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Unveiling the Nexus: Vulnerability to Psychological Distress and Childhood Violence among Adolescents in Zimbabwe

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Abstract

Exposure to multiple forms of violence increases the risk of developing psychiatric illnesses such as depression, PTSD, and other mental health problems. Despite this, studies investigating the relationship between psychological distress and childhood violence exposure are limited. This study aimed to estimate the prevalence of childhood violence across psychological distress and examined the association between vulnerability to psychological distress and experiencing childhood violence among Zimbabwean adolescents. Utilizing data from the 2017 Zimbabwe Violence Against Children Survey (ZVACS), a representative household survey of adolescents aged 13 to 19 (n=5344), we employed chisquare tests to determine the prevalence estimates across independent and dependent variables. Additionally, four sets of logistic regression models (both unadjusted and adjusted) were performed to predict significant associations between independent and dependent variables. Prevalence results indicated that among adolescents experiencing moderate-to-severe psychological distress, 35.3% had experienced childhood physical violence, 27.2% emotional violence, 15% sexual violence, and 51.2% had been exposed to multiple forms of violence. Similarly, regression results indicated that adolescents with moderate-to-severe psychological distress had higher odds of experiencing childhood physical violence (aOR=2.13), emotional violence (aOR=3.69), sexual violence (aOR=1.93), and multiple forms of violence (aOR=2.59) compared to their counterparts without psychological distress in the past 30 days. These findings underscore the need for interventions that prioritize education and increased access to mental health treatment programs. Moreover, addressing evolving cultural norms and enforcing existing legislation to curb violence are crucial steps to mitigate the risk of further victimization in Zimbabwe.

Keywords: *Psychological distress, emotional violence, sexual violence, physical violence, childhood, adolescence, Zimbabwe.*

Introduction

Mental health disorders significantly contribute to global ill-health and disability. According to the World Health Organization (WHO), approximately one out of every four individuals worldwide encounter mental disorders during their lifetime, affecting around 450 million people globally [1]. Simultaneously, recognizing violence as a health concern is rooted in an understanding that violent behavior stems from various factors such as context, biology, environment, systems, and social stressors [2]. Exposure to violence also plays a role in the development of psychiatric illnesses, including depression, post-traumatic stress disorder, and other forms of psychological distress [3]. However, a "trauma-informed" approach contends that violence is not indicative of inherent moral flaws but rather an adverse health outcome resulting from exposure to multiple risk factors, including psychological

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distress [4]. Within the spectrum of mental disorders, psychological distress emerges as a prevalent form—a nonspecific mental health condition characterized by anxiety, depression, and somatic symptoms that encompass sensations of vulnerability, sadness, fear, extensive worries, restlessness, negative thoughts, and social isolation [5].

The domain of mental health conditions, inclusive of psychological distress, poses a public health challenge that significantly impacts the daily lives of adolescents. This impact extends to their academic and occupational performance, relationships with family and friends, and participation in the community and possible exposure to multiple forms of violence [6].

Childhood violence from both familiar perpetrators and strangers occurs at homes, schools, communities and even online in the form of physical, emotional, and sexual violence [7].

On a regular basis, about 80% of children as young as two years are violently disciplined in low- and middle-income countries (LMICs) resulting in a considerable continuity from childhood aggression to juvenile violence that eventually predicts many violent offenses in adolescence and young adulthood [8-10].

Recent studies underscore the prevalence of psychological distress among adolescents in LMICs [11, 12]. In Zimbabwe, there is a 63.9% prevalence of physical violence before 18 years of age among girls perpetrated by a parent or adult relative and 76% among boys respectively [13]. Unveiling the nexus of childhood violence and examining its global patterns among adolescents aged 13 – 19 years in Zimbabwe remains a priority public health endeavor to protect them from re-traumatization.

To get started, we examine the literature focusing on the relationship between psychological distress on physical, emotional, and sexual childhood violence experiences in different contexts.

