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Original Research Article

A STUDY ON PSYCHOSOCIAL FACTORS AND PSYCHOPATHOLOGY OF PERSONS ACCUSED OF SEXUAL OFFENCES

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ABSTRACT

Background: Sexual offences pose a major global public health concern, causing harm to victims. The causes of sexual offending are multifaceted, involving psychosocial factors such as childhood trauma, family issues, social isolation, substance use, and relationship problems, as well as psychopathology, including mood, anxiety, substance use, and personality disorders. Despite growing awareness, research from India remains limited. Understanding the psychosocial and psychiatric profiles of accused individuals is crucial for forensic assessment, risk identification, targeted interventions, and reducing recidivism. This study aims to examine these factors among persons accused of sexual offences. The objective is to examine psychosocial factors and psychopathology among individuals accused of sexual offences and to analyse their relationship. **Materials and Methods:** This 12-month cross-sectional study in the Psychiatry Out-Patient Department of Government General Hospital, Vijayawada, included 100 adults accused of sexual offences who gave informed consent. Exclusions were under 18, intellectual disability, or non-consent. Data on socio-demographics and psychosocial factors were collected via a semi-structured proforma. Socioeconomic status was assessed using the Modified B.G. Prasad Scale, psychopathology using the Mini International Neuropsychiatric Interview (M.I.N.I.), and personality using the Big Five Personality Test. Ethical approval was obtained from Siddhartha Medical College. Data analysis used SPSS 28.0, with frequencies and percentages for categorical variables and mean ± SD for continuous variables. Chi-square and Fisher's exact tests were used to compare groups, with $p<0.05$ indicating significance. **Result:** Among persons accused of sexual offences, psychosocial adversities such as emotional neglect, abuse, community violence, and family substance use were common. Substance Use Disorder (70%), Alcohol Use Disorder (56%), and Antisocial Personality Disorder (41%) were the most frequent psychiatric conditions. Personality assessment showed high neuroticism and low agreeableness, conscientiousness, and openness. Psychopathology correlated with adverse educational factors, past psychiatric issues, substance intoxication during offences, paraphilic behaviours, emotional abuse, and neglect, emphasising psychosocial and psychiatric influences in sexual offending. **Conclusion:** The study finds high rates of adverse childhood experiences, substance use disorders, antisocial traits, and psychopathology among those accused of sexual offences. Psychopathology is significantly linked to emotional abuse, neglect, paraphilic behaviours, past psychiatric issues, educational factors, and substance intoxication during offences. These findings highlight the need for thorough psychosocial and psychiatric assessments to understand sexual offending and develop prevention and rehabilitation strategies.

INTRODUCTION

Sexual offences are a major concern across global health, social, and criminal justice systems due to their serious effects on victims, families, and communities. They include a range of illegal sexual behaviours such as rape, sexual assault, child abuse, exhibitionism, and other non-consensual acts. The WHO defines sexual violence broadly as any sexual act, attempts to secure a sexual act, unwanted comments or advances, or acts against someone's sexuality through coercion, regardless of the relationship between the perpetrator and the victim.[1] Modern theories see sexual offending as caused by multiple factors—including biological, psychological, developmental, and social influences—rather than a single cause.[2] Understanding these factors is essential for creating effective prevention, assessment, and rehabilitation programs. Sexual violence affects millions worldwide each year and causes physical, psychological, social, and economic harm. WHO reports that about one in three women globally experiences physical or sexual violence in her lifetime, underlining the seriousness of the problem.[3] Such offences are often underreported due to stigma, fear, social pressures, and mistrust of legal systems, meaning the true numbers are likely much higher.[1] In India, sexual offences remain a significant societal issue, with increasing cases involving women and children. Data from the NCRB show that crimes like rape and child sexual abuse make up a large part of reported violent crimes annually, highlighting the need for a better understanding of offender traits and risk factors.[4]

The aetiology of sexual offending is complex, involving multiple psychosocial and psychopathological factors. Research has consistently shown that adverse childhood experiences, including physical and emotional abuse, neglect, parental conflict, family dysfunction, and exposure to violence, are more prevalent among sexual offenders than among non-offenders.[5,6] These experiences may contribute to maladaptive cognitive schemas, impaired emotional regulation, insecure attachment patterns, and difficulties in adult interpersonal relationships.[7] Additional psychosocial factors, such as social isolation, poor peer relationships, unemployment, substance misuse, and relationship instability, have also been identified as important contributors to sexual offending behaviour.[8] Furthermore, cognitive distortions, empathy deficits, intimacy problems, impulsivity, and deviant sexual interests have been recognised as significant psychological correlates of sexual offending.[9]

