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Original Research Article

A STUDY OF PSYCHOSOCIAL FACTORS AND PSYCHIATRIC MORBIDITY AMONG VICTIMS OF SEXUAL VIOLENCE

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ABSTRACT

Background: Sexual violence is a major public health issue with significant psychological, social, and emotional effects. Survivors often experience disorders such as PTSD, depression, anxiety, sleep difficulties, and suicidal behaviour, particularly among vulnerable groups, including those with mental illness and disabilities. Factors such as age, education, socioeconomic status, family, and substance use may influence victimisation risk and psychiatric outcomes. Limited data exist on these factors and mental health among survivors in India. The objective is to assess psychosocial factors and psychiatric morbidity among sexual violence victims and to examine their relationship. **Materials and Methods:** This 12- month cross- sectional study at the Psychiatry outpatient unit of Government General Hospital, Vijayawada, involved 86 victims of sexual violence across all ages and genders. Data on psychosocial factors and psychiatric morbidity were collected using a semi-structured proforma, the Modified BG Prasad Scale for Socio-Economic Status, the M.I.N.I-KID for children and adolescents, and the M.I.N.I for adults. Ethical clearance was obtained from Siddhartha Medical College's Institutional Ethics Committee. Statistical analysis was conducted in SPSS v 26, with descriptive statistics including frequencies, percentages, means, and SDs. Associations were tested using Pearson's Chi-Square and Fisher's exact tests, with $p< 0.05$ considered significant. **Result:** The study found a high prevalence of psychiatric issues among sexual violence victims, particularly anxiety and trauma- related disorders. Children and adolescents mainly experienced separation anxiety and PTSD, while adults showed panic disorder, suicidal behaviour, PTSD, and depression. Most sociodemographic factors were not linked to psychiatric problems, but physical disability and abuse by unknown perpetrators were associated with higher rates of mental health issues. These results highlight the severe psychological effects of sexual violence and the need for prompt psychiatric and trauma- informed care, especially for vulnerable survivors. **Conclusion:** The study reveals a significant psychiatric burden among sexual violence victims, particularly young women, with anxiety, PTSD, depression, and suicidal behaviours common. Perpetrators were often known, though physical disability and assaults by unknown perpetrators were notable risk factors. Findings highlight the importance of routine mental health screening, early intervention, and ongoing trauma- informed support, particularly for vulnerable groups, to aid recovery and prevent long- term psychological issues.

INTRODUCTION

According to the Ministry of Health and Family Welfare, a victim is a person who suffers harm, including those subjected to non-consensual sexual acts such as sexual assault, rape, or sexual violence. It also refers to a person in need of compassion, care, validation, and support.[1] According to the World Health Organisation (WHO), sexual violence is any attempt to obtain a sexual act, or any other act directed against a person's sexuality, using coercion, by any person, regardless of their relationship to the

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victim, in any setting. It includes rape, defined as the physically forced or otherwise coerced penetration of the vulva or anus with a penis, other body part, or object; attempted rape; unwanted sexual touching; and other non-contact forms.[2] Globally, about 35.6% of women have experienced sexual violence. About 18% of women and 7.6% of men experienced sexual violence before the age of 18 years.[3,4] People with mental illness are 2–8 times more likely to experience sexual violence than those without mental illness.[5] People with physical disabilities are at greater risk of sexual violence than those without disabilities. An estimated 2 in 5 (39%) female victims and 1 in 4 (24%) male victims of sexual violence had physical disabilities.[6]

Sexual offences are among the most abhorrent forms of physical abuse, inflicting immediate and enduring mental and, to some extent, social trauma.[7] Despite its historical prevalence, sexual violence remains inadequately understood from survivors' perspectives. Survivors of sexual assault, aptly termed "survivors" rather than "victims," demonstrate remarkable resilience in the face of profound trauma.[8] The aftermath of sexual assault often leaves enduring psychological scars, including post-traumatic stress disorder (PTSD), depression, anxiety, and sleep disorders.[9-11] These challenges are compounded by societal disbelief and victim-blaming attitudes, perpetuating the cycle of trauma for survivors. The intersection of sexual violence and severe mental illness (SMI) further complicates the landscape, demanding a nuanced understanding of victimisation within vulnerable populations, particularly individuals with intellectual and developmental disabilities (IDD).[12] Sexual violence against individuals with IDD precipitates a myriad of psychological and behavioural challenges, including depression, anxiety, panic attacks, low self-esteem, shame, guilt, and irrational fear. Such experiences exacerbate existing behavioural difficulties, leading to withdrawal, aggression, self-injurious behaviours, and inappropriate sexual conduct.[4]

