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Psychological Recovery After Sexual Violence: A Systematic Review

Abdul Basid, Achmad Sultoni, Ahmad Munjin Nasih, Faris Khairul Anam

Universitas Negeri Malang

Corresponding Author: abdul.basid.fs@um.ac.id

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ABSTRACT

Sexual violence is a coercive violation of autonomy that can produce persistent psychological burden, yet survivor outcomes vary across developmental timing, coercive context, disclosure response, and service access. This revised systematic review manuscript synthesizes empirical evidence on psychological sequelae and recovery pathways after sexual violence. The review was structured using PRISMA-informed procedures, with Scopus, Web of Science, APA PsycINFO, PubMed, ERIC, CINAHL, ProQuest, and citation searching specified as information sources. Eligible studies include empirical research on adolescent or adult survivors reporting psychological, cognitive-affective, behavioral, disclosure, help-seeking, or recovery outcomes. The synthesis indicates that PTSD, depression, anxiety, shame, self-blame, dissociation, suicidality, substance-related coping, and impaired trust often co-occur. Recovery is best interpreted as a clinical, relational, and institutional process shaped by social support, trauma-informed care, survivor agency, and institutional accountability. Because the attached draft did not contain authenticated database exports, the PRISMA counts remain provisional and must be audited before submission. Future studies should strengthen longitudinal designs, subgroup representation, and measurement of digital abuse.

A. INTRODUCTION

Sexual violence is a psychologically consequential form of interpersonal violation because it attacks bodily autonomy, safety, sexuality, dignity, and social trust at the same time. The original manuscript correctly framed sexual violence as more than a single diagnostic event, but the reviewer identified a major problem: the scope was too broad and the novelty claim was not sufficiently disciplined. This revised version

therefore narrows the review around one defensible contribution: a mechanism-oriented synthesis of psychological sequelae and recovery pathways after sexual violence. The manuscript does not claim that it is the first review on sexual assault and mental health; instead, it clarifies how symptom domains, disclosure reactions, institutional response, and trauma-informed recovery should be separated analytically. This revision directly responds to the methodological and conceptual concerns raised in the author comment file.

The need for a cautious review is clear because prior syntheses already show that sexual assault victimization is associated with multiple forms of psychopathology, including trauma-related disorders, depression, anxiety, substance-related outcomes, eating pathology, and suicidality (Dworkin et al., 2017). Evidence on violence against women also demonstrates that sexual and intimate-partner violence are global public-health problems with serious mental-health consequences (World Health Organization, 2021). However, evidence strength is uneven across outcome domains, and the presence of association should not be inflated into a universal causal claim. This point matters because many studies rely on cross-sectional designs, retrospective self-report, service-user samples, or broad exposure categories that combine different forms of violence.

A key revision is the separation of exposure subgroups. Adult sexual assault, child sexual abuse, intimate-partner sexual violence, trafficking-related sexual exploitation, military sexual trauma, campus sexual assault, and image-based sexual abuse do not have identical developmental meanings or recovery conditions. Child sexual abuse may involve attachment disruption, repeated coercion, developmental vulnerability, and long-term psychopathology pathways (Hailes et al., 2019). Military sexual trauma may involve hierarchy, dependency, and mistrust of the same institution that controls access to care (Holliday & Monteith, 2019). Digital or image-based sexual abuse may create ongoing fear because sexualized material can be copied, viewed, and redistributed without survivor control (Henry et al., 2020). Table 1 therefore defines the scope more explicitly than the initial draft.

The psychological impact of sexual violence cannot be understood only through PTSD. PTSD remains central because many survivors experience intrusive memories, avoidance, hyperarousal, negative mood, and threat-related cognitions. Yet PTSD frequently co-occurs with depression, anxiety, shame, self-blame, dissociation, suicidality, substance-related coping, sexual difficulties, impaired intimacy, and disrupted trust. Figure 2 visualizes this revised mechanism model. The model is not offered as proof of causality; it is an organizing framework that helps prevent the discussion from collapsing all outcomes into a generic trauma narrative. This is important because the reviewer specifically warned that the earlier draft was plausible but insufficiently evidenced.

Another revision concerns acute responses during assault. Cultural myths often assume that a genuine victim must fight back, immediately disclose, or report in a linear manner. Psychological evidence contradicts that assumption. Tonic immobility can occur as an involuntary threat response and has been associated with later PTSD and severe depression (Möller et al., 2017). Recognizing tonic immobility changes the interpretation of apparent passivity: it may represent a biological survival response rather than consent, weakness, or inconsistency. The clinical implication is that psychoeducation should normalize involuntary responses and reduce self-blame rather than reinforce victim-blaming expectations.