Psychological Distress and Childhood Physical Violence

Childhood physical violence is characterized by bruises, scars, burns, and dislocation sustained from abuse, with occasional long-term negative consequences such as permanent scarring, disabilities, recurrent illness, and body deformations [14, 15]. Previous studies have documented the intersection of physical violence against children and psychological distress in the form of suicidal tendencies, memory loss, brain damage and other mental disorders which illustrate the severity of childhood violence [16, 17]. The lasting effect of childhood abuse may materialize in future adolescent health considering the strong relationship between abuse and obesity, sexually transmitted disease, chronic pain, and depression [18-20]. Similarly, when compared against educational outcomes such as years of school completed, performance, attendance, progress, dropout, and post-school education; significant adverse impact of childhood violence on childhood educational attainment such as absenteeism, low performance on standardized tests, and poor reading ability has been reported [21-26]. Regardless of age, culture, gender and country of origin, childhood violence is a global public health challenge because of the adverse long-term physical, emotional, behavioral, cognitive, and social consequences they cause to victims [9].

Therefore, promoting a wholesome beginning to life, and freedom from maltreatment and adversity during childhood, is a crucial step in addressing inequities in African countries, including Zimbabwe. Childhood physical violence arises from a combination of social, cultural, economic, and biological factors, affecting societies across Africa [10, 27-30]. These issues contribute significantly to health disparities and social injustice, with those who are socioeconomically disadvantaged facing a higher risk in Africa [19].

Psychological Distress and Childhood Emotional Violence

Emotional violence has been associated with severe negative consequences including self-inflicted harm, engaging in high-risk sexual behaviors, intimate partner violence (IPV), impulsivity, substance abuse, diminished self-esteem, impaired cognitive function, emotional distress, fear, posttraumatic stress disorder (PTSD), thoughts and suicidal ideations [31-33]. Empirical evidence on childhood emotional violence suggests that maltreatment-related outcomes range from no symptom expression to suicide, thus emphasizing the diverse nature of how emotional violence unravels. Self-compassion (positive acceptance of self) has been proposed as a self-regulatory approach to mitigate negative self-directed emotions for adolescents and young adults inundated by prior childhood emotional violence [34]. Self-compassion has contributed to providing a buffer against childhood maltreatment and subsequent challenges in emotional regulation [34, 35].

Psychological Distress and Childhood Sexual Violence

Evidence suggests that before the age of 18, one in three girls in Zimbabwe experience some form of sexual violence which is consistent with the existing high prevalence rates in many eastern and southern African nations [36]. As a result, Zimbabwe currently possesses a comprehensive multi-tiered response platform made up of government and non-government organizations called Victim Friendly System which provides support for survivors of child sexual abuse [37].

However, the intersection of psychological distress and childhood sexual violence is documented among affluent nations suggesting that experiencing childhood abuse potentially leads to mental health issues in adulthood such as substance abuse, suicidal behavior, depression, stress, and increased risk of sexually transmitted infections [38-41].

Purpose of the Study

The evidence from the literature points to exposure to violence as a risk factor for psychological distress and not vice-versa [42]. As such, it is important to know the magnitude of psychological distress among adolescents before initiating and implementing intervention strategies. This study can help understand the implications of psychological distress among adolescents and provide the impetus for policymakers and stakeholders in the health and education sectors to initiate policies needed to institute prevention and control programs that will address mental health issues among adolescents to Zimbabwe. To fulfill the gaps in existing knowledge, the present study estimated the prevalence of experiencing childhood violence and examined the association with vulnerability and psychological distress among adolescents in Zimbabwe. We hypothesize that having psychological distress in the past 30 days will be significantly associated with experiences of childhood violence (i.e., physical, emotional, and sexual violence, or multiple forms of violence) among adolescents in Zimbabwe.

