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Factors related with sexual assault revictimization: a comparison between revictimized and non-revictimized girls and women in a Dutch sexual assault centre.

Master thesis Clinical Psychology

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Summary

Sexual assault is affecting a lot of girls and women. Experiencing sexual assault increases the risk of experiencing repeated sexual assault over the life course from either the same or different perpetrators, which is also defined as sexual revictimization. The purpose of the present study is to investigate whether the presence of mental health issues, reporting to the police, divorced parents and level of education are related to sexual revictimization by comparing revictimized and non-revictimized girls and women. This retrospective cohort study was conducted at a Dutch sexual assault centre where multidisciplinary post-assault services are provided within one week post-assault. From January 2012 to December 2017, information about sexual revictimization was collected by self-report from 295 females, with a mean age of 21.4 years (*SD* = 9.0). A *Pearson* correlation was implemented to see if there is a correlation between sexual revictimization and mental health issues, report to the police, divorced parents and level of education. To make a statement about which factors are related to sexual revictimization, the significant correlates were included in a logistic regression analysis adjusting for age. The most important finding of this study is that revictimized girls and women more often suffer from mental health issues than non-revictimized girls and women. Longitudinal research is recommended to sort out the risk factors for sexual revictimization from the consequences of sexual revictimization. Furthermore, more research is needed to identify short-term and cost-effective mental health interventions to offer after experiencing sexual assault. This highlights the importance of the existence of sexual assault centres, a safe place where multidisciplinary help and guidance is provided for victims of sexual assault.

Introduction

Sexual assault is affecting a considerable percentage of women in the Netherlands; in 2017, 22% of the women in the age between 18-80 years old reported one or more experiences of sexual assault (Rutgers, 2017). Sexual assault can be defined as any type of non-consensual oral, anal, or vaginal contact and/or penetration in which the perpetrator has used force, intimidation, coercion and/or other means to acquire such sexual contact from a potential victim (Angelone, Marcantionio & Melillo, 2017). Sexual victimization increases the victim's risk of repeated sexual violence over the life course from either the same or different perpetrators. This phenomenon of repeated sexual victimization is called revictimization (Macy, 2008). Cloitre, Scarvalone and Difede (1997) suggest that the high level of dissociation among girls and women who experienced sexual victimization makes them not only often unaware of their environment, but also makes them look distracted or confused, which can mark them as 'easy targets' to sexual predators, which may result in revictimization. Furthermore, Cloitre and colleague's (1997) suggest that sexual victimised girls and women can experience a difficulty in identifying and labelling emotional states, which impairs their ability to fully experience and recognize internally generated 'danger' signals when confronted with threats, such as potentially dangerous

individuals. Given the high number of girls and women who experience sexual assault and their vulnerability to experience repeated sexual assault, revictimization clearly is a relevant societal problem (Bockers, Roepke, Michael, Renneberg & Knaevelsrud, 2014).

Initial studies about sexual revictimization mainly focus on studying child sexual abuse (CSA) and revictimization in girls and women. Findings suggests that two out of three females who have a history of CSA are likely to experience repeated sexual assault in adolescence or adulthood (Classen, Palesh & Aggarwal, 2005). Finkelhor and Browne (1985) propose a model for understanding the effects of CSA based on four factors. These so called 'traumagenic dynamics' are traumatic sexualization, betrayal, powerlessness and stigmatization. The researchers suggest that these dynamics can be used to better understand the different types of problems experienced by CSA victims. Especially the dynamics traumatic sexualization and powerlessness are important in revictimization. For example, traumatic sexualization refers to a process in which a child's sexual feelings and attitudes are shaped in a developmentally inappropriate and dysfunctional pattern as a result of CSA. This dynamic may explain effects of CSA such as repetitive or inappropriate sexual behaviours, promiscuity, sexual aggression or sexual revictimization. Similarly are the dynamics of powerlessness, which refers to the process in which the child's desires, will and sense of efficacy are constantly in conflict. The dynamics of powerlessness might explain impaired coping behaviours that can play a role in increasing the risk of revictimization.