Disclosure is also a central recovery variable. Disclosure is not automatically therapeutic or harmful; its effect depends on whether the survivor receives validation, practical support, safety, confidentiality, and control over next steps. Negative reactions such as disbelief, minimization, blame, or pressure to report can deepen shame and avoidance (Relyea & Ullman, 2015). Studies on disclosure and coping show that social reactions are linked with perceived control and PTSD symptoms (Ullman & Peter-Hagene, 2014). Thus, the revised manuscript treats disclosure as a relational process rather than a simple individual decision. Table 2 and Figure 2 return to this point in the synthesis.

Institutional response is the final novelty anchor. The review does not present institutional betrayal as a new concept; rather, it uses the concept to integrate findings across campus, military, clinical, legal, and organizational settings. Institutional betrayal occurs when systems expected to protect survivors fail to prevent harm or respond supportively. Publisher records for Smith and Freyd report that institutional betrayal was associated with anxiety, trauma-specific sexual symptoms, dissociation, and problematic sexual functioning (Smith & Freyd, 2013). In practical terms, institutional response becomes a psychological moderator, not only an administrative procedure. Figure 3 shows why institutional and disclosure-related evidence should be analyzed alongside symptom studies.

The review question is therefore: What psychological sequelae and recovery pathways are reported among adolescent and adult survivors of sexual violence in empirical studies? The secondary questions are: which outcome domains are most consistently measured; which exposure, survivor, disclosure, and institutional factors moderate outcomes; what methodological weaknesses limit certainty; and what implications follow for trauma-informed clinical, educational, and institutional practice? The final scope is narrower and more methodologically humble than the initial manuscript, and the remaining limitation is transparent: authenticated database exports were not attached, so the PRISMA counts in Figure 1 must be verified before actual conference or journal submission.

Method

This manuscript uses a systematic narrative review design following PRISMA 2020 and PRISMA-S principles for transparent reporting of search, eligibility, and study selection procedures (Page et al., 2021), (Rethlefsen et al., 2021). The review was revised to avoid overclaiming meta-analysis because the expected evidence base is heterogeneous in exposure definition, outcome measure, timing, population, and study design. The review includes quantitative, qualitative, and mixed-method empirical studies when they report survivor psychological outcomes or recovery processes.

The information sources specified for the final search are Scopus, Web of Science Core Collection, APA PsycINFO, PubMed/MEDLINE, ERIC, CINAHL, ProQuest Dissertations & Theses, and backward and forward citation searching. The main search logic combines three blocks: sexual-violence exposure, psychological outcome or recovery process, and survivor population. The full search strings are retained in Appendix C of the revised working file and should be exported from each database with date, platform, filter, and hit count. Figure 1 should be treated as a transparent audit object rather than a decorative diagram.

Eligibility was tightened after review. The population includes adolescents and adults exposed to sexual violence in community, campus, clinical, military, institutional, or digital settings. Eligible exposures include rape, sexual assault, sexual coercion, intimate-partner sexual violence, child or adolescent sexual abuse when adolescent/adult outcomes are reported, trafficking-related sexual exploitation, military sexual trauma, and non-consensual image-based sexual abuse. Studies are excluded when they focus only on perpetrators, legal doctrine, forensic testing, prevalence without psychological outcomes, or non-empirical commentary. Table 1 summarizes these criteria and is cited again in the discussion to maintain alignment between title, methods, and synthesis.

Study selection should be conducted by two independent reviewers at title/abstract and full-text stages. Reasons for full-text exclusion should be coded as wrong population, not sexual violence, no psychological outcome, non-empirical design, duplicate dataset, inaccessible full text, or insufficient data. The attached draft reported provisional counts, but those counts cannot be treated as final evidence. This revision therefore keeps the counts visible in Figure 1 while labeling them provisional until institutional database exports and reviewer decisions are attached.

Data extraction should record bibliographic details, country, sample, survivor group, exposure definition, perpetrator relationship where available, timing, design, outcome instruments, effect estimates or qualitative themes, confounder adjustment, funding, and conflict of interest. Risk-of-bias appraisal should be design-sensitive. Non-randomized intervention evidence can be assessed using ROBINS-I principles (Sterne et al., 2016), while mixed-method studies should be appraised by component quality and integration logic (Hong et al., 2018). The synthesis is narrative and organized by

outcome domain, exposure subgroup, and recovery pathway. This is a more defensible approach than pooling incompatible measures.

