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Review Paper

# Impact of Trauma, Prevalent Interventions, and Help-Seeking Attitudes among Sexual-Assault Survivors: A Systematic Review

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As a traumatic life experience, sexual-assault can have a life-long impact on an individual's overall health, including their psychological well-being. As a traumatic life experience, sexual-assault can have a life-long impact on an individual's overall health, including their psychological well-being. The goal of this review is to effectively examine the role that trauma plays in the survivors' well-being and prevalent interventions that facilitate healing and recovery. The paper also seeks to highlight the role played by differences in cultural backgrounds and gender identities in aggravating the trauma associated with sexual violence. Six databases including PubMed, PsychINFO, JSTOR, Wiley Online Library, Academia.edu, and EBSCO were searched for studies on the impact of sexual assault on cisgendered females and transgendered females. The key findings were summarized under three themes: Physical-Impact, Psychological-Impact, and Interventions and Help-seeking attitudes among Sexual-Assault Survivors. The physical-impact of sexual-assault discusses the differences between help- seeking attitudes for physical symptoms and psychological distress, highlighting the common resultant physical symptoms - tension headaches, nausea, back pain, allergies, skin disorders, etc. The psychological-impact points out the subsequent health impact this experience has on the survivors' well-being and self-image, including depression, PTSD, anxiety, and other such issues. It also highlights the role of self-stigma, cultural differences, and revictimization in aggravating the distress. The importance of legal, medical, mental health and community systems responsible for intervening are discussed under the theme of interventions. Currently, most interventions are focused on providing medical and legal aid.

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While these social systems also need to be strengthened, the need for developing psychological interventions at par with these systems has also been emphasized upon. Finally, further suggestions for an ecological model have also been discussed.

***Keywords:*** *Sexual Assault, Trauma, Depression, Anxiety, Self-Image, PTSD, Interventions, Ecological Model*

Over the years, the definitions of gender-based violence (GBV) and sexual violence have undergone several changes. What is broadly understood as 'sexual violence' today includes a much wider ambit of issues concerning gendered violence. In Understanding and Addressing Violence Against Women, the World Health Organization (WHO) and Pan American Health Organization (PAHO) define sexual violence as several acts "that range from verbal harassment to forced penetration, and an array of types of coercion, from social pressure and intimation to physical force" (WHO & PAHO, 2012). Thus, one can gauge that the overall impact of sexual violence goes much beyond physical afflictions. It impinges on one's emotional and behavioural health, reproductive health, and overall socio-economic wellbeing. To this extent, the enormous detrimental impact of sexual violence has caused it to be acknowledged as a public health issue (Ulloa et al., 2016). Mental trauma induced by sexual violence can now be understood as one of the major "health consequences of violence against women" (WHO & PAHO, 2012). Yet local definitions and policy responses to both sexual violence and its interventions tend to be narrower, not necessarily considering the international trends and debates.

Understanding the trauma induced by sexual violence in women survivors has two major facets: gender and culture. The former provides an insight into how and why the case of women survivors is particularly different from other cases of GBV. This is because violence against women (VAW), of which sexual violence forms a subset, originates from particular sociocultural constructs about gender. These guide how women are generally perceived within a particular society. Thus, the trauma of women survivors of sexual violence also finds roots within the general treatment extended to women in that society. Further, culture plays a crucial role in examining trauma since it influences various social processes. It influences the meanings and perceptions of trauma in different societies.

In this context, the present review of literature on the physical and psychological impact of sexual violence on women survivors discusses the linkages between gender, culture, trauma, and sexual violence. Further, it also discusses the various interventions available for survivors in the Indian context.

***Gender and sexual violence***

At the core of understanding sexual violence against women lies the necessity to acknowledge sex as a "weapon to demonstrate power" (Gordon & Crehan, 2000). Sex mediates gender relations, which then influence how sexual violence plays out. Gender roles and the power dynamics between different sexes define perceptions and interventions towards sexual violence. According to the tenets of feminist epistemology, understanding the psychological impact of sexual violence on women survivors requires acknowledging the impact of the violence on the survivor's self-image. This goes beyond privileging the 'rational', the 'public', and other male dominated spheres of knowledge. "Not only has reason been contrasted with emotion, but it has also been associated with the mental, the cultural, the universal, the public and the male, whereas emotion has been associated with the irrational, the physical, the natural, the particular, the private and, of course, the female" (Jaggar, 1998). To delve into 'emotions' and the psychological aspect of inflicted violence, then, is in itself an act of deviance requiring one to go beyond the 'rational' epistemic viewpoint.