Various research shows that there is a strong connection between experiencing CSA and experiencing repeated sexual assault in adolescence and adulthood by different perpetrators (Hanson, 2016). However, there has been little research done on other factors that may be related to revictimization, such as mental health issues. Some studies have found a relationship between revictimization and depression, such as Cloitre et al. (1997), who found that revictimized women more suffered from depression compared to non-abused women. However, this finding is not supported in all studies (Classen et al., 2005). When looking at posttraumatic stress disorder (PTSD) symptoms in revictimized women, Cloitre et al. (1997) found that the group of revictimized women in their study suffered significantly more from PTSD and other anxiety disorders than the non-abused group of women. Other research supports this finding (Hanson, 2016). Additionally, there is evidence that suggests that alcohol and substance abuse can be either a risk factor for or a consequence of revictimization (Classen et al., 2005). It is proposed that alcohol and other substances are used by victims of sexual assault as a form of self-medication, which can help them to cope with overwhelming pain. Some evidence shows that alcohol abuse can be seen as a risk factor, but not necessarily as a mediator of sexual revictimization (Classen et al., 2005). Other mental health problems, such as schizophrenia, are also found to be a risk factor for revictimization. Especially women with a history of CSA and schizophrenia were at greater risk for revictimization (Classen et al., 2005). Personality disorders are associated with impulsive and risky behaviours, which are seen as possible risk factors for revictimization also. In particular when these behaviours are sexual, such as

multiple sexual encounters with different people and the infrequent use of contraception (Hanson, 2016). Golda, Sinclaira and Balgea (1999) stated that having more sex partners is associated with an increased risk for sexual revictimization and that women with borderline personality characteristics may also be more susceptible to revictimization. When looking at eating disorders and revictimization, Wonderlich and colleagues (2001) found that revictimized women had the highest rates of eating disordered behaviour and associated impulsivity. Overall, numerous studies found an association between revictimization and multiple mental health issues.

Aside from mental health issues, higher rates of shame and self-blame are also consistently found to be associated with revictimization (Classen et al., 2005). Tapia (2014) describes that shame is thought to be one primary mechanism by which victims of sexual assault develop behavioural problems that may lead to revictimization. Shame is an emotion that is highly characteristic of victims who tend to denigrate themselves and have the desire to hide or avoid exposure. Moreover, revictimized girls and women tend to believe that they have brought the abuse on themselves (Zijlstra et al., 2017). These interpersonal issues can be reasons for victims to not seek help and not report the assault to the police, which can make them vulnerable for revictimization. Victims might be afraid that formal systems will not help them or will psychologically harm them. Instead of feeling that they get the opportunity to get justice, the victims feel ashamed, are afraid of the perpetrator and fear that they will be blamed by the police, who they believe will not take the assault seriously (Zijlstra et al., 2017). A study conducted in a Dutch sexual assault centre found that only one-third of the victims officially report to the police (Bicanic, Snetselaar, de Jongh & van de Putte, 2014). This is a distressing low percentage, considering the fact that sexual assault is a serious crime and not seeking the right help can cause more problems for the victim. In short, high rates of shame and self-blame in revictimization may be immense thresholds for victims to report the assault to the police and seeking the right help.

Family characteristics have been associated with sexual revictimization as well. Examples are families in which a member has an alcohol or drug issue, families in which there has been a change in caregivers and families where there is a conflict, including parental conflict (Classen et al., 2005). Bicanic et al. (2014) reported that in their sample of acute assault victims, who sought help within seven days after the assault, most minors were not living with both biological parents, which has been associated with an enhanced risk of PTSD onset and revictimization. Grauerholz (2000) describes that many of the effects of sexual assault can be explained by early life family experiences. For instance, family breakdown is more common among families of sexual assault victims than in non-victims. Furthermore, sexual assault is more likely to occur in children living with disorganized family systems and in those with high marital dysfunction (Grauerholz, 2000). Thus, familial- and parental conflict seem to be related to revictimization.