Psychopathology is another important area of investigation among persons accused of sexual offences. Studies have reported elevated rates of mood, anxiety, substance use, and personality disorders, and, in some cases, psychotic disorders, among offender populations compared with the general population.[10,11] Although mental illness alone does not explain sexual offending, psychiatric disorders may interact with psychosocial vulnerabilities and environmental stressors to increase the risk of offending in susceptible individuals.[12] Despite growing international evidence, there remains a relative paucity of research from India examining both psychosocial factors and psychopathology among persons accused of sexual offences. Understanding these dimensions is crucial for identifying modifiable risk factors, improving forensic assessment, developing targeted treatment interventions, reducing recidivism, and informing policy decisions. Therefore, the present study was undertaken to assess psychosocial factors and psychopathology among persons accused of sexual offences and to explore the relationship between these variables within the Indian socio-cultural context.

MATERIALS AND METHODS

Study population and Setting: persons accused of Sexual Offences brought to the Out-Patient Department of Psychiatry at Government General Hospital, Vijayawada, Andhra Pradesh.

Sample size: 100

Type of study: Cross-sectional observational study.

Duration of study: 12 months

Inclusion Criteria:

1. Subjects accused of sexual offences who consented to the study.
2. Subjects accused of sexual offences aged above 18 years.
3. Subjects of all genders accused of sexual offences.

Exclusion Criteria:

1. Subjects accused of sexual offences who did not consent to the study
2. Subjects accused of sexual offences who are under 18 years of age
3. Subjects with intellectual disability accused of sexual offences

Study Tools:

1. Modified BG Prasad Scale for Socio-Economic Status
2. M.I.N.I (Mini International Neuropsychiatric Interview)
3. Big Five Personality Test

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

Study Procedure: Subjects were recruited in accordance with the study's inclusion and exclusion criteria, and their socio-demographic data and psychosocial factors were collected using a semi-structured proforma. Assessment tools included the Modified BG Prasad Scale for Socio-Economic Status, the M.I.N.I. (Mini International

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Neuropsychiatric Interview) to assess psychopathology, and the Big Five personality test to assess personality traits.

Statistical Analysis: Data were analysed using SPSS version 28.0. 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.

RESULTS

A total of 100 participants were included in the study. The majority were aged 18–28 years (68%), followed by 29–38 years (24%), with only 8% aged 38 or older. The mean age of the participants was 27 ± 9.45 years, indicating that the study population predominantly consisted of young adults. Regarding educational status, 46% had completed primary school, 24% had completed high school, and 25% were illiterate. Only 5% were graduates, and none had attained postgraduate education, suggesting generally low educational attainment among the participants. With respect to occupation, 53% were unemployed, and 47% were employed, reflecting a slight predominance of economic inactivity in the study group. In terms of marital status, the majority were unmarried (72%), whereas 28% were married. Assessment of socio-economic status revealed that 45% belonged to the middle socio-economic class, followed by 28% in the upper-middle class and 25% in the upper class. Only 2% were from the lower-middle class, and none belonged to the lower socio-economic category. The religious composition showed that Hindus constituted the largest proportion (58%), followed by Christians (30%) and Muslims (12%). Regarding place of residence, 58% of participants lived in rural areas, while 42% lived in urban areas, indicating a predominantly rural study population.

Table 1: Socio-demographic variables

Variable	Category	Frequency (n)	Percentage (%)
Age (Years)	18-28	68	68
	29-38	24	24
	39-48	6	6
	>48	2	2
	MEAN±SD: 27±9.45		
Education	Illiterate	25	25
	Primary school	46	46
	High school	24	24
	Graduate	5	5
	Post-graduate	0	0
Occupation	Employed	47	47
	Unemployed	53	53
Marital Status	Married	28	28
	Unmarried	72	72
Socio-Economic Status	Upper	25	25
	Upper Middle	28	28
	Middle	45	45
	Lower Middle	2	2
	Lower	0	0
Religion	Hindu	58	58
	Muslim	12	12
	Christian	30	30
Place of Residence	Urban	42	42
	Rural	58	58