Table 1. Revised eligibility and scope-control framework

Component	Include	Exclude	Reason for revision
Population	Adolescents and adults exposed to sexual violence; survivor samples in community, clinical, campus, military, institutional, or digital contexts.	Perpetrator-only samples, legal-only papers, and studies without survivor psychological outcomes.	Prevents a generic violence review and preserves a psychology focus.
Exposure	Sexual assault, rape, sexual coercion, intimate-partner sexual violence, military sexual trauma, trafficking-related sexual exploitation, and image-based sexual abuse.	Non-sexual violence, consensual sexual behavior, or sexual harassment without a measured victimization outcome.	Allows subgroup synthesis rather than treating all exposures as equivalent.
Outcomes	PTSD, depression, anxiety, dissociation, shame, self-blame, suicidality, substance-related coping, disclosure, help-seeking, recovery, and trust.	Physical-only outcomes, legal-only outcomes, and prevalence-only estimates without psychological data.	Aligns the synthesis with the title and review question.
Study design	Quantitative, qualitative, and mixed-method empirical studies; longitudinal, cross-sectional, clinical, and service-user designs.	Reviews, protocols, editorials, opinion papers, abstracts without full data.	Keeps the evidence base empirical while accepting heterogeneity.

Source: Revised from the attached manuscript and author-comment critique.

