Original Article

Barriers to Seeking Healthcare Services After Sexual Assault: A Scoping Review

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Background: Sexual violence by an intimate partner or by a stranger remains highly prevalent in the United States. Yet, the use of post-sexual-assault health care is still underutilized. Persons in vulnerable populations such as immigrants, LGBTQIA+, and Black women may experience additional barriers to care.
Objective: We sought to determine the extant research in this area, the methodologies used, and whether specific barriers exist for seeking sexual assault services. We sought to understand if barriers differed for vulnerable populations.
Inclusion Criteria: Peer-reviewed literature published before September 2023, written in English, conducted in the United States, and that included survivors of sexual violence and explored barriers to seeking care postassault (i.e., sexual assault nurse examiners) were included in the review.
Methods: Preferred Reporting Items for Systematic Reviews and Meta-analyses Extension for Scoping Reviews protocols were followed. PubMed, Scopus, CINAHL, PsycINFO, and PTSDpubs databases were used to identify literature that met the inclusion criteria, from which we selected 14 publications.
Results: Much of the literature employed qualitative or mixed methods designs. Several studies focused on underserved minority groups, including immigrant women, Black women, and homeless youth. Common barriers existed on the intrapersonal, interpersonal, organizational, community, and societal levels.
Conclusion: The literature provided substantive context for the multilevel barriers, all contributing to survivors remaining silent rather than seeking much-needed help. Although there is a need for additional research on barriers to sexual assault services specifically, the extant research supports strengthening multilevel, alternative approaches to deliver much-needed services.

KEY WORDS:
Barriers to care; health care; sexual assault; sexual violence

Sexual violence (SV) remains a pervasive problem in the United States. According to the report on SV from the Centers for Disease Control and Prevention National Intimate Partner Violence Survey, more than one in three women and nearly one in four men have experienced some type of lifetime SV in the United States (Basile et al., 2022). One in four women and one in 26 men report having experienced either completed or attempted rape in their lifetimes (Basile et al., 2022).

SV can be defined as any attempt of or actual sexual act obtained through coercion or violence, including rape by strangers, marital or partnership rape, and sexual abuse. These assaults are associated with a myriad of adverse physical and mental health sequelae (Garcia-Moreno et al., 2013). The violence can result in immediate physical injuries and an elevated risk for sexually transmitted infections (Chivers-Wilson, 2006; Hernandez Ragpa et al., 2019). The internalized trauma from the violence also has long-term health effects. SV has been associated with an increased risk for chronic diseases such as high blood pressure, asthma, and diabetes (Basile et al., 2021). It can have a detrimental impact on both personal regard and interpersonal

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well-being (Basile et al., 2021). Survivors of SV have reported both a decreased interest in sex and increased risky sexual behaviors (i.e., multiple sex partners; O'Callaghan et al., 2019). In addition, survivors can experience long-term health consequences such as an increased risk for HIV (Linden, 2011) and downstream mental health effects, including posttraumatic stress disorder (Chivers-Wilson, 2006), depression, and anxiety (Basile et al., 2021).

Some of the adverse health sequelae of SV can be addressed and potentially minimized if timely medical care and treatment are provided. Importantly, access to healthcare services is crucial to mitigate negative health consequences and attend to the mental trauma that is associated with SV. Sexual assault nurse examiner (SANE) programs are one avenue for addressing immediate health concerns and providing trauma-informed care for survivors. These programs began in the 1970s when nurses noticed that sexual assault survivors were not offered high-quality, specialized care when they presented to emergency departments (Holloway & Swan, 1993; O'Brien, 1996). In the 1990s, forensic nursing was formalized as a subspecialty within nursing. At the same time, a growing body of evidence has shown that the care through SANE programs yielded much better outcomes than general emergency department care. Over the following decades, SANE programs in the United States grew to over 950 by 2020 (International Association of Forensic Nurses, 2023).