***Trauma and sexual assault***

The medical definition of trauma has evolved since French physician Jean M. Charcot's attempt at establishing a connection between trauma and mental illness. The first Diagnostic and Statistical Manual of Mental Disorders (DSM) (1952) included a category termed 'gross stress reaction' (GSR) to categorize the traumatization observed chiefly among patients in the aftermath of World War II. However, it was criticized for inaccurate usage of the word 'reaction'. Thereafter, with DSM-III officially recognizing PTSD (post-traumatic stress disorder) as a diagnosis, copious empirical research on trauma followed. From DSM-III onwards, the word 'trauma' came to possess a medical definition, leading to subsequent research identifying domestic violence, childhood sexual abuse, criminal violence, rape, and sexual assault also as forms of trauma (Figley, Ellis, Reuther, & Gold, 2017). Sexual assault has been linked to increased risk for and severity of all disorders (Dworkin, Menon, Bystrynski & Allen, 2017).

***Culture and trauma***

Culture can be broadly understood as a 'way of life'. Previous studies on trauma and the stigma surrounding sexual assault highlight those different cultures impact trauma symptoms, survivors' self-image and health-seeking behaviour, and their experiences with stigmatization and healthcare differently. Research demonstrates that social networks impact the nature of selfblaming among survivors differently. If a woman's social network blames her for the assault, she is also more likely to indulge in self-blame (Deitz, Williams, Rife, & Cantrell, 2015). Studies have also found linkages between cultural stereotypes and coping mechanisms, social networks, self-blame, and individuals' trauma history including diagnoses such as PTSD (Deitz, Williams, Rife, & Cantrell, 2015).

The present study aims to effectively examine and evaluate the physical and psychological health impact of sexual assault on cisgender women and transwomen survivors. Additionally, the help-seeking attitude and current interventions for the survivors have also been examined.

***Search Strategy***

The search strategy included searching literature across six databases including PubMed, PsychINFO, JSTOR, Wiley Online Library, Academia.edu, and EBSCO. Google Scholar was used to further look for the references from the included studies. The search was done using relevant terms: 'trauma', 'physical impact of trauma', 'psychological impact of trauma', 'interventions' AND/OR 'sexual assault victims/survivors.' The review was conducted according to the Preferred Reporting Items for Systematic Reviews and Meta-Analyses (PRISMA) guidelines. The inclusion criteria in terms of PICOS (participants, interventions, comparisons, outcomes, and study design) were: participants—sexual assault survivors and victims, cisgender women and transwomen; interventions—for providing care and support to the victims; outcomes—impact on the physical and psychological health of victims and survivors; and study design—empirical quantitative as well as qualitative studies, and review articles.

***Study selection***

The study selection process was carried out on the basis of preliminary selection which was based on title/abstract review followed by the specific inclusion criteria (cisgender women and transwomen sexual assault survivors; impact on their physical and psychological health; and interventions provided to them). Simultaneously, the studies were also reviewed by all the authors independently. Disagreements, if any, were resolved and the final consensus was reached. A total of 17 studies were finally included and reviewed under three themes of analysis—the physical impact of trauma, the psychological impact of trauma, and interventions and help-seeking attitudes.

***Data extraction***

After the inclusion and exclusion criterion was set the researchers independently screened all the relevant studies across the databases and the replications or the duplicates were removed. From the included studies, the data was extracted on the following basis: outcome variables (physical and psychological health impact of trauma, interventions); participants (cisgender women and transwomen sexual assault survivors), study design

(quantitative/qualitative design and review articles), All the relevant information extracted was checked by the researchers independently.