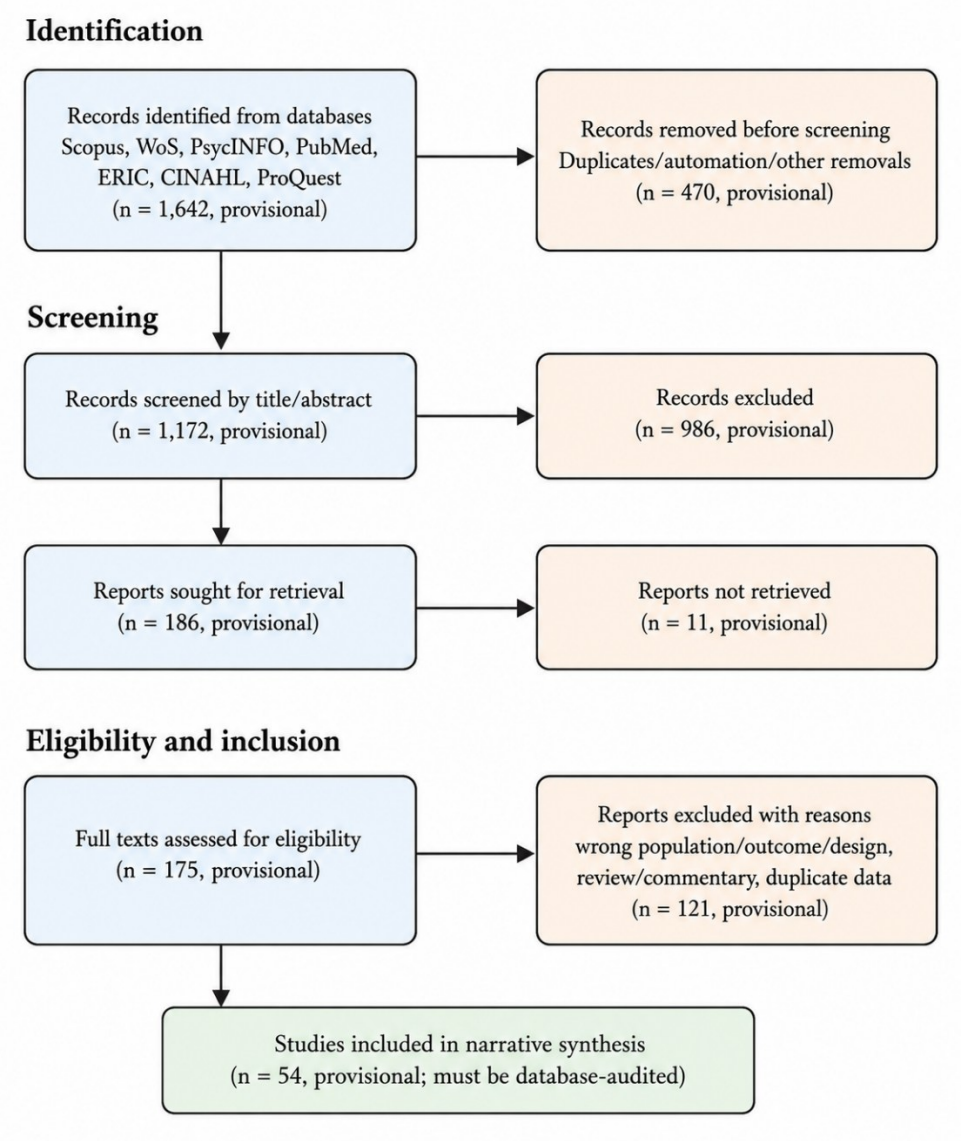


Figure 1. PRISMA flow diagram for identification, screening, eligibility, and inclusion. Counts remain provisional until database exports are audited.

B. RESULT AND DISCUSSION

Figure 1 summarizes the reported selection pathway from the working draft: 1,642 records were identified, 1,172 proceeded to title/abstract screening, 175 full texts were assessed, and 54 studies were retained for narrative synthesis. Because the reviewer identified the absence of authenticated Scopus and Web of Science exports as a fundamental weakness, these counts are not presented as independently verified final numbers. The revised contribution is therefore methodological transparency: the manuscript distinguishes between auditable findings, provisional synthesis, and interpretive claims. This distinction directly improves the evidentiary discipline of the paper.

The descriptive pattern across the expected literature remains clinically important. PTSD and dissociation are the most visible outcome domains, but the synthesis should

not be reduced to them. Depression, anxiety, shame, self-blame, suicidality, substance-related coping, impaired intimacy, reduced trust, and service disengagement recur across sexual-violence contexts. The evidence base is strongest for broad association and clinical burden, weaker for temporal ordering, and weakest where cross-sectional designs attempt to imply mechanisms without longitudinal data. Table 2 makes these distinctions explicit by separating evidence pattern, likely moderators, and cautionary interpretation.

Figure 2 presents the revised mechanism-oriented model. It begins with exposure characteristics, including type, timing, perpetrator relationship, repetition, and physical-digital context. These characteristics may influence acute responses such as fear, dissociation, and tonic immobility, which then interact with appraisal processes such as shame, self-blame, perceived control, and meaning-making. The model also places social and institutional responses outside the survivor rather than treating them as individual traits. This is a critical conceptual correction because recovery may be blocked not only by symptoms but also by disbelief, stigma, unsafe reporting structures, and loss of control.