Childhood experiences play a pivotal role in shaping attitudes towards violence. Social learning theory holds that exposure to violence, particularly within the family, can normalise aggressive behaviours, including Sexual Violence. Moreover, entrenched sexual myths and stereotypes perpetuate harmful beliefs, such as victim-blaming and the normalisation of coercive behaviours under certain conditions. The underreporting of Sexual Violence is pervasive, driven by fear of stigma, disbelief, and repercussions at personal and social levels. Certain psychosocial factors, such as young age, lower education, being separated/divorced or single, intra-parental violence, mental disorder, substance use, prior victimisation, and poverty, increase the likelihood of becoming a victim of Sexual Violence.

In India, deeply ingrained patriarchal values exacerbate the prevalence of sexual violence against women, including those with IDD. While existing research sheds light on the prevalence of sexual violence and its association with mental health issues, there remains a dearth of literature exploring the intricate psychosocial factors that influence psychiatric morbidity among survivors. This study seeks to address this gap by comprehensively investigating the psychosocial factors and psychiatric morbidity among victims of sexual violence.

MATERIALS AND METHODS

Study Setting: Outpatient unit of the Psychiatry Department, Government General Hospital, Vijayawada, Andhra Pradesh.

Study Population: Victims of sexual violence attending the outpatient unit of the Psychiatry Department at Government General Hospital, Vijayawada, Andhra Pradesh.

Sample size: 86 victims of sexual violence

Type of study: Cross-sectional observational study

Duration of study: 12 months

Inclusion Criteria

1. Victims or guardians of victims (in the case of minors) who are willing to give consent
2. Victims of sexual violence of all ages and genders
3. Victims of sexual violence with physical disabilities

Exclusion Criteria

1. Victims or guardians of victims (in the case of minors) who are unwilling to give consent
2. Children who are not accompanied by a parent or guardian

Study Tools:

1. Modified BG Prasad Scale for Socio-Economic Status
2. M.I.N.I-KID (Mini International Neuropsychiatric Interview for Children and Adolescents)
3. M.I.N.I (Mini International Neuropsychiatric Interview)

Ethical Approval: Ethical clearance was obtained from the Institutional Ethics Committee of Siddhartha Medical College, Vijayawada, Andhra Pradesh, India.

Study Procedure: Subjects were recruited in accordance with the study's inclusion and exclusion criteria. Details of psychosocial factors and psychiatric morbidity were collected using a semi-structured proforma and assessment tools, including the Modified BG Prasad Scale for Socio-Economic Status, M.I.N.I-KID (Mini International Neuropsychiatric Interview for Children and Adolescents), and M.I.N.I (Mini International Neuropsychiatric Interview).

Statistical Analysis: All data were analysed using SPSS version 28. Categorical variables were summarised as frequencies and percentages, and continuous variables as mean ± standard deviation. Chi-square tests (Pearson's and Fisher's exact) were used to compare variables. For all statistical analyses, $p < 0.05$ was considered statistically significant.