***Table-1: Overview of Included Studies by Theme***

| ***Theme 1: Physical Health Impact of Trauma*** | | | | |
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| **Study (Author, Year, Country)** | **Analysis Sample (n)** | **Study Design** | **Study Focus/ Purpose** | **Findings/Suggestions** |
| Kimerling & Calhoun (1994); USA | 115 | Comparison group analysis | To clarify the relationship between the experience of sexual assault and physical health during the year immediately after the assault. | 1. Victims did not show significantly higher use of mental health services and continued to seek only medical attention, even when symptoms were not elevated<br>2. Social support effectively moderated somatic symptoms and subjective health ratings |
| Clum, Nishith & Resick (2001) | 167 | Correlational | To assess the relationship between trauma-related sleep disturbance and physical health symptoms in treatment-seeking female rape victims | Trauma-related sleep disturbance is one potential factor contributing to physical health symptoms in rape victims with PTSD. |
| Campbell, Sefl & Ahrens (2016) | - | Qualitative | To assess the physical health consequences of rape and survivors' somatic symptoms in a racially diverse population | 1. More than 1/3rd of rape victims reported more than 20 distinct health symptoms involving all bodily systems.<br>2. The frequency and range of reported health symptoms suggest that the experience of being raped will involve a woman's entire body, affecting more than the precise places where she was attacked or injured |
| **Theme 2: Psychological Health Impact of Trauma** | | | | |
| **Study (Author, year, country)** | **Analysis Sample (n)** | **Study Design** | **Study Focus/Purpose** | **Findings/Suggestions** |
| Nishith, Mechanic &. Resick, (2000) | 117 | - | To disentangle the relationship of childhood sexual and physical abuse from prior adult sexual and physical victimization in predicting current posttraumatic stress disorder (PTSD) symptoms in recent rape victims | History of child sexual abuse seems to increase vulnerability for adult sexual and physical victimization and appears to contribute to current PTSD symptoms within the cumulative context of other adult trauma. |
| De Visser R.O., et. al | 885 | Logistic regression bivariate analyses | Impact of sexual coercion on | 1. Significantly greater psychosocial distress |

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| (2006), Australia | | | psychological health, focusing on self-concept, psychological distress | (depression, PTSD, shame, hopelessness, social withdrawal) reported in women who have been victimized more than once.<br>Women first coerced when aged 13–16 reported poorer physical well-being than women first coerced at younger or older ages. |
| Campbell, (2008) | - | Empirical investigation | To examine experiences of sexual assault survivors and the impact on psychological health; the concept of secondary | 1. The survivors' post-rape distress may be due not only to the rape itself but also to how they are treated by social systems after the assault.<br>2. Ethnic minority and/or low-SES victims and those raped by victimization due to social structures someone they know are at particularly high risk for having difficult post-assault help-seeking experiences.<br>3. Immigrant victims, survivors living in rural areas, lesbian, bisexual, and transgendered victims, and survivors with disabilities may face even more difficulties. |
| Davis, Chung & Tillman, (2009) | - | Empirical investigation | To view sexual assault through the lens of societal trauma and how the social identities of various minorities impact their experience of sexual assault | The trauma of sexual assault is heightened for many women by the interlocking experience of societal traumas such as racism, sexism, and poverty. The mental health effects of sexual assault are mediated by race and ethnicity. |
| Alboebadi F. et. al (2015), Ahvaz City | 128 | Cross-sectional (descriptive and analytical) involving a study group and a control group | Relationship of sexual assault with self-concept and general health in victims | The self-image and general health of rape victims were significantly reduced compared to the control group as they reported lower self-esteem, self-efficacy |
| Deitz, Williams, Rife & Cantrell, (2015) | - | - | Investigated model explaining sexual assault victims' severity of trauma-based on three levels of stigma—cultural, social, and the self. | 1. Self-stigma was significantly and positively related to trauma symptom severity.<br>2. The internalized aspect of stigma can lead to increased levels of trauma symptom severity, highlighting the importance of assessing self-stigma in women reporting sexual assault experiences. |
| **Theme 3: Interventions and Help-seeking Attitudes** | | | | |
| **Study** | **Analysis Sample (n)** | **Study Design** | **Study Focus/Purpose** | **Findings/Suggestions** |