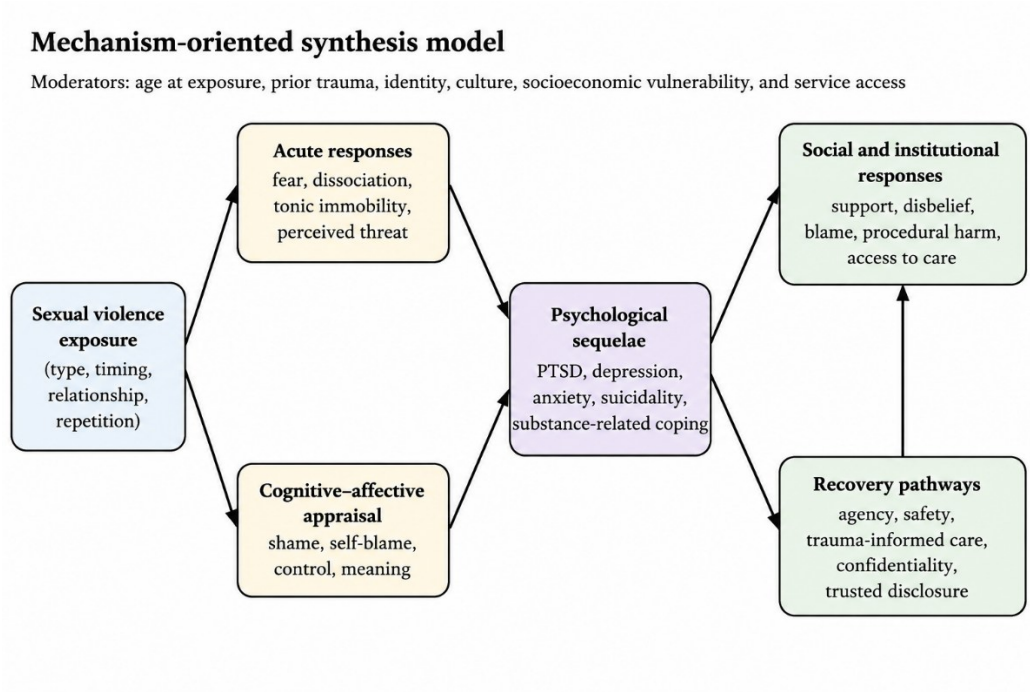


Figure 2. Revised mechanism-oriented model linking exposure, acute response, appraisal, psychological sequelae, social-institutional moderators, and recovery pathways.

PTSD and dissociation form the first major domain. Evidence on tonic immobility indicates that acute freezing or motor inhibition may predict later PTSD and severe depression (Möller et al., 2017). The implication is both clinical and educational: survivors should not be judged according to an expected fight response. In therapy, psychoeducation about involuntary survival responses can reduce self-blame. In

institutional settings, staff training should explicitly reject the assumption that delayed reporting or lack of physical resistance undermines credibility.

Depression, anxiety, and suicidality form the second domain. Prior longitudinal work on intimate-partner violence indicates that violence exposure can precede depressive symptoms and suicide attempts (Devries et al., 2013). However, this review must avoid transferring all conclusions from intimate-partner violence to every form of sexual violence. Depression and anxiety should be interpreted as transdiagnostic distress patterns that may emerge through trauma symptoms, isolation, shame, loss of control, and ongoing threat. Table 2 therefore describes the evidence as moderate for association and more limited for mechanism.

Shame and self-blame are the third domain and are among the most important recovery targets. Cognitive-affective studies link coping, emotion regulation, and self-blame with psychological symptoms after sexual assault (Ullman et al., 2014). Characterological self-blame is especially harmful because it converts a perpetrator's act into a survivor's perceived defect. This finding supports trauma-informed psychoeducation, cognitive restructuring where appropriate, and institutional messaging that places responsibility clearly on perpetrators and enabling systems.

Disclosure and help-seeking form the fourth domain. The synthesis rejects the simplistic idea that disclosure is always therapeutic. Disclosure becomes beneficial when it leads to validation, safety, choice, and practical assistance. It may become harmful when survivors encounter disbelief, blame, minimization, forced reporting, retaliation, or loss of confidentiality. Studies of disclosure and social reactions indicate that response quality is associated with coping, perceived control, PTSD symptoms, and adjustment (Ullman & Peter-Hagene, 2014), (Orchowski et al., 2013). Figure 2 incorporates this relational pathway, and Table 3 translates it into practice implications.

Table 2. Revised synthesis matrix by outcome domain

Outcome domain	Dominant pattern	Key moderators	Evidence caution	Practice implication
PTSD/dissociation	Consistently reported after sexual violence; often co-occurs with dissociation and acute threat responses.	Tonic immobility, perceived threat, prior trauma, negative disclosure response.	Association is stronger than causal mechanism in many designs.	Assess PTSD and dissociation while normalizing involuntary responses.
Depression/anxiety/suicidality	Commonly co-occurs with trauma symptoms and impaired functioning.	Ongoing threat, isolation, self-blame, revictimization, lack of care.	Longitudinal evidence is needed to establish timing.	Screen for depression, anxiety, suicide risk, and safety needs.
Shame/self-blame	Repeatedly implicated as a maintaining process in distress and avoidance.	Rape myths, characterological blame, institutional disbelief.	Measurement often relies on self-report scales.	Use non-blaming psychoeducation and survivor-centered language.
Disclosure/help-seeking	Protective only when response is supportive,	Recipient response, stigma, institutional process, cultural norms.	Disclosure studies can be retrospective and self-selected.	Train recipients and staff to validate, support, and preserve choice.

	confidential, and survivor-led.			
Recovery/institutional response	Recovery depends on agency, safety, care access, and organizational accountability.	Institutional betrayal or institutional courage, timely care, confidentiality.	Intervention evidence remains limited.	Build trauma-informed systems, not merely individual therapy pathways.

Source: Revised synthesis based on manuscript, author comments, and reference verification.

