e-ISSN: 0976-822X, p-ISSN:2961-6042

Available online on http://www.ijcpr.com/

International Journal of Current Pharmaceutical Review and Research 2026; 18(3); 1325-1332

Original Research Article

Clinical Study of Cases of Sexual Assault and their Management in Tertiary Care Centre

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Received: 04-01-2026 / Revised: 04-02-2026 / Accepted: 06-03-2026

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Conflict of interest: Nil

Abstract:

Background: The study aimed to identify the impact of sexual assault on mental and psychosocial health.

Methodology: The study was conducted as an observational study at tertiary care centre on women reporting with history of sexual assault. All females were subjected to detailed history and general, local and systemic examination. Samples were subjected to laboratory and forensic examination.

Results: A total of 236 sexual assault cases were observed. Majority of victims of sexual assault belonged to 11 to 20 years of age group (59.7%). Home of victim was the most common place of sexual assault (61.9% cases). Sexual assault resulted in psychological and mental trauma in 75% cases. Of them, behaviour changes were most commonly observed in 17.7% cases, whereas helplessness or hopelessness was observed in 10.59% cases.

Conclusion: Sexual Violence continues to be a major public health problem that lasting harmful effects on victims' family, friends, and communities. The reality is probably underestimated because many cases are not reported due to fear of indignity, denial and social stigma. The victims are mostly children and adolescents. Education and awareness of the population is very essential for early consultation and in seeking medical help. Delay in medical examination and reporting of cases resulted in loss of vital physical evidences. Medical consequences of sexual assault include STI, unwanted pregnancy, mental and psychological disorder.

Keywords: Sexual Assault, Management, Pregnancy, Mental and Psychosocial Impact.

DOI: 10.25258/ijcpr.18.3.211

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Introduction

Sexual assault is defined as a non-consensual sexual contact or activity, including the threat, done by one person or a group of persons to a different.[1] Sexual assault includes activities ranging from unwanted sexual touching, kissing, or foundling to forced sexual intercourse.[1] Sexual assault, a form of sexual violence, often used synonymously with rape. According to ACOG, the term rape and sexual assault are used interchangeably and legal definitions of both varies with state.[2] The various components of sexual violence are any form of rape, sexual assault, sexual harassment (at school, work or other areas.); sexual slavery {that are common in armed conflicts (e.g. forced impregnation)}; sexual abuse of mentally or physically disabled people; rape and sexual abuse of children; and customary' forms of sexual violence, such as forced marriage or cohabitation and wife inheritance.[3]

It has been estimated that approximately one in four women experience sexual violence by an intimate partner, whereas one third adolescent girls experience forced sexual relationship. [4-6] The data is often underreported as majority of victims of sexual assault and violence do not seek medical help and often hide their experience due to associated social stigma. It has been estimated that worldwide, approximately 20% of women have been sexually abused in their childhood.[7] However, in Asian countries, incidence of sexual assault has been reported to be high and reported to be 25%.[8]

Sexual assault has significant impact on physical, mental as well psychosocial health of the individual. Apart from this, sexual assault may be associated with increased risk of sexual as well as reproductive health problems and may increase the risk of acquiring sexually transmitted diseases including HIV.[4] Mode of presentation varies for individual victim. Female may present immediately following assault with physical injury (that can sometimes be serious or life threatening), or with genital tract

infections such as urinary tract infection and sexually transmitted disease, or with signs of psychological trauma. Later, female may present with pregnancy, sexually transmitted disease, post-traumatic stress disorder, depression, sleep disorders, eating disorders, post incident substance abuse and even self-harm.[9]

Healthcare workers play an important role in management of patients with sexual assault or violence as they are first to examine such patients. Eliciting the history of sexual assault from the victim is one of the tedious tasks as patient may not reveal the history of sexual assault immediately, however many patients never disclose history regarding sexual assault unless it becomes relevant to their care.[10] Thus a detailed history taking must include the assessment of safety of the victim and immediate needs. As the sexual assault have significant impact on psychosocial health of individual, psychosocial support must be provided with maintenance of confidentiality. [9]