Table 2: Psycho social factors

Variable	Category	Frequency (n)	Percentage (%)
Educational and Occupational Factors	Bullying (victim /perpetrator)	14	14
	Other conflicts	15	15
	History of conflicts with colleagues	22	22
	History of sexualized behaviours	0	0
Previous forensic history	Yes	19	19
	No	81	81
Past Psychiatric issues	Yes	14	14
	No	86	86
Familial history of psychiatric issues	Yes	11	11
	No	89	89
Details regarding the current offence	Victim-known	82	82
	Victim- unknown	18	18
	Under the influence of psychoactive substance	60	60
	Not under the influence of psychoactive substances	40	40

The psychosocial characteristics of the study participants revealed several factors that may have contributed to the offence. Regarding educational and occupational factors, 22% reported a history of

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conflicts with colleagues, the most common issue identified. This was followed by other interpersonal conflicts (15%) and bullying, either as a victim or a perpetrator (14%). None of the participants reported a history of sexualised behaviours in educational or occupational settings. A prior history of forensic involvement was present in 19% of participants, while the majority (81%) had no prior involvement with the legal system. Similarly, 14% reported past psychiatric issues, whereas 86% had no documented psychiatric history. A family history of psychiatric illness was identified in 11% of participants, while 89% denied such a history. Analysis of the circumstances surrounding the current offence showed that in the majority of cases (82%), the victim was known to the perpetrator, whereas only 18% involved unknown victims. Furthermore, a substantial proportion of participants (60%) were under the influence of psychoactive substances at the time of the offence, while 40% were not intoxicated, highlighting the potential role of substance use in the commission of the offence.

Table 3: Psycho sexual history

Categories	Responses	Frequency (n)	Percentage (%)
Sexual knowledge	Yes	100	100
	No	0	0
Source of sexual knowledge	Pornography	88	88
	Sex education (school, parents, friends)	85	85
	Movies	35	35
Nude pictures/ pornography	Yes	88	88
	No	12	12
Observed sexual acts	Adult to adult	30	30
	Adult with child	0	0
Sexual abuse	Yes	12	12
	No	88	88
Performs/ receives oral sex	Yes	20	20
	No	80	80
Vaginal /anal intercourse	Yes	100	100
	No	0	0
Penetration with object	Yes	22	22
	No	78	78
Premature ejaculation	Yes	8	8
	No	92	92
Erectile dysfunction	Yes	15	15
	No	85	85

Assessment of psychosexual history revealed that all participants (100%) possessed some form of sexual knowledge, indicating universal awareness of sexual matters within the study population. The most commonly reported sources of sexual knowledge were pornography (88%) and sex education from schools, parents, or friends (85%), while 35% reported movies as a source of sexual information. Correspondingly, 88% of participants had viewed nude pictures or pornography, whereas 12% had never been exposed to such material. Regarding exposure to sexual behaviour, 30% reported observing sexual acts between adults, while none reported witnessing sexual acts involving an adult and a child. A history of sexual abuse was reported by 12% of participants, whereas the majority (88%) denied any such experience. Concerning sexual practices, 20% reported performing or receiving oral sex, while 80% had never engaged in such activities. All participants (100%) reported a history of vaginal and/or anal intercourse, indicating prior sexual experience across the entire study population. Additionally, 22% reported object penetration, while 78% denied such behaviour. Assessment of sexual functioning showed that 8% of participants experienced premature ejaculation, whereas 15% reported erectile dysfunction. The majority of participants did not report these sexual dysfunctions (92% and 85%, respectively).

Table 4: Adverse early life experiences

Categories	Frequency (n)	Percentage (%)
Physical abuse	70	70
Emotional abuse	56	56
Contact sexual abuse	12	12
Alcohol or drug use by family members	72	72
Physical neglect	52	52
Emotional neglect	80	80
Family member treated violently	72	72
Bullying	10	10
Community violence	75	75
Separated/divorced parents/death of any parent	22	22

The assessment of adverse early life experiences revealed a high prevalence of childhood adversities among the study participants. Emotional neglect was the most commonly reported adverse experience

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(80%), followed by community violence (75%), alcohol or drug use by family members (72%), and having a family member treated violently (72%). A substantial proportion of participants also reported experiencing physical abuse (70%), indicating widespread exposure to harmful and traumatic environments during childhood. More than half of the participants reported emotional abuse (56%) and physical neglect (52%), suggesting significant deficits in both emotional support and basic caregiving during their developmental years. Additionally, 22% had experienced parental separation, divorce, or the death of a parent, events that may contribute to emotional instability and disrupted family functioning. Less frequently reported adversities included contact sexual abuse (12%) and bullying (10%); however, these experiences remain clinically significant due to their potential long-term psychological consequences.