| (Author, Year,Country) | | | | |
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| Harvey (1996); USA | - | Empirical investigation | To demonstrate that the efficacy of trauma-based interventions depends upon the degree to which they attend to the social, cultural, and political context of victimization through the ecological view of trauma | 1. Emphasizes a multidimensional definition of trauma recovery, which focuses on impairments as well as strengths, and include resiliency<br>2. Clinical interventions should focus on changing the relationship of the survivor with the larger community<br>3. Community-based intervention which includes educational programs on psychological trauma and violence |
| Prasad (1999); India | 105 | Empirical investigation | Examine the experiences of survivors of abuse with the medico-legal system in New Delhi, to consider the extent to which women can access their rights | 1. State-employed physicians performing medicolegal tests for the rape survivors lack sensitive care.<br>2. The first contact persons (police or physicians) show an attitude of negligence and insensitivity.<br>3. Various deficiencies in the implementation of examination of rap.<br>4. Re-victimization during the legal procedures and hearing. |
| Wasco (2003)., USA | - | Empirical Investigation | Highlights limitations of trauma response models and applications of posttraumatic stress to characterize the experiences of women who are raped. | Identifies two primary problems with trauma response theories.<br>1. First, traditional notions of trauma are likely too narrow to accurately capture the complexities of women's experiences of sexual violence in a gendered society.<br>2. The symptoms emphasized by clinical applications of the trauma model may legitimate one sociocultural manifestation of distress while excluding others.<br>3. Alternative conceptualizations are presented to stimulate a more ecologically grounded and culturally inclusive study of sexual violence. |
| Campbell, Dworkin & Cabral (2009); USA | - | Empirical Investigation | To examine the psychological impact of adult sexual assault through an ecological theoretical perspective | 1. The negative mental health sequelae of sexual assault stem from multiple factors: aspects of the assault itself, postassault disclosure, help-seeking, and |

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| | | | | socio-cultural norms; which shape how trauma shapes psychological well-being<br>2. Women's victimization and the response from the social world affect how any one incident of sexual violence is going to affect their mental health<br>3. Self-blame has been conceptualized as a meta-construct that develops from and is shaped by multiple levels in the ecological system<br>4. PTSD model as an intervention is limited in scope; the ecological model can suggest multiple strategies at multiple levels of analysis, for alleviating the psychological harm caused by assault. |
| Ahrens, Abeling, Ahmad & Hinman (2010); USA | 100 | Mixed-methods design | Examining the relationship between religious coping and mental health outcomes among survivors of sexual assault | 1. Positive religious coping is related to higher levels of psychological well-being and lower levels of depression, whereas negative religious coping is related to higher levels of depression, regardless of ethnicity.<br>2. Ethnicity makes a difference in posttraumatic growth with a<br>3. Very little support from religious institutions due to stigma. |
| Smith et al. (2013); Africa | 106 | Mixed-method study | Evaluate the effect of multi- media training on the attitudes, knowledge, confidence, and practices of Healthcare providers towards sexual assault survivors. | 1. Negative attitudes, including blaming and disbelieving women who report sexual assault did not decrease.<br>2. Respect for patient rights to self-determination and nondiscrimination increased.<br>3. Healthcare providers' knowledge and confidence in clinical care for sexual assault survivors increased. |
| Denis, Seyller & Chariot (2015); Europe | 232 | Prospective observational study | To identify patient expectations of doctors after a sexual assault and to assess how they rated the doctors' responses. | 1. Patients expected trauma care and immediate medical support if they initially approached emergency doctors.<br>2. Patients expected psychological support if they approached a general practitioner.<br>3. In many cases, doctors initially advised legal forensic support to the patients. |

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| | | | | 4. Patients more frequently considered the provided support to be crucial when they received both forensic support and trauma care, along with psychological support or gynaecological care. |
| Lodhia (2015); India | - | Empirical investigation | In response to the December 2012 gang rape in Delhi, the article addresses the relationship between the evolving social, political, and legal discourses surrounding rape in India that permeated the attack and its aftermath. | 1. The article highlighted the static assumptions about "acceptable" female behaviour and narrow constructions of "legitimate" victimhood.<br>2. The patriarchal norms and values that shape the state's. perceptions of rape were challenged by media and protestor.<br>3. The Verma Committee report provided a blueprint of the changes necessary to address the hostile socio-legal climate for women in India- proposed multidimensional interventions; called for increased police accountability; changes in the medical-legal system; linkages between violence against women and broader aspects of gender socialization; expanded the idea of gender justice beyond women, calling for the protection of rights of all sexual and gender identities, naming "lesbian, gay, bisexual, transgender, and intersexual persons". |

The present systematic review aimed to integrate the studies which have investigated the impact of sexual assault on the physical and psychological health of the survivors, along with examining the prevalent interventions and help-seeking attitudes among the survivors. The impact of sexual violence goes beyond the physical damage to the survivors, as it entails inflictions on their psychological health as well. Further, the post-assault journey is influenced by the manifestations of the physical and psychological trauma, the survivor's help-seeking attitude and the impact of interventions provided. Therefore, the focus of the present review was to examine the experience of trauma from the lens of three important aspects- physical health, psychological health and interventions and help-seeking attitudes. This shall provide a holistic perspective while also bringing to the surface the importance of restoring the psychological wellbeing of the survivors post the assault. A total of 17 studies were reviewed for this purpose under the three themes of analysis.