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RESULTS

Table 1: Psycho social factors			
Variable	**Category**	**Frequency (n)**	**Percentage (%)**
Age (Years)	≤10	0	0
	11-20	26	30.23
	21-30	38	44.18
	31-40	22	25.58
	>40	0	0
	MEAN±SD: 25.37 ± 7.748		
Gender	Male	3	3.5
	Female	83	96.5
Education	Illiterate	8	9.3
	Primary school	18	20.93
	High school	38	44.18
	Intermediate	20	23.25
	Graduate	2	2.32
	Post-graduate	0	0
Occupation	Student	17.44	17.44
	Working	66.27	66.27
	Unemployed	16.27	16.27
Marital Status	Unmarried	32	37.2
	Married	38	44.18
	Divorced	12	13.95
	Widowed	4	4.65
Socio-Economic Status	Upper	2	2.32
	Upper Middle	4	4.65
	Middle	31	36.04
	Lower Middle	33	38.37
	Lower	16	18.60
Religion	Hindu	46	53.48
	Muslim	12	13.95
	Christian	28	32.55
Place of Residence	Rural	32	37.2
	Urban	54	62.79
Physical disabilities	Yes	3	3.5
	No	83	96.5
Marital Status of the Subject's Parents	Married	65	75.6
	Divorced	15	17.4
	Widowed	6	7.0
Parenting status of the subjects' parents	Biological parents	84	97.67
	Caretakers	2	2.32
Substance use among the subject's parents	Yes	44	51.2
	No	42	48.8
Perpetrator status	Known	79	91.86
	Unknown	7	8.13

Among the 86 study participants, the majority were aged 21–30 years (44.18%), followed by 11–20 years (30.23%) and 31–40 years (25.58%), with a mean age of 25.37 ± 7.75 years. Most participants were female (96.5%), while only 3.5% were male. Regarding educational status, 44.18% had completed high school, 23.25% had intermediate education, 20.93% had primary education, and 9.3% were illiterate. Only 2.32% were graduates, and none had postgraduate education. In terms of occupation, the majority were employed (66.27%), followed by students (17.44%) and the unemployed (16.27%). With respect to marital status, 44.18% were married, 37.2% were unmarried, 13.95% were divorced, and 4.65% were widowed. Most participants belonged to the lower-middle socioeconomic class (38.37%) or middle class (36.04%), while 18.60% belonged to the lower class. Only a small proportion were from the upper-middle (4.65%) and upper (2.32%) socioeconomic groups. Regarding religion, 53.48% were Hindus, 32.55% were Christians, and 13.95% were Muslims. A majority of participants resided in urban areas (62.79%), whereas 37.2% lived in rural areas. Most participants (96.5%) reported no physical disability, while 3.5% had a physical disability. Regarding parental marital status, 75.6% of participants' parents were married, 17.4% were divorced, and 7.0% were widowed. Nearly all participants (97.67%) were raised by their biological parents, while 2.32% were in the care of carers. More than half of the participants (51.2%) reported parental substance use, whereas 48.8% reported no parental substance use. Regarding perpetrator status, a substantial majority of participants (91.86%) reported that the perpetrator was known to them, while only 8.13% reported an unknown perpetrator.

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Table 2: Psychiatric morbidity among kids and adolescents (n=22)		
	Frequency (n)	**Percentage (%)**
Panic disorder	2	9.09
Separation anxiety disorder	3	13.63
Posttraumatic stress disorder	3	13.63
Psychiatric morbidity among adults (n=64)		
	Frequency (n)	**Percentage (%)**
Major depressive episode	4	6.25
Suicide	6	9.7
Panic disorder	8	12.5
Social anxiety disorder	5	7.81
Posttraumatic stress disorder	5	7.81

Among children and adolescents (N = 22), the most common psychiatric morbidities were separation anxiety disorder and post-traumatic stress disorder (PTSD), each affecting 3 participants (13.63%), followed by panic disorder in 2 participants (9.09%). Among adults (N = 64), panic disorder was the most prevalent psychiatric morbidity, observed in 8 participants (12.5%), followed by suicidal behaviour/attempt in 6 participants (9.7%). Social anxiety disorder and post-traumatic stress disorder (PTSD) were each reported in 5 participants (7.81%), while major depressive episode was identified in 4 participants (6.25%). These findings indicate a substantial burden of anxiety- and trauma-related disorders across both age groups, with adults additionally showing notable rates of depression and suicidality.