Table 5: Psychopathology (according to M.I.N.I. Interview)

Module	Time frame	Frequency
Major Depressive Disorder	Current	10
	Past	8
Suicidality	current	5
	Past	3
Bipolar 1 Disorder	current	0
	Past	1
Panic Disorder	Current	6
	Lifetime	0
Post-Traumatic Stress Disorder	Current	5
Alcohol Use Disorder	Current (past 12 months)	56
Substance Use Disorder	Current (past 12 months)	70
Generalised Anxiety Disorder	Current	5
Anti-Social Personality Disorder	Lifetime	41

Assessment of psychiatric disorders using the Mini International Neuropsychiatric Interview (M.I.N.I.) revealed a considerable burden of mental health disorders and substance-related conditions among the study participants. Among mood disorders, Major Depressive Disorder (MDD) was present in 10% of participants at the time of assessment, and 8% had a past history of MDD, indicating that depressive symptoms were relatively common. Suicidality was present in 5% of participants at the time of assessment, while 3% reported a past history of suicidal behaviour or ideation, highlighting the need for ongoing risk assessment and mental health support. Only one participant (1%) had a past history of Bipolar I Disorder, and no current cases were identified. Regarding anxiety-related disorders, Panic Disorder was diagnosed in 6% of participants, while Generalised Anxiety Disorder (GAD) and Post-Traumatic Stress Disorder (PTSD) were each present in 5% of participants. These findings suggest that although anxiety and trauma-related disorders were less prevalent than substance-related disorders, they still affected a notable proportion of the study population. Substance-related psychopathology emerged as the most prominent finding. Alcohol Use Disorder was identified in 56% of participants during the previous 12 months, while Substance Use Disorder was present in 70%, making it the most common psychiatric diagnosis in the study. This high prevalence underscores the significant role of psychoactive substance use in the psychosocial and behavioural profile of the participants. Furthermore, Anti-Social Personality Disorder (ASPD) was identified in 41% of participants, indicating a substantial prevalence of enduring personality traits characterised by disregard for social norms, impulsivity, aggression, and violation of the rights of others.

Table 6: Big Five Personality Test

Components	Frequency	
	0-20 SCORE	21-40 SCORE
Neuroticism (N)	35	65
Extroversion (E)	56	44
Conscientiousness (C)	58	42
Agreeableness (A)	68	32
Openness (O)	81	19

Personality assessment using the Big Five Personality Test revealed distinct patterns across the five major personality dimensions. A majority of participants (65%) scored in the 21–40 range for Neuroticism, indicating higher levels of emotional instability, anxiety, mood fluctuations, and vulnerability to stress, while 35% scored in the lower range (0–20). For Extraversion, 56% of participants scored in the lower range (0–20), suggesting a tendency towards introversion, social withdrawal, reserved behaviour, and reduced social engagement. The remaining 44% scored higher, reflecting greater sociability and assertiveness. Similarly, 58% of participants had lower Conscientiousness scores, indicating reduced self-discipline, organisation, responsibility, and impulse control, whereas 42% demonstrated higher Conscientiousness traits. Low conscientiousness may be associated with difficulties

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in behavioural regulation and adherence to social norms. Regarding Agreeableness, 68% scored in the lower range, making it one of the most prominent findings of the study. Lower agreeableness is often characterised by hostility, distrust, competitiveness, reduced empathy, and difficulty maintaining harmonious interpersonal relationships. Only 32% of participants exhibited higher levels of agreeableness. The most striking finding was observed in Openness to Experience, where 81% of participants scored in the lower range, indicating a preference for conventional thinking, limited curiosity, resistance to new experiences, and reduced cognitive flexibility. Only 19% demonstrated higher levels of openness.

Table 7: Association between psycho social factors and psychopathology

Categories			Psychopathology		P-value
			Yes	No	
Educational factors	Yes		21	7	0.019
	No		67	5	
Occupational factors	Yes		22	2	0.411
	No		66	10	
Previous forensic history	Yes		16	3	0.408
	No		72	9	
Past Psychiatric issues	Yes		12	2	0.004
	No		76	10	
Familial history of psychiatric issues	Yes		11	0	0.226
	No		77	12	
Details regarding the current offence	Victim-Known/ Unknown	Yes	71	10	0.63
		No	16	2	
	Under the influence of a psychoactive substance		50	10	0.045
	Not under the influence of a psychoactive substance		38	2	
Association between psycho sexual history and psychopathology					
Psycho sexual history (Paraphilias)	Yes		28	7	0.045
	No		60	5	