Patients must be provided adequate medical care. It includes management of injuries, emergency contraception, screening of sexually transmitted disease including HIV and giving prophylaxis against them. Apart from this, counselling and support is an integral part for management of such patients. Support of social organization must be taken when needed which are working for the support and counselling of such patients.[11] Management of pregnancy is an important issue in such cases. Antenatal care must be offered to victims who decide to continue the pregnancy.[12]

ACOG recommends that Obstetricians and other health care providers must screen all women for history of sexual assault especially among females reporting with lower abdominal pain, dysmenorrhea or sexual dysfunction. Earlier identification of sexual assault among females will help in prevention of long term and persistent physical and mental health consequences. The present study was thus conducted with the broad objective of identifying the proportion of sexual assault cases and its impact on mental and psychosocial health and to contribute to better management.

Materials and Methods

The present study was conducted as an observational study at Department of Obstetrics and Gynaecology, Gandhi Medical College, and associated Sultania Zanana Hospital Bhopal for a period of 1 year i.e. from 1st December 2018 to 30th November 2019 among females presenting with history of sexual assault. All the consenting women of sexual assault reporting to Department of Obstetrics & Gynecology at Sultania Zanana hospital were included whereas patients without any history of sexual assault or with only physical assault were excluded form the study.

After obtaining ethical clearance from Institute ‘s ethical committee, all the females fulfilling inclusion criteria were selected using convenient sampling. After taking consent from the participants, a detailed data regarding sociodemographic details such as age, socioeconomic status, residence was obtained from all the study participants. Further detailed history regarding the incident was obtained from all the study participants and findings were noted in pretested proforma. Participants were comforted and encouraged to narrate the incident and direct questions were avoided. Detailed menstrual and relevant history was obtained. Females were then subjected to detailed clinical and physical examination and findings were noted. Nature, site, extent, and number of injuries were noted. General examination i.e. heart rate, respiratory rate, blood pressure was noted. Systemic examination of respiratory, cardiac, abdominal, and central nervous system was conducted.

Local examination of genitalia was conducted under good light and findings were documented. Per vaginal and per rectum examination was conducted when needed and findings were noted. All the participants were subjected to investigations such as HIV, HBsAg, VDRL, urine test for pregnancy, ultrasound for pregnancy/internal injury, X-Ray for injury. For forensic examination, following samples were collected by forensic expert

- Scalp hair (10-15 strands)
- Nail scrapings (both hands separately)
- Nail clippings (both hands separately)
- Blood for grouping, testing drug/alcohol intoxication (plain vial)
- Blood for DNA analysis (EDTA vial)

Based upon the history and examination, patients were managed and the treatment given was documented.

Observation Chart

A total of 236 sexual assault cases were observed during the study period.

Table 1: Distribution According to Socioeconomic Status

Sociodemographic variables		No. of cases (n=236)	Percentage
Age	0-10	10	4.2
	11-20	141	59.7
	21-30	64	27.1
	31-40	15	6.3
	41-50	5	2.1
	>50	1	0.4
Religion	Hindu	181	76.7
	Muslim	55	23.3
Education	Illiterate	24	10.2
	Play group/KG	6	2.5
	Primary	57	24.2
	Middle	112	47.5
	High	25	10.6
	Higher secondary	3	1.3
	College	9	3.8
Occupation	Student	74	31.35
	House wife	45	19.06
	Unemployed	68	29.23
	Labourer	39	16.5
Socioeconomic status	Class II (Upper Middle)	1	0.4
	Class III (Lower middle)	27	11.4
	Class IV (Upper lower)	173	73.3
	Class V (Lower)	35	14.8
Marital status	Married	59	25.0
	Unmarried	172	72.9
	Divorce	4	1.7
	Widow	1	0.4

Table 2: Distribution According to Presentation of Assault

Variables		No. of cases (n=236)	Percentage
Number of episodes	1 episode	73	30.9
	2-3 episodes	21	8.9
	4-5 episodes	19	8.1
	6-7 episodes	5	2.1
	Multiple	116	49.2
	Don‘t know	2	0.8
Duration between assault and reporting	On the same day	31	13.1
	After 24hours to 1 week	111	47.0
	1week-4week	44	18.6
	1month-6months	44	18.6
	> 6months	6	2.5
Place of incidence	Victims house	146	61.9
	Accused house	50	21.2
	Relative house	12	5.1
	Friends room	14	5.9
	Hotel room	5	2.1
	Near by market place/road side	2	0.8
	Lonely place	7	3.0
No. of accused	1	225	95.3
	2	4	1.7
	3	3	1.3
	4	2	0.8
	>4	2	0.8
Relationship with survivor	Boyfriend	15	6.4
	Brother's friend	3	1.3
	Father	3	1.3