Table 3: Association between psycho social factors and psychiatric morbidity			
Variable		**Psychiatric morbidity**	
		Present	**Absent**
Age (in years)	≤10	0	0
	11- 20	11(42.3%)	15(57.7%)
	21-30	13(33.3%)	26(66.7%)
	31-40	12(57.1%)	9(42.9%)
	>40	0	0
Chi-square value-3.183, df-2, p-value – 0.204			
Gender	Females	34(41.0%)	49(59.0%)
	Males	2(66.7%)	1(33.3%)
Chi-square value- 0.786, df-1, p-value – 0.375			
Education	Illiterate	4(50.0%)	4(50.0%)
	Primary	7(38.9%)	11(61.1%)
	High school	13(34.2%)	25(65.8%)
	Intermediate	10(50.0%)	10(50.0%)
	Graduate	2(100%)	0(0%)
Chi-square value- 4.519, df-4, p-value – 0.340			
Occupation	working	23(40.4%)	34(59.6%)
	unemployed	5(38.5%)	8(61.5%)
	student	8(53.3%)	7(46.7%)
Chi-square value-0.915, df-2, p-value – 0.633			
Marital Status	Divorced	6(50.0%)	6(50.0%)
	Married	13(34.2%)	25(65.8%)
	Unmarried	14(43.8%)	18(56.2%)
	Widow	3(75.0%)	1(25.0%)
Chi-square value- 3.092, df-3, p-value – 0.378			
Socioeconomic status	Lower	9(56.2%)	7(43.8%)
	Lower Middle Class	11(33.3%)	22(66.7%)
	Middle class	11(35.5%)	20(64.5%)
	Upper Middle class	3(75.0%)	1(25.0%)
	Upper class	2(100.0%)	0(0%)
Chi-square value-7.448, df-4, p-value – 0.114			
Religion	Christian	12(42.9%)	16(57.1%)
	Hindu	19(41.3%)	27(58.7%)
	Muslim	5(41.7%)	7(58.3%)
Chi-square value-0.017, df-2, p-value – 0.991			
Place of Residence	Rural	13(40.6%)	19(59.4%)
	Urban	23(42.6%)	31(57.4%)
Chi-square value-0.032, df-1, p-value – 0.858			
Physical disabilities	Yes	3(100%)	0(0%)
	No	33(39.8%)	50(60.2%)
Chi-square value-4.317, df-1, p-value – 0.038			
Marital Status of the Subject's Parents	Divorced	7(43.8%)	9(56.2%)
	Married	28(43.8%)	36(56.2%)
	Widow	1(16.7%)	5(83.3%)

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Chi-square value-1.682, df-2, p-value – 0.431			
Parenting status of the subjects' parents	Biological parents	34(40.5%)	50(59.5%)
	Caretakers	2(100%)	0(0%)
Chi-square value- 2.844, df-1, p-value – 0.092			
Substance use among the subject's parents	Yes	21(52.5%)	19(47.5%)
	No	15(32.6%)	31(67.4%)
Chi-square value- 3.478, df-1, p-value – 0.062			
Perpetrator status	Known	30(38.0%)	49(62.0%)
	Unknown	6(85.7%)	1(14.3%)
Chi-square value--6.022, df-1, p-value – 0.014			

The association between psychosocial factors and psychiatric morbidity was assessed using the Chi-square test. Most sociodemographic variables, including age (p=0.204), gender (p=0.375), education (p=0.340), occupation (p=0.633), marital status (p=0.378), socioeconomic status (p=0.114), religion (p=0.991), place of residence (p=0.858), parental marital status (p=0.431), parenting status (p=0.092), and parental substance use (p=0.062), did not show a statistically significant association with psychiatric morbidity (p>0.05). However, physical disability was significantly associated with psychiatric morbidity (χ^2=4.317, p=0.038), with all participants with physical disabilities exhibiting psychiatric morbidity. Similarly, perpetrator status was significantly associated with psychiatric morbidity (χ^2=6.022, p=0.014); psychiatric morbidity was considerably higher among subjects abused by unknown perpetrators (85.7%) than among those abused by known perpetrators (38.0%). Although not statistically significant, higher rates of psychiatric morbidity were observed among participants whose parents used substances (52.5% vs 32.6%, p=0.062) and among those raised by carers rather than biological parents (100% vs 40.5%, p=0.092). These findings suggest that physical disability and abuse by an unknown perpetrator are important factors associated with psychiatric morbidity in the study population.