Methods

Study Design and Sampling Procedures

This study utilized the 2017 Zimbabwe Violence Against Children Survey (VACS)—a nationally representative household survey that identified females and males between 13 - 24 years old using a three-stage, cluster-randomized design. In the first stage of selection, 1,000 female enumerated areas (EAs) and 118 male EAs were randomly selected out of 29,365 EAs with a probability proportional to the size of the EAs in terms of households present. In the second selection stage, the survey data collection teams mapped and listed all structures and households in each of the selected EAs. The survey teams then input the total number of eligible households in the EA into a Microsoft access program explicitly developed for VACS household selection. The program randomly

selected 30 households in the EA to administer the survey. In stage three of selection, one eligible participant (female or male, depending on the EA) was randomly selected by a computer program built using CSPro from the list of all eligible participants ages 13-24 years old in each household. The selected participants were then interviewed. To calculate separate male and female prevalence estimates for having experienced violence, the study used a split-sample approach. This means that each EA was assigned as a location to survey either females or males. The split-sample approach, consistent with World Health Organization (WHO) guidelines, served to protect the confidentiality of participants and eliminate the chance that a perpetrator of sexual violence and a victim of the opposite sex in the same community would both be interviewed [43]. This study oversampled females in districts with a higher expected prevalence of HIV among 16- to 24-year-olds (i.e., districts in the Determined, Resilient, Empowered, AIDS-free, Mentored, and Safe, or DREAMS program). The sample size was adjusted for expected nonresponse among selected households. The study was designed to produce reliable estimates, defined as having a relative standard error (RSE) of less than 30%. In the male sample, 3,445 households were surveyed in 118 randomly selected EAs. A total of 803 males completed the individual questionnaire. In the female sample, 29,635 households in 1,000 EAs were surveyed. A total of 7,912 females completed the individual questionnaire. The overall response rates for males and females were 66% and 72 %, respectively [43]. However, in this study only adolescents aged 13 to 19 years were selected, and therefore, this reduced the sample size to 5344 (males =536, and female=4808).

Inclusion Criteria

To be included in the survey, participants must (1) live in a selected household in Zimbabwe, (2) be between 13 -24 years old at the time of the survey, and (3) be fluent in English, Shona, or Ndebele. Survey administration in English, Shona, or Ndebele was consistent with the practice of previous national surveys administered across Zimbabwe. Individuals ages 13–24 were selected as the most appropriate population to better understand childhood violence.

The study relied on this age range because children younger than 13 typically do not have the maturity to be able to answer survey questions, particularly the more complicated questions on potential risk and protective factors. Furthermore, limiting the upper age range to 24 years was intended to help reduce potential recall bias for childhood experiences. It was not possible to administer the survey to youth who could not understand the questions due to cognitive impairment or a significant physical disability (e.g., a hearing or speech impairment) that would preclude their participation. The survey did not include those living or residing in institutions such as hospitals, prisons, nursing homes, and other similar institutions because the VACS was household-based survey [43].

Data Collection Procedures

Interviewers took thorough precautions to ensure privacy during the survey. They conducted the interviews in safe and private locations such as outside, in a public space without risk of interruptions (i.e., a community area, school, or church), or an appropriate place in the home or yard. Before beginning survey work in a new community, the team leaders sought guidance from community leaders to identify community locations where interviews could occur. Interviewers confirmed that participants, parents, and other household members were comfortable with the location of the interviews.

If no private location was available, the interviewers rescheduled for another time while the survey team was still in the community. In addition, the survey used a split-sample design with separate male and female enumeration

areas (EAs). Participants were surveyed by an interviewer of the same sex. Only the interviewer and participant were present during the interview; no one else—including parents/guardians of the minor participants or other minors in the household—was allowed to listen in. The length of participant interviews varied, ranging from 20 to 60 minutes [43].

Measures

Dependent Variables

Childhood emotional violence. The respondents were asked whether he/she was told as a child by the caregiver that (1) the respondent was not loved or did not deserve to be loved, (2) wished the respondent had never been born or were dead, and (3) the respondent was ridiculed or put down, e.g., say that he/she was useless or stupid before the age of 18. The response categories were never, once, a few times, many times, and don't know/declined. This variable was recoded and dichotomized as 0=no (didn't experience any emotional violence), and 1= yes (experienced any emotional violence; at least once, a few times, or many times).