Even with the proliferation of SANE programs in all 50 states and hospitals now charged with offering options for trauma-informed sexual assault forensic care, many survivors do not seek medical care for their abuse or assaults. In an earlier national survey, only 21% of victims sought medical services after their assault (Zinzow et al., 2012). Understanding the barriers from the survivors' perspectives are essential to making these programs fully accessible to those who need them. Human behavior is heavily influenced by multiple factors, especially during times of stress and trauma. Therefore, we organized the barriers in the literature according to the socioecological model. First developed by Urie Brofenbrenner and widely applied in public health literature (Carmona et al., 2023; Chen et al., 2023; Korom et al., 2023; Paul & Mondal, 2021; Sun et al., 2023), this model examines multilevel factors that influence human behavior and health outcomes. It recognizes that individuals are embedded in various systems, including intrapersonal (i.e., personal knowledge, attitudes, beliefs, and biological factors), interpersonal (i.e., relationships and social networks, including family, friends, and coworkers), organizational (i.e., schools, workplaces, and healthcare settings, which can influence access to resources and social norms), community (the physical and social environment in which individuals live), and societal (i.e., the broader social, economic, and political context, encompassing public policies, laws, social inequality, and cultural values).

Existing Reviews

A preliminary search of MEDLINE, the Cochrane Database of Systematic Reviews, and JBI Evidence Synthesis was conducted to identify systematic and scoping reviews on help-seeking after sexual assault. Some reviews have been done on topics adjacent to this one. One literature review examined barriers to disclosure of sexual assault among Black women, which included stigma, shame, and racism (Tillman et al., 2010). It is important to note that although disclosure of the assault and active help-seeking are connected, they are distinct components of the processing of SV experiences. Disclosure refers to revealing something to others that could otherwise be kept secret. Help-seeking requires action to address the SV or sequelae related to the SV. Not all disclosure includes seeking help, yet all help-seeking involves some element of disclosure.

Other reviews examined help-seeking intentions and facilitators for help-seeking. Teens experiencing dating violence, not specific to SV, expressed interest in using informal sources of support, such as parents or friends, rather than formal systems, but shame, mistrust, and embarrassment served as powerful barriers for the youth (Padilla-Medina et al., 2022). Survivors of intimate partner SV were more likely than those experiencing intimate partner physical and emotional violence to pursue formal more than informal supports, yet stigma and difficulty identifying the SV served as barriers to care (Wright et al., 2022). Two other scoping reviews examined obstacles to care for sexual assault survivors from the service provision standpoint, finding barriers pertaining to access, inadequate support for subpopulations, provider attitudes, hurried interactions, and incompetence in caring for survivors among others (Bach et al., 2021; Fitzgerald et al., 2017).

To date, no review has examined the literature that focuses specifically on survivors' perspectives of barriers to seeking post-sexual-assault medical care, particularly among vulnerable populations. There is a need to better understand the barriers that sexual assault survivors face when deciding to pursue health care after assault, specifically those of underserved communities. Therefore, a scoping review was conducted to determine the extant research in this area, the methodologies used, and whether specific barriers exist for marginalized subpopulations and for seeking sexual assault services specifically. The following research questions were formulated: What is known from the literature about barriers to seeking post-sexual-assault health care, and how well represented are marginalized subpopulations in the research?

Review Methods

Our protocol was drafted using the Preferred Reporting Items for Systematic Reviews and Meta-analyses Extension for Scoping Reviews (PRISMA-ScR; Tricco et al., 2018).

The research team revised the protocol before implementing the review, pursuing the type of scoping study outlined in Arksey and O'Malley (2005) that would identify research gaps in the existing literature but not include a full quality assessment of the extant body of research. We used the PRISMA-ScR evidence-based 22-item checklist and the four-phased flow diagram to select articles (see Figure 1). The final protocol is published online (see https://osf.io/nf8qj/files/osfstorage/65d7e0db0d9acb008dc2e930).

Eligibility Criteria

The following were the inclusion criteria: (a) published in peer-reviewed journals before August 2023, which was the end date for article selection; (b) conducted in the United States, which was our region of focus; (c) written in English; (d) specifically included survivors of SV; and (e) explored barriers of seeking health care after sexual assault. No limitations were placed on the populations of interest aside from being SV survivors. No limits were set on study design; as a result, this scoping review considered quantitative, qualitative, and mixed methods studies.

Articles were excluded from the review if they (a) did not include SV victimization, (b) focused solely on disclosure of violent experiences but not on help-seeking, (c) did not discuss barriers to medical care, or (d) were limited to help-seeking via the criminal justice system or mental health services only.

