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Prevalence and Risk Factors of Sexual Revictimization in Adult Sexual Assault Victims

Master Thesis

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This thesis, including the scientific article, has been written collaboratively. However, the character count has been equally divided. Sections marked with "(SD)" in the heading were written by Sidsel Drejer, those marked with "(SØ)" by Sofie Ølgod, and sections marked with "(C)" are joint contributions.

Abstract

Sexual assault affects millions globally and can have severe consequences for mental and physical health. While repeated victimization is known to worsen trauma outcomes, research on revictimization following an initial assault in adulthood remains limited. Existing findings on the prevalence of revictimization are mixed. Estimates of prevalences range from 11.3% to 69% and are dependent on e.g., sample composition as well as sexual assault definitions. This thesis sought to answer the research question on, "*what is the prevalence and risk factors of revictimization among adult sexual assault survivors?".* Specifically, the objective of this thesis was to conduct a cross-sectional analysis of the registered data (2018-2024) from the Center of Sexual Assault (CSO) at the main hospital in Copenhagen. Participants consisted of all patients in the defined period who had experienced their first sexual assault after the age of 15 (N = 4161). An analysis of demographic factors revealed that the sample consisted of predominantly female, ethnically Danish, young adult victims.

A prevalence rate of 34% was found in the sample, meaning that more than one third of the patients at CSO experience more than one sexual victimization during adulthood. Several differences among the groups indicated relevant risk factors including psychological vulnerability, specific psychiatric disorders and substance abuse, as well as the relation to the perpetrator. Despite previous findings, we did not find significant differences in degree of violence or whether or not resistance was practiced. Different demographic characteristics differed significantly between groups which suggest that certain societal groups may face elevated vulnerabilities, an insight that, through an ecological lens, point to the potential impact of structural and socioeconomic inequalities on victimization risk.

Despite limitations, this study contributes to the literature by highlighting clinical and demographic risk profiles that may otherwise be overlooked. It also calls for greater clinical awareness of revictimization as a recurrent and structurally embedded problem.

1. Introduction (C)

Sexual assault is a widespread global issue with profound consequences for the victim's physical and mental health (World Health Organization, 2013). It is estimated by the World Health Organization that 7.2% of women globally have been subjected to at least one sexual assault by a non-partner throughout their lifetime, and in high-income countries in Europe the figure rises to 12.6%. The high incidence of sexual assault poses a threat to public health in more ways than one, as the consequences range from elevated rates of depression and PTSD to increased risk of HIV and unwanted pregnancy (World Health Organization, 2013). Numerous studies have demonstrated that being sexually assaulted repeatedly exacerbates the psychological consequences of the initial trauma and is associated with significantly increased rates of lifetime PTSD (Arata, 2002; Cividanes et al., 2019; Macy, 2008). These findings underscore the urgent need to better understand the mechanisms that increase vulnerability to repeated assaults in order to improve prevention and intervention strategies. A way of achieving this is to assess and interpret differences between single-incidents (non-revictimized) and revictimized individuals as potential risk factors for revictimization. Sexual assault is generally defined heterogeneously in the literature, with definitions ranging from unwanted sexual contact to completed rape (Anderson et al., 2020; Walsh et al., 2023). Most commonly, revictimization is defined as at least one subsequent sexual victimization, regardless of its type (e.g., rape in the initial incident and sexual coercion in the second incident; Fisher et al., 2010).

Research on sexual revictimization has previously been dominated by studies on child sexual abuse and subsequent sexual assault in adulthood (Walker et al., 2019). Since childhood is a particularly sensitive period when it comes to emotional, relational and sexual development, there is reason to believe that sexual revictimization of adults whose initial sexual victimization happened in adulthood, is a distinct phenomenon (Humphrey & White, 2000). Adolescents and adults whose first experiences of sexual assault occur later in life also appear to face a heightened risk of repeated victimization (Angelone et al., 2018; Cusack et al., 2021; Edwards & Banyard, 2022; Humphrey & White, 2000). Despite this, research on revictimization among individuals whose first assault occurred in adolescence or adulthood remains relatively scarce and methodologically heterogeneous, leaving important questions unanswered about risk patterns and relevant factors in this population (Macy, 2008).

1.1 Aim (C)

This thesis aims to investigate the prevalence of revictimization as well as risk factors that may distinguish revictimized individuals from non-revictimized ones. Specifically, the following research question has been sought answered: *What is the prevalence and risk factors of revictimization among adult sexual assault survivors?*

This aim is pursued by reviewing existing literature on different prevalence rates and prominent risk factors. This empirical foundation is relevant in guiding our cross-sectional study on patients at the Center of Sexual Assault (CSO), a Danish hospital ward for both acute and late referrals of victims of sexual assault. To contribute to the literature on revictimization among adult victims of sexual assault, recorded characteristics of patients above the age of 15 will be used to investigate selected risk factors associated with revictimization with the purpose of guiding future prevention strategies.

1.2 Content (C)

This master thesis consists of 2 parts. The first part contains an in-depth extension on the work presented in the subsequent article. The extension provides a more comprehensive review of existing findings in the literature as well as a presentation of the study design and method and the considerations regarding it. Furthermore, it includes a discussion of the results, a methodological discussion and relevant perspectives on our research. The research article follows the extension. It presents a cross-sectional study, with data from CSO, of revictimization and certain risk factors that distinguish revictimized patients from non-revictimized patients. The article has been prepared for submission to the peer-reviewed journal "*Journal of Interpersonal Violence"* and follows the format guidelines issued by the American Psychological Association, as well as the submission guidelines issued by the journal.

1.3 Literature Selection Procedure (C)

First, exploratory searches of studies investigating prevalence and risk factors associated with revictimization were performed. The most notable aspect about the studies identified was that specifically focused on revictimization and not single sexual assaults.

Studies were selected based on systematic search in the databases PsychInfo and Pubmed. Following string was used in PsychInfo: ("sexual revictimization" OR "Repeated

sexual assault" OR "subsequent sexual assault") NOT (child abuse or child neglect or child maltreatment or children abuse or abused children). It resulted in 95 hits out of which 14 were included as references in present study.

Furthermore, following string were used in PubMed: (("sexual abuse"[All Fields]) OR ("sexual assault"[All Fields]) OR ("rape"[All Fields])) AND ("revictimization"[All Fields]) AND (("prevalence"[All Fields]) OR ("risk factor"[All Fields])) NOT ("childhood"[All Fields]) NOT ("child sexual abuse"[All Fields]). The string resulted in 41 articles of which 13 were included.

Articles were excluded if they mainly focused on revictimization as a result of Child sexual abuse. Others were excluded because their samples were too specific for comparison (e.g., veterans exposed to military sexual violence). Moreover, all included articles were published in recognized academic journals. Although it was intended at first, studies were not immediately excluded on the basis of being too old. This was due to limited research on both revictimization and some specific risk factors, such as victim-perpetrator relationships. Additionally, several relevant articles were also found through reference scanning in the searched literature. All relevant literature will be reviewed in the following sections.

2. Review of the Literature on Revictimization (C)

To contextualize the present study, an overview of the existing research literature is first presented. In this initial part of the literature review, the prevalence of revictimization will be unfolded. Based on empirical research, an argument will be made for the separation of child and adult sexual abuse when examining revictimization as a phenomenon. Next, the existing research on revictimization in adults and adolescents will be outlined, and the content of this review will be presented in Table 1. Finally, the study will explore how the length of time since one's last assault potentially affects the risk of being exposed to a new assault.

2.1 Child Sexual Abuse (CSA) and Revictimization in Adolescence (SD)

There is a particular robust body of evidence that supports that individuals with a history of child sexual abuse (CSA) are at a significantly higher risk of being sexually revictimized later in life (Arata, 2002; Classen et al., 2005). A comprehensive meta-analysis by Walker et al. (2019) calculated an average prevalence rate of sexual revictimization among individuals with a history of CSA. They included 80 studies covering a total of 12.252

people who had been exposed to CSA and found an average prevalence of sexual revictimization of 47.9%, meaning that almost half of people with a history of CSA experience sexual victimization again later in life. Several other studies have examined revictimization rates among survivors of CSA and have found revictimization rates of 67% (Classen et al., 2005) and 33% (Arata, 2002). Arata (2002) highlighted that CSA involving physical contact (e.g., penetration or genital touching) and sexual victimization during adolescence were particularly strong predictors of later revictimization (Arata, 2002).