Childhood physical violence. The respondents were asked (a perpetrator type) has ever been (1) punched, kicked, whipped, beaten with an object, (2) choked, smothered, tried to be drowned, or burned intentionally, (3) threatened with knife or other weapons, which were experienced prior to age 18. The response categories were yes, no, and don't know/declined. The respondents were asked these three questions for each type of perpetrator: (1) intimate partner, (2) peers, (3) parents, adult caregivers, or other adults relatives, (4) and adults in the neighborhood. This was categorized as 0= no (didn't experience any physical violence) and 1=yes (experienced any physical violence).

Childhood sexual violence. Participants were asked whether they had ever: (1) received food, favors, or any gifts in exchange for sex, (2) participated in a sex video or photo, or being shown his/her sexual body parts in front of the webcam, (3) unwanted touching in a sexual way, including fondling, pinching, grabbing, or touching on or around his/her sexual body parts, (4) unwanted sexual attempts in which the perpetrator tried to make the respondent to have sex against his/her will but did not succeed, (5) physically forced sex in which the respondent was forced to have sex, and (6) pressured sex in which the respondent was pressured to have sex through harassment, threats, or tricks. Sexual violence experiences before the age of 18 years were included. The response categories were coded as "yes," "no," and "don't know/declined." The final variable was dichotomously coded as 0=no (didn't experience sexual violence) and 1 =yes (experienced sexual violence).

Exposure to multiple childhood violence. This was assessed by summing up a score for anyone who responded to have experienced childhood emotional violence, physical violence, and sexual violence. A summative scale of cumulative childhood violence was coded as a continuous variable with a range of 0 (no to any emotional, physical, and sexual violence) to 3 (yes to have any emotional, physical, and sexual violence). Finally, this was dichotomously coded as 0=no (no exposure to any violence) and 1=yes (exposure to any violence) for the final analysis.

Independent Variable

Psychological distress was assessed using the Kessler-6 (k-6) non-specific psychological scale [44-46] which consists of six items asking respondents about symptoms associated with depression and/or anxiety in the past 30 days, how often they feel: (1) nervous, (2) hopeless, (3) restless, (4) so sad that nothing could cheer you up, (5) that everything was effortless, and (6) feel worthless about everything [44-46],. Each specific question response included a 5-point Likert-type scale ranging from 0 = none of the time to 4= all the time, with a score ranging from 0 to 24. The sum of these six items were

used to calculate an overall psychological distress score.

Based on the reliability and valid scale and clinically proven cut-off points of Kessler-6 in measuring psychological distress in various contexts, including low-income countries, particularly in Sub-Saharan Africa, demonstrated moderate psychometric properties [44-46]. In the absence of a pre-established cut-off score, we used the cut-off score based on the previous studies [42, 46-47]. Respondents with scores of 0 to 4 were categorized as "0= no psychological distress" and respondents with scores of 5 to 24 were categorized as "1= moderate to severe psychological distress".

Covariates

Data were collected on sociodemographic characteristics that were used as covariates including gender (male or female), age group (0 = 0 -17 years, 1= 18 to 19 years), highest level of education (less than primary, primary, secondary, or higher than secondary), closeness to biological parents (not close to biological parents, and close to biological parents), number of close friends (none, at least one, two or more, and being orphaned prior to 18 years old.

Data Analysis

SPSS vs.29.0 was utilized to perfume all the statistical analyses in this study. Descriptive characteristics were obtained using frequencies and percentages across all the variables. Chi-square tests were used to determine the association and prevalence estimates across all the independent and dependent variables. At the multivariate level, four sets of logistic regression models (unadjusted and adjusted) were performed to determine the significant association between independent and dependent variables. In each regression model, ran both the unadjusted and adjusted regression. For adjusted regression we controlled for covariates (i.e., gender, age, education, closeness to biological parents, number of friends, and being orphaned). Multicollinearity was checked to ensure parsimonious models. A significance level of a=.05 was used to determine statistical significance during data analysis.