Information Sources and Search Criteria

A scoping search of peer-reviewed journal articles published in English through August 30, 2023, was conducted via an electronic search of PubMed, Scopus, CINAHL, PsycINFO, and PTSDpubs databases. Combinations of the following representative subject headings and key words were used to identify studies for inclusion: *rape*, *sexual assault*, *sexual abuse*, *intimate partner violence*, *forced sex*, or *sexual abuse* AND *health services*, *delivery of health care*, *assault care*, *help seeking*, *forensic*, or *sexual assault care* AND *barriers*, *challenges*, *hurdles*, or *fears* (see Supplemental Digital Content 1 for the complete list of search terms, http://links.lww.com/JFN/A158).

Data Extraction

Two authors used a standardized form independently to abstract specific details of the studies' aims, methodologies, participants, and key findings including the type of SV experienced, the barriers to care discussed, and the type of care considered or sought. The interrater reliability for the data abstraction was >95%. Discrepancies were discussed and resolved with the first author. We did not assess aspects of the studies that were beyond the objectives of the scoping review, such as methodological limitations and risk for bias. Data were extracted from each article into tables that followed the guidelines suggested in the PRISMA-ScR checklist.

Definitions

When examining the literature, we applied a general definition of "barriers" to help-seeking to include any aspect, whether intrinsic or extrinsic, that was seen as impeding a person's ability to seek care services. SV included any sexual act obtained through coercion or violence including rape by strangers, marital or partnership rape, and sexual abuse. We

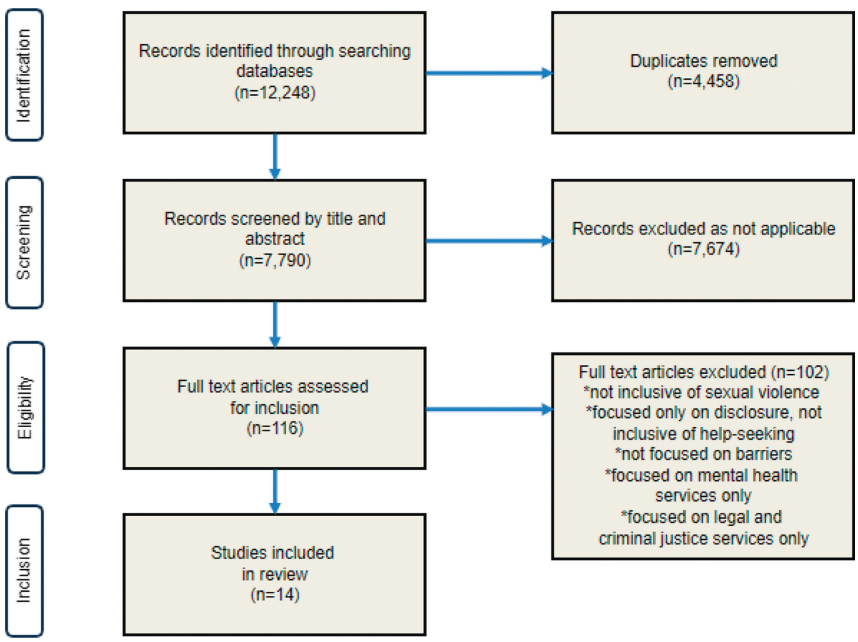

FIGURE 1. Preferred Reporting Items for Systematic Reviews and Meta-analyses Extension for Scoping Reviews flow diagram for article selection.

did not include sexual harassment or intimidation, as these are not usually the experiences that prompt a person to pursue post-sexual-assault medical care and treatment. For the purposes of this review, post-sexual-assault care had to include some aspect of healthcare provision beyond mental health services. Any articles that included mention of health care were considered. Articles that only included engagement with the legal and criminal justice system were excluded from consideration.

Review Results

The review began with a literature search, yielding over 12,000 records from multiple databases. After removing 4,458 duplicates, two authors reviewed the remaining titles to exclude the nonapplicable articles. Further review of the remaining abstracts identified 116 potentially eligible studies. The full-text articles were assessed to determine whether they met the inclusion criteria. Any discrepancies on inclusion/exclusion were resolved through discussion and reaching a consensus. The first author gave final verification to include 14 studies (see Figure 1).