Although there is much evidence on CSA as a prominent risk factor, several authors point to the fact that a person is especially vulnerable towards revictimization if the first sexual assault happens in adolescence instead (Angelone et al, 2018; Arata, 2002; Classen et al, 2005; Humphrey & White, 2000). Humphrey and White (2000) examined how vulnerability towards sexual victimization develops from childhood and until young adulthood. Specifically, they examined how CSA affects the risk of revictimization in adolescence and how sexual assault in adolescence also increases the probability of revictimization in college. They performed a longitudinal examination on N = 1569 women at college in two cohorts with a baseline measurement at 1.st semester and follow-up measurepoints each year for four years. They divided revictimization in 3 different categories; 1. CSA (before the age 14), 2. Adolescent victimization (14-18 yrs.), and 3. Victimization in college (18-22 yrs.). They found that 49,5% of the sample experienced sexual victimization in adolescence and that the risk of first-time assault peaked at the age of 14-18. Additionally, they found that women who had experienced sexual assaults in adolescence had a 4,6 times increased risk of revictimization later in college. CSA did also increase the risk of sexual victimization in adolescence, but did not directly affect the risk in college unless there had also been revictimization in adolescence (Humphrey & White, 2000). This then makes sexual victimization in adolescence an even bigger predictor of revictimization than CSA. Similarly, Angelone et al. (2018) argued that sexual assault (SA) occurs more frequently among young people, especially those who are younger than 25. They did a cross-sectional study of 656 female college students and found that there was a 4 times higher risk of sexual revictimization for those who had experienced SA between the ages of 14-17.

To summarize, while there is extensive evidence for the association between early sexual abuse and later revictimization, several recent studies have also suggested that adolescents and adults whose first abuse occurs in adolescence or adulthood are at significant risk of revictimization (Angelone et al., 2018; Cusack et al., 2021; Edwards & Banyard,

2022; Humphrey & White, 2000). However, because research in this group is less systematic and more methodologically varied it is essential to explore this field further (Macy, 2008).

2.2 The Prevalence of Revictimization Among Adults (SØ)

Sexual victimization has shown to be one of the strongest predictors of subsequent sexual assault across different contexts. The following section provides an overview of different revictimization rates found in the literature. The evidence varies in several areas, but will be reviewed based on the largest groupings, adolescents and young adults, college samples and longitudinal studies. An overview of the following papers is presented in Table 1.

Focusing on adolescent and young adults, Walsh et al. (2023) conducted phone interviews with 233 female rape victims who came to the emergency room following a rape between 2009 and 2023. They found that 21,7% of the victims experienced either sexual or physical revictimization within six months of the initial assault. In a broader sample which also included adult women, Walsh et al. (2014) reported a revictimization rate of 50%, highlighting that around one in two women, who had experienced a rape, later reported additional assaults. They collected data from a sample consisting of 1763 teenagers between 12 and 17 years old, 2000 university students and 3001 adult women in households. Data were obtained via telephone interviews using a set of questionnaires.

Among college students findings are even more varied. As described by Humphrey and White (2000) college is a particularly high risk setting for sexual victimization, and former sexual assault in adolescence is a high risk factor for additional assault in college (Angelone et al., 2018; Humphrey & White, 2000). In a large sample, Cusack et al. (2021) have investigated the prevalence and risk of revictimization among college students in the United States. They based their study on data from the “Spit for Science” project with 9889 participants out of whom 3294 had experienced at least one sexual victimization before or during college. They found that 39,5% of the students experienced at least one sexual revictimization during college. Sexual revictimization was defined as anything in between unwanted sexual contact to rape. They found that the earlier the first sexual victimization occurred in adolescence, the greater the risk of revictimization (Cusack et al., 2021). Katz et al. (2010) also studied the risk of revictimization in a smaller college-sample, under the assumption that it would be particularly high within this group. They tested four hypotheses, including that women who had experienced sexual victimization before or early in college

would be at higher risk of revictimization later in their first year. They followed 93 female freshmen at college and used questionnaires to measure sexual victimization, which they likewise defined as anything between unwanted sexual contact and rape. They did however estimate individual prevalences for each type of sexual victimization. They measured their sample twice, 6 months apart, and found that 31% of the ones who had experienced an initial sexual victimization already reported revictimization at the second measurement. Specifically of the 31%, 56% reported unwanted sexual contact, 44% sexual coercion, 19% attempted rape and 26% completed rape. In spite of a relatively small sample, they found evidence in support of the trend in previous research showing that women with a history of sexual victimization are at increased risk of revictimization (Katz et al., 2010).

Longitudinal studies consistently find high rates of revictimization. For instance Relyea and Ullman (2017) followed 1.012 women from Chicago who had previously experiences sexual abuse in adulthood. They were asked to complete a series of questionnaires at 3 measurement points over the course of 3 years. Similar to Katz et al. (2010) they also distinguished between different types of sexual revictimization: 1. unwanted sexual contact, 2. sexual coercion, 3. drug-related assault, and 4. violent assault. Of the 1012 women 49% experienced at least one form of sexual revictimization over three years. The most common forms were unwanted sexual contact (43%) and sexual coercion (38%), while violent assault (25%) and drug-related assault (21%) were less common. Similarly Ullman and Najdowski (2009) have also done a longitudinal study where they followed 555 women across a year. The women were asked to complete questionnaires 2 times 1 year apart and were collected via postal responses in an American context. They found a revictimization rate of 45%, although they did not specify which types of sexual revictimization that occurs more frequently. Livingston et al. (2007) similarly did a longitudinal examination on sexual revictimization. They followed 1014 women between 18 ans 30 years living in the US for 2 years with 3 measurement points 12 months apart. They measured sexual victimization as unwanted sexual experiences including physical coercion, incapacitation and sexual coercion. Similar to the above-mentioned papers, they found a revictimization rate of 50,3%.

While variations in revictimization rates across studies may be attributed to differences in sample demographics, definitions and measurement methods, the overall evidence points to a substantial risk of recurrent victimization among victims. This section provided a review of key findings in the revictimization field, but aforementioned and additional research will be outlined in Table 1. Although many of the studies have been used

to account for prevalence rates, several of them also address risk factors. These will among others be elaborated in upcoming sections.

Table 1

Characteristics of Included Studies Assessing Sexual Revictimization

Authors	Definition of revictimization	Sample	Measurement tool(s)	Study design	Prevalence of Revictimization
Anderson et al. (2020)	Any type of sexual violence ranging from unwanted sexual touching to unwanted penetration.	College students	Survey	Longitudinal	53%
Angelone et al. (2018)	Any unwanted sexual experience	College students	Survey	Longitudinal	11%
Christ et al. (2022)	Any unwanted sexual touch against one's will	Adults with depression	Interview and surveys	Cross-sectional	48.4%
Conley et al. (2017)	Rape, attempted rape, or forced sexual act via threat or harm	College students	Survey	Cross-sectional	39.7%
Cusack et al. (2021)	4 categories (from unwanted sexual contact to rape)	College students	Survey	Longitudinal	39.5%
Edwards & Banyard (2022)	Unwanted sexual contact to violent sexual assault	Adolescents (7^{th} – 10^{th} grade)	Survey	Cross-sectional (school sample)	24.2%
Fisher et al. (2010)	Forcible or incapacitated rape	College students	Telephone interview	Cross-sectional	40.8%
Humphrey & White (2000)	Unwanted sexual contact, sexual coercion, attempted rape and rape	College students	Survey	Longitudinal	69%
Katz et al. (2010)	Broad SA (ranging from unwanted sexual contact to rape)	College students	Survey	Cross-sectional	31%
Kearns & Calhoun (2010)	Unwanted sexual contact, coercion, rape	College students	Survey	Cross-sectional	11.3%
Littleton & Ullman (2013)	Unwanted sexual experiences	Adult women (M = 34 yrs)	Survey	Cross-sectional	23.3%[a] and 14.55%[b]
Livingston et al. (2007)	Broad SA (ranging from unwanted sexual contact to rape)	Adult women	Interview and Survey	Longitudinal	50.3%

Messman-Moore et al. (2013)	Unwanted sexual incidents (kiss, orally or vaginally)	College women	Weekly surveys	Prospective design	20.7%
Neilson et al. (2019)	Unwanted sexual contact, rape, coersion	College women	Survey	Cross-sectional	14%
Norris et al. (2018)	Attempted and/or completed sexual assault by the use of force, threats, or incapacitation	College women	Survey	Longitudinal	54%
Ullman (2016)	Rape, rape attempt, sexual coercion and unwanted sexual contact	Adult women	Surveys and scales	Longitudinal	36.4% and 31.9%
Relyea & Ullman (2017)	Sexual contact, sexual coercion, attempted or completed forcible assault, and attempted or completed substance-involved sexual assault	Adult women	Survey	Longitudinal	49%
Ullman & Najdowski (2007)	Does not specify	Adult women	Survey	Longitudinal	45%
Walsh et al. (2014)	Rape	Teens, college, household adult women	Structured telephone interviews	Cross-sectional (national samples)	50%
Walsh et al. (2023)	Rape	Women >15 years (ER, post-rape)	Medical examination at baseline and structured telephone interviews at follow-up.	Longitudinal	21.7%

[a] African American participants

[b] European American participants

2.3 Time Since Initial Sexual Victimization (SD)

Several studies using longitudinal designs with follow-ups within 1–2 years have found relatively high rates of revictimization. This has led researchers to explore whether ‘time since the initial assault’ may influence the risk of experiencing an additional one.