Moreover, a small amount of research focused on the connection between revictimization and socioeconomic status and intellectual disability. An association is found between revictimization and socioeconomic status, possible due to lack of resources, which may increase the risk of revictimization

(Classen et al., 2005; Grauerholz, 2000). Zijlstra and colleague's (2017) found that girls and women who have high rates of psychosocial problems and/or intellectual disability are vulnerable for revictimization. Intellectual disability might increase the risk of repeated assault, and this risk might be even greater when paired with other potential problems caused by the first assault, such as mental health issues, inadequate coping and shame (Zijlstra et al., 2017).

As mentioned before, previous research about sexual revictimization primarily focuses on the experience of CSA and revictimization (Hanson, 2016). However, not much research has been conducted about pathways for repeated victimization risk in adolescent and adult sexual assault victims. This is remarkable, because 30% of adolescent/adult sexual assault victims experienced a new completed rape over a follow-up period, what shows that revictimization is not an uncommon phenomenon (Ullman & Vasquez, 2015). The high prevalence of victims experiencing revictimization suggests the importance to study risk factors and other underlying processes that are related to sexual revictimization in all age-categories, with the aim of better understanding the vulnerability to revictimization. Furthermore, in 2012, the first sexual assault centre in the Netherlands was founded. Sexual assault centres offer 24/7 medical, forensic and psychological services to individuals who believe that they have been the victim of a recent (< one week) sexual assault (Bicanic et al., 2014). Girls and women consulting a sexual assault centre appeared to have background characteristics that put them at risk for revictimization (Bicanic et al., 2014). This suggests the importance of studying sexual revictimization within girls and women who seek help at a sexual assault centre. In contrast to initial studies, the present study will provide information about this group of girls and women. More research about sexual revictimization provides more information and knowledge about what might help to reduce risk and build resilience following sexual assault (Hanson, 2016).

The current study will investigate whether other factors, besides CSA, are related to sexual revictimization. A comparison will be made between two groups: female victims of sexual assault who experienced revictimization and female victims of sexual assault who did not. First, it is expected that revictimized girls and women more often suffer from mental health issues than non-revictimized girls and women. Second, it is expected that revictimized girls and women less often report the sexual assault to the police than non-revictimized girls and women. Third, it is expected that revictimized girls and women more often come from families where the parents are divorced than non-revictimized girls and women. At last, it is expected that revictimized girls and women have a lower level of education than non-revictimized girls and women.

Method

Subjects and data collection

This retrospective cohort study was conducted at the sexual assault centre in the University Medical Centre Utrecht (UMCU). This centre focuses on providing multidisciplinary post-assault services

within one week post-assault. Patients who seek help at the centre are guided by a trained (forensic) nurse. Only patients who intend to report to the police go through a forensic-medical examination for evidence collection. Emergency medical care is being provided, such as emergency contraception and treatment for sexually transmitted diseases (STDs). One day after the visit, a case-manager is appointed to the patient. The case-manager is a mental health professional who is responsible for the provision of psychological care according to the 'watchful waiting protocol' in the first month following assault. After this period of time, if necessary, evidence-based treatment for PTSD is provided such as cognitive behaviour therapy (CBT) or eye movement desensitisation reprocessing (EMDR) therapy.

In the period between January 2012 and December 2017, a total of 428 victims made use of the services of the sexual assault centre within one week post-assault. Most victims were female (N = 394). Information about sex was missing from nine victims. Because of the small group of men (N = 25), the decision was made to only include the female victims who used the services of the sexual assault centre within one week post-assault in this study. There were no other exclusion criteria. Eventually, due to missing data on revictimization, the study consisted of 295 females. The mean age of this group is 21.4 years (*SD* = 9.0). All participants older than 16 years and the parents/caregivers of children younger than 16 years gave informed consent and all information was anonymised.