Study Designs and Aims

Table 1 outlines the included studies, their aims, and their designs. Most (7, 47%) of the selected publications were qualitative, employing in-depth interviews (Acosta & Morris McEwen, 2023; Patterson et al., 2009; Tummala-Narra et al., 2019; Wadsworth et al., 2019), focus group discussions (Logan et al., 2005), or both (Christensen et al., 2021; Donne et al., 2018). Five studies (33%) were quantitative, using cross-sectional surveys for data gathering (Masho & Alvanzo, 2010; Sabina et al., 2015; Santa Maria et al., 2020; Weist et al., 2014; Zadnik et al., 2016). The remaining two were mixed methods designs, one employing a retrospective chart review and in-depth interviews (Adams et al., 2016) and the other using cross-sectional surveys with focus group discussions (Sualp et al., 2021).

Although the qualitative studies attended to qualitative rigor and the analyses provided contextualization of findings, their limited sample sizes prevent generalizability to the overall populations of interest. Only three of the quantitative studies had a large ($N > 1{,}400$) population-based samples. As cross-sectional surveys, these were able to identify some risk factors for sexual assault and forced sex as well as barriers and predictors of help-seeking, but they were unable to ascertain interaction effects and causality of relationships.

Populations of Focus

Many of the articles included in this review focused on specific subpopulations that may face unique barriers to care (see Table 1). Tummala-Narra et al. (2019) examined the experiences of Indian American immigrants, and five other studies focused on Latinx women, including immigrant women (Acosta & Morris McEwen, 2023; Adams et al., 2016; Sabina et al., 2015; Zadnik et al., 2016) and college youth (Christensen et al., 2021), specifically exploring how the immigrant experience and acculturation can impact help-seeking behaviors (Christensen et al., 2021). Sualp et al. (2021) gathered perspectives from Black women, whereas Weist et al. (2014) compared the perspectives of Black survivors with White survivors. Two articles focused on the experiences of cisgender, transgender, gay, and straight men (Donne et al., 2018; Masho & Alvanzo, 2010). Environmental circumstances were also used to highlight the experiences of particularly vulnerable persons. Santa Maria et al. (2020) focused on the experiences of homeless youth, whereas Logan et al. (2005) compared the barriers facing rape survivors in rural settings compared with urban environments. These are highlighted in Table 1.

Barriers to Care

Through this scoping review, we identified several barriers from the selected literature. Whereas some barriers related to the individual, most included elements of relational context, cultural norms, health system access, and societal influences. These are summarized broadly in Table 2 and discussed by populations and services.

Only two articles specifically examined barriers to accessing post-sexual-assault examinations. Adams et al. (2016) conducted a chart review of Latinx immigrants pursuing sexual assault forensic examinations and medical care. They also interviewed community service providers working with these women in an urban setting. Santa Maria et al. (2020) surveyed homeless youth. The youth were not widely aware of sexual assault forensic examinations, their location, or the process of obtaining one. Similarly, the community service providers working with immigrant women were also relatively unaware of the resources available (Adams et al., 2016). The immigrant women who sought care did so under "Jane Doe" pseudonyms more frequently than White women, potentially out of fears for personal safety and of reprisal. The perception that accessing care would automatically engage the legal system was another salient barrier for both groups, but the root causes of this fear depended on their context. The homeless youth who might be victims of human trafficking may not be able to safely leave the situation and did not want to report their trafficker (Santa Maria et al., 2020). Immigrant women felt the engagement with the legal system was potential for documentation issues and deportation risk, a barrier present in all articles focusing on Latinx women (Acosta & Morris McEwen, 2023; Adams et al., 2016; Sabina et al., 2015; Zadnik et al., 2016).