Classen et al. (2005) highlight how the risk of revictimization tends to be highest shortly after an assault which then declines over time. This has been interpreted as a reflection of acute psychological vulnerability, including trauma responses and the use of maladaptive coping strategies. Supporting this, Ullman (2016) found elevated revictimization rates within the first year after an initial assault. Similarly, Walsh et al. (2023) reported that over 20% of women who had recently been raped experienced a new sexual or physical assault within just six months. However, findings are not entirely consistent. For instance Walsh et al. (2014) found that adults with an average age of 46 had the highest revictimization rates compared to younger groups potentially due to having had more time to experience additional assaults. Relyea and Ullman (2017) also included a "time since most serious assault" variable but found it to be non-significant. They suggest that other factors such as maladaptive coping, symptom severity, and social support, may be more fitting predictors.

Given these mixed findings the present study considers it relevant to further investigate how time since the first assault relates to the risk of revictimization.

3. Review of the Literature on Risk Factors (C)

In this second part of the literature review, possible risk factors of revictimization will be unfolded. Much research has attempted to capture and clarify the mechanisms and factors that distinguish revictimized individuals from non-revictimized victims of sexual assault, however due to scattered focus, a plethora of risk pathways have been discussed. Inspired by Fisher et al. (2010) a meaningful way to understand a wide range of risk factors simultaneously is to categorize them as either demographic factors, psychological vulnerability factors, or assault characteristics.

3.1 Demographics (C)

Sexual revictimization does not occur uniformly across populations (Dworkin et al., 2021). Trauma history, especially in terms of former sexual victimization, is one out of several demographic characteristics that have been identified as potential risk factors that may influence vulnerability to recurrent sexual victimization. Demographic factors are often considered in risk analysis because they may influence individuals' exposure to risk environments, coping capacities and access to protective resources (Decker & Littleton,

2018; Loya, 2014). While the existing literature often highlights the central role of psychological and interpersonal factors, demographic variables such as gender, socioeconomic status (SES), age and ethnicity may also contribute to shaping the revictimization risk. Exploring these demographic variables is crucial for understanding possible vulnerable groups and may provide information on the representativeness as well as inform targeted prevention and intervention efforts.

Age (SD). As previously described, adolescence (ages 12–17) is a particularly high-risk period for sexual victimization, with most assaults occurring during this stage (Angelone et al., 2018; Arata, 2002; Classen et al., 2005; Humphrey & White, 2000). Victimization in adolescence significantly increases the risk of revictimization in young adulthood, especially during college, possibly due to factors such as increased social freedom, peer exposure, risk-taking, and limited experience with sexual boundaries (Angelone et al., 2018). Humphrey and White (2000) similarly found that first-time victimization peaks between ages 14 and 18, and that adolescent, rather than childhood, victimization best predicted revictimization in college.

Supporting this pattern, Conley et al. (2017) report that individuals aged 16–25 are at heightened risk of sexual victimization, with college students specifically identified as a particularly vulnerable subgroup. In line with these findings, Fisher et al. (2010) compared women aged 18–22 (traditional college age) with those aged 23 and older and also found that younger women had a significantly increased risk of sexual victimization. However, age did not differentiate between women who were victimized once and those who were revictimized, suggesting that once victimization has occurred age may play a less significant role in predicting future assaults. These findings support the notion that the traditional college-age period constitutes a particularly high-risk environment for sexual victimization, though not necessarily for revictimization, since prior victimization remains the strongest predictor of recurrence.

Other studies similarly, found no significant effect of age on risk for revictimization. For instance, Christ et al. (2022) did not identify age as a significant risk factor in their clinical sample of individuals with depression, and Littleton and Ullman (2013) similarly found no direct relationship between age and revictimization in their sample. Walsh et al. (2014), who compared three age groups, found similarly high revictimization rates across all groups, although adult women (mean age = 46) had the highest prevalence which the authors speculate may be due to previous assaults (e.g., in adolescence or college) followed by revictimization occurring later in life.

Overall, several researchers find age to be a statistically significant predictor of revictimization, with most of the literature suggesting that adolescence and young adulthood, particularly during college, represent high-risk periods. Still, the effect of age may be masked by methodological differences, limited age ranges, and other effects influencing these stages in life.

Gender (SD). There is no lack of evidence that women are largely overrepresented among victims of sexual assault (Angelone et al., 2018; Cusack et al., 2021; Walker et al., 2019). This means that there are also more women to experience revictimization than there are men. However, many studies also focus mainly on women (Classen et al. 2005; Fisher et al., 20010; Humphrey & White, 2000), and some do not specify their gender breakdown (Classen et al., 2005; Conley et al., 2017).

Explicated Walker et al.'s (2019) meta-analysis, women are more exposed to sexual victimization. However, when it comes to revictimization, once you have experienced an initial sexual victimization gender is no longer a significant risk factor (Cusack et al, 2019; Walker et al., 2019). Conversely Edwards and Banyard (2020) did find gender differences in revictimization in a younger sample. And similarly, Conley et al. (2017) also found a higher revictimization rate among college-women (40,6%) compared to college-men (33,5%). While this may be because there is a clear difference in who is subjected to abuse, it may also be exacerbated by a difference in reporting and disclosure of experiences between men and women (Jeffrey & Senn, 2024). Jeffrey and Senn (2024) investigated how women and men report sexual assault, and they found that women reported it more frequently than men. It was argued that it may be because men are less likely to report or seek help after a sexual assault. Thus, there is reason to believe that there are unreported figures regarding male sexual assault.

Although women are more frequently victims of sexual assault, and thus overrepresented in revictimization statistics, several studies suggest that once victimization has occurred the risk of revictimization is less dependent on gender. Hence, researchers should not limit their examinations of revictimizations to women only.

Socioeconomic Status (SØ). To explore the potential influence of socioeconomic status on victimization, Walsh et al. (2023) investigated how yearly income and employment status was distributed in a sample of sexually assaulted women. Income emerged as a

significant predictor of revictimization, and the results indicated that victims earning more than 10.000 dollars yearly had a lower risk of revictimization than those earning below 10.000 dollars. Surprisingly, Walsh et al. (2023) found income to be the only variable other than previous victimizations that could predict new victimizations. These findings were understood as an indication that financial assets can make a difference for both avoidance and recovery from sexual victimizations (Loya, 2014). Being financially stable can make it possible to take time off work without risking unemployment, as well as help you get immediate and specialized psychological support. The psychological and cognitive impairments that many victims face after an initial assault can be difficult to handle on top of the stress that usually comes with low socioeconomic status (e.g., fear of unemployment and being evicted from a current residence). These complications to the mental recovery of sexual assault victims can arguably make them more vulnerable to new victimizations (Loya, 2014). Walsh et al. (2023) additionally argued that victims without financial independence could also be less likely to leave or seek help if they were assaulted by a significant other.

During their research, Relyea and Ullman (2017) have also argued that the interaction between socioeconomic status and risk of revictimization was important to uncover. However, contrary to their hypothesis, income failed to predict revictimization. They explained that the missing correlation was due to an inclusion of a measure of the participants' history of dangerous contexts (such as experiencing neighborhood or community violence). This variable was predictive of revictimization while also correlating strongly with income. It was hypothesized that individuals with less financial resources have fewer options when it comes to housing. This potentially means that they are more likely to end up living in areas with higher crime rates, which could increase the exposure to possible perpetrators (Loya, 2014; Walsh, 2023).

The distress from lacking financial resources can in some instances also push people into risky professions such as prostitution or drug dealing. Under such circumstances, it can be more difficult to seek help after experiencing initial victimization, as one may be financially dependent on the perpetrator or fear judgement or legal repercussions related to their work (Loya, 2014; Relyea & Ullman, 2017). Supporting this theory, Relyea and Ullman (2017) identified that participating in transactional sex was a risk factor for experiencing new

forcible sexual assaults. Furthermore, having many sexual partners could also predict revictimization which again puts sexworkers at risk.

Ethnicity (SØ). Another demographic variable that could be tied to revictimization is ethnicity. When researching the risk of sexual assault in a sample of college students, Caamano-Isorna et al. (2021) found in a multivariate model, that the participants' ethnicities were associated with whether they experienced sexual assault or not. African American women were twice as likely to be victims of sexual assault as students with other ethnicities. Although the socio-demographic variables in Caamano-Isorna et al.'s (2021) study were neither elaborated further or used to assess risk of revictimization, the effect it had on sexual victimization generates curiosity for ethnicity when investigating revictimization.