Measurements

For the present study, the database from the sexual assault centre was used. This database was created for research purposes and improving caregiving. Information from the patient's (mental) health record generated by self-report at the time of admission in the sexual assault centre was encoded into this database. Information about patient characteristics, including age, gender and highest level of education (high/middle/low) was used. Low level of education included no education, primary school and special education. Middle level of education included VMBO and MBO. HAVO, VWO, HBO and WO were meant by a high level of education. Furthermore, data about whether the parents are divorced (yes/no), whether the victims reported the assault to the police (yes/no) and whether the victims have mental health issues were used. In this study, a diagnosis of an anxiety disorder, personality disorder, mood disorder, psychotic disorder, PTSD, substance abuse disorder and eating disorder were defined as mental health issues. Whether or not there was a present diagnosis of one of these mental health issues was based on information given by the victim. Data about sexual revictimization were based on information about the victims history of sexual assault. There was only information available about whether the victim experienced sexual assault in the past (sexual revictimization) or whether the victim did not (no sexual revictimization). No further specific information was gathered about the previous experienced sexual assault event(s). Because all age categories are included, there will be corrected for age to prevent biased results, because there is a

greater chance that someone who is older experienced sexual revictimization.

Data-analysis

The present study analysed which factors are related to sexual revictimization by using *Pearson* correlation and logistic regression analysis. The presence of mental health issues, whether the victim reported to the police, whether the parents are divorced and level of education were used as independent variables. Sexual revictimization was used as a dependent variable. The assumptions for regression analysis were checked.

A *Pearson* correlation was implemented to see if there is a correlation between sexual revictimization and mental health issues, report to the police, divorced parents and level of education. The independent variables that do not have a significant correlation ($p < 0.05$) with sexual revictimization, will not be included in multivariate analysis.

Ultimately, to make a statement about which factors are related to sexual revictimization, a logistic regression analysis was used, with 'age' as a covariate to correct for the potential influence of age. The overall fit of the model will be assessed using Nagelkerke *R*-square.

All statistical analyses were conducted using SPSS version 21.0.

Results

Descriptives

Of the 295 included female victims who experienced sexual assault, 130 females (44.1%) experienced revictimization, with a mean age of 23.4 years (*SD* = 8.7). The 165 non-revictimized females (55.9%) had an average age of 19.9 years (*SD* = 9.0). Information about mental health issues, report to the police, divorced parents and level of education from both revictimized and non-revictimized females are, as far as known because of missing data, presented in Table 1.

Table 1
Descriptives of revictimized and non-revictimized females (N = 295).

	N	Revictimized	Non-revictimized
Mental health issues	79		
Yes	33 (41.8 %)	25 (65.8 %)	8 (19.5 %)
No	46 (58.2 %)	13 (34.2 %)	33 (80.5 %)
Report to the police	270		
Yes	117 (43.3 %)	47 (39.5 %)	70 (46.4 %)
No	153 56.7 %)	72 (60.5 %)	81 (53.6 %)
Parents divorced	115		
Yes	59 (51.3 %)	22 (59.5 %)	37 (47.4 %)
No	56 (48.7 %)	15 (40.5 %)	41 (52.6 %)
Level of education	197		
Low	39 (19.8 %)	13 (17.8 %)	26 (21.0 %)
Middle	80 (40.6 %)	33 (45.2 %)	47 (37.9 %)
High	78 (39.6 %)	27 (37.0 %)	51 (41.1 %)

Analysis

All the assumptions met the criteria of regression analysis, except the assumption of linearity. The normal distribution of the variable age is skewed, with a peak on age 16. However, the variable age is used as a covariate instead of a predictor in the analysis, so it was decided to include the variable.

Table 2 shows the *Pearson* correlations between revictimization, mental health issues, report to the police, divorced parents and level of education.

Table 2
The correlations between revictimization (R), mental health issues (MHI), report to the police (P), divorced parents (D) and level of education (E) (N = 295).

	R	MHI	P	D	E
Revictimization	1				
Mental health issues	.50*	1			
Report to the police	-.07	-.14	1		
Divorced parents	-.11	-.15	.08	1	
Level of education	-.01	.31*	-.19**	.17	1

Note. * $p < .05$ (two-tailed). ** $p < .01$ (two-tailed)

As shown in Table 2, revictimization has a significant relationship with mental health issues. Because of the decision to only include the significant variables in the logistic regression analysis, the total sample size for the logistic regression analysis consisted of n = 78. There was one missing variable on age.

