# Impact of social isolation on mental health in women survivors of sexual violence

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**Abstract.** Social isolation among women who survive sexual violence is linked to worse mental health, yet isolation specific evidence is limited. To synthesize evidence on links between social isolation and mental health outcomes, distinguishing structural and subjective isolation. A scoping review was conducted under PRISMA-ScR and the Arksey and O'Malley/JBI framework. 4 databases were searched for studies from 2000 to August 2025. Eligibility required explicit isolation measures in women survivors and reported mental health outcomes studies of social support or loneliness alone were excluded. Data were charted and synthesized narratively. 5 studies met inclusion criteria. 2 used subjective scales, 3 used structural network indicators. Across studies, greater isolation correlated with higher PTSD distress, depressive symptoms, and suicidality risk. One group program reduced isolation and hopelessness versus waitlist. Negative disclosure reactions, especially online, correlated with higher isolation. Despite the small evidence base, findings consistently indicate that isolation worsens mental health and hinders recovery after sexual violence. Survivor centred, gender responsive, trauma informed strategies that expand networks and reduce disclosure harms are warranted. Future research should standardize measures, test mechanisms, and evaluate culturally grounded interventions in low resource.

## 1 Introduction

Sexual violence is a pervasive public health problem and a fundamental violation of human rights. Global estimates indicate high lifetime exposure to physical and or sexual violence among women, with many affected by non-partner sexual violence across regions and settings [1,2]. The psychological sequelae of sexual violence are substantial, encompassing post-traumatic stress disorder (PTSD), depression, anxiety, and suicidal ideation, with downstream disruption to functioning, relationships, education, and employment. Against this backdrop, social isolation conceptualised as restricted or reduced social ties, contacts, and participation is increasingly recognised as a consequential correlate of survivors' mental health trajectories. Although conceptually related, social isolation is distinct from loneliness: isolation indexes the objective structure of social connection such as network size, density, role diversity, whereas loneliness reflects the subjective appraisal of unmet social needs.

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Conflating these constructs risks obscuring mechanisms and misdirecting intervention targets.

Following sexual violence, isolation may arise via several routes. First, negative social responses to disclosure such as blaming, minimising, or disbelief can precipitate withdrawal from social engagement and reduce future help seeking. Recent work among adults who disclosed victimisation in online environments found that hostile reactions were associated with higher levels of social isolation; interestingly, certain forms of unsupportive acknowledgement showed nuanced, inverse associations, signalling the complexity of disclosure dynamics in digital contexts [3]. Second, isolation can be structural, reflecting erosion of network size, density, and retention of close ties. Among adult survivors, reductions in network size and retention after assault have been linked to poorer mental health functioning, suggesting that network contraction operates as a risk pathway in the aftermath of trauma [4]. Related social network analyses indicate that more segmented networks characterised by weak connectivity between subgroups are associated with a smaller share of alters who receive disclosures of assault, implying constrained access to supportive resources when structural bridges are lacking [5]. Third, isolation can function as both cause and consequence of psychological morbidity: avoidance and hyperarousal may limit social participation, while diminished contact deprives survivors of corrective experiences such as validation, advocacy, and instrumental help, that buffer against PTSD and depression.

Evidence from intervention contexts further suggests that isolation is modifiable. A quasi-experimental study with adult female survivors of childhood sexual abuse reported that a group-based program reduced isolation and hopelessness relative to a waitlist condition, indicating that structured peer contact can restore affiliation and improve affective outcomes [6]. In humanitarian and migration settings, isolation may be intensified by disrupted kin ties and reduced role diversity. Among North Korean refugee women living in South Korea, pre-migration sexual violence was associated with suicide related risk, with lower kin ties and network diversity mediating the association again implicating structural isolation as a mechanism of harm [7].