	Husband	5	2.1
	Friend/ colleague	16	6.8
	Distant relative	145	61.4
	Husband friend	3	1.3
	Neighbor	22	9.3
	Step father	1	0.4
	Unknown	23	9.7

Table 3: Distribution According to Medical Consequences and Type of Violence

Variables		**No. of cases (n=236)**	**Percentage**
Type of violence	Physical violence	5	2.1
	Emotional violence	2	0.8
	Drug intoxication	12	5.1
	Alcohol intoxication	2	0.8
	Blackmailing	24	10.2
	Threat to life	11	4.7
	No answer	180	76.3
Type of penetration	Fingering In Vagina	1	0.4
	Vaginal	203	86.0
	Vaginal and Oral	9	3.8
	Vaginal and Anal	6	2.5
	Vaginal, Oral and Anal	2	0.8
Injuries	General	39	16.5
	Breast	8	3.38
	Fresh hymen tear	34	14.4
	Old hymen tear	146	61.8
	Vaginal injury	28	11.8
	3rd degree perineal tear	2	0.84
	4th degree perineal tear	1	0.4
	Anal injury	1	0.4
	Others: Deep burn	1	0.4

Table 4: Psychological And Mental Impact of Sexual Assault

Psychological & mental impact	**No. of cases**	**Percentage**
Behavior changes	42	17.7
Depression	19	8.0
Fear, helpless, hopeless	25	10.59
Flash backs	17	7.2
Lack of trust	9	3.8
Loss of concentration	18	7.6
Anger outburst	22	9.3
Self-harm	18	7.6
Self-isolation	11	4.6
None	55	23.3

Results

Majority of victims of sexual assault belonged to 11 to 20 years of age group (59.7%) and only 0.4% cases belonged to more than 50 years of age. About 76.7% victims were Hindu and about 72.9% were unmarried. Majority i.e. 47.5% cases were educated up to middle school and 31.35% were students. Majority of cases belonged to upper lower socioeconomic status (73.3%). Majority of assailants of sexual assault belonged to 26 to 30 years of age (37.7%), whereas age of assailant was not known in 1.3% cases.

Majority of females i.e. 49.2% reported multiple episodes of assault whereas 0.8% females could not recall exact number of episodes of sexual assault. About 47% cases reported between 1 day and 1 week following the assault. Only 13.1% females presented on same day whereas only 2.5% females reported after 6 months following the incidence. Thus, this study shows hesitance in reporting due to social stigma.

Home of victim was the most common place of sexual assault documented in 61.9% cases, followed by accused house and relative house in 21.1% and 5.1% cases respectively. In majority of cases of

sexual assault, assailant was single (95.3%). Majority of assailant were known to the survivors.

Out of 236 cases of sexual assault, about 4.7% females were subjected to threat to life where as in 5.1% there was drug intoxication, blackmailing in 10.2%, physical violence in 2.1% and alcohol intoxication and emotional violence in 0.8% cases each. Majority i.e. 76.3% females did not reveal type of violence. Most common type of penetration documented amongst cases of sexual assault was vaginal (86.0%) followed by vaginal, oral, and vaginal, anal in 3.8% and 2.5% cases respectively. Amongst various injuries, general injuries were noted in 16.5% and injuries on breast were noted in 3.38% cases. Pregnancy was observed in 29 (12.3%) cases of sexual assault. Of them, 16 (55.2%) presented in first trimester and 27.6% presented in third trimester.

Sexual assault resulted in psychological and mental trauma in 75% cases. Of them, behaviour changes were most observed in 17.7% cases, whereas helplessness or hopelessness was observed in 10.59% cases. Anger burst observed in 9.3% cases, Loss of concentration was in 7.6% cases, depression observed in 8% cases, self-harm observed in 7.6 cases and self-isolation was observed following sexual assault in 4.6% cases.