Of the 78 female victims who experienced sexual assault, 37 females (47.4%) experienced revictimization (mean age of 22.1 years, *SD* = 8.7). The 41 non-revictimized females (52.6%) had an average age of 17.7 years (*SD* = 7.0). Information about mental health issues, report to the police, divorced parents and level of education from both revictimized and non-revictimized females are, as far as known because of missing data, presented in Table 3.

Table 3
Descriptives of revictimized and non-revictimized females of which information about mental health issues is known (N = 78).

	N	Revictimized	Non-revictimized
Mental health issues	78		
Yes	32 (41.0 %)	24 (64.9 %)	8 (19.5 %)
No	46 (59.0 %)	13 (35.1 %)	33 (80.5 %)
Report to the police	64		
Yes	32 (50.0 %)	12 (38.7 %)	20 (60.6 %)
No	32 (50.0 %)	19 (61.3 %)	13 (39.4 %)
Parents divorced	42		
Yes	17 (40.5 %)	7 (46.7 %)	10 (37.0 %)
No	25 (59.5 %)	8 (53.3 %)	17 (63.0 %)
Level of education	45		
Low	11 (24.4 %)	2 (11.8 %)	9 (32.1 %)
Middle	13 (28.9 %)	7 (41.2 %)	6 (21.4 %)
High	21 (46.7 %)	8 (47.1 %)	13 (46.4 %)

The logistic regression analysis (Table 4) in which the relationship between revictimization and mental health issues was adjusted for age, shows a significant model fit from step 1 ($\chi^2 = 5.68$, $df = 1$, $p = .02$). The model fit from step 2 is significant as well ($\chi^2 = 17.21$, $df = 2$, $p < .001$).

Table 4
Logistic regression of revictimization, with age as a covariate (N = 78).

		R^2	*B*	*S.E.*	*OR* (95% CI)
Step 1		.09			
	Constant		-1.46*	0.66	
	Age		0.07*	0.03	
Step 2		.26			
	Constant		-1.06	0.67	
	Age		0.01	0.04	
	Mental health issues		1.96**	0.61	7.09 (2.14, 23.50)

Note. Table shows Nagelkerke R^2.
* $p < .05$ (two-tailed). ** $p < .01$ (two-tailed)

Discussion

The current study investigated whether the factors mental health issues, report to the police, divorced parents and level of education are related to sexual revictimization. A comparison was made between two groups: female victims of sexual assault who experienced revictimization and female victims of sexual assault who did not. It was expected that revictimized girls and women more often suffer from mental health issues, less often report to the police, more often have divorced parents and more often have a lower level of education than non-revictimized girls and women. The most important finding of this study is that revictimized girls and women more often suffer from mental health issues than non-revictimized girls and women.

In accordance to the expectation and prior research (Classen et al., 2005; Cloitre et al., 1997; Golda et al., 1999; Hanson, 2016; Wonderlich et al., 2001), the results indicate that revictimized girls and women more often suffer from mental health issues than non-revictimized girls and women. However, given the fact that this is a cross-sectional study, no conclusions can be drawn about whether mental health issues are a risk factor for revictimization or a consequence of revictimization, or both.

In contrast to what was expected, the results did not show that revictimized girls and women less often report to the police than non-revictimized girls and women. It was suggested that high rates of shame and self-blame in revictimization might be immense thresholds for victims to report to the police (Zijlstra et al., 2017). However, information from the current study was gathered in a sexual assault centre where multidisciplinary help is offered. It is possible that girls and women who disclose in a sexual assault centre are well informed and guided, what could make it more accessible to report the assault to the police.