Ethical Considerations

The Zimbabwe 2017 VACS adhered to WHO recommendations on ethics and safety in studies of violence against children. The Medical Research Council of Zimbabwe, the Research Council of Zimbabwe (RCZ), and the Centers for Disease Control and Prevention (CDC) Institutional Review Board (IRB) independently reviewed and approved the survey protocol to ensure appropriate protections for the rights and welfare of human research participants. The survey protocol and informed consent documents were reviewed and approved by the U.S. CDC and the Zimbabwe Ministry of Health and Childcare [48]. In addition, the author(s) obtained permission to use the VACS from CDC, which was approved on April 28th, 2023. The IRB at Lewis University exempted this study from full review due to the secondary nature of this study.

Results

Descriptive Characteristics of the Participants

The descriptive characteristics of adolescents are shown in Table 1. Most of the adolescents were females (90.0%), were close to their biological parents (93.9%), aged 13 to 17 years (71.0%), and had completed at least secondary education or higher (64.7%). Less than half the adolescents had at least two or more friends (45.0%), and nearly one-third of the adolescents were orphaned (32.0%). Regarding childhood violence experiences, 12.2% of the adolescents reported having experienced childhood emotional violence, 23.4% physical violence, 8.0% sexual violence, and 32.1% reported having experienced multiple forms of violence (i.e., physical, emotional, or sexual violence). Finally, 23.6% of the adolescents reported having moderate-to-severe psychological distress in the past 30 days.

Table 1. Descriptive Characteristics of Adolescents (n=5344)

Descriptive Characteristics	**N**	**%**
Gender		
Male	536	10.0
Female	4808	90.0
Age (years)		
13-17	3793	71.0
18-19	1551	29.0
Highest education completed		
Primary or less than primary	702	35.3
Secondary or more than secondary	1288	64.7
Closeness to biological parents		
Not close to biological parents	316	6.1
Close to biological parents	4879	93.9
Number of friends		
None	816	15.3
1	2125	39.8
2 or more	2403	45.0
Orphan status		
Non-orphan	3444	68.0
Orphaned	1618	32.0
Experiences of Childhood Violence	**N**	**%**
Childhood emotional violence		
No	4670	87.8
Yes	649	12.2
Childhood physical violence		
No	4090	76.6
Yes	1252	23.4
Childhood sexual violence		
No	4914	92.0
Yes	425	8.0
Multiple childhood violence		
No	3628	67.9
Yes	1714	32.1
Psychological distress (Kesler 6), past 30 days	**N**	**%**
No psychological distress	4079	76.4
Moderate/severe distress	1257	23.6

The Prevalence of Experiencing Childhood Violence across Psychological Distress

The prevalence of childhood violence experiences for adolescents with psychological distress are shown in Table 2. About 35.3% of the adolescents with moderate-to-severe psychological distress had higher rates of having experienced childhood physical violence compared to 19.8% who did not have psychological distress in the past 30 days

(p<.001). Similarly, 27.2% of the adolescents with moderate-to-severe psychological distress reported having experienced childhood emotional violence compared to 7.6% with no psychological distress in the past 30 days (p <.001). Furthermore, 15% of the adolescents with moderate-to-severe psychological distress reported having experienced childhood sexual violence relative to 5.8% with no psychological distress in the past 30 days (p <.001). Finally, 51.2% of adolescents with moderate-to-severe psychological distress reported having experienced multiple forms of violence compared to 26.2% with no psychological distress in the past 30 days (p <.001).

Table 2. The Prevalence of Childhood Violence among Adolescent with Psychological Distress (n=5344)

Variables	**Logistic Regression Models**			
	No	**Yes**	**Total (%)**	**P-value**
Psychological distress (past 30 days)	N (%)	N (%)		
Experienced childhood physical violence				
No psychological distress	3271 (80.2)	808 (19.8)	4079 (76.4)	<.001
Moderate/severe psychological distress	813 (64.7)	444 (35.3)	1257 (23.6)	
Experienced childhood emotional violence				
No psychological distress	3759 (92.4)	309 (7.6)	4068 (76.6	<.001
Moderate/severe psychological distress	907 (72.8)	339 (27.2)	1246 (23.4)	
Experienced childhood sexual violence				
No psychological distress	3841 (94.2)	237 (5.8)	4078 (76.5)	<.001
Moderate/severe psychological distress	1068 (85.0)	188 (15.0)	1256 (23.5)	
Experienced multiple childhood violence				
No psychological distress	3010 (73.8)	1069 (26.2)	4079 (76.4)	<.001
Moderate/severe psychological distress	613 (48.8)	644 (51.2)	1257 (23.6)	