Other interpersonal and intrapersonal issues reinforced the hesitation to seek care services for immigrant women, including perceived language barriers (Acosta & Morris McEwen, 2023; Adams et al., 2016; Sabina et al., 2015; Zadnik et al., 2016), potential for personal and familial

TABLE 1. Overview of Studies Included in the Scoping Review

Authors	Aims	Study design	Sample size	Participants	Gender, age, race/ethnicity	Type of violence	Help-seeking measures
Adams et al. (2016)	To assess usage of SANE services by Hispanic women and to ascertain service accessibility and acceptability in the community	Mixed methods retrospective chart review with in-depth interviews (IDIs)	*N* = 2,322 charts *N* = 7 IDIs	Charts of women seen at the SAFE program between January 1, 2010, and December 31, 2013 IDIs: service providers in community	All women	Sexual assault, domestic violence	SAFE services
Acosta & Morris McEwen (2023)	To explore postrape experiences of undocumented immigrant women of Mexican origin	IDIs	*N* = 6 IDIs	Female survivors of rape	Mexican immigrant women, aged 24–66 years	Rape	Law enforcement, health care, social services
Christensen et al. (2021)	To examine the barriers Latinx women experience in seeking help for sexual assault	Focus group discussions (FGDs) and IDIs	5 FGDs (*n* = 35): 8 men, 27 women; 4 IDIs with women	Latinx students attending college in Southwestern United States	Latinx students, aged 18–24 years	Sexual assault	Reporting/disclosing sexual violence
Donne et al. (2018)	To understand how men, both straight and gay as well as cisgender and transgender, conceptualize, understand, and seek help related to sexual violence	IDIs and FGDs	*N* = 19 IDIs *N* = 13 FGDs	Men who experienced a recent sexual experience that meets criteria for sexual coercion, harassment, or violence	All cisgender and transgender men	Sexual violence or coercion, unwanted sexual experience, rape	Mental health counseling, therapy, support groups, sexual assault services
Logan et al. (2005)	To examine perceived barriers to care for survivors of rape and the similarities and differences for rural vs. urban survivors	FGDs	*N* = 30	Rape survivors and mothers of rape survivors	All people	Rape	Criminal justice services, health and mental health services
Masho & Alvanzo (2010)	To examine predictors of help-seeking practices among male sexual assault survivors	Survey	*N* = 91	Male survivors of sexual assault	Men, aged 18 years and older	Rape, sexual assault, attempted rape, childhood rape or molestation	Professional services (counseling, sexual assault hotline, seeing a medical doctor)

continues

TABLE 1. Overview of Studies Included in the Scoping Review, Continued

Authors	Aims	Study design	Sample size	Participants	Gender, age, race/ethnicity	Type of violence	Help-seeking measures
Patterson et al. (2009)	To examine factors that prevent survivors from seeking help from the legal, medical, and mental health systems	IDIs	*N* = 29	Women survivors of sexual assault	Women, aged 18 years and older	Rape, sexual assault	Disclosure to anyone; seeking help from legal, medical, and mental health systems; rape crisis centers
Sabina et al. (2015)	To examine the interpersonal victimization experiences and help-seeking responses to victimization by ethnic group variations within Latino populations	Survey	*N* = 2,000	Latina women contacted through a random digit dial	Latina women, aged 18 years and older	Stalking, threatening behaviors, physical assault, sexual assault	*Informal:* talk to family, friends, clergy member, or others *Formal:* reporting to police, seeking legal remedies, counseling services or other social services, and injured women seeking medical services
Santa Maria et al. (2020)	To determine the prevalence and correlates of sexual violence and examine the correlates of post-sexual-assault examination utilization	Survey	*N* = 1,405	Homeless young adults between June 2016 and July 2017	Homeless youth	Dating violence, sexual assault, forced sex, involved in sex trafficking, childhood sexual abuse	Post-sexual-assault examination
Sualp et al. (2021)	To examine victim service barriers on local and state levels for Black sexual assault survivors	Mixed methods survey and FGDs	*N* = 48 surveys *N* = 8 FGDs	Black sexual assault survivors; service providers	Black, all ages	Sexual violence	Sexual assault services and other resources