***Physical health impact of sexual assault***

Traumatization due to sexual assault is life-altering in nature and can have an extensive impact on the psycho-physical health of survivors. De Visser (2007) highlight that traumatization cannot be viewed from a single perspective, that is, by contextualizing merely the aftermath of the distress experienced by the individual. There is a further need to conceptualize traumatization as a process rather than a singular, psychologically distressing event. This helps in drawing attention to the aspects of medical, legal, financial, and psychological assistance that survivors often need after the event.

Another study conducted in 1994 finds that physical symptoms such as rapid or pounding heartbeats, tension, headaches, nausea, back pain, allergies, skin disorders, menstrual symptoms, and sudden weight changes are initially the most frequently occurring symptoms post the event. However, these symptoms decline in frequency and severity over the year. Instead, results show that psychological symptoms of the survivors continue to elevate throughout the year post the assault. (Kimerling & Calhoun, 1994). Similarly, in a more recent study, the physical health consequences of rape and the survivors' somatic symptoms have been assessed to reveal that more than one-third of rape survivors report beyond 20 distinct health symptoms involving all bodily systems. This suggests that the experience of rape affects more than just the precise physical areas having undergone injury (Campbell et al., 2016).

In their research exploring the plausible reasons for differences in help-seeking for psychological and physical pain, Koss et al. (1991) find that those who have been sexually assaulted are more likely to seek treatment for physical distress—mostly from primary care services—than to opt for mental health assistance programs. An association between one's history of sexual assault and increased use of medical services has also been made in several studies, including those by Koss et al. (1991), Goldstein et al. (1988), and Koss et al. (1990). These report similar findings: that sexual assault victims perceive themselves as having poorer physical health than non-victims. Thus, in cases where physical symptoms are perceived to be more salient than psychological distress, seeking medical aid is preferred to seeking psychological help.

It has also been noted that the most frequently reported physical symptoms are somatic and psychophysiological reactions to severe stress. They do not necessarily emerge from the injuries sustained from the assault. This is because psychological distress can manifest as somatization or may simply be labelled as a physical illness and be perceived as such (Kimerling & Calhoun, 1994). Ergo, the distress experienced by victims continues long after the event. Further, the effects of additional stress are explained by psychoneuroimmunology suggesting that extreme levels of psychological and physical stress could directly lead to a greater number of physical symptoms and poorer physical health (Kiecolt-Glasser & Glaser, 1992; McKinnon et al. 1989; Pennebaker et al. 1988; Zakowski et al. 1992).

***Psychological health impact of sexual assault***

Research studies and review papers have previously attempted to analyse the relationship between sexual assault and its subsequent impact on women survivors' psychological and physical health and well-being. De Visser et al. (2006) examine the association between the characteristics of sexual coercion and its effect on women's psychological, physical, and sexual health. The results find no consistent associations between particular characteristics

and health outcomes. Rather than focusing on specific aspects, then, it can be said that any experience of sexual coercion in itself can have negative repercussions for women's psychological, physical, and sexual health.

Several studies have also tried to understand and assess the relationship between the theme of "victimization" and sexual assault. Campbell (2008) examines rape victims' experiences when seeking post-assault assistance from the legal, medical, and mental healthcare systems, and how those interactions impact their psychological well-being. Although some victims have a positive experience with social system personnel such as medical professionals, lawyers, and the police; for many help-seeking after an assault becomes a "second rape"—secondary victimization to the initial trauma. In response to growing concerns about the community response to rape, new interventions and programs have emerged to improve services and prevent secondary victimization.

Nishith et al. (2000) assess the relative contributions of childhood physical and sexual abuse in the prediction of adult victimization and post-traumatic symptomatology following a recent sexual assault. The results show that a higher rate of childhood sexual abuse is related to high rates of subsequent sexual and physical victimization among adults, which in turn contributes to the level of PTSD symptomatology following a recent rape. Childhood sexual abuse predicts subsequent exposure to high-impact, high-magnitude traumatic events such as physical and sexual assault in adulthood.