Medical management was most common mode of management given to 95% victims of sexual assault in present study. Delivery was conducted in 0.4% cases whereas MTP and MVA was done in 1.3% and 1.3% cases respectively. Surgical management was given in 1.6 % cases. Of them Surgical management for 4th degree perineal tear and management of ruptured ectopic pregnancy was conducted in 0.4% cases each.

Statistical Analysis: The collected data was summarized by using frequency, percentage, mean & S.D. To compare the qualitative outcome measures Chi-square test or Fisher's exact test was used. To compare the quantitative outcome measures independent t test was used. If data was not following normal distribution, Mann Whitney U test was used. SPSS version 22 software was used to analyse the collected data. p value of <0.05 was statistically significant.

Discussion

Sexual assault and violence against women and child in India continue to be a major public health problem which is often under reported due to associated social stigma. Such incidences not only have physical consequences but also have adverse impact on psychological and mental health of the victim.[13] According to Lancet study by Raj et al [14], sexual assault in the form of rape is most common form in India. Overall, the authors reported 9% prevalence of sexual violence in India. Of them, only 1% cases are reported in India.[14]

Sexual assault has been reported in females of all age ranges, however, adolescent are victims of sexual assault in maximum cases. Also, adolescents are at high risk of repeated assault.[13] In present study, majority of females belonged to 11 to 20 years of age, majority of victim were Hindu (76.7%). Mean age of victims in a study by Singh et al [15] was 20.8 years and majority of victims belonged to 6 to 20 years of age in a study by Rawat et al. [16] At this adolescent period, girls need to be given some form of sex information, so that they understand the meaning and related consequences of rape. So appropriate programmes to be planned to impart sex education with the help of the schools.

In our study, about 47.5% and 24.2% victims of sexual assault were educated up to middle and primary school respectively. These findings were concordant to findings of Tamuli et al in which about 76 and 66 cases were educated up to high school and primary school respectively and only 46 cases were illiterate.[17] Students in majority of cases i.e. 31.35% were the victim of sexual assault. Mellins et al concluded that students are at high risk of sexual assault and often report multiple forms of sexual assault incidents (i.e., sexualized touching, attempted penetrative, and penetrative assault) as well as multiple incidents experienced of each type.[18]The higher incidence of sexual assault among students especially those living away from their home could be attributed to higher exposure of these females to external world and higher opportunity of assailant to come in contact with these females.

Almost all the females are at risk of sexual assault irrespective of socioeconomic status. Our study was conducted at tertiary care centre where females especially of lower socioeconomic strata seek care and thus majority of victims of sexual assault belonged to lower socioeconomic status. Rawat et al [16] and Ram et al [19] also observed maximum incidence of sexual assault in lower and upper lower socioeconomic status respectively. Individuals especially adolescents of lower socioeconomic status have poorer health, less social interaction, lower life satisfaction, and lower levels of support from friends and family. These effects last life long and may lead to abnormal behaviour leading to abnormal behaviour.[20]

In our study, assailant in majority of cases belonged to age range of 21 to 30 years (>60%) whereas age was less than 20 years in 21.2% cases. Similarly, Sarkar et al also reported age range of 16 to 25years in maximum number of assailants 75(64.10%).[21]

Majority of females were subjected to sexual assault multiple times (49.2%) whereas only 30.9% victims

reported after first incidence. Sorenson et al documented that more than two third females reported multiple episodes of assault.[22] Victims subjected to sexual assault often did not report the incident due to associated social stigma and are usually threatened. Due to constant threat or blackmailing, they are repeatedly exposed to similar incident especially when the accused is known or is family member.

Table 5: Reporting And Place of Incidence

	Reporting of incidence	Place of incidence
Our study	After 24hours to 1 week (47) > 6months (2.5)	Victims house (61.9) Accused house Neighbourhood (21.2)
Ali et al [23]	Within 3 days (44.8) More than 3 days (41)	Victims'houses (64.2) Assailants' houses (13.3)
Tamuli et al [17]	3-7 days (34) 7-15 days (19)	Relative house (60) Hotel room (62) Rented house (76)
Rawat et al [16]	Within 24hrs (44.7) After weeks (38.3)	Survivor house (23.4) Accused house (23.4) Roadside /other place (38.3)

Majority of cases of sexual assault took place at victim's own house. Parents and young girls should be sensitized to this aspect be more aware of possibilities of such events to take place both their homes and outside. Such sensitization would help the girls and her parents to take necessary steps to avoid carelessness on their part.