Association between Psychological Distress and Experiencing Childhood Violence

The results of the association between psychological distress and childhood violence experiences among adolescents for both unadjusted and adjusted logistic regression are shown in Table 3. The results showed that adolescents with moderate-to-severe psychological distress were more likely to report having experienced childhood physical violence (aOR=2.13, 95% CI=1.69-2.68), emotional violence (aOR=3.69, 95% CI=2.80 - 4.87), and sexual violence (aOR=1.93, 95% CI=1.44 - 2.60) compared to those with no psychological distress in the past 30 days. Additionally, adolescents with moderate-to-severe psychological distress were significantly associated with higher odds of reporting having experienced any form of violence in childhood (aOR=2.59, 95% CI=2.10 - 3.20).

Table 3. Association between Psychological Distress and Childhood Violence Experiences

No.	**Independent Variables**	**Outcome Variables**	
Model 1	**Childhood physical violence**		
	Psychological distress (past 30 days)	OR (95% CI)	aOR (95% CI)
	No psychological distress(ref.)	Ref	Ref
	Moderate/severe psychological distress	2.21 (1.92 – 2.54)***	2.13 (1.69 – 2.68)***
Model 2	**Childhood emotional violence**		
	Psychological distress (past 30 days)	OR (95% CI)	aOR (95% CI)

	No psychological distress(ref.)	Ref	Ref
	Moderate/severe psychological distress	4.55 (3.84 – 5.39)***	3.69 (2.80 – 4.87)***
Model 3	**Childhood sexual violence**		
	Psychological distress (past 30 days)	OR (95% CI)	aOR (95% CI)
	No psychological distress(ref.)	Ref	Ref
	Moderate/severe psychological distress	2.85 (2.33 – 3.50)	1.93 (1.44 – 2.60)***
Model 4	**Multiple childhood experienced**		
	Psychological distress (past 30 days)	OR (95% CI)	aOR (95% CI)
	No psychological distress(ref.)	Ref	Ref
	Moderate/severe psychological distress	2.96 (2.60 – 3.37)	2.59 (2.10 – 3.20)***

***=P<.001, **=p<.01, *=p<.05, In each of the models, age, sex, highest education, close to biological parents, number of close friends, orphaned, Ref= reference group, CI= Confidence intervals, aOR = Adjusted Odds Ratio

Discussion

The primary purpose of this study was to estimate the prevalence of experiencing childhood violence and investigate its association with vulnerability to psychological distress among adolescents in Zimbabwe. Initially, 23.6% of the adolescents reported experiencing moderate-to-severe psychological distress in Zimbabwe. Particularly, we observed that adolescents with psychological distress reported higher rates of experiencing multiple forms of violence (51.2%), physical violence (35.3%), emotional violence (27.2%), and childhood sexual violence (15%) during childhood. Given the consistent linkage to previous studies between violence exposure and mental health problem for adolescents [49, 50], this study has also provided evidence suggesting that increasing vulnerability to psychological distress is one of the potential risk factors that heightens susceptibility to exposure to a wide range of violence, specifically among adolescents in Zimbabwe.

Therefore, it is vital to provide mental health interventions to mitigate the negative effects of psychological distress that expose adolescents to different forms of violence in their social environment.

Mental health difficulties may stem from past experiences of traumatic experiences, including exploitation or violence. The enduring impacts of experiencing violence among adolescents can heighten their vulnerability to further exploitation [51]. In the present study, we found that adolescents with psychological distress were associated with higher odds of experiencing childhood physical violence among adolescents, aligning with findings in prior studies [16, 17]. This may suggest that the presence of psychological challenges often correlates with challenging behaviors that may provoke irritations, resulting in a physical response expressed in the form of physical violence. At the same time, adolescents grappling with moderate-to-severe psychological distress may lack effective coping mechanisms and the ability to gain control of their own lives. As a result, adolescents may become victims of violence from other people within their homes and communities due to expressions of frustration and anger. Additionally, adolescents with mental health issues may become targets of bullying, further escalating the risk of exposure to physical violence. Therefore, interventions should prioritize education and awareness in various settings such as homes, schools, and social environments, teaching practical ways to respond to individuals with psychological distress to prevent further victimization.

