



Vulnerability and revictimization: Victim characteristics in a Dutch assault center



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ABSTRACT

Sexual and family violence are highly prevalent problems with numerous negative health consequences. Assault centres, such as the Centre for Sexual and Family Violence (CSFV) in the Netherlands, have been set up to provide optimal care to victims. We wanted to gain insight into characteristics of the population that presented to the Centre in order to customize care to their needs. File analysis was conducted of victims who attended the CSFV between 2013 and 2016. Data were analyzed in SPSS. A total of 121 victims entered the Centre, 93% of them being female. Forty-two per cent were adult victims of sexual violence, 28% minor victims of sexual violence and 30% adult victims of family violence. One-third of sexual and two-third of family violence victims had experienced prior abuse. Current use of psychosocial services and psychiatric medication was high, and a cognitive disability was present in 18% of the sexual violence victims. Half the victims reported, but when the perpetrator was a recent contact, e.g., someone met at a party, reporting rates went down. Sexual and family violence victims share characteristics that indicate vulnerability, suggesting that care for both groups might best be combined in one single assault centre. In this way, victims can make use of the same services and knowledge of gender-based violence. One of the major aims of assault centres is to provide psychosocial follow-up care and facilities for reporting. The victims' needs in these matters deserve further research.

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1. Introduction

In the Netherlands, one in eight women and one in twenty-five men have ever been raped,¹ and 45% experienced a form of family violence.² Sexual and family violence cause numerous negative health problems such as sexually transmitted infections (STIs), pregnancy complications and unwanted pregnancies, depression, post traumatic stress disorder (PTSD), substance abuse and an increased risk of suicide.^{3–5}

Unfortunately, many victims do not seek help from legal, medical and mental health services. Victims are afraid that formal systems will not help them or will psychologically harm them.⁶ When they do seek formal help, the care provided often does not

meet the victims' medical and psychological needs. Victims often perceive the care providers' attitudes and communication as negative.⁷ Instead of feeling they are given the opportunity to press charges, they are ashamed, are afraid of the perpetrator and fear they will be blamed by the police, who will probably not take the assault seriously enough.^{8,9} Most reported sexual assaults are not prosecuted in court.⁷ As a consequence, victims feel misunderstood and miss out on the care they need.

To improve care for victims of violence, assault centres have been set up. In these centres, medical, psychosocial and legal services work together to provide the best possible care. Assault centres report promising outcomes on victims' help-seeking experiences; victims are satisfied with the care providers' attitude; care providers indicate that their communication skills have improved, resulting in a less traumatic care process; legal outcomes appear to improve; and there is enhanced communication among collaborating organizations.^{10,11}

A Centre for Sexual and Family Violence (CSFV) was set up in

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Nijmegen in 2012 as one of the first assault centres in the Netherlands. The Centre provides medical, forensic and police care at an Emergency Department. A case manager conducts psychosocial follow-up care to prevent problems such as PTSD, depression and revictimization. Literature on whether or not services for sexual and family violence should be combined shows that these services share needs, goals and expertise, but there is some concern that combined services lead to diminished effectiveness, lack of attention and lack of funding for sexual assault specifically.¹² We believe that care for these victims could be based on the same interprofessional, integrated approach. Both family and sexual violence are considered gender-based violence: both share risk factors and health consequences, and both evoke feelings of fear, shame and guilt and increase the risk of future violence.^{13–16} Both victim groups are often characterized by vulnerability, defined as being female, being young, having an intellectual disability or suffering from mental illnesses.^{17,18}

We wanted to find out whether our three target groups, namely adult and minor victims of sexual violence and adult victims of family violence, share background characteristics and care needs. Our research questions are: 1. What are the similarities and differences between adult victims of sexual and family violence with regard to vulnerabilities and use of services? 2. What are the similarities and differences between minor and adult victims of sexual assault with regard to vulnerabilities and use of services? 3. Do victim, assault and perpetrator characteristics influence reporting rates? This knowledge of assault centre populations can help existing and new centres to improve their care delivery.