Table 6: Comparison of Relation with Assailant

Study	Known	Most common among known
Singh et al [15]	76.7%	Neighbors- 34.8%
Ali et al [23]	64.6%	Acquantance -32
Rawat et al [16]	63.8 %	-
Present study	90.3%	Distant relative- 61.4%

It is easier for a known person to convince or lure the victim for commission of the offence. Sexual assault has significant impact on mental as well as psychosocial wellbeing of victim. In our study, Behavior changes observed in 17.7% of cases, depression in 8% of cases, lack of concentration in 7.6% cases. Lack of trust was seen in 3.8% cases. Self-harm observed in 7.6% of cases. Other psychological and mental trauma were in the form of feeling helplessness, anger outburst, flash backs and self-isolation. Suprakash et al documented that Survivors of sexual abuse suffer numerous psychological effects along with a spectrum of physical and psychiatric disorders resulting in higher health care use.[24] Alshekaili et al documented psychological variables as significant risk factors for depression in children with sexual abuse. They documented higher odds of depression in children with penetrative abuse (OR = 24.897, p =0.044) as compared to non-penetrative children. Also, children who reported problems with sleep-wake cycles (OR = 44.636, p = 0.012) were more at risk of depression as compared to children who reported no such problem.[25]

Conclusion

Sexual violence continues to be a major public health problem that lasting harmful effects on victims' family, friends, and communities. The reality is probably underestimated because many cases are not reported due to fear of indignity, denial and social stigma. The victims are mostly children and adolescents. Education and awareness of the population is very essential for early consultation and in seeking medical help. Delay in medical examination and reporting of cases resulted in loss of vital physical evidences. Medical consequences of sexual assault include STI, unwanted pregnancy, mental and psychological disorder. Obstetrician - gynaecologists and other women health care providers play an important role in evaluation and management of sexual assault survivors.

Declarations:

Funding: None **Conflicts of interest/Competing interests**: None **Availability of data and material**: Department of Obstetrics and Gynaecology, Gandhi Medical College and associated Sultania Zanana Hospital Bhopal **Code availability**: Not applicable **Consent to participate**: Consent taken **Ethical Consideration**: There are no ethical conflicts related to this study. **Consent for publication**: Consent taken

What This Study Add to Existing Knowledge

The Primary prevention of sexual violence is supporting the victims of sexual assault, perpetrators

of rape will be caught and punished. Particularly, the judiciary has to take it upon itself to see no perpetrator of these crimes goes unpunished. Along with the criminal justice functionaries, media people, political leaders, social workers, nongovernmental organizations and even the common man have to coordinate to create an environment in which sexual violence against women and children will not proliferate. Promote Social norms that protect against sexual violence. The general attitude of society needs to be changed in favour of the dignity of women and children which would increase large scale literacy among women. Parents should teach the girls about whom and when to trust, which touch is wrong, and what move by either relative, friends and strangers can put them in to difficult situation.