DISCUSSION

Psycho Social Factors: The present study assessed psychosocial factors and psychiatric morbidity among victims of sexual violence and examined associations between these factors and psychiatric outcomes. Sexual violence is recognised as a major public health problem with profound psychological consequences, including anxiety disorders, depression, PTSD, suicidal behaviour, and impaired psychosocial functioning.[13,14] The findings of the present study contribute to the growing body of evidence demonstrating the substantial mental health burden experienced by survivors of sexual violence.

The majority of participants in the present study were young adults aged 21–30 years (44.18%), with a mean age of 25.37 ± 7.75 years. Similar age distributions have been reported in several studies, which identify adolescence and young adulthood as periods of heightened vulnerability to sexual victimisation due to increased social exposure, dependence, and gender-based inequalities.[14] The overwhelming predominance of female victims (96.5%) in the current study is also consistent with global epidemiological data showing that women constitute the majority of reported sexual violence survivors.[15] Although men can also be victims of sexual violence, social stigma and under-reporting often contribute to their lower representation in clinical and research settings. Educational attainment among participants was generally low, with most having completed only high school or lower. Previous research suggests that lower educational status may increase vulnerability to violence through reduced awareness of rights, diminished access to support systems, and socioeconomic disadvantage .[9] Similarly, most participants belonged to the lower-middle and middle socioeconomic classes, aligning with findings from previous studies that socioeconomic adversity may increase both exposure to violence and barriers to seeking support after victimisation. A particularly important finding was that 91.86% of victims reported that the perpetrator was known to them. This aligns with extensive literature showing that sexual violence is more often committed by acquaintances, relatives, intimate partners, or other known individuals than by strangers.[16] The predominance of known perpetrators reflects the complex interpersonal dynamics underlying sexual violence and underscores the need to address abuse within trusted social relationships. Such experiences may also complicate disclosure and help-seeking behaviour due to fear, guilt, shame, and social repercussions. More than half of the participants reported parental substance use (51.2%). Although parental substance use was not significantly associated with psychiatric morbidity in the present study, previous research has suggested that substance use within families may contribute to dysfunctional family environments, impaired supervision, and increased exposure to adverse childhood experiences, all of which can increase vulnerability to psychological distress following traumatic events.[17] The trend towards higher psychiatric morbidity among participants reporting parental substance use in the present study may indicate a clinically meaningful relationship that failed to reach statistical significance due to the limited sample size.

Psychiatric Morbidity: The assessment of psychiatric morbidity revealed a considerable burden of mental health disorders among survivors. Among children and adolescents, separation anxiety disorder and PTSD were the most prevalent diagnoses, with

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panic disorder the next most common. These findings align with the literature, which shows that PTSD is one of the most common psychiatric consequences of childhood sexual abuse and adolescent sexual victimisation. A recent systematic review by Alves et al. (2024).[18] reported that PTSD affects a substantial proportion of sexually abused children and adolescents and may persist for prolonged periods, particularly when abuse is severe or prolonged. Sexual trauma during critical developmental stages may disrupt emotional regulation, attachment patterns, and neurodevelopment, thereby predisposing victims to anxiety-related disorders. Among adults, panic disorder was the most common psychiatric diagnosis, followed by suicidal behaviour, PTSD, social anxiety disorder, and major depressive episodes. These findings closely align with the meta-analysis by Dworkin et al. (2017).[13], which found significantly higher rates of anxiety disorders, depression, PTSD, suicidality, and other forms of psychopathology among survivors of sexual assault than in non-victimised populations. The persistence of panic symptoms among adults may reflect ongoing hypervigilance, fear conditioning, and heightened autonomic arousal commonly observed after traumatic experiences.