Research has also attempted to understand the relationship between sexual assault and self-concept among survivors. Alboebadi et al. (2015) demonstrate that there is a statistically significant difference between the average scores of self-concept and positive and negative selfconcept among the survivors and control groups. The study shows that an increase in unwanted sexual intercourse is accompanied by a decrease in self-confidence and negative self-concept. Bryant-Davis et al. (2009) attempt to understand how the trauma of sexual assault is heightened for many women due to intertwined experiences of various forms of societal trauma including racism, sexism, and poverty. The mental health effects of sexual assault are mediated by race and ethnicity. In investigating the experiences of African American, Asian American, Latina, and Native American female survivors, the authors explore how socio-historical contexts of intergenerational trauma in the lives of ethnic minorities become a part of contemporary experiences of sexualized violence.

Some studies also analyse the severity of trauma symptoms and their association with stigma in that particular society. Deitz et al. (2015), for instance, attempt to understand traumarelated symptoms of sexual assault by examining three levels of stigma—cultural, social, and the self. Responses to traumatic events may involve intense fear, anxiety, and helplessness along with re-experiencing the emotions related to trauma through distressing recollections and nightmares; a heightened sense of arousal; and avoidance of circumstances connected with the trauma. Other forms of negative emotions common as reactions to traumatic events include shame, guilt, anger, and sadness. Additional trauma symptoms may include the inability to experience pleasure, pessimistic or negative attitudes, general distrust in others, social detachment, isolation, and a belief that the world is unsafe and unpredictable.

***Interventions and help-seeking attitude among sexual assault survivors***

Along with understanding the experience of trauma and its physical and psychological impact, providing gender-sensitive interventions and promoting health-seeking attitudes among survivors is equally important. Sexual assault survivors have extensive post-assault needs and may turn to multiple social systems for assistance. How these systems interact can then have significant implications for recovery. First-hand accounts and research have both exemplified that victim can have positive as well as severely traumatizing experiences with assistance. Moreover, the high share of post-assault traumatizing experiences impacts patterns of helpseeking and the kind of help received by many survivors. The manner in which trauma shapes the psychological well-being of survivors stems from multiple factors including aspects of the assault itself, post-assault disclosure, help-seeking, and sociocultural norms. Lodhia (2015) highlights those static assumptions about "acceptable" female behaviour and other patriarchal norms shaping society and its narrow constructions of "legitimate" victimhood are also the fuel to gendered patterns of thinking. As a result, post-assault, the 'credibility' of the assault and the victim's experience are brutally endangered by the various social systems involved. Victimization and self-blaming are aggravated manifold among survivors. Post-assault helpseeking, then, becomes a "second rape" for many victims (Campbell, 2008).

The social systems responsible for interventions in sexual violence include the legal, medical, mental health and community systems. The medico-legal systems are the primary point of contact for any victim of sexual assault in most cases. These victims have multiple medical needs including injury detection and care, medical forensic examination, screening and treatment for sexually transmitted infections (STIs), and pregnancy testing and emergency contraception.

Denis et al. (2015) find that patients expect trauma care and immediate medical support if they initially approach emergency doctors. Kimerling and Calhoun (1994) report that survivor's do not show a significantly higher use of mental health services post-assault. They may continue to seek only medical attention, even when the physical and psychological symptoms were not elevated. Campbell (2008) finds that victims do not receive comprehensive medical care and that their treatment is cold and impersonal. Healthcare providers may even display negative attitudes towards the victims, including blaming and disbelieving them (Smith et al., 2013). Most hospital personnel lack training in medical and forensic examinations relevant to sexual assault. Emergency doctors and nurses may also have to ask questions regarding details of the assault, just as the legal personnel do, which has been found to harm the victims' state of mind and mental health. Prasad (1999) also finds that state-employed physicians performing medicolegal tests for rape survivors lack sensitive care and display negligence and insensitivity.

Women have stated that if they had known what they were in for, they would not have reported (Logan et al., 2005). Although designed to provide support, the legal system in countries like India does not provide easy access to justice. The victim's first contact, immediately after the assault, could be a patrolling officer whose attitude and sensitivity plays a pivotal role. The filing of a complaint and subsequent legal proceedings can lead to experiences of revictimization due to callous victim-blaming as well as the recollection of assault details, all severely painful for the victim. Because of such barriers in the legal and

social institutions impeding access to rights, women have acknowledged to delaying or failing to report abuse (Prasad, 1999). In India, they have reported that pressing charges lead to emotional pain, loss of family honour, and in some cases even custodial rape.