References

1. Definitions. Sexual violence: support and prevention Available from https://www.uottawa.ca/sexual-violence-support-and-prevention/definitions Last accessed on 16th November 2020.
2. ACOG Committee Opinion No. 777: Sexual Assault. Obstet Gynecol. 2019 Apr;133(4):e296-e302.
3. Understanding and addressing violence against women. WHO. Available from https://apps.who.int/iris/bitstream/handle/10665/77434/ WHO RHR 12.37 eng.pdf;jsessionid=2988EA7BC50A0C111451EA4E6A 1EB5F1? sequence=1 Last accessed on 16th November 2020.
4. Jewkes R, Vundule C, Maforah F, Jordaan E. Relationship dynamics and teenage pregnancy in South Africa. Social science & medicine. 2001 Mar 1;52(5):733-44.
5. Matasha E, Ntembelea T, Mayaud P, Saidi W, Todd J, Mujaya B, Tendo - Wambua L. Sexual and reproductive health among primary and secondary school pupils in Mwanza, Tanzania: need for intervention. AIDS care. 1998 Oct 1;10(5):571-82.
6. Buga GA, Amoko DH, Ncayiyana DJ. Sexual behaviour, contraceptive practice and reproductive health among school adolescents in rural Transkei. South African Medical Journal, 1996, 86:523–7.
7. Krug EG, Mercy JA, Dahlberg LL, Zwi AB. The world report on violence and health. Laneet: 2002 Oct 5;360(9339):1083-88.
8. Babu BV, Kar SK. Domestic violence against women in eastern Indian: a population study on prevalence and related issues. BMC Public Health 2009;9:129.
9. Freedman E. Clinical management of patients presenting following a sexual assault. Australian journal of general practice. 2020 Jul;49(7):406.
10. Taylor SC, Pugh J, Goodwach R, Coles J. Sexual trauma in women – The importance of identifying a history of sexual violence. Aust Fam Physician 2012;41(7):538–41.
11. Rogers D, Newton M. Evidence-based forensic sampling—more questions then answer. J Clin Forensic Med 2006. ;13:162 -3
12. Cybulska B. Sexual assault: key issues. Journal of the Royal Society of Medicine. 2007 Jul;100(7):321-4.
13. Crawford-Jakubiak JE, Alderman EM, Leventhal JM, Committee on Child Abuse and Neglect. Care of the adolescent after an acute sexual assault. Pediatrics. 2017 Mar 1;139(3).
14. Raj A, McDougal L. Sexual violence and rape in India. Lancet. 2014 Mar 8;383(9920):865.
15. Singh M, Punia RK, Pathak D, Sharma S. An Observational Study on the Sexual Assault Victims in the Year 2018 at Tartiary Health Care Center of Rajasthan. Medico Legal Update. 2020 Jul 24;20(3):117-21.
16. Rawat S, Guin G, Dadich R. An overview of sexual assault survivors: a 5 year retrospective study in gynaecology department of NSCB medical college, Jabalpur, Madhya Pradesh, India. Int J Reprod Contracept Obstet Gynecol 2018;7:2714-8.
17. Tamuli RP Paul B Mahanta P. A statistical analysis of alleged victims of sexual assault - a retrospective study. J Punjab Acad Forensic Med Toxicol 2013;13(1):7-13.
18. Mellins CA, Walsh K, Sarvet AL, Wall M, Gilbert L, Santelli JS, Thompson M, Wilson PA, Khan S, Benson S, Bah K, Kaufman KA, Reardon L, Hirsch JS. Sexual assault incidents among college undergraduates: Prevalence and factors associated with risk. PLoS One. 2017 Nov 8;12(11):e0186471
19. Ram A, Victor CP, Christy H, Hembrom S, Cherian AG, Mohan VR. Domestic Violence and its Determinants among 15-49-Year-Old Women in a Rural Block in South India. Indian J Community Med. 2019 Oct-Dec;44(4):362-7.
20. Inchley J, Currie D. Health Behaviour in School-Aged Children (HBSC) Study: International Report from the 2013/2014 Survey. WHO Regional Office for Europe; Copenhagen, Denmark: 2016. Growing up unequal:Gender and socioeconomic differences in young people‘s health and well-being. Health Policy for Children and Adolescents.
21. Sarkar SC, Lalwani S, Rautji R, Bhardwaj DN, Dogra TD. A study on victims of sexual offences in South Delhi. Journal of Family Welfare. 2005 Jun;51(1):60
22. Sorenson SB, Siegel JM, Golding JM, Stein JA. Repeated sexual victimization. Violence Vict. 1991;6(4):299-308

23. Ali N, Akhter S, Hossain N, Khan NT. Rape in rural Bangladesh. Delta Medical College Journal. 2015 Feb 14;3(1):31-5.
24. Suprakash C, Ajay K B, P S Murthy, Biswajit J. Psychological Aspects of Rape and Its Consequences. Psychol Behav Sci Int J. 2017; 2(3) : 555586
25. Alshekaili M, Alkalbani Y, Hassan W, Alsulimani F, Alkasbi S, Chan MF, Al-Adawi S. Characteristic and psychosocial consequences of sexually abused children referred to a tertiary care facility in Oman: Sentinel study. Heliyon. 2020 Jan 1;6(1):e03150.