to ensure humanized and
611 trauma-informed care during pregnancy and childbirth. Further efforts deemed
612 necessary to prevent secondary victimization in women who report obstetric violence,
613 given that it negatively affects their psychological functioning.

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625

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822 **Table 1**823 *Sociodemographic and Childbirth Care Characteristics*

Variable	N (%)
Number of children	
1 child	8 (42.1)
2 children	10 (52.6)
3 children	1 (5.3)
Education Level	
Elementary school	1 (5.3)
High School	3 (15.8)
Higher education (bachelor's degree, master and PHD)	15 (78.9)
Marital Status	
Married	12 (63.2)
Life Partners	7 (36.8)
Nationality	
Portuguese	16 (84.2)
Others	3 (15.9)
Working Status	
Employed	14 (73.7)
Employed and Student	4 (21.1)
Unemployed	1 (5.3)
Delivery type	
Vaginal delivery	15 (78.9)
Cesarean section	4 (21.1)
Procedure	
Episiotomy	12 (63.2)
Induction of labor	11 (57.9)
Analgesia	17 (89.5)
Childbirth care	
Had a birth partner	15 (78.9)
Skin-to-skin	13 (68.4)
Birth Plan	
Yes, partially followed	1 (5.3)
Yes, but not followed	4 (21.1)
No birth plan	14 (73.7)

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827 **Table 2**

828 *Themes and Subthemes*

Themes	Sub-themes
Obstetric Violence (<i>N</i> =19; <i>f</i> =813)	Poor rapport between women and provider (<i>N</i> =19; <i>f</i> =468)
	Failure to meet professional standards of care (<i>N</i> =19; <i>f</i> =188)
	Physical abuse (<i>N</i> =17; <i>f</i> =62)
	Verbal abuse (<i>N</i> =17; <i>f</i> =60)
	Secondary victimization (<i>N</i> =10; <i>f</i> =22)
	Birth partners mistreatment (<i>N</i> =8; <i>f</i> =27)
	Prejudice (<i>N</i> =6; <i>f</i> =14)
Impact of Obstetric Violence (<i>N</i> =19; <i>f</i> =271)	Psychological impact (<i>N</i> =19; <i>f</i> =222)
	Interpersonal impact (<i>N</i> =12; <i>f</i> =24)
	Physical impact (<i>N</i> =10; <i>f</i> =24)
Victims' Awareness (<i>N</i> =17; <i>f</i> =70)	Mistreatment recognition (<i>N</i> =13; <i>f</i> =22)
	Challenging 'normality' (<i>N</i> =8; <i>f</i> =18)
	Recognition of birth partners mistreatment (<i>N</i> =7; <i>f</i> =20)
Coping Strategies (<i>N</i> =16; <i>f</i> =126)	Primary strategies (<i>N</i> =11; <i>f</i> =46)
	Sharing the experience (<i>N</i> =11; <i>f</i> =46)
	Search for formal support (<i>N</i> =9; <i>f</i> =22)
	Meaning making (<i>N</i> =9; <i>f</i> =17)
	Search for informal support (<i>N</i> =7; <i>f</i> =15)
	File a complaint (<i>N</i> =6; <i>f</i> =28)
Explanatory Factors of Obstetric Violence (<i>N</i> =16; <i>f</i> =44)	Social endorsement (<i>N</i> =11; <i>f</i> =24)
	Healthcare system constraints (<i>N</i> =10; <i>f</i> =20)

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