continues

TABLE 1. Overview of Studies Included in the Scoping Review, Continued

Authors	Aims	Study design	Sample size	Participants	Gender, age, race/ethnicity	Type of violence	Help-seeking measures
Tummala-Narra et al. (2019)	To gain understandings of perspectives and experiences of sexual violence among 1.5- and second-generation Indian American women including barriers to help-seeking	IDIs	*N* = 19	Indian American female sexual violence survivors	Indian American, aged 19–46 years	Sexual abuse, rape, sexual assault, sexual molestation, stalking, sexual violence	Mental health service providers and law enforcement
Wadsworth et al. (2019)	To learn the barriers and facilitators in healthcare seeking and engagement from victims/survivors	IDIs	*N* = 22	Female survivors of sexual assault	All women, aged 18 years and older	Sexual assault	Health care (preventative and episodic care after assault)
Weist et al. (2014)	To broaden the understanding of the needs of women who are sexually assaulted as well as their use of traditional services and alternative resources	Survey	*N* = 213	Female survivors of sexual assault	White and Black women, aged 18 years and older	Sexual assault	Police, medical, and psychological services, sexual assault crisis center, mental health services
Zadnik et al. (2016)	To ascertain whether legal status was related to interpersonal victimization and help-seeking among Latina women	Survey	*N* = 2,000	Latina women contacted through a random digit dial	Latina women	Stalking, physical assault, sexual assault, threatening behaviors	Police; legal, medical, social, and informal services

Note. SANE = sexual assault nurse examiner; SAFE = sexual assault forensic examination.

shame (Christensen et al., 2021), and fear of being blamed because of traditional cultural norms (Christensen et al., 2021). The literature also discussed how struggling with self-blame, guilt, and fear of the perpetrator can be barriers to care for several different populations (Christensen et al., 2021; Logan et al., 2005).

At the organizational level, perceived cost was noted by several groups across the literature as a barrier (Acosta & Morris McEwen, 2023; Adams et al., 2016; Donne et al., 2018; Logan et al., 2005; Ullman & Lorenz, 2020). The barrier of perceived cost was compounded for Black women for whom medical mistrust and cultural mismatch between survivor and provider were also profound barriers (Sualp et al., 2021; Weist et al., 2014). Some respondents also cited fear of retraumatization by the healthcare and legal systems (Patterson et al., 2009).

Although most of the literature in this review focused on women, men also faced barriers. Difficulty discerning whether what they experienced was considered sexual assault or abuse was common (Donne et al., 2018). Gay men cited having to confront stereotypes such as "you're supposed to like it" (Donne et al., 2018) and overlapping

TABLE 2. Common Barriers to Post-Sexual-Assault Care Organized by Socioecological Model

Level	Barrier identified	Example
Intrapersonal	• Uninsured	Survivor does not have health insurance (Acosta & Morris McEwen, 2023; Donne et al., 2018); the healthcare provider does not accept the health insurance the survivor has (Acosta & Morris McEwen, 2023; Adams et al., 2016)
	• Past individual trauma	Survivor has experienced child abuse or previous sexual assaults (Acosta & Morris McEwen, 2023; Weist et al., 2014)
	• Lack of awareness of services	The services available are not talked about in the community; nothing is known about what post-sexual-assault examinations entail (Logan et al., 2005; Santa Maria et al., 2020; Weist et al., 2014)
	• Reluctance acknowledging what happened	Survivor does not want to appear weak; doubts others will believe them (Masho & Alvanzo, 2010)
	• Fear for personal safety posttreatment	People in their communities may judge them for going to get treatment (Tummala-Narra et al., 2019); they may be at an increased risk for retaliatory violence if in a trafficked situation (Santa Maria et al., 2020)
	• Feeling responsible for assault	Survivor blames themselves for the trauma (Logan et al., 2005; Patterson et al., 2009; Ullman & Lorenz, 2020); survivor believes if they had done something different, the assault would not have happened; fears being blamed (Donne et al., 2018; Masho & Alvanzo, 2010; Sualp et al., 2021; Tummala-Narra et al., 2019)
	• Not seeing self as a priority	They believe others have a greater need (Logan et al., 2005)
	• Language	The survivor has limited English proficiency; fears they will not be understood (Acosta & Morris McEwen, 2023; Adams et al., 2016; Sabina et al., 2015; Zadnik et al., 2016)
	• Family norms	*Respecto* (respect); *famiismo* (family loyalty; Christensen et al., 2021); family pride (Acosta & Morris McEwen, 2023; Adams et al., 2016; Sualp et al., 2021; Zadnik et al., 2016)
Interpersonal	• Fear of the abuser/retaliation	The survivor is fearful that the perpetrator may harm them for getting help (Logan et al., 2005; Masho & Alvanzo, 2010; Sualp et al., 2021)
	• Did not want others to find out	The survivor is fearful of family/community backlash (Logan et al., 2005; Sualp et al., 2021; Ullman & Lorenz, 2020)
	• Social and physical isolation	Survivor fears being shunned by community; victim may be treated differently (Acosta & Morris McEwen, 2023)
	• Medical mistrust	Survivor thought the medical providers would contact law enforcement (Acosta & Morris McEwen, 2023; Logan et al., 2005; Santa Maria et al., 2020; Zadnik et al., 2016); the medical provider kept asking for unnecessary examinations to be done, revictimized the survivor (Donne et al., 2018; Logan et al., 2005; Patterson et al., 2009; Ullman & Lorenz, 2020; Wadsworth et al., 2019; Zadnik et al., 2016)