The association between psychosocial factors and psychopathology revealed several significant findings. Educational factors showed a statistically significant association with psychopathology (p = 0.019). Among participants with adverse educational factors, 21 had psychopathology compared with 7 without, suggesting that educational difficulties and related experiences may contribute to the development of psychiatric disorders. A highly significant association was also observed between past psychiatric issues and current psychopathology (p = 0.004). Participants with a history of psychiatric illness were more likely to exhibit current psychopathology, indicating persistence or recurrence of mental health problems over time. Similarly, being under the influence of psychoactive substances during the current offence was significantly associated with psychopathology (p = 0.045). Participants who were intoxicated at the time of the offence had a higher prevalence of psychiatric disorders than those who were not under the influence of psychoactive substances, highlighting the close relationship between substance use and mental illness. In contrast, occupational factors (p = 0.411), previous forensic history (p = 0.408), familial history of psychiatric illness (p = 0.226), and whether the victim was known or unknown to the offender (p = 0.630) were not significantly associated with psychopathology. These findings suggest that these factors did not independently influence the occurrence of psychiatric disorders in the study population.

Analysis of psychosexual history showed a statistically significant association between paraphilic behaviours and psychopathology (p = 0.045). Among participants with a history of paraphilic behaviours, 28 had psychopathology compared with 7 without. Among those without such behaviours, 60 had psychopathology, and 5 did not. This finding suggests that atypical sexual interests or behaviours may be linked to a higher likelihood of coexisting psychiatric disorders.

Table 8: Association between adverse early life experiences and psychopathology

Categories		Psychopathology		P-value
		Yes	No	
Physical abuse	Yes	62	8	0.413
	No	27	3	
Emotional abuse	Yes	51	5	0.019
	No	17	27	
Contact sexual abuse	Yes	10	2	0.439
	No	78	10	
Alcohol or drug use by family members	Yes	65	7	0.213
	No	23	5	
Physical neglect	Yes	47	5	0.324
	No	41	7	
Emotional neglect	Yes	69	11	0.023

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	No	8	12	
Family member treated violently	Yes	63	9	0.554
	No	25	3	
Bullying	Yes	8	2	0.343
	No	80	10	
Community violence	Yes	67	8	0.347
	No	21	4	
Separated/ divorced parents or the death of any parent	Yes	19	3	0.519
	No	69	9	

The relationship between adverse early life experiences and psychopathology was examined to identify childhood factors linked to the development of psychiatric disorders. The analysis found that emotional abuse and emotional neglect were significantly associated with psychopathology, whereas other adverse childhood experiences did not show statistically significant associations. Emotional abuse was significantly associated with psychopathology ($p = 0.019$). Among participants who reported emotional abuse, 51 had psychopathology compared with only 5 without. This suggests that exposure to emotional maltreatment in childhood may increase vulnerability to psychiatric disorders in later life. Similarly, emotional neglect was significantly associated with psychopathology ($p = 0.023$). Participants who experienced emotional neglect had a substantially higher prevalence of psychiatric disorders than those who did not. This highlights the critical role of emotional support and nurturing in childhood for healthy psychological development. In contrast, several other adverse childhood experiences were not significantly associated with psychopathology. These included physical abuse ($p = 0.413$), contact sexual abuse ($p = 0.439$), alcohol or drug use by family members ($p = 0.213$), physical neglect ($p = 0.324$), family members being treated violently ($p = 0.554$), bullying ($p = 0.343$), exposure to community violence ($p = 0.347$), and parental separation, divorce, or death of a parent ($p = 0.519$). Although these adversities were common in the study population, their individual associations with psychopathology did not reach statistical significance.

DISCUSSION

This study explored psychosocial factors, psychosexual history, early adverse experiences, personality traits, and psychopathology in individuals accused of sexual offences. Findings show that sexual offending results from a complex mix of developmental challenges, psychopathology, personality, substance use, and social dysfunction. These align with models suggesting that biological, psychological, social, and environmental factors all contribute to offending.[2]