2. Method

2.1. Setting

The study was performed at the Centre for Sexual and Family Violence Nijmegen (CSFV), which provides interprofessional care for victims of sexual and family violence. The CSFV was set up as a collaborative network involving the Emergency Department (ED) of the Radboud University Medical Center, the District Police Department, the Community Health Services and an academic Primary Health Care Centre. Acute care takes place at the ED and is conducted by an ED physician and nurse. Initially, urgent medical care is carried out with attention of preserving traces. Victims are informed about legal proceedings. If victims wish to report, a police officer comes to the Centre to provide information on reporting. If victims consider reporting, a forensic physician is subsequently called in by the police to perform a forensic medical examination. Before victims are examined, the ED physician, police and forensic physician discuss the plan of work in which they aim to keep the burden for the victim as low as possible. The forensic physician takes swabs for STI-testing. After forensic medical examination, the ED physician counsels, tests and takes preventive treatment for STIs, including hepatitis B and HIV; counsels on pregnancy and takes pregnancy measures if necessary; and treats injuries. The victims' safety and that of their children is assessed by the ED nurse. The victims' General Practitioner (GP) is informed by letter. Follow-up medical attention for STIs is carried out by an infectious disease specialist at the Radboud University Medical Centre 2–4 weeks after acute care.

A case manager, based at the academic Primary Health Care Centre, calls victims the day after acute care has been provided. This case manager is in charge of psychosocial follow-up care such as providing psychoeducation and referral to psychosocial or legal help, if necessary. Follow-up care can be done by phone or in face-to-face contacts, depending on the victims' preferences. The case manager screens for PTSD at one month and three months after the

incident according to the NICE guidelines.¹⁹ The case manager keeps files, registering the victims' needs and action plans. If victims do not want or need follow-up care, the case manager asks for the reason why and registers this as well. After three months, the case manager usually transfers the care to the victims' GP.

2.2. Subjects and study design

The study is a file analysis of victims of who presented to the Centre for Sexual and Family Violence, using the medical files, follow-up files, district police reports and forensic examiners' files. Female and male victims of acute sexual violence of all ages, and female and male victims of family violence aged ≥ 18 years old who presented to the Centre between January 2013 and January 2016 were included. Acute sexual violence was defined as the assault happening ≤ 7 days ago as traces can be preserved and STI measures can be taken up until seven days after the event. Acute **family** violence was defined as physical violence conducted by an ex partner, partner or family member, which happened less than 24 h ago and/or needed ED treatment. The emphasis on physical violence ≤ 24 h ago and/or needing ED treatment was chosen to stress the Centre's focus on a need for acute, emergency medical treatment. If an acute **sexual** assault by an ex partner, partner or family member was the only and main reason for attending the Centre, we categorized these victims among the sexual violence victims.

The treatment of physical and emotional family violence for victims aged < 18 years old was covered by another protocol at the hospital and was not conducted by CSFV staff. Minor victims of family violence, therefore, were excluded from this study.

2.3. Measurements and definitions

A registration form was developed based on the expertise of the supervising committee (the authors) and previous literature.²⁰ The registration form contained items on background, assault and perpetrator characteristics and use of services. The background characteristics focused on vulnerabilities, such as previous abuse and use of psychiatric medication.

The following definitions were used for background characteristics: 'Having an intellectual disability' was noted as 'yes' if an intellectual disability was mentioned in the ED file. The ED based this knowledge on prior medical files, information of the person accompanying the victim or the place of residence being known to give care to intellectually disabled persons. 'Prior sexual or family violence' was defined as having experienced ≥ 1 event of sexual and/or family violence before entering the CSFV by the same or a different perpetrator, in childhood or adulthood. 'Psychiatric medication' included antidepressants, antipsychotics, anxiolytics/hypnotics, mood stabilizers and stimulants. 'Current use of psychosocial services' included the services victims used at the time they entered the CSFV, such as social work, psychologist, psychiatrist, Child Protection Services, living in an institution and/or assisted living.

The following definitions were used for assault and perpetrator characteristics: 'Penetration' included vaginal and/or oral and/or anal penetration. In the case of children, 'Penetration' included penetration of the vulvar vestibule. 'Psychological violence' consisted of victims feeling unsafe with the perpetrator or being threatened with or without a weapon. If the assault took place in the victim's or perpetrator's house, we defined this as 'Private location'; if it took place in streets, parks, cars, clubs, parties and woods, it was defined as 'Public location'. 'Alcohol/drug use before the assault' was established by anamnesis or by clinical estimation at the ED and not confirmed by bio-specimen. This included victims

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