

Letter

Addressing the psychiatric implications of AI-enabled non-consensual sexual imagery

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Keywords

AI deepfakes; non-consensual sexual imagery; depression; digital victimisation; mental health.

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The rapid proliferation of generative artificial intelligence (AI) has facilitated new forms of sexual violence with significant psychiatric implications that result in profound and lasting psychological harm.¹ A recent investigation revealed that an online service made a profit of more than USD 36 million by creating and distributing AI-generated nude sexualised images of women and girls without consent.² Extant discussions on AI-related sexual violence mainly address misinformation and security and often overlook its psychological impacts,³ especially in Asia, where cultural, legal and clinical frameworks present distinct challenges. This gap represents a pressing concern for mental health professionals worldwide, particularly in Asian contexts, in which existing systems may struggle to address these violations adequately.

Advances in diffusion models and deep neural networks have made it possible to generate hyper-realistic sexualised images from ordinary photographs. Publicly accessible ‘nudifying’ applications can remove clothing from images or map faces on to pornographic material, enabling convincing but fabricated content to be produced with minimal technical skill. These tools operate anonymously across jurisdictions, enabling large-scale victimisation. Once created, such images are often disseminated rapidly and persist indefinitely online, creating conditions for enduring psychological harm to the unsuspecting victim.

Although the violation occurs in digital space, survivors frequently describe experiences akin to those resulting from physical sexual assault, such as loss of control, violation of bodily autonomy and persistent fear of further exposure.⁴ The indefinite circulation of images and the persistence of digital content mean that trauma trajectories frequently extend over years, leading to lifelong permanent victimisation and transforming a single event into a chronic traumatic stress environment. Each resurfacing of the image can reactivate trauma pathways, leading to alteration of sense of self and identity, the individual’s relationships with their own body and others, hyperarousal, intrusive thoughts and avoidance behaviours.⁵ Non-consensual sexual imagery (NCSI), including AI-generated deepfakes, has been associated with anxiety, depressive disorders, post-traumatic stress disorder (PTSD) and suicidality.⁶ For clinicians, these presentations often resemble complex trauma, compounded by shame, stigma and impaired help-seeking. Without timely, trauma-informed intervention, this ongoing exposure can entrench PTSD symptoms and depressive states, resulting in long-term psychiatric morbidity.

The psychiatric impacts of NCSI are amplified in many Asian contexts by intersecting cultural and legal factors. Honour-based norms, victim-blaming attitudes, and stigma surrounding sexuality and mental illness can intensify distress and deter help-seeking.⁷ Victims in India and elsewhere often encounter institutional barriers, including police inaction, evidentiary challenges and a lack of legal recognition of AI-generated sexual imagery. Regulatory

frameworks often lag behind technological advancements, resulting in procedural delays and low conviction rates. These gaps generate feelings of helplessness and institutional betrayal, both of which are associated with worsened PTSD and depression.⁸

Stigma surrounding sexual victimisation further limits disclosure and care-seeking, particularly in settings in which mental health resources remain scarce. Mental health service delivery remains uneven across Asia, with shortages of trained professionals and persistent stigma around psychiatric care. Digital mental health interventions offer promising avenues for expanding access, as seen in India.⁹ However, most existing platforms were not designed to address the specific psychological sequelae of NCSI, and privacy concerns may deter survivors from engaging with them. Moreover, interventions must be culturally adapted, as disclosure patterns and trauma narratives vary across societies.

Addressing these challenges requires a multi-pronged approach that emphasises specific psychiatric interventions. Clinicians should be trained to identify trauma symptoms arising from AI-enabled NCSI and to provide trauma-informed, culturally sensitive care. Recognising NCSI as a distinct trauma pathway is essential. Routine clinical assessments, specifically for adolescents and young adults presenting with anxiety, depression or trauma-related symptoms, should include sensitive questions about digital sexual victimisation. Trauma-informed therapeutic strategies, including cognitive processing therapy and culturally adapted psychoeducation on digital permanence, can support survivors in regaining a sense of agency and reduce shame.

At the policy and systems level, interdisciplinary collaboration among mental health professionals, legal authorities and digital rights organisations is essential. Priorities include rapid removal of harmful content, provision of timely psychological support, and development of survivor-centred technological and legal frameworks that criminalise AI-enabled NCSI. Specialised digital mental health interventions that ensure anonymity, cultural sensitivity and robust data protection can complement in-person services, especially in resource-limited settings. Strengthening legal and regulatory frameworks to govern AI-generated sexual content is particularly critical in low- and middle-income countries, where protective mechanisms remain underdeveloped.

In conclusion, AI-enabled sexual violence through NCSI represents a rapidly evolving challenge with profound psychiatric implications. Its capacity to induce depression, PTSD and lifelong trauma underscores the need for psychiatry to integrate digital sexual victimisation into clinical practice, research and policy advocacy. In Asia, where cultural stigma, legal gaps and mental health resource limitations intersect, this represents both a pressing challenge and an opportunity to develop culturally informed, trauma-focused, interdisciplinary responses. Recognising and addressing these harms is not peripheral but central to protecting mental health in the digital age.

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