continues

TABLE 2. Common Barriers to Post-Sexual-Assault Care Organized by Socioecological Model, Continued

Level	Barrier identified	Example
Organizational	• Access to care	Limited services available (Logan et al., 2005; Sualp et al., 2021); long travel times for rural women to get to a healthcare provider (Logan et al., 2005); scheduling issues with healthcare systems (Donne et al., 2018); limited transportation options (Logan et al., 2005; Sualp et al., 2021)
	• Cost of care (misperceptions that sexual assault services are not affordable)	There is a perception that sexual assault services are not affordable if the survivor does not have health insurance; unaware that SAFEs are often free of charge (Adams et al., 2016; Donne et al., 2018; Masho & Alvanzo, 2010; Ullman & Lorenz, 2020)
	• Staff incompetence/lacking sensitivity training	Staff does not have proper training to help the survivors; the staff did not treat the survivors with sensitivity (Logan et al., 2005; Patterson et al., 2009; Sualp et al., 2021; Wadsworth et al., 2019)
	• Cultural norms and values	Taboos of talking about sex and abuse (Acosta & Morris McEwen, 2023; Tummala-Narra et al., 2019; Ullman & Lorenz, 2020); *marianismo* (virginal behaviors in women); traditional views about marriage and sex; preventing *chisme* (gossip; Christensen et al., 2021)
Community	• Distrust of law enforcement	Did not think system could help (Patterson et al., 2009; Sualp et al., 2021; Weist et al., 2014); afraid of being blamed by law enforcement (Acosta & Morris McEwen, 2023; Logan et al., 2005; Santa Maria et al., 2020; Zadnik et al., 2016)
	• Distrust of law enforcement	Did not think system could help (Patterson et al., 2009; Sualp et al., 2021; Weist et al., 2014); afraid of being blamed by law enforcement (Acosta & Morris McEwen, 2023; Logan et al., 2005; Santa Maria et al., 2020; Zadnik et al., 2016)
	• Traditional gender-role ideologies in society	Heterosexual men fear being labeled as weak or gay (Masho & Alvanzo, 2010); gay men fear homophobic responses from others (Donne et al., 2018); women are expected to be submissive to their male partners (Sabina et al., 2015; Tummala-Narra et al., 2019); traditional beliefs about marriage and sex (Christensen et al., 2021)
Societal	• Immigration environment	Documentation status concerns; afraid that interacting with system will result in deportation; fear they will not be protected (Acosta & Morris McEwen, 2023; Adams et al., 2016; Sabina et al., 2015; Zadnik et al., 2016)
	• Racism and discrimination	Ethnic, religious, and racial minority status in society (Acosta & Morris McEwen, 2023); reluctant to disclose outside ethnic/religious community for fear of discrimination and further isolation (Acosta & Morris McEwen, 2023; Tummala-Narra et al., 2019); fear of workplace discrimination if assault occurred there (Sualp et al., 2021)

Note. SAFE = sexual assault forensic examination.

stigmas (being gay and experiencing sexual assault) as prohibitive to seeking help. Although cis-heterosexual White men are not often seen as a vulnerable population in healthcare research today, in the case of sexual assault, they face several barriers as well. Help-seeking requires them to confront the mainstream gender and masculinity norms (i.e., men should be tough and emotionless), and most do not pursue care (Donne et al., 2018; Masho & Alvanzo, 2010). Those who were victims of child sexual abuse were also less likely to seek help than those experiencing assault in adulthood. Both gay and heterosexual men who were injured were 11 times more likely to seek help, and those who perceived serious risk were 6.5 times more likely to seek help, which also contributes to the limited reported incidence of SV (Masho & Alvanzo, 2010).