Assessment of psychosocial factors revealed that participants experienced notable interpersonal and behavioural challenges, including conflicts with colleagues (22%), other disputes (15%), and bullying (14%). These findings are consistent with research indicating that sexual offenders often lack essential social skills and conflict resolution abilities.[13] Hanson and Morton-Bourgon (2005) associated poor social adjustment and instability with sexual offending.[8] Nineteen percent of participants had prior forensic involvement, reflecting persistent antisocial tendencies, analogous to Fazel and Danesh (2002), who documented higher rates of criminal and psychiatric issues among offenders compared to the general population.[10] Although prior forensic history was not significantly correlated with psychopathology in this study, it may serve as an indicator of broader behavioural problems. Notably, 82% of victims were acquaintances of the offender, aligning with research that most sexual offences are committed against known individuals rather than strangers.[14] Sixty percent of offenders reported being intoxicated at the time of the offence, a factor significantly associated with psychopathology, corroborating studies that suggest alcohol impairs judgment and exacerbates aggression.[13,15] Furthermore, adverse educational experiences were linked to psychiatric disorders, as discussed by Moffitt (1993), highlighting the connection between educational difficulties and issues related to social functioning, self-esteem, and behaviour.[16]

The psychosexual assessment revealed widespread sexual awareness among the participants, with pornography (88%) and sex education (85%) identified as common sources of knowledge. Exposure to pornography was notably prevalent, with 88% of participants viewing explicit material. Research indicates that pornography does not directly cause offending behaviour; however, it may serve to reinforce deviant fantasies in susceptible individuals.[17,18]. Twelve percent of participants reported a history of sexual abuse, a figure consistent with studies linking childhood victimisation to subsequent offending.[5] The "victim-to-offender" hypothesis posits that childhood abuse can influence development and elevate the risk of offending, although not all victims proceed to become offenders. The study identified a significant association between paraphilic behaviours and psychopathology, aligning with existing literature that suggests these interests frequently coexist with psychiatric disorders, thereby implying that psychosexual issues may be indicative of underlying psychological concerns.[19,20]

The study identified elevated incidences of adverse childhood experiences (ACEs), including emotional neglect (80%), community violence (75%), family substance abuse (72%), violence against family members (72%), and physical abuse (70%). These findings concur with those of Felitti et al. (1998), who

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established a connection between childhood adversity and subsequent behavioural, psychological, and health issues in adulthood.[21] Levenson et al. (2016) reported increased rates of abuse, neglect, and household dysfunction among offenders.[6] In this research, only emotional abuse and neglect demonstrated a significant association with psychopathology, corroborated by Norman et al. (2012), who associated emotional maltreatment with depression, anxiety, substance misuse, personality disorders, and suicidal behaviour.[22] Emotional neglect impairs attachment and emotional regulation, which are essential for healthy psychological development.[23] Attachment theory elucidates that insufficient emotional responsiveness results in insecure attachment, empathy deficits, emotional dysregulation, and impaired interpersonal skills, thereby contributing to psychopathology and criminal behaviour.[2] Although physical abuse, sexual abuse, bullying, family violence, parental separation, and community violence were prevalent, they did not exhibit a significant association with psychopathology. This aligns with Levenson et al. (2016), who emphasised the cumulative impact of adversity over individual incidents.[6]

The assessment of psychopathology revealed a significant burden of mental disorders among the subjects. Substance Use Disorder was identified in 70% of cases, while Alcohol Use Disorder was observed in 56%, followed by Anti-Social Personality Disorder in 41%. These prevalence rates are consistent with prior research indicating increased alcohol and substance dependence among offenders.[24] Substance misuse may affect sexual offending behaviour by impairing judgment, impulse control, and inhibitions.[15] Anti-Social Personality Disorder was diagnosed in 41% of the sample, aligning with previous studies reporting high rates of ASPD among offenders. Traits such as impulsivity, aggression, and lack of remorse are frequently observed in this population and are associated with recidivism and criminal conduct.[25,26] Mood and anxiety disorders were also identified, with Major Depressive Disorder present in 10%, and Panic Disorder, Generalised Anxiety Disorder, and Post-Traumatic Stress Disorder in 5–6%. These findings are concordant with earlier reports of elevated mood and anxiety disorders in offender populations.[27] Post-Traumatic Stress Disorder is linked to the effects of childhood trauma on emotional regulation.[28] The correlation between historical psychiatric illness and current mental health issues suggests persistent mental health challenges. Howard et al. (2013) demonstrated that untreated psychiatric disorders frequently persist and contribute to recurrent behavioural and social difficulties.[29]