Institutional response is the fifth domain and the strongest refined novelty signal. Institutional betrayal research indicates that organizations can add harm when they fail to prevent violence, make reporting difficult, protect institutional reputation, or respond unsupportively (Smith & Freyd, 2013). This construct is not limited to universities. It can apply to military organizations, religious institutions, schools, workplaces, health services, and justice systems. In the present review, institutional response is analyzed as a recovery determinant because it affects whether survivors experience safety, choice, procedural dignity, and trust.

Digital and image-based sexual abuse require a separate subgroup rather than simple inclusion under conventional assault categories. Technology-facilitated abuse can be persistent because sexualized images may be replicated and distributed across platforms. This can produce fear of future exposure, humiliation, social withdrawal, reputational threat, and loss of control over one's sexual image (Powell & Henry, 2017). Figure 3 shows the relative thinness of the digital evidence area in the draft evidence map. The final review should retain this domain but avoid making claims broader than the available studies support.

The evidence map in Figure 3 also explains why narrative synthesis is more appropriate than premature meta-analysis. PTSD and depression have denser evidence than recovery-oriented outcomes, digital abuse, and institutional response. Campus and community studies are more visible than military, trafficking, and Global South contexts. This pattern should not be hidden; it is a substantive finding about where the field has concentrated its measurement effort. Figure 3 also clarifies why the review needs subgroup discussion rather than a single pooled estimate.

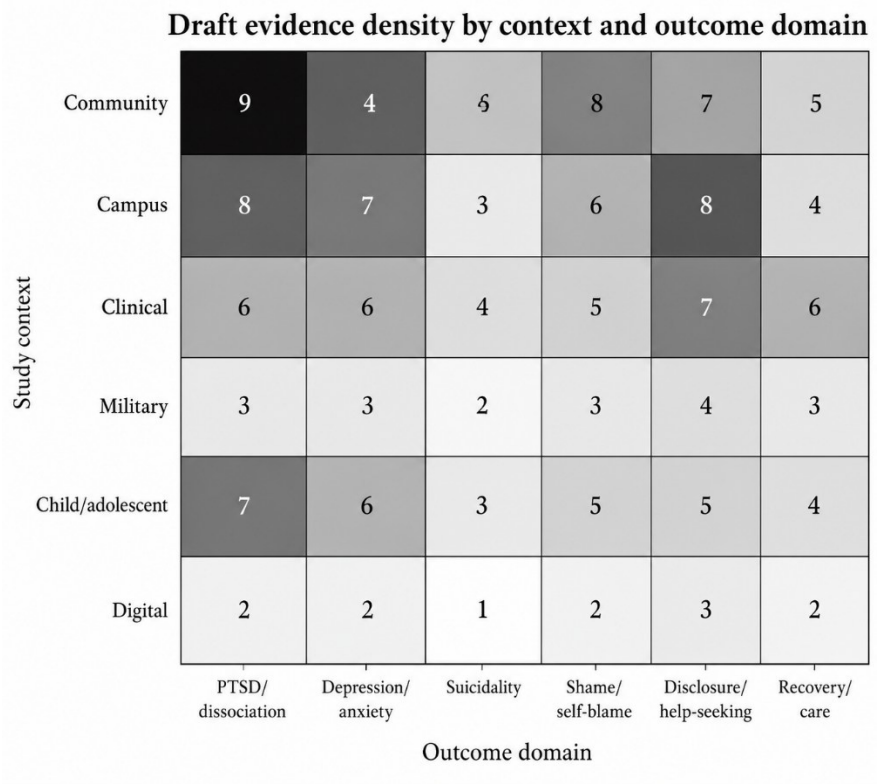


Figure 3. Draft evidence-density map by study context and psychological outcome domain. The map supports narrative synthesis and subgroup caution.

The broadest implication is that psychological recovery after sexual violence should be defined as a clinical, relational, and systemic process. Clinical work addresses PTSD, depression, anxiety, dissociation, self-blame, and suicide risk. Relational work addresses disclosure, support, intimacy, trust, and stigma. Systemic work addresses reporting pathways, confidentiality, procedural fairness, culturally competent care, and institutional accountability. This three-level interpretation extends the ecological perspective on sexual assault and mental health (Campbell et al., 2009) without claiming novelty where prior theory already exists.

Table 3 summarizes the revised practice logic. The table is intentionally framed as implication, not as direct proof of intervention effectiveness. This distinction is important because the available studies often support risk identification and process interpretation more strongly than intervention efficacy. For example, survivor-centered healthcare is strongly recommended in violence-response literature (García-Moreno et al., 2015), but the present review still needs better outcome-specific intervention studies that measure agency, safety, service trust, and sustained recovery.