Despite these indications, the isolation specific evidence base remains sparse relative to the much larger literature on social support or loneliness. Many studies foreground perceived support or global network satisfaction without directly measuring isolation indicators such as network size/density, kin ties, retention or isolation/affiliation scales. This gap limits comparative inference, hinders meta-analytic synthesis, and complicates the design of network targeted interventions. More broadly, the heterogeneity of constructs and measures produces ambiguity about which social dimensions are most actionable for improving survivor outcomes.

Given these challenges, a scoping review approach is appropriate to map existing evidence, clarify definitional boundaries, and identify measurement and intervention gaps. The present review distinguishes structural isolation (objective network indicators such as size, density, role diversity, kin ties, and retention) from subjective isolation (isolation/affiliation scales or items explicitly labelled isolation), and focuses on studies that include mental health outcomes relevant to post-assault recovery such as PTSD, depressive symptoms, hopelessness, suicidality. Articles that assess only social support or loneliness without isolation indicators are treated as contextual evidence rather than core outcomes. By organising findings across these isolation domains, the review aims to delineate how isolation relates to mental health morbidity among women survivors of sexual violence, highlight potential modifiable targets including disclosure processes and network structure, and articulate a future research agenda prioritising standardised measurement, longitudinal designs, and trials of network strengthening and peer-based interventions in resource-constrained settings.

Ultimately, addressing social isolation aligns with survivor centred, gender responsive, and trauma informed care. Standardised screening for isolation, attention to the quality and topology of survivors' networks, and mitigation of disclosure related harms particularly in online spaces may together reduce psychological morbidity and improve recovery pathways. This focus is consistent with global efforts to reduce the burden of sexual violence and its mental-health consequences at population scale [1,2]. To map and integrate evidence on how social isolation influences mental health and recovery among women survivors of sexual violence, and to identify measurement gaps to guide future interventions.

## 2 Methods

Design and reporting: the review followed PRISMA-ScR and the Arksey & O'Malley/JBI framework [7–9]. Sources and search. PubMed, Scopus, Web of Science, and PsycINFO were searched for records published from January 2000 to August 2025, using controlled vocabulary and keywords for sexual violence, women, social isolation, and mental health. Reference lists of included studies were screened. Eligibility: records were eligible if they: sampled women or predominantly female survivors of sexual violence, explicitly measured social isolation (objective network indicators: such as network size/density/diversity, kin ties, retention or isolation/affiliation scales), reported at least one mental health outcome such as: PTSD, depression, anxiety, suicidality, hopelessness, and used any empirical design. Studies focused solely on loneliness or general social support without isolation indicators were excluded from the core evidence set. Selection and charting: Screening proceeded in two stages (title/abstract, full text). Data were charted for study characteristics, isolation measurement, outcomes, and key findings. Given the scoping purpose, formal risk of bias appraisal was not undertaken, synthesis was narrative.