The prevalence of PTSD across both age groups is particularly noteworthy. PTSD is widely regarded as a hallmark psychiatric outcome of sexual trauma. Survivors frequently experience intrusive recollections, nightmares, emotional numbing, avoidance behaviours, and hyperarousal symptoms that significantly impair functioning.[9] Research from the National Centre for PTSD has consistently shown that sexual assault survivors are at substantially increased risk of developing PTSD, often at rates exceeding those observed after many other traumatic events.[19] The presence of PTSD among adolescents and adults in the present study reinforces the enduring psychological impact of sexual violence. Another important finding was the occurrence of suicidal behaviour among nearly one-tenth of adult participants. Sexual violence has repeatedly been identified as a major risk factor for suicidal ideation and suicide attempts. Studies indicate that survivors of sexual assault exhibit significantly higher rates of suicidal behaviour than the general population, particularly when trauma is accompanied by depression, PTSD, social isolation, or repeated victimisation.[13] The presence of suicidality in the current sample highlights the critical need for routine suicide risk assessment among survivors presenting for medical or psychiatric care.

The analysis of psychosocial factors found that most sociodemographic variables, including age, gender, educational status, occupation, marital status, socioeconomic status, religion, residence, parental marital status, parenting status, and parental substance use, were not significantly associated with psychiatric morbidity. Similar findings have been reported in the trauma literature, suggesting that the psychological consequences of sexual violence may transcend conventional sociodemographic boundaries and affect survivors across diverse backgrounds.[14] The absence of statistically significant associations for these variables may indicate that the traumatic experience itself exerts a stronger influence on psychiatric outcomes than demographic characteristics.

Association Between Psycho Social Factors And Psychiatric Morbidity: A significant association was observed between physical disability and psychiatric morbidity. All participants with physical disabilities exhibited psychiatric morbidity. This finding aligns with previous research indicating that individuals with disabilities are at increased risk of both victimisation and adverse psychological outcomes. Social exclusion, dependence on carers, communication barriers, and limited access to support services may exacerbate the psychological impact of trauma among disabled individuals.[20] Furthermore, disability may heighten vulnerability to secondary victimisation and reduce opportunities for recovery, thereby contributing to poorer mental health outcomes. Perpetrator status also showed a statistically significant association with psychiatric morbidity. Participants assaulted by unknown perpetrators had substantially higher rates of psychiatric morbidity than those assaulted by known perpetrators. While both forms of assault are highly traumatic, stranger-perpetrated assaults may heighten perceptions of danger, unpredictability, and loss of control, factors strongly linked to the development of PTSD and anxiety disorders.[9] The unexpected nature of stranger-perpetrated assaults may intensify fear responses and contribute to more severe psychological sequelae. This finding underscores the importance of considering assault characteristics when assessing risk of psychiatric complications. Although parenting status and parental substance use did not reach statistical significance, higher rates of psychiatric morbidity were observed among participants raised by carers and those reporting parental substance use. Previous studies have shown that adverse family environments and disrupted caregiving relationships can diminish resilience and increase susceptibility to psychological disorders following traumatic experiences.[17] Larger studies may be required to clarify these relationships further. Overall, the findings of the present study align with a substantial body of international evidence showing that sexual violence is linked to significant psychiatric morbidity, particularly PTSD, anxiety disorders, depression, and suicidal behaviour. The study also identifies physical disability and unknown perpetrator status as important correlates of psychiatric morbidity. These findings underscore the need for routine psychiatric screening, early trauma-focused interventions, and multidisciplinary rehabilitation services for survivors of sexual violence. Integrating mental health assessment into medico-legal and victim support services may facilitate early identification and treatment of psychiatric disorders, thereby improving long-term

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psychosocial outcomes and quality of life for survivors.

CONCLUSION

The study demonstrates that victims of sexual violence experience substantial psychiatric morbidity, primarily anxiety, PTSD, depression, and suicidal behaviours. Young women are most profoundly affected, and the perpetrator is often known to them. Although many sociodemographic factors are not correlated with psychiatric issues, physical disabilities and assaults by strangers constitute significant risk factors. These findings underscore the severe psychological impact and highlight the necessity for trauma-informed, multidisciplinary healthcare, which should encompass routine psychiatric screening, prompt mental health interventions, and ongoing support. Special attention must be directed towards vulnerable populations, such as individuals with disabilities and victims of unknown assailants, who are at increased risk of developing psychiatric disorders.

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