Additionally, the results did not support the expectation that revictimized girls and women more often have divorced parents than non-revictimized girls and women. Family characteristics have been associated with revictimization, such as family conflicts, including parental conflict (Classen et al., 2005) and living in disorganized family systems with high marital dysfunction (Grauerholz, 2000). However, these studies focused on early family experiences, but the current study had no available information about when the parents got divorced. It might be possible that early family experiences are associated with revictimization and that due to missing information, the current study did not support this expectation.

Furthermore, the results did not show that revictimized girls and women have a lower level of education than non-revictimized girls and women. Studies suggest that socioeconomic status and intellectual disability make individuals more vulnerable for revictimization (Classen et al., 2005; Grauerholz, 2000; Zijlstra et al., 2017). However, Wilson, Calhoun and Bernat (1999, in Classen et al., 2005) observed that women who were revictimized took longer to recognize risk, what suggests that revictimized women may be at greater risk of victimization because of difficulties in assessing when a situation is dangerous. It might be possible that not necessarily only intellectual disability contributes to this vulnerability, but other cognitive processes as well. Future research should further investigate the role of intellectual disability and other cognitive processes in revictimization. Moreover, the current study included highest level of education and not socioeconomic status or information about intellectual disability, because limited data about these factors were available. This may have influenced the results.

Several limitations of the study should be acknowledged. First, there were a lot of missing data, causing that the analysis was conducted on a small subgroup. However, this small subgroup is representative, which rules out selection bias. Second, all the information was gathered by self-report. This may have influenced the reliability of the information especially for mental health issues, considering that unrecognized or undiagnosed mental health issues were not included. Third, no information was available about when the previous sexual assault event(s) took place when revictimized. The only available information included was information about the event for which the victims sought help at the sexual assault centre. This makes it hard to draw certain conclusions about the revictimization, for example how much time past between the events and whether it was an event with a different or the same known perpetrator(s) or stranger rape. Future research should include this information. Additionally, in mental health issues, no information was available about the specific diagnosis and when the diagnosis was made and by whom. Future research should also include this information. In reporting to the police, no information was available about whether the report became an official report or not, which may have influenced the results. Lastly, information about whether the parents were divorced or not did not include information about when they got divorced (e.g. before or after the sexual assault event and early or later in life) and how the victim experiences this divorce (e.g. how they describe their family structure and if they experience the divorce as disturbing). Future

research should take these limitations and suggestions into account. When more information is gathered about these factors, further conclusions can be made. For example, if the information about mental health issues is gathered by a structured diagnostic interview instead of self-report, the information is more reliable and all present mental health issues will be recognized. Additionally, suggestions can be made about which mental health issues cause more vulnerability for sexual revictimization. Furthermore, future research should not only focus on sexual revictimization in girls and women, but also in boys and men. Longitudinal research is recommended to sort out the risk factors for sexual revictimization from the consequences of sexual revictimization.

Despite its limitations, current study provides relevant information for clinicians working with victims of sexual assault. It emphasizes the importance of providing the right help after sexual assault and the importance of providing special attention and treatment for mental health issues in revictimized girls and women. When girls and women experience sexual assault, they are at elevated risk for experiencing repeated sexual assault by either the same of different perpetrators (Macy, 2008). Current study shows that revictimized girls and women more often suffer from mental health issues, which shows the importance of research identifying short-term and cost-effective post-rape mental health interventions for these girls and women. Tarquinio, Brennstuhl, Reichenbach, Rydberg and Tarquinio (2012) aimed to evaluate the effectiveness of EMDR therapy sessions for rape victims within hours after the incident. The results indicated a reduction in posttraumatic stress and sexual problems that remained stable at 4 weeks and 6 months after the sessions. A study in a Dutch sexual assault centre is currently conducting a randomised controlled trial investigating whether two sessions of EMDR treatment between two to four weeks post-assault is effective in reducing posttraumatic stress. The necessity of post-assault treatment highlights the importance of the existence of sexual assault centres, a safe place that provides multidisciplinary help and guidance for victims after experiencing sexual assault. More awareness for these centres is needed, because it is evident that receiving the right help and treatment after experiencing sexual assault is essential when it comes to preventing revictimization and mental health issues.

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