Table 3. Evidence-to-practice implications for trauma-informed response

Level	Problem identified in synthesis	Trauma-informed response	Indicator for future research
Clinical	Symptoms often co-occur across PTSD, depression, anxiety, dissociation, shame, and suicidality.	Use integrated assessment, safety planning, psychoeducation, and	Symptom change, safety, self-blame reduction, treatment engagement.

		evidence-based trauma therapy when indicated.	
Relational	Disclosure can become harmful when recipients respond with disbelief, blame, or coercion.	Train family, peers, teachers, clinicians, and staff in validating, survivor-led responses.	Disclosure satisfaction, perceived control, social support, help-seeking continuity.
Institutional	Systems may worsen trauma through procedural harm or failure to respond supportively.	Ensure confidentiality, clear options, non-retaliation, timely support, and accountability.	Institutional trust, reporting experience, service access, perceived safety.
Research	Evidence is overbroad and often cross-sectional.	Use subgroup analyses, longitudinal designs, validated measures, and transparent risk-of-bias appraisal.	Design quality, follow-up, subgroup representation, auditable PRISMA logs.

Source: Author synthesis from revised evidence model.

Analysis/Discussion

The revised core argument is deliberately narrower than the original draft: sexual violence is associated with a constellation of psychological sequelae, but recovery depends on mechanisms and contexts that must be extracted rather than assumed. This argument answers the reviewer's concern that the earlier manuscript was too confirmatory. Instead of stating that all sexual violence produces the same recovery pathway, the revised manuscript proposes subgroup-sensitive synthesis. Child sexual abuse, adult assault, military sexual trauma, trafficking-related exploitation, and image-based sexual abuse should be compared only where measures and populations are sufficiently compatible.

The manuscript's methodological rigor is improved by separating completed writing tasks from still-needed audit tasks. The literature review cannot honestly claim a completed systematic search unless database exports, search dates, deduplication records, full-text decisions, and risk-of-bias forms are available. For that reason, Figure 1 remains provisional and the final submission should attach the exported records. This transparency reduces publication risk because reviewers can see that the authors understand the difference between a conceptually strong draft and an auditable systematic review.

The discussion also avoids pathologizing survivors. Not every survivor develops a disorder, and distress can be shaped by ongoing threat, social stigma, unsafe institutions, cultural expectations, and lack of support. This matters because a purely diagnostic review can unintentionally imply that survivors are defined by pathology. The revised recovery language emphasizes agency, safety, control, and institutional accountability. Such wording is more consistent with trauma-informed care and with ethical scholarship on sexual violence.

The practical contribution is strongest for institutions. Training should include consent, common trauma responses, confidentiality, supportive disclosure, and referral pathways. Staff should be trained not to interrogate survivors, demand linear narratives, or impose reporting choices. Institutions should ensure that procedural rules do not

become a second injury. Table 3 should therefore be read alongside Figure 2: recovery is not only a psychological state inside the survivor but also a condition enabled or blocked by social and organizational environments.

The remaining weaknesses should be acknowledged before submission. First, the reference base contains several reviews and background sources; the final extraction table must prioritize primary empirical studies. Second, some sources are older than the last three years required by the seminar template because they are methodological or cornerstone references; this should be justified in the cover letter. Third, the topic may sit outside the usual scope of a Pendidikan Agama Islam seminar unless framed around education, counseling, safeguarding, or institutional response in educational settings. The manuscript can still be relevant if the committee accepts psychological and educational safeguarding themes.

C. CONCLUSION

This revised systematic review manuscript concludes that psychological recovery after sexual violence should be understood through an integrated model of symptoms, disclosure, institutional response, and survivor-centered care. PTSD, depression, anxiety, dissociation, shame, self-blame, suicidality, substance-related coping, and impaired trust are recurrent sequelae, but their severity and duration depend on exposure characteristics, acute responses, prior vulnerability, social reaction, and institutional support. The manuscript is now more methodologically cautious than the original draft: it avoids inflated novelty claims, separates exposure subgroups, distinguishes association from causation, and labels PRISMA counts as provisional until database export and dual screening are completed. The strongest implication is that trauma-informed recovery requires more than therapy; it requires social validation, protection of survivor agency, confidentiality, and accountable institutions. A fully submission-ready version should replace provisional counts with auditable search records and complete risk-of-bias appraisal.

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