The personality assessment revealed high Neuroticism and low levels of Agreeableness, Conscientiousness, and Openness to Experience. Notably, 65% of participants showed high Neuroticism, indicating increased emotional instability, anxiety, stress sensitivity, and vulnerability to psychological distress. Research has linked Neuroticism with depression, anxiety disorders, substance use, and maladaptive coping strategies.[30] Additionally, 68% of participants scored low in Agreeableness, a trait characterised by hostility, distrust, antagonism, reduced empathy, and interpersonal conflict. Miller and Lynam (2003) identified low Agreeableness as a strong predictor of antisocial and criminal behaviour.[31] Furthermore, 58% exhibited low Conscientiousness, associated with poor self-discipline, impulse control, irresponsibility, and behavioural dysregulation—traits connected to delinquency, aggression, substance misuse, and criminality.[32] The high prevalence of low Openness to Experience (81%) indicates cognitive rigidity, conventional thinking, and decreased adaptability. Though less studied in offender populations, low Openness may hinder perspective-taking and flexible problem-solving.[31] Overall, the personality profile aligns with patterns linked to antisocial and criminal behaviour—marked by emotional instability, low empathy, poor impulse control, and interpersonal antagonism.

Associations Between Psychosocial Factors and Psychopathology: The present study identified significant associations between psychopathology and adverse educational factors, prior psychiatric illness, and intoxication at the time of the offence. These findings support developmental and biopsychosocial models of mental illness, which emphasise the interplay among early adversity, environmental stressors, substance use, and psychological vulnerability.[33] The association between prior psychiatric illness and current psychopathology is unsurprising and aligns with evidence that many psychiatric disorders follow chronic or recurrent courses when untreated.[29] Likewise, the relationship between substance intoxication and psychopathology reinforces previous evidence highlighting the bidirectional interaction between substance use disorders and other psychiatric conditions.[24]

Associations Between Psychosexual Factors and Psychopathology: Paraphilic behaviours were significantly associated with psychopathology. This finding aligns with studies reporting high rates of psychiatric comorbidity among individuals with deviant sexual interests.[19,20] The co-occurrence of paraphilic behaviours and psychiatric disorders suggests that comprehensive psychosexual and psychiatric assessments are essential to forensic evaluations.

Associations Between Adverse Childhood Experiences and Psychopathology: The significant associations between emotional abuse, emotional neglect, and psychopathology further underscore the lasting psychological consequences of childhood emotional maltreatment. Norman et al. (2012) concluded that emotional abuse may be as predictive of adult psychiatric disorders as, or more predictive than, physical abuse.[22] The present findings therefore highlight the importance of addressing

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childhood emotional trauma during psychiatric assessment and rehabilitation of offenders. Overall, the study supports the Integrated Theory of Sexual Offending proposed by Ward and Beech (2006), which posits that sexual offending arises from interactions among neurodevelopmental vulnerabilities, adverse childhood experiences, personality traits, psychopathology, substance misuse, and environmental influences.[2] The high prevalence of childhood adversity, substance use disorders, antisocial personality traits, and emotional maltreatment observed in this study provides substantial support for this multifactorial conceptualisation of sexual offending.

CONCLUSION

In this study, individuals accused of sexual offences had a high prevalence of adverse childhood experiences, substance use disorders, antisocial personality traits, and significant psychopathology. Emotional abuse, emotional neglect, paraphilic behaviours, adverse educational factors, past psychiatric illness, and substance intoxication at the time of the offence were significantly associated with psychopathology. These findings highlight the multifactorial nature of sexual offending and underscore the importance of comprehensive psychosocial, psychosexual, and psychiatric assessment to identify risk factors, guide rehabilitation, and inform preventive interventions.