Discussion and Implications for Forensic Nursing

Seeking healthcare services after sexual assault begins with recognizing it and acknowledging its occurrence. Unfortunately,

both men and women struggle to do so (Donne et al., 2018; Masho & Alvanzo, 2010; Sualp et al., 2021; Tummala-Narra et al., 2019), echoing the research done with married women recognizing marital rape (Wright et al., 2022).

The extant literature highlights compounding barriers to post-sexual-assault health care that can become insurmountable, preventing survivors from getting the formal services and care that they may need. Many of these barriers were similar to those in the literature focusing on disclosure and help-seeking for other kinds of violence, including fear of being blamed, general mistrust of the systems, fear of retribution, and concerns for privacy (Ullman & Lorenz, 2020; Wolitzky-Taylor et al., 2011).

This review highlights that SV and specific post-sexual-assault health care are rarely examined outside other types of interpersonal violence and other types of services, respectively. Only two of the articles in this scoping review examined post-sexual-assault healthcare provision specifically (Adams et al., 2016; Santa Maria et al., 2020). These articles highlighted the substantial lack of knowledge about the services, their locations, their cost, and the processes, even among community support service providers. Raising awareness of the existing services is a preliminary step, and ensuring the affordability and confidentiality of post-sexual-assault services are understood in the community follows. To that end, outreach between community support services and the SANE programs is vital. We cannot assume that because a program exists, people in the community know about it. Public service announcements, posters, and billboards about sexual assault health care may also make inroads for decreasing stigma related to help-seeking after assault.

In addition, SANE programs need to collaborate closely with each other to ensure complete coverage of the population. For instance, collaboration between forensic nurses within city limits and those in surrounding counties is essential to creating holistic coverage in a region. In addition, phone-based applications that highlight all SANE programs in proximity to the person's location with details on how to access them could be further developed.

The literature highlights that those in minority groups experience unique barriers to help-seeking. These additional barriers include cultural values and customs, fear of deportation and immigration status, and limited English language ability. In addition, the complexity of the shame felt by both women and men, as well as the stereotyping of sexual minorities, needs to be further explored to enable sexual health advocates to address these barriers. Incorporating a multifaceted, trauma-informed care approach is essential to prevent further trauma for the survivors.

Marginalized groups of survivors voice reticence to interact with the system, which might include hospitals. To address the hesitation to engage with the "system," SANEs could reshape care delivery locations. Although the hospital-based SANE programs are crucial, we may also need to expand into the community. Examining the viability of providing similar services in community-based clinics is warranted. The clinics situated in and providing care to vulnerable communities have already established a sense of trust with their clients. As such, survivors might be more willing to obtain care through a trusted entity. Further research into the viability of such options is warranted. Forensic nurses partnering with researchers and the community can pilot alternative locations, evaluate success, and share findings with other practitioners.

This scoping review is not without limitations. Given the paucity of research specifically focused on the provision of sexual assault forensic care, we cannot garner a comprehensive understanding of whether barriers to care in general translate over to care specific to sexual assault. In addition, most of the literature was qualitative, providing excellent contextual understanding for the participants in the given studies, but cannot be generalized to larger populations. Quantitative studies, potentially leveraging the findings of the current literature and using population-based surveys, could shed light on the interplay between barriers and any compounding effects these have on survivors' likelihood to seek care.

Conclusions

Understanding the barriers to care is essential for making progress in the care and treatment of survivors of SV. This scoping review highlights the limited research into this specific area and yet highlights some of the common barriers to care among vulnerable populations. There is not a "one-size-fits-all" solution. Advances in the availability of services continue to be made. We must continue to enhance the accessibility and cultural acceptability of the services for all women and men who need them.

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