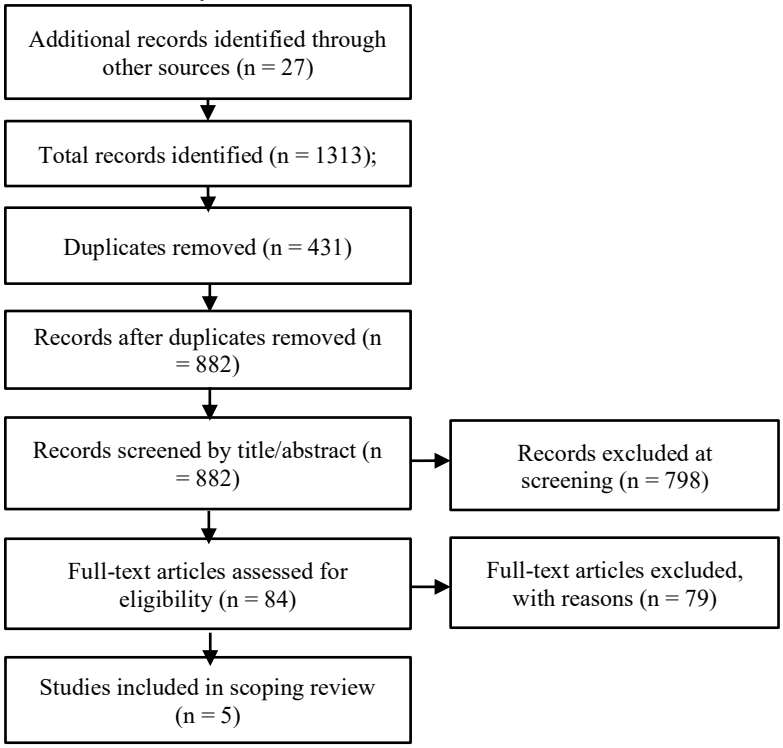


**Fig 1.** PRISMA-ScR flow diagram of study selecti

## 3 Result

Five studies met inclusion criteria, 2 assessed subjective isolation and 3 assessed structural indicators. Across studies, greater isolation was associated with higher PTSD related distress, depressive symptoms, hopelessness, and suicidality risk. Group based programming was associated with reductions in isolation among survivors of childhood sexual abuse. Network analyses indicated that more segmented networks constrained disclosure reach, implying reduced access to supportive resources.

**Table 1.** Included studies measuring social isolation in women survivors of sexual violence

| Author (Year) | Country / Sample | Design | Isolation Type | Isolation Measure | Outcomes | Core Finding |
|---|---|---|---|---|---|---|
| Bhuptani et al. (2024) | USA, adults disclosing via #MeToo (n=195) | Cross-sectional survey | Subjective | Study-specific isolation items | Coping; PTSD-related distress | Negative online reactions isolation, some unsupportive acknowledgement ↔ lower isolation |
| Gorey et al. (2001) | Canada, adult female CSA survivors (group n=78, waitlist n=80) | Quasi-experimental (secondary analysis) | Subjective | Isolation/Affiliation composite | Isolation, hopelessness | Group program reduced isolation & hopelessness vs waitlist |
| Jaffe et al. (2022) | USA, adult sexual-assault survivors | Network study | Structural | Network size, density, retention | Mental-health functioning | Smaller/less retentive networks → poorer MH functioning |
| Dworkin et al. (2016) | USA, young adult survivors | Mixed-method SNA | Structural | Network segmentation/connectivity, % alters aware | Disclosure stress, functioning | More segmented networks → smaller share receiving disclosure |
| Um et al. (2021) | South Korea, North Korean refugee women | Cross-sectional | Structural | Kin ties, role diversity | Suicidality | Lower kin ties/diversity mediate path SV→suicidality |

## 4 Discussion

Findings converge on the role of social isolation captured subjectively or via objective network indicators as a correlate of post-assault psychological morbidity. Isolation appears modifiable through structured peer programs and may be influenced by disclosure processes, especially in online contexts. Clinical pathways should integrate isolation screening and network-strengthening components within survivor centred, gender responsive, and trauma informed care. Future research should standardise isolation measures, adopt longitudinal designs to clarify temporality, and test culturally grounded interventions in low resource settings.

## 5 Conclusion

The isolation focused evidence base, while small, indicates that social isolation worsens mental health and impedes recovery after sexual violence. Interventions that expand supportive ties and reduce disclosure-related harms are warranted.

## 6 Implication

The review contributes theoretical refinement of isolation constructs, highlights clinical pathways for integrating network strengthening approaches, and sets an agenda for culturally grounded research in low resource settings.

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**Author Contributions:** PEW conceptualized the study, designed the review framework, conducted literature search, screening, and data synthesis, and drafted the manuscript. LL contributed to methodological design, data charting, and critical review of the findings. DD provided theoretical input on trauma and refined the discussion and implications, and reviewed the final draft. All authors approved the final version of the manuscript.

**Conflict of Interest:** The author declares no conflicts of interest.

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