REFERENCES

1. World Health Organization. World report on violence and health. Geneva: World Health Organization; 2002.
2. Ward T, Beech AR. An integrated theory of sexual offending. Aggress Violent Behav. 2006;11(1):44-63.
3. World Health Organization. Violence against women prevalence estimates, 2018. Geneva: World Health Organization; 2021.
4. National Crime Records Bureau. Crime in India 2023. New Delhi: Ministry of Home Affairs, Government of India; 2023.
5. Jespersen AF, Lalumière ML, Seto MC. Sexual abuse history among adult sex offenders and non-sex offenders: a meta-analysis. Child Abuse Negl. 2009;33(3):179-92.
6. Levenson JS, Willis GM, Prescott DS. Adverse childhood experiences in the lives of male sex offenders. Sex Abuse. 2016;28(4):340-59.
7. Marshall WL, Marshall LE. The importance of attachment bonds in the development and treatment of sexual offenders. J Sex Aggress. 2017;23(2):177-90.
8. Hanson RK, Morton-Bourgon KE. The characteristics of persistent sexual offenders: a meta-analysis of recidivism studies. J Consult Clin Psychol. 2005;73(6):1154-63.
9. Ward T, Siegert RJ. Toward a comprehensive theory of child sexual abuse: a theory-knitting perspective. Psychol Crime Law. 2002;8(4):319-51.
10. Fazel S, Danesh J. Serious mental disorder in 23,000 prisoners: a systematic review of 62 surveys. Lancet. 2002;359(9306):545-50.
11. Kingston DA, Firestone P, Moulden HM, Bradford JM. The relationship between mental illness and sexual offending. Sex Abuse. 2013;25(4):366-89.
12. Seto MC. Pedophilia and sexual offending against children: theory, assessment, and intervention. 2nd ed. Washington (DC): American Psychological Association; 2019.
13. Marshall WL, Anderson D, Fernandez YM. Cognitive behavioural treatment of sexual offenders. Chichester: John Wiley & Sons; 1999.
14. Seto MC. The motivation-facilitation model of sexual offending. Sex Abuse. 2019;31(1):3-24.
15. Abbey A, Zawacki T, Buck PO, Clinton AM, McAuslan P. Sexual assault and alcohol consumption: what do we know about their relationship and what types of research are still needed? Aggress Violent Behav. 2004;9(3):271-303.
16. Moffitt TE. Adolescence-limited and life-course-persistent antisocial behavior: a developmental taxonomy. Psychol Rev. 1993;100(4):674-701.
17. Kingston DA, Fedoroff P, Firestone P, Curry S, Bradford JM. Pornography use and sexual aggression: the impact of frequency and type of pornography use on recidivism among sexual offenders. Aggress Behav. 2008;34(4):341-51.
18. Seto MC, Lalumière ML. What is so special about male adolescent sexual offending? A review and test of explanations through meta-analysis. Annu Rev Sex Res. 2010;21(1):35-58.
19. Seto MC. Pedophilia and sexual offending against children: theory, assessment, and intervention. Washington (DC): American Psychological Association; 2008.
20. Kafka MP. Hypersexual disorder: a proposed diagnosis for DSM-V. Arch Sex Behav. 2010;39(2):377-400.
21. Felitti VJ, Anda RF, Nordenberg D, Williamson DF, Spitz AM, Edwards VJ, Koss MP, Marks JS. Relationship of childhood abuse and household dysfunction to many of the leading causes of death in adults: the Adverse Childhood Experiences (ACE) Study. Am J Prev Med. 1998;14(4):245-58.
22. Norman RE, Byambaa M, De R, Butchart A, Scott J, Vos T. The long-term health consequences of child physical abuse, emotional abuse, and neglect: a systematic review and meta-analysis. PLoS Med. 2012;9(11).
23. Bowlby J. A secure base: parent-child attachment and healthy human development. New York: Basic Books; 1988.
24. Fazel S, Bains P, Doll H. Substance abuse and dependence in prisoners: a systematic review. Addiction. 2006;101(2):181-91.
25. Blackburn R. The psychology of criminal conduct. Chichester: Wiley; 1993.
26. Knight RA, Guay JP. The role of psychopathy in sexual coercion against women. In: Jackson LM, Bekerian DA, editors. The Wiley handbook of forensic clinical psychology. Chichester: John Wiley & Sons; 2006. p.381-406.
27. Stinson FS, Dawson DA, Goldstein RB, Chou SP, Huang B, Smith SM, Ruan WJ, Pulay AJ, Saha TD, Pickering RP, Grant BF. Prevalence, correlates, disability, and comorbidity of DSM-IV antisocial personality disorder: results from the Wave 2 National Epidemiologic Survey on Alcohol and Related Conditions. Compr Psychiatry. 2008;49(4):330-39.
28. Widom CS. The cycle of violence. Science. 1989;244(4901):160-66.
29. Howard R, Huband N, Duggan C, Mannion A. Exploring the link between personality disorder and criminal behaviour: a systematic review. Psychol Crime Law. 2013;19(3):257-79.
30. Costa PT Jr, McCrae RR. Revised NEO Personality Inventory (NEO PI-R) and NEO Five-Factor Inventory (NEO-FFI) professional manual. Odessa (FL): Psychological Assessment Resources; 1992.
31. Miller JD, Lynam DR. Psychopathy and the five-factor model of personality: a replication and extension. J Pers. 2003;71(5):731-59.
32. Jones SE, Miller JD, Lynam DR. Personality, antisocial behavior, and aggression: a meta-analytic review. J Pers Disord. 2011;25(2):190-210.
33. Engel GL. The need for a new medical model: a challenge for biomedicine. Science. 1977;196(4286):129-36.

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