Mental health issues arising from sexual assault are extensively evident among victims, with cases of PTSD, depression, anxiety, suicide ideation and other damages to emotional wellbeing and a sense of identity being reported. Further, as mentioned above, negative responses from various social systems exacerbate the victims' distress. Thus, as important as the medicolegal systems are, psychological support plays an equally important and long-term role in the recovery process. However, minimal research has been conducted in this sphere and regarding the implementation of mental health services. Campbell (2008) report that many victims do not have access to quality mental health services. They currently receive mental healthcare through community-based care centres, psychologists, psychiatrists, or social workers in private or public clinic settings, rape crisis centres and shelter programs. Ahrens et al. (2010) find that religious coping (or spiritual coping) can also impact the psychological well-being of the survivors, wherein they see meaning in life, display lower levels of depression and a higher level of psychological well-being compared to other survivors with religious disconnect.

Along with reporting the findings of current interventions and help-seeking patterns, numerous studies have also given suggestions to improve the quality of interventions for sexual assault survivors. Wasco (2003) highlights that the traditional notions of trauma are likely too narrow to accurately capture the complexities of women's experiences of sexual violence in a gendered society. Harley (1996) also emphasizes a multidimensional definition of trauma recovery focusing on impairments as well as strengths, such as the resilience of survivors. Further, research studies have proposed an ecological model to understand the manifestations of psychological trauma and provide holistic intervention. The ecological model posits that various layers of the individual's environment to which he or she belongs and draws identity from influences the reactions to violent and/or traumatic events. Neither the assault occurs in isolation nor can the intervention be implemented in isolation. Thus, ecological models can help understand the role of micro and macro environments proliferating gendered-norms and also suggest multiple strategies at multiple levels of analysis for alleviating psychological harm caused by the assault. Such interventions focus on changing the survivors' relationship with the community. Studies have also suggested various community-based programs including educational programs for the general public on violence and psychological trauma, restorative justice programs (where victims feel heard and recognized), and public health initiatives providing both medical and psychological help. Mental healthcare providers should be given central roles in immediate post-assault interventions and specialized training be provided to the hospital and legal system personnel to ensure sensitive and effective caregiving.

The present study extensively reviews the impact of trauma on the survivor's well-being and examines existent interventions to develop the basis of an effective intervention for the holistic recovery of survivors. The impact of trauma on survivors' physical health includes somatization, allergies, skin disorders, nausea, pain, headaches, and sleep disturbances. Survivors may also face low self-esteem, depression, anxiety, PTSD, and an overall

deterioration in their psychological well-being. Currently, primary aid rests mostly in the hands of the medicolegal system which needs further improvements to facilitate sensitive care and rehabilitation. Additionally, psychological help has to be implemented in the realm of primary care for the victim's long-term recovery and overall well-being. Interventions should also view the experience of trauma from the lens of an ecological model and make provisions for extending aid at each level of the survivor's environment.

***Limitations***

The limitations of the present review reflect a lack of research in the areas of the impact of sexual assault and consequent trauma on psychosocial interventions and the psychological health of survivors. Most studies included in this review focused on the physical health of the survivors and undertook an evaluation of medico-legal support systems. Besides, there is a dearth of studies specific to the Indian context which further impacts the generalization of the findings.

***Recommendations***

To holistically understand the experience of trauma and provide effective interventions, extensive research needs to be conducted on the psychological health of the survivors first. The post-assault journey must not only involve healing physical wounds but also emphasize restoring and empowering their mental health and social lives.

A critical future recommendation here is the development of ecological model-based interventions. Such interventions can help examine interactions across different levels of the survivor's environment. Individual characteristics influencing coping strategies and help-seeking behaviour, and the survivors' social environment, including identity, social status, family background, and community variables influence the post-assault experience. By understanding the impact of each of these variables at different levels, interventions can be provided at each level to enable the survivor's holistic recovery and change their relationship with the community.

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***Conflict of Interest***

• The authors have no relevant financial or non-financial interests to disclose.

• The authors have no conflicts of interest to declare that are relevant to the content of this article.

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