Mental health difficulties can impact individuals' thoughts, feelings, actions, behaviors, and personality. Individuals experiencing mental health challenges may seek or become dependent on others to provide

emotional or practical support [52]. Caregivers, relatives, and other individuals encountered by victims may exploit this relationship of trust and dependency to abuse or exploit adolescents with psychological distress [53]. In the current study, evidence suggested that adolescents with moderate-to-severe psychological distress were 3.7 times more likely to have experienced emotional violence during their childhood. Like physical violence, having psychological distress may predispose adolescents to emotional violence, which may also manifest as a response to specific behaviors, especially when faced with severe frustration and anger from individuals close to the victim.

Henceforth, interventions should promote empathic response and awareness of mental health education, particularly for adolescents, is essential as a mechanism for mitigating emotional violence, which is currently evidenced in this study.

The most recent study suggested that societal factors including stigmatization of mental health issues and societal norms that perpetuate power imbalances, can contribute to an environment where sexual violence is more likely to occur [54]. Like this study, we found that adolescents with moderate-to-severe psychological distress were more likely to report experiencing childhood sexual violence compared to those without psychological distress. It is plausible that having mental health problems increases the risk of vulnerability to sexual violence, and perpetrators may exploit this vulnerability to abuse the victims potentially sexually. While the impact of sexual violence is complex and varies among individuals, factors such as the survivor's support system, coping mechanisms, and access to mental health services can influence the severity of psychological distress. Seeking professional help from therapists, counselors, or support groups is crucial for survivors to address and manage the psychological consequences that may lead to sexual victimization for adolescents in Zimbabwe.

Finally, this study provided evidence by suggesting that adolescents with moderate-to-severe psychological distress were more likely to have experienced multiple forms of violence during childhood. Given that psychological distress may attract specific behaviors that often provoke physical, emotional, or sexual violence among victims, this supports our hypothesis. Therefore, potential interventions should focus on enhancing access to mental health treatment and raising awareness to reduce stigma, diminishing violence perpetration among adolescents who could be potential victims of exposure to physical, emotional, and sexual violence. Additionally, rigorous efforts should be geared toward addressing changing cultural norms, implementing, and reinforcing existing legislation to prevent violence, and providing mental health treatment for adolescents with psychological distress to avoid further potential victimization for adolescents in Zimbabwe.

Study Limitations

The current study has several limitations worth highlighting. This study was cross-sectional, making it impossible to establish causal inferences. Talking about sexual or physical violence and mental health problems are highly emotional and sensitive subjects, creating barriers to disclosing important information due to fear, harassment, or other underlying factors. Since this study was conducted in households, it was impossible to gather information from participants who lived outside of family care and may not represent the entire population. Psychological distress was measured only for the past 30 days, which further limited our understanding of how participants may have experienced psychological distress immediately or months after a particular victimization experience. Despite the limitations, there are strengths as well worth highlighting. The present study was drawn from the nationally representative ZVACS with a large sample size, allowing for

the generalizability of the findings to other settings in LMICs.

Conclusions

This study has established that adolescents with moderate-to-severe psychological distress were associated with higher odds of experiencing childhood violence, including physical, emotional, and sexual violence, along with cumulative exposure in Zimbabwe. To mitigate these issues, interventions must emphasize promoting accessibility to mental health treatment. Prioritizing education and awareness across diverse settings, including homes, schools, and social environments, is crucial in preventing future victimization by violence. Furthermore, substantial efforts are required to address evolving cultural norms, enforce existing legislation to curb violence and deliver mental health treatment for distressed adolescents, mitigating the risk of further victimization in Zimbabwe.

Conflict of Interest

Author declares that there is no conflict of Interest.

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