Fortunately, some researchers have reported on and discussed the effects of ethnicity when investigating revictimization. In their investigation of 1012 women with previous experiences of sexual assault, Relyea and Ullman (2017) zoomed in on the differences between European American women and African American women. Overall European American women were victimized at a lower rate than African American women (39% vs 55%). This statistical relationship was significant across different types of victimization. With a similar research design Littleton and Ullman (2013) examined how ethnicity interacts with different types of sexual assault. They focused specifically on "incapacitated" assaults, i.e. sexual assaults where the victim is unable to give consent because they are under the influence of alcohol or drugs, and new "forcible" assaults, where the new assault was characterized by threats of violence or physical force. They also found evidence which suggested that African American women were significantly more likely to experience a new forcible rape during their follow-up than European American women. There were however no ethnic differences when they looked at the frequency of new incapacitated rapes during follow-up, suggesting that ethnicity might only increase the risk of some types of sexual assault.

According to Relyea and Ullman (2017) the ethnic differences that were found in research on victimization risk could partially be caused by a general difference in socioeconomic status between the two demographic groups. Due to cultural and historical inequalities, low socioeconomic status is more common among minority groups, potentially putting them at greater risk. Medical and social aid might also be designed to accommodate the majority population, which can make it harder for ethnic minorities to access help after

being assaulted (Weist et al., 2014). They might face barriers when seeking help, such as linguistic difficulties or discrimination, which can hinder their recovery process (Littleton & Ullman, 2017; Relyea & Ullman, 2017).

In summary, a review of the existing research literature on demographic characteristics has indicated that young women are at higher risk of sexual assault (Angelone et al., 2018; Cusack et al., 2021; Walker et al., 2019). However, several studies indicate that after experiencing one sexual assault, age and gender no longer influence the risk of revictimization (Cusack et al., 2019; Fisher et al., 2010; Walker et al., 2019). Research has indicated that socioeconomic factors such as low income and partaking in risky professions, such as prostitution or drug-dealing, increase the risk of revictimization (Loya, 2014; Relyea & Ullman, 2017; Walsh et al., 2023). It is argued that few financial assets and employment instability can make it harder to avoid and recover from sexual assault (Walsh, 2023). Being part of an ethnic minority has also been shown to increase the risk of sexual victimizations because low socioeconomic status and barriers when seeking help after assaults can be more frequent in minority groups (Caamano-Isorna et al., 2021; Littleton & Ullman, 2013; Macy, 2008; Relyea & Ullman, 2017).

3.2 Psychological Vulnerability (C)

Psychiatric disorders and substance abuse are often investigated in extension or in interaction with each other (Cusack et al., 2021; Larsen, 2015). In particular, depression, PTSD, and alcohol abuse have frequently been identified as factors that can both result from sexual assault and increase the risk of subsequent revictimization (Angelone et al., 2018; Littleton & Ullman, 2013; Messman-Moore et al., 2013). In this study, both are treated as psychological vulnerability factors.

Mental Health Concerns (SD). Several studies have examined the role of mental health issues as a concern regarding the risk of being victimized and later revictimized (Christ et al., 2022; Cusack et al., 2021; Jouriles et al., 2017; Larsen, 2015; Policastro et al., 2016). Research has shown that people with mental illness are more likely to be homeless, have an addiction, or be involved in socially challenging environments which can increase their vulnerability to violence and abuse compared to people without mental illness (Policastro et al, 2015). ·

Although many studies have examined the link between mental disorders and revictimization, there are major differences in which disorders are investigated, making the association more complex to grasp. First of all, Cusack et al. (2021) investigated the connection between the prevalence of revictimization and mental health disorders such as traumatic stress, alcohol use disorder (AUD), depression and anxiety. Out of the total sample, consisting of 9889 college students, 3294 had experienced at least one sexual victimization before or during college. They found that participants with depressive symptoms were at an increased risk of experiencing revictimization more than once. Those with symptoms of trauma related distress (e.g., PTSD symptoms) were also at an increased risk of being revictimized by 2 or more times compared to the referencegroup, as well as those with AUD. However, symptoms of anxiety were not associated with a higher risk of being revictimized. Cusack et al.'s (2021) study then supports the hypothesis that mental disorders, specifically depression, traumatic stress and AUD, increase the risk of experiencing multiple sexual victimizations.

Other noticeable findings were made by Larsen (2014). She examined women's mental and somatic health before and after rape by analyzing data from the Centre of Sexual Assault in Copenhagen. She examined data from N = 2.501 women who had visited CSO between 2000 and 2010 and compared them to a controlgroup of 10.004 women without known sexual assault history. Larsen (2014) found that women who had experienced sexual assault had a much higher prevalence of psychiatric diagnosis both before and after the assault compared to the controlgroup. Specifically, 27% of the patients had a diagnosis 5 years before the assault compared to only 5% of the control group. Furthermore, 34% of them also had a psychiatric diagnosis after the sexual assault compared to 6% of the controlgroup. One of the most significant findings was that psychiatric disorders related to drug and alcohol misuse were 22.9 times more common pre-assault and 15.7 times more after assault compared to the controls. This may indicate that engaging in a high amount of substance abuse can increase the risk of being sexually assaulted. Anxiety- and stress related diagnoses like PTSD were also 6 times more normal both pre- and post-assault compared to the control group. According to Larsen (2014) most of the psychiatric disorders were present before the assault, which indicated a potential vulnerability factor. However, a consistently high prevalence of psychiatric disorders following assault was observed, further suggesting a cyclical relationship: pre-existing psychiatric diagnoses may increase the risk of sexual assault, while sexual assault may in turn exacerbate existing mental illness. In accordance

with Larsen's (2014) findings, several studies have focused more specifically on individual diagnoses which will be specified in the following.

***Depression* (SD).** The particular link between depression and revictimization has been investigated by several authors (Christ et al., 2022; Edwards & Banyard, 2022; Smith et al., 2022). Edwards and Banyard (2022) have examined how binge drinking, depression, suicidal ideation and demographic factors differ among nonvictims, single-assault victims and sexually revictimized victims. According to the authors, depression and suicidal ideation are related to an increased risk for sexual revictimization. Specifically, they argue that depression and suicidal ideation can result from sexual assault and may make an individual less likely to respond assertively in a subsequent assault situation due to feelings of worthlessness and powerlessness (Edwards & Barnyard, 2022). The authors investigated a sample of $N = 1706$ adolescents in 7th-10th grade. Participants completed surveys at the beginning of the semester and again 6 months later. Of the total sample, 125 of them reported having experienced sexual victimization once and 40 reported sexual revictimization. Among other findings, they found a larger prevalence of depression and suicidal ideation among revictimized students compared to single-victims and non-victims (Edwards & Banyard, 2022).

Nevertheless, Christ et al. (2022) have found that depression alone does not necessarily predict revictimization. They examined characteristics of the context, employment, disclosure rates and gender differences related to violent victimizations in $N = 153$ newly victimized depressive patients. They conducted a cross-sectional study and found that both depressive symptoms and employment status were significantly associated with revictimization when tested separately. However, the association between depression and revictimization disappeared in the multivariate model when they adjusted for other factors.

This may indicate that depression is more likely a consequence of the initial victimization than a cause, or that it exerts an indirect effect as a mediating factor. For example, depression may increase vulnerability through heightened alcohol consumption or, as suggested by Edwards and Banyard (2022), by reducing sexual refusal assertiveness, i.e., the ability to reject or resist sexual acts and advances.

***PTSD* (SD).** Several studies also agree that PTSD is a risk factor for revictimization (Conley et al., 2017; Jouriles et al., 2017; Ullman, 2016). Nevertheless, there is also a difference in whether it has been studied as a cause of revictimization, as a result of

revictimization, or whether the relationship might be reciprocal. Ullman (2016) used a structural equation model to examine data from a 3 wave panel with $N = 1012$ female survivors of sexual assault, to examine if repeated sexual victimization is related to greater PTSD and problem drinking. The women were between 18 and 70 years old ($M = 36$) and reported experiencing at least one sexual victimization since the age of 14. Not only did Ullman (2016) find that revictimization increased the PTSD rates, but also that PTSD mediated the connection between initial childhood sexual abuse and revictimization. She did however point out that there is a lack of evidence regarding the same connection for adults whose initial victimization also happened in adulthood.

Jouriles et al. (2017) have also examined whether trauma symptoms mediate the connection between teen dating violence and future dating violence. They followed a sample of 843 high school students who filled out surveys at yearly follow-ups through 5 years. They found that trauma symptoms did mediate the connection between teen dating violence and victimization through early adulthood (Jouriles et al., 2017). Conley et al. (2017) have similarly examined the prevalence of and connections between repeated sexual assault and mental health in participants pre-college and in college. Like Cusack et al. (2021) they also analyzed data from the "Spit for Science" project. $N = 7603$ students had completed a survey that informed about sexual assault pre-college, other traumas, personality, relationships and mental health. Approximately 20% of the sample reported having experienced sexual assault, and the rates were higher for women than for men. Among the most significant risk factors for women were PTSD-symptoms, high alcohol use, depression, and low social support. Similar risk factors were found in men except for depressive symptoms and high alcohol use (Conley et al., 2017).

Similar to the studies on depression, authors have also investigated PTSD as an indirect factor in revictimization. Relyea and Ullman (2017) investigated PTSD's influence on revictimization and specifically focused on the numbing symptoms. They found that it increases the risk, but that it is most likely mediated by other factors. Furthermore, they found that PTSD may contribute to a risk of revictimization through the aggravation of emotional regulation and increased dependence on harmful coping mechanisms. Relyea and Ullman (2017) argue that women with PTSD were more vulnerable towards sexual victimization because the symptoms weaken one's risk perception and resistance towards possible assault attempts. Additionally, Littleton and Ullman (2013) also found PTSD as a significant risk factor, but only indirectly through a change in risk perception Their results supported that PTSD symptomatology among sexually victimized individuals is prospectively associated

with the risk of both forcible and incapacitated rape. They also hypothesized that PTSD symptoms may affect risk recognition and responding. For example, numbing symptoms such as emotional disconnection have a strong effect on risk recognition whereas re-experience symptoms (e.g., flashbacks, intrusive nightmares), could have a stronger effect on effective risk response (Littleton & Ullman, 2013).

***The Stress Generation Model* (SD).** A possible explanatory model for the connection could be the *stress generation hypothesis* by Hammen (2006, In Smith et al, 2022). According to the hypothesis, individuals with depression and anxiety are at higher risk of revictimization because the mental health disorders can generate interpersonal stress in the form of internalized negative cognitions about self-worth and feelings of helplessness. This in turn may lead them into riskier situations, for example by using maladaptive coping-strategies such as substance abuse, which weakens their ability to protect themselves (Smith et al., 2022). In their study, Smith et al (2022) used the hypothesis to investigate whether adolescents with depression are at higher risk of experiencing peer victimization and thereby later victimization in relationships. They conducted a longitudinal study with three waves of measurement from the Quebec Youth Romantic Relationships Survey ($N = 4.923$) and found a significant association between peer victimization and revictimization in romantic relationships, mediated by internalized problems such as low self-esteem. The stress generation hypothesis should then be understood as a vicious circle, where one victimization may increase the psychological distress, which increases the risk of experiencing an additional victimization. This could be a possible explanation for why some diagnoses are significantly correlated with revictimization rates.

In sum, a considerable amount of research suggests that mental health concerns, particularly PTSD, depression, and substance use disorders, are associated with an increased risk of sexual revictimization. Despite inconsistencies in methods and measures across studies, the overall evidence points to both direct and indirect pathways through which psychological vulnerabilities may have an influence on one's risk perception, coping strategies, and assertive resistance, which thereby increases susceptibility towards subsequent sexual victimization.

Substance Abuse (SØ). The relationship between substance abuse and sexual assault is a frequent research focus (DeCou & Skewes, 2021; Gidycz et al., 2007; Messman-Moore et al., 2013; Norris et al., 2021; Park & Monaghan, 2022; Testa et al., 2007, 2010; Walsh et

al., 2014). Even so, the results point in various directions and a lack of common understanding therefore persists. In the presented research, alcohol is more often the focus of substance abuse research, while less attention has been paid to the use of non-prescription drugs (Littleton & Ullman, 2013). Alcohol consumption is typically measured as either how often participants drink (frequency), how often participants drink a lot (binge drinking), or how much participants drink when they drink the most (peak drinking, Angelone et al., 2018; Decou and Skewes, 2021). A characteristic of the research presented is that it is dominated by studies that have sampled American college students exclusively (DeCou & Skewes, 2021; Walsh et al., 2014). This is likely due to college being a context where both alcohol consumption and the occurrence of sexual assault are particularly high. There has also been a particular interest in preventing sexual assault on American college campuses, and alcohol has frequently been the target of interventions as it has been identified as a significant risk factor (DeCou & Skewes, 2021). Some studies have found that 50-70% of all sexual assaults committed in a college setting involve at least one person under the influence of alcohol (Anderson et al., 2020).

The previously mentioned study by Angelone et al. (2018) also included a measure of substance use in their investigation of sexual assault on college students. Among other surveys, the sample received a questionnaire that could uncover use of alcohol and non-prescription drugs. Frequency analysis revealed that revictimized women were the group of participants that were most likely to report any alcohol intake (76,1%) and drug use (45,1%) during the past 30 days before measurement. When comparing the groups' alcohol consumption by specific characteristics, Angelone et al. (2018) found that women who have been revictimized reported significantly higher alcohol consumption than the control group, who had never experienced abuse (Angelone et al., 2018). However, the revictimized women did not differ significantly from women who had only experienced a single assault. Similarly, the researchers found no significant difference in the frequency or maximum amount of alcohol consumed by women with one or more victimizations in one evening during the survey period. Nevertheless, when examining drug usage Angelone et al.'s (2018) research indicated that women who experience revictimization consume drugs significantly more often than women who only experience a single sexual assault.

Based on these results, it was first argued that alcohol consumption is associated with the experience of sexual assault (Angelone et al., 2018). But as the questionnaires were completed after the participants were victimized, it is difficult to determine the causality of Angelone et al.'s (2018) findings. The participants' alcohol consumption may have increased

their risk of being sexually assaulted but could also be a coping strategy for dealing with the consequences of being sexually assaulted (Angelone et al., 2018). In previous studies, victims of sexual assault have often reported using drugs and alcohol because it numbs the negative emotions they might feel and thus makes it easier for them to cope in the absence of more effective strategies (Angelone et al., 2018; Messman-Moore et al., 2013).

Although there appeared to be a connection between alcohol consumption and sexual assault, there was not sufficient evidence to suggest that alcohol use was differently associated with the experience of revictimization compared to a single victimization (Angelone et al., 2018). The authors presented several explanations for the absence of group differences. Among other things, they criticized their recruitment process, emphasizing that their participants were attending college, where people typically drink more alcohol than the general population. If the same hypotheses had been tested in a more representative sample, an effect could potentially have been found.

While Angelone et al. (2018) contemplated if their lack of significant correlations between alcohol and revictimization was due to their way of sampling, other researchers have found significant effects with a similar research design. Anderson et al. (2020) had 2292 college students fill out questionnaires about their experiences with sexual assault and substance abuse. Of these participants 931 had experienced sexual assault prior to enrollment, and during college 492 (53%) of these victims were revictimized. The results indicated that individuals who reported revictimization were more likely to also report binge drinking during the past 30 days compared to those who only reported victimization before college. Among participants who reported past 30-day binge drinking, the risk of also reporting revictimization was approximately twice as high as for those who did not binge drink. It is argued that the relationship between these constructs may be cyclical: experiencing sexual assault can increase the likelihood of binge drinking, and because alcohol is often consumed in contexts with heightened risk of assault, drinking may in turn elevate the risk of revictimization (Anderson et al., 2020; Littleton & Ullman, 2013; Testa et al., 2007).

DeCou and Skewes (2021) has likewise examined college students' alcohol consumption and its association with revictimization. Their approach was to treat alcohol intake as a variable that can moderate the correlation between adolescent sexual assault and revictimization in college. To conduct this study, they collected responses to a series of questionnaires from 201 college students. The questionnaires were used to uncover alcohol intake, history of sexual assault, and demographic characteristics of the participants. In line with Angelone et al. (2018), Decou and Skewes (2021) found that alcohol consumption was

not an independent predictor of revictimization, if the first assault had occurred in adolescence (p = .851). The interaction between adolescent sexual assault and alcohol consumption was found to be significant (p = .004). Of the students who had experienced victimization in adolescence, those who reported the highest weekly alcohol consumption were also found to have the highest increase in revictimization risk. In comparison, students who reported the lowest weekly alcohol consumption had the lowest increase in revictimization risk out of those who had experienced victimization in adolescence. However, the increase was still significant (p = .02). Similar results were found when students' weekly alcohol consumption was replaced with questions about binge drinking. To summarize, Decou and Skewes (2021) found that alcohol consumption moderated the connection between previous sexual assault and revictimization.

Alcohol as a coping strategy **(SØ).** Several of the studies that find a link between alcohol and revictimization subsequently discuss whether alcohol consumption is a coping strategy for dealing with psychological distress such as PTSD (Anderson et al., 2020; Angelone et al., 2018; DeCou & Skewes, 2021; Littleton & Ullman, 2013). In line with the self-medication hypothesis, it can be argued that victims who have developed PTSD after their first assault will tend to use alcohol to relieve their psychological distress, increasing their overall consumption (Littleton & Ullman, 2013, Walsh et al., 2014).

To test the interaction between PTSD and alcohol use, a previously mentioned study by Littleton and Ullman (2013) also examined the impact of these factors on different types of revictimization cases (incapacitated and forcible assaults). Littleton and Ullman (2013) had 1084 American women answer the same questionnaire at 2 measurement points a year apart. To uncover the participants' experiences of sexual assault, the baseline survey contained questions about previous experiences of assault, whereas the follow-up additionally collected informations about new sexual assaults. PTSD symptoms and various aspects of one's alcohol consumption during the past year were also assessed in both surveys. Results showed that 489 participants were revictimized during college (Littleton & Ullman, 2013). The results also indicated that high alcohol consumption increased the risk of a new incapacitated assault but was not associated with new forcible assaults. Because PTSD symptoms were associated with increased risk of both types of revictimization, it was argued that alcohol consumption as a coping mechanism couldn’t explain the entire correlation between PTSD and revictimization.

Finally, Littleton and Ullman (2013) had some additional explanations for why alcohol could increase the risk of victimization. First, they highlighted the alcohol myopia effect, which refers to how the influence of alcohol can make it more difficult to attend to risk cues in the victims' surroundings, especially subtle and ambiguous cues. Alcohol might also dampen the victims' stress response, making physically unpleasant stimuli less noticeable because physical arousal is less attended to. Both of these mechanisms can make it harder to avert dangerous situations, increasing the likelihood of being targeted by a possible perpetrator. Lastly, it is argued that being under the influence of alcohol can make it harder to display both verbal and physical resistance (Littleton and Ullman, 2013; Testa et al., 2007).

Overall, the studies differed on whether alcohol emerged as an independent predictor of sexual revictimization or not. This may be because high alcohol consumption only increases the risk of specific types of sexual assaults, or because alcohol consumption only moderates the relationship between previous and new victimizations (Decou and Skewes, 2021; Littleton & Ullman, 2013). Substance abuse is often understood as a strategy for coping with the psychological distress of being victimized, however certain drinking-related effects and contexts have also been implicated as increasing the risk of victimizations (Anderson et al., 2020; Angelone et al., 2018; DeCou & Skewes, 2021; Littleton & Ullman, 2013; Testa et al., 2007).

3.3 Assault Characteristics (C)

Fisher et al. (2010) has noted that state dependence, also known as incident characteristics, may be a factor in determining who experiences subsequent sexual assaults. In this paper, the following incident characteristics will be examined: the sexual violence experienced during a sexual assault, whether the victim exercised verbal or physical resistance, and the relationship between the victim and the perpetrator.

Sexual Violence as a Risk Factor (SD). A few studies have explored how the severity of sexual victimization, particularly in terms of perceived life threat and use of force, relates to the risk of revictimization. According to Classen et al. (2005), prior CSA involving physical force are associated with an increased likelihood of later revictimization in adulthood. While much research has focused on the use of force during childhood sexual abuse only, Collins (1998 in Classen et al., 2005) found that young mothers who had experienced revictimization were more likely to report use of force by the perpetrator, not

only during CSA but also during their most recent rape, compared to those who had not been revictimized.

Beyond physical force, the perception of life threat during assault has also been investigated. According to Walsh et al. (2023), life threat during abuse is associated with later victimization, and they argue that it may also be linked to increased distress and feelings of persistent danger afterwards. The authors found that individuals who experienced life threat during an assault had 5.5 times higher odds of being revictimized within six months. They suggest that greater memory of the rape and fear during the rape may increase distress, which in turn may predict risk for new victimizations (Walsh et al., 2023). However, when controlling for other factors such as history of substance abuse and socioeconomic status, the effect was no longer significant, emphasizing the complexity of these associations. Similar findings emerged in research on intimate partner violence (IPV). Kuijpers et al. (2011) reviewed 15 longitudinal studies and concluded that both the frequency and severity of past IPV were consistent predictors of sexual revictimization. While these results are specific to IPV and may therefore not be generalizable to all forms of sexual violence, they nonetheless highlight a broader underlying pattern: the more severe the past victimization was, the higher the future risk is.

This connection between severity and risk also appears in studies of risk perception. Neilson et al. (2018) carried out a study on factors tied to sexual assault history and risk perception. They focused on a college sample of 660 undergraduate women, where they expected that the risk of sexual victimization would be high. They measured the severity of sexual assault using the SES, a scale that includes specific questions about experiences such as verbal coercion, threats, violence, and abuse. The women were shown a hypothetical scenario involving sexual assault and asked when and why they would leave the situation. Among other things, the study found that women with more severe assault histories tended to wait longer to leave the hypothetical risk scenario. Thus, it seems that a more severe assault history could impair risk perception and potentially make one more vulnerable to revictimization.

Overall, the literature suggests that there is a correlation between the severity of the abuse, in terms of force, threats, or psychological impact, and the likelihood of revictimization. However, this relationship is not necessarily direct. Littleton and Ullman (2013) argued that the observed effect of severity may be mediated by PTSD symptoms rather than by severity itself. Furthermore, Walsh et al. (2023) warned that there may be systematic biases in the literature, as individuals with more severe trauma may be

underrepresented in follow-up studies. Despite these apparent contradictions, there is sufficient theoretical and empirical evidence to support an examination of assault severity in this analysis.

Sexual Refusal Assertiveness (SD). Multiple papers have handled the phenomenon of sexual refusal assertiveness. There is variation in how the literature defines sexual refusal assertiveness (SRA), ranging from a person's ability to reject sexual advances to the ability to refuse or resist sexual assault. However, most studies agree that sexual assertiveness refers to one's ability to initiate, and especially to reject, sexual activity, negotiate protection use, discuss sexual history, and communicate sexual desires and needs (López Alvarado et al., 2020). It is usually developed during adolescence and throughout adulthood, when the individual discovers sexual boundaries and consciousness. It also differs whether their research-focus has been on what predicts sexual assertiveness, whether SRA predicts recurrent sexual victimization, or if it has a reciprocal influence on each other. López Alvarado et al. (2020) have reviewed the literature on sexual assertiveness and its influence on human sexuality. They focused on the factors that could potentially contribute to the development of SRA, as well as how SRA affects sexual and relational situations, and how it varies between cultural contexts. They included a total number of 46 articles. According to the literature, a high SRA means having clear sexual boundaries, being able to communicate them, and being able to recognize and act appropriately when they are crossed. On the other hand, a low SRA means being less aware of one's own boundaries, and/or being unable to prevent or resist transgressive sexual behaviour (López Alvarado et al., 2020). The main findings of their review identified SRA as a tool for prevention of unwanted sexual advances and indicated that it could enhance reciprocal respect in relations as well as more safe sexual experiences (López Alvarado et al., 2020). Several studies have found similar results with increased SRA as a protective factor against sexual victimization (Katz et al., 2010; Relyea & Ullman, 2017).

Kirwan et al. (2022) also describes how previous research has identified several factors, including sexual risk behaviours, alcohol consumption, low SRA, and impulse control difficulties, as associated with the risk of being sexually assaulted. They aimed to explain how these different factors contributed to a higher risk of sexual victimization, as well as how they related to one another (Kirwan et al., 2022). Data were collected from N = 454 college women using different surveys, and among the strongest findings was that low SRA is a significant predictor of sexual victimization. Furthermore, they also found that

several different factors contributed to low SRA. Among these factors was “risky sexual behaviour” (more unprotected sex and more random sexual relations) which was associated with a decreased ability to refuse unwanted sexual contact. They also found that maladaptive coping via alcohol also reduced one's SRA because of the effects of alcohol intoxication. To summarize, according to Kirwin et al. (2022), factors such as using intoxicating substances and participating in sexually risky situations contribute to low SRA, which in turn increases the risk of revictimization.

Multiple researchers have also examined the role of SRA in sexual revictimization in college women. Besides estimating a revictimization rate in their sample, Katz et al. (2010) also tried to determine risk factors. More specifically, they examined how former sexual victimization is connected to higher self-blame and lower SRA, and how this might predict later revictimization. They found that women with former sexual victimization reported lower SRA compared to women with no sexual victimization. They also found that those who reported lower SRA at baseline showed a higher prevalence of revictimization six months later, thereby indicating that sexual assaults may decrease one’s SRA, which in turn can increase the risk of revictimization. Two additional studies have come to similar results. Kelley et al. (2016) examined the role of SRA together with other resistance variables among $N = 296$ college students in a 7-month period. They also found that the connection between former victimization and later revictimization is influenced by SRA. Furthermore, Kearns and Calhoun (2010) tried to estimate different connections between SRA level, social perception, and self-efficacy, as well as their influence on the risk of revictimization in a bigger sample of female college students $N = 1150$. According to Kearns and Calhoun (2010), self-efficacy refers to the belief in one's own ability to act effectively in challenging situations. In this article, they separated the term sexual self-efficacy (belief in one's ability to reject unwanted sexual advances) from global self-efficacy (general belief in one's own abilities). The participants were distributed in groups according to their victimization history, and they found that women with repeated victimizations after the age of 14 had a significantly lower SRA and sexual self-efficacy compared to the other groups. The authors believe that this can be explained by low sexual self-efficacy leading to less assertive behaviour, as belief in one's own agency in sexual situations can be a determining factor in whether a sexual assault is carried out.

Conceptually, Oesterle et al. (2022) have chosen to separate assertive resistance strategy from sexual refusal assertiveness. They investigated both as potential moderators of sexual revictimization among $N = 623$ college women. The participants took part in the study

by answering web-based surveys about their sexual experiences, substance use, sexual assertiveness, and which resistance strategies they would use in a potential assault. The 28 possible answers regarding intended strategies were divided into assertive- (threatening to call the police or saying no directly) and non-assertive strategies (joking about the situation or drinking to relax). The results revealed that the connection between victimization before and after college was significantly stronger among women with low SRA than among women with a higher SRA. Additionally, they found that the prevalence of revictimization was higher among the participants who in a hypothetical assault-scenario used non-assertive resistance strategies.

This also relates to a finding by Fisher et al. (2010) which indicated that trying to prevent an assault by using effective strategies could reduce the likelihood of completed assault. Fisher et al. (2010) collected data from $N = 4399$ women at college from an ongoing national study called *National Women Sexual Victimization Study* (NCWSV) with the aim of determining whether lifestyle-routine activities and characteristics of the first assault increases the risk of revictimization. The NCWSV study has a national sample of women at college that describes the compass and nature of sexual victimization in college women in an academic year. The researchers used a probability proportional model to select women from 233 institutions across the United States. Professionally trained interviewees interviewed the participants by telephone and asked about their experiences with sexual victimization pre-college, their lifestyle-routines, and information about relationship status, living situation, other demographic variables, and characteristics concerning their initial victimization. Specifically, they also examined how and if they defended themselves during the initial victimization. They found a significant effect of the self-protective action taken at the first assault on the risk of later revictimization. This means that women who tried to avert or refuse their first victimization reduced the risk of being revictimized later. It is then possible to theorize that low sexual refusal assertiveness is a mechanism through which sexual revictimization occurs, and that victimization among other factors also contributes to low SRA. This supports the idea that it is a reciprocal relationship. However, it should be noted that the previously described articles only included college students in their samples.

Livingston et al. (2007) has also examined the connection between sexual victimization and the ability to refuse unwanted sexual advances on $N = 1014$ women in the age of 18-30. They hypothesized that victimization could result in emotions of powerlessness and helplessness which can influence an individual's beliefs about their capability of resistance. They sought to investigate whether a history of sexual victimization (either CSA

or adult sexual victimization at baseline) is negatively associated with SRA. The authors found that sexual victimization occurring after the age of 14 was associated with lower sexual refusal assertiveness, whereas no such effect was observed in cases of CSA. They also examined whether low SRA at baseline could predict sexual victimization at later measurepoints and found significant evidence to support this. Additionally, they found that sexual victimization at later measurepoints also had influence in terms of decreasing ones SRA. Their results then also showed support for a reciprocal relationship between sexual victimization and sexual refusal assertiveness. To summarize, there is evidence that sexually victimized women are likely to develop low SRA, and thereby low sexual self-efficacy, which then increases the risk of sexual revictimization.

The Effect of Victim-Perpetrator Relationship (SØ). Only a small selection of research-articles have included measures of perpetrator type in their analysis to nuance how the perpetrator's relationship with the victim influences the aftermath of their assault (Fisher et al., 2010; Johnson et al., 2020). According to Testa et al. (2007) this relationship should always be taken into account before different assaults are compared. Evidence suggests that the characteristics of an assault are dependent on the relationship in which the assault was committed. Previous research has, for example, found evidence that sexual assaults where the victim was intoxicated are more often committed by strangers than intimate partners (Testa & and Livingston, 2009). Victims of assaults by strangers are also more likely to report problematic substance use (Johnson et al., 2020). A study of assaults committed by strangers conducted at the Center of Sexual Assault in the Region of Southern Denmark also found that threats were used more often, specifically verbal threats, when the perpetrator was a stranger (Friis-Rødel et al., 2021). Unknow perpetrators were also more likely to use violence during the sexual assault, compared to other perpetrators. Conversely, assaults involving verbal sexual coercion are more likely to be committed by intimate partners than other acquaintances (Depireux & Glowacz, 2024; Testa et al., 2007; Willis & Jozkowski, 2019).

A type of perpetrator that may be relevant to select for closer inspection is the intimate partner (Johnson et al., 2020; Park & Monaghan, 2022; Testa et al., 2007). Intimate relationships can be characterized as involving previous instances of consensual sex such as the relationship with a current or previous boyfriend/girlfriend or husband/wife (Willis & Jozkowski, 2019; Testa et al., 2007). It has been argued that this relationship might hold a greater risk of victimization primarily because of two factors: proximity and sexual precedence (Fisher et al., 2010; Park & Monaghan, 2022). The risk of sexual victimization is

greatly increased when the victim is in close proximity to a motivated perpetrator. Having an abusive partner (both physically, psychologically or sexually) can therefore increase the risk of both first time victimization and revictimization (Johnson et al., 2020). In an empirical study by Fisher et al. (2010) being in a committed relationship was, for example, found to be significantly related to being a victim of sexual abuse. In relation to the sexual precedence in intimate relationships, much research has attempted to uncover how it increases the risk of assault rooted in both force and sexual coercion (Testa et al., 2007; Willis et al., 2019). Compared to other victimizations, intimate partner assaults can be characterized by use of, for example, guilt tripping, duty, proof of love, because of prior instances of consensual sex. These demands and threats can both be explicit and implicit, and the type of victimization experienced in an intimate relationship can therefore become harder to identify and get treatment for (Bagwell-Gray, 2021; Depireux & Glowacz, 2024). It should be noted that several of the studies presented did not specify within their measures, whether revictimization could include multiple sexual assaults by the same intimate partner (Fisher et al., 2010; Testa et al., 2007). It was therefore unclear whether being victimized within an intimate relationship increased the risk of future victimizations within the same relationship or future victimizations in general.

Because abuse committed in an intimate relationship and abuse committed in a non-intimate relationship can be understood as distinct constructs, some researchers recommend separating them when investigating revictimization (Depireux & glowacz 2024; Fisher et al., 2010; Testa et al., 2007; Johnson et al., 2020). If the sample is dominated by a certain type of victim-perpetrator relationship, it might influence which risk factors emerge as significant. This could, among other things, explain the contradictory findings in research on substance abuse and SRA (Park & Monaghan, 2022; Testa et al., 2007).

To investigate if there is an interaction between relationship-type and revictimization risk, Testa et al. (2007) interviewed 927 women between the age of 18 and 30. Participants were recruited by randomized phone calls with yearly measurement points for three years. At baseline the researchers found a clear overrepresentation of assaults committed in intimate relationships (Testa et al., 2007). When reporting which factors at baseline could predict revictimization later in the study, they found that risk factors were determined by relationship type. Victimizations by non-intimate perpetrators could be predicted by frequent episodes of heavy drinking and a high number of sexual partners. Meanwhile assaults by intimate

perpetrators were predicted by low SRA, frequency of drug use, and previous sexual assaults by intimate partners. Because these results indicated that different risk factors are associated with assaults by different types of perpetrators, Testa et al. (2007) concluded that there is a need for research in this field to divide assaults based on perpetrator type to better understand and prevent it. Despite Testa et al. 's (2007) encouragement to the research community, it has not become common practice to separate assaults on the basis of perpetrator type. However, a limited number of studies have included the victim's relationship to the perpetrator during the initial assault as a variable, enabling both frequency analyses and subsequent risk factor analysis.

In a previous section of this paper, a study by Anderson et al. (2020) was described. In their study, all participants were asked to report the victim-perpetrator at their first assault. Based on frequency analysis, the researchers were able to highlight that participants most often reported that they had been assaulted by acquaintances, such as friends, ex-boyfriends, and hook ups. This is fairly consistent with the results of Testa et al.'s (2007) frequency analysis. However, when analyzing which perpetrators were significantly associated with later revictimization compared to a single assault, a different set of relationships stood out: strangers, friends, teachers, and hook-ups (Anderson et al., 2020). After testing the variables in clustered multivariable analyses, only assaults by strangers persisted as a factor that could increase the risk of revictimization. It was concluded that if a victim's first assault was committed by a stranger, it could double the risk of revictimization. Anderson et al.'s (2020) did not attempt to explain the correlation. They emphasized that although the relationship with the perpetrator may increase the chances of later revictimization, it was only one of multiple risk-pathways. Subsequent research on college student samples has similarly failed to replicate the findings of Testa et al. (2007; Johnson et al., 2020). Johnson et al. (2020) for example, reported that the majority of assaults were committed by non-intimate perpetrators, and suggested that the most common perpetrator type may vary depending on the population under study. The divergence from Testa et al.'s (2007) results may be attributable to their inclusion of a broader sample.

To sum up, the existing literature on perpetrator type indicates that the relationship between victim and perpetrator influences which factors are increasing the risk for new sexual assaults (Anderson et al., 2020; Testa, et al., 2007). There has still not been

found sufficient scientific evidence to conclude which victim-perpetrator relationship increases the revictimization risk the most. It is argued that the distribution of perpetrator-types might be determined by the type of sample used for investigation (Johnson et al., 2020). According to Testa et al. (2007) an uneven distribution could skew the results of other studies where perpetrator-type has not been taken into account.

4. Study Design

4.1 Sample Selection (SD)

Participants were drawn from the Centre of Sexual Assaults (CSO) and consisted of all patients in Copenhagen between 2018 and 2024. The center mainly accepts people above the age of 15, however 12-15 year olds can be admitted for emergency examinations before they are referred elsewhere. The sample consists of all patients who have had an emergency examination with a nurse or a clarifying conversation with a psychologist in the defined period. CSO accepts patients who have been victims of sexual assault or attempted sexual assault. They define a sexual assault as a 'sexual act in the form of vaginal, anal or oral penetration or attempted penetration without ones consent' (Center for Seksuelle Overgreb, n.d.). As the center includes an urgent care unit, victims from the entire Capital Region of Denmark and Region Zealand are accepted if they seek help within 7 days of their assault. If the referral occurs more than 7 days after the assault, the patient will be assessed at their local hospital. Patients who contact CSO within 30 days of their assault are classified as acute patients, whereas patients who contact after 30 days are classified as late referrals.

The full dataset consisted of 4581 patients. However, to avoid mixing CSA with adult revictimization, patients whose first assault occurred before the age of 15 were excluded (n = 393). Patients who reported an additional assault, but one that occurred after the one they sought help for, were also excluded to ensure that responses about previous assaults were only based on assaults prior to the current one (n = 27). Thus, the full sample in this study was N = 4161 patients.

4.2 Procedure and Criteria (SØ)

The general procedure at CSO is that emergency patients come in for medical treatment as well as a consultation with a nurse. If the patient is a late referral, they will

instead come in for a clarifying interview with a psychologist. In both cases, the employee then fills out registration sheets with various information about the assault, patient demographics and medical history. This study's data is extracted from these registration sheets from the CSO database. It is common practice for staff to have a detailed conversation with the patient but only record the most necessary and relevant information. In 2022, CSO changed their registration forms, which means that their data has been recorded with 2 different measurement tools. The overlap between the previous form and the new one is extensive, but small adjustments have been made to make them compatible.

In addition to the results of the medical examinations, the *Arrival and background* form records basic information about the patient, as well as any information about the recent assault that the patient can remember. This includes the sequence of events, information about the abuser, and the circumstances under which the abuse occurred. In the *Medical History* form, information about previous trauma is noted, as well as whether the patient suffers from substance abuse, self-harming behaviour, or has any psychiatric diagnoses. Because the registration forms are used after the nurses' interviews, records are available for most emergency responders. However, the same is not the case for late-arriving patients. Since these patients do not undergo medical examinations, there has been a less systematic screening of this patient group.

There were many ethical concerns regarding extraction of patient data that influenced the process of choosing measurements. It was a requirement from CSO, that specific patients could not be recognized from our dataset, as this would require informed consent from these individuals. We were prohibited in advance from receiving selected variables that CSO considered sensitive or knew were sparsely filled in, such as specifications of patients' country of origin. It was also decided in advance that all variables with less than 5 responses would not be reported in the final results. Before extracting data for analysis, approval was received from the hospital’s legal department.

4.3 Assembly of Datafiles (SØ)

The use of two different measurement tools during the periods 2018–2022 and 2022–2024 resulted in two separate datasets from CSO. The data was initially cleansed, and we cross-checked the variable coding in the different sheets to ensure that the data was compatible in terms of variable names, variable type, response options and coding of these, before merging them. Most variables were coded similarly across the two datasets, but some

included additional response options in one dataset compared to the other, which were therefore incorporated into the combined version. Several variables were also recoded to align with the most relevant format. For example, in cases where one dataset allowed multiple responses for types of drug use, and the other only recorded the most heavily consumed type, the data were adjusted accordingly. To reduce the total number of variables, it was at times necessary to combine multiple variables into a single composite variable.

4.4 Measurements (SØ)

Sexual Revictimization. Multiple experiences of sexual assault was measured as, "*Has the patient been sexually assaulted by another offender prior to the reason for referral?*". Answers were coded into binary response options: "Yes, prior to [the current assault]" or "No". Multiple assaults by the same perpetrator were considered one reason for referral at CSO, and these patients have therefore been registered as non-revictimized. Patients who recorded previous sexual assaults were additionally asked, "*How long before contacting CSO did the previous assault/last previous assault take place?"*. The length of time was measured as 1 = "Less than half a year ago", 2 = "½-1 year ago", 3 = "1-3 years ago", and 4 = "More than 3 years ago".

Demographics. Participants' age, gender, ethnicity, education and employment status was recorded. Ethnicity was organized as either 1 = "Danish", 2 = "Immigrant/descendant from a western country", or 3 = "immigrant/descendant from a non-western country". Education was measured as the patient's highest level of completed education and could be answered as follows: 1 = "Completed less education than ninth grade", 2 = "Primary school", 3 = "High school", 4 = "Vocational education", 5 = "Short-cycle higher education (less than three years)", 6 = "medium-cycle higher education (three-four years)", or 7 = "Long-cycle higher education (more than four years)". Employment status was recorded as 1 = "Student", 2 = "In employment" or 3 = "Not in employment". If the patient answered 2 = "In employment", another question was asked where the type of work could be specified as either 1 = "Self-employed", 2 = "Top executive, employee of highest paylevel", 3 = "Employee of medium paylevel" or 4 = "Employee of lowest paylevel or other". Both editions of the registration scheme also had an item where it could be logged if a patient identified as a sex worker.

Psychological Vulnerability. Mental illnesses that have been diagnosed or are currently being assessed are measured in an independent item that can be dichotomously answered with "Yes" or "No". For the patients experiencing mental illness, their specific disorders can be recorded in predefined categories. Due to different recording practices between the previous and new registration sheet, it was decided to only utilize data from the new scheme during the investigation of this measure.

Substance abuse was measured by frequency of alcohol and drug use. The patient's general alcohol intake was registered as either 1 = "No use", 2 = "Regular use, not daily", 3 = "Daily use", or 4 = "Has been or is in recovery and/or doesn't use any longer". In line with existing literature, items were dichotomized as 1 = "No alcohol use or regular, but not daily, use" or 2 = "Daily use or in/has been in recovery from substance abuse" (Anderson et al., 2020). Usage of non-prescription drugs was initially measured according to the type of drug. Patients were asked separately about their intake of mild (marijuana), intermediate (cocaine, pills and ecstasy), and hard drugs (Heroin and morphine). Response options were equal to those under the question on alcohol use. The measures were merged to a singular, ordinal variable in which only the participants' most severe form of drug use was registered. Drug use was in the final analysis measured as 1 = "No drug use or only tried mild drugs a few times", 2 = "Any current or previous use of mild drugs", 3 = "Any current or previous use of intermediate drugs" and 4 = "Any current or previous use of hard drugs".

Assault Characteristics. The victim's relationship with the perpetrator at the time of the assault was selected from a list of possible types of relationships, such as *boyfriend, familymember, Scoutleader, classmate* etc.. As suggested by the existing literature, we categorized relationships according to whether they were "Intimate" or "Non-intimate" to have a basis for comparison (Testa et al., 2007).

The degree of violence experienced during the most recent assault was recorded with a list of possible forms of violence such as: *restraint, blunt violence, sharp violence, strangulation* etc. For analytical purposes, answers were tallied and registered as the total number of violent elements answered. The answers were coded in line with Neilson et al.'s (2018) paper, so the final variable depicts a patient's sum of experienced violence. An upper category of 5 or more types of violence was created.

Assertive resistance strategy during the most recent assault was also recorded as displayed resistance, such as verbal resistance (e.g., saying no directly or saying no by mentioning obstacles) and physical resistance (e.g., crying, running, pushing, etc.). As coded

by Fisher et al. (2010) we created a binary variable where answers were dichotomized as either “No type of resistance was performed” or “Any type of resistance was performed”.

4.5 Data Analysis (SD)

The purpose of the data analysis is to find the prevalence of revictimization in CSO patients and to investigate differences between revictimized and non-revictimized patients. The data were analyzed using SPSS version 29.0.2.0 (20). Frequency analyses were used to identify trends and differences between revictimized and non-revictimized, which were then tested with inferential statistics, including Chi-square tests and Mann-Whitney U tests.

To assess the representativeness of the sample, background analyses were conducted where key demographic variables (e.g. age and gender distribution) in the dataset were compared with figures from Statistics Denmark to examine whether the sample deviates from the population in the capital region.

Associations between groups and categorical variables were analyzed using Chi-Square tests, while differences in ordinal scale data and interval scale data were analyzed using Mann-Whitney U tests and t-tests. The amount of missing data has varied across variables. It has ranged from 0 to approximately 2000. However, for the purpose of our analysis, we have assumed that there is no systematic difference in missing data between the groups. To ensure the anonymity of the patients in the datasets, all measures with $n < 5$ will remain unreported in the results.

Chi-square tests have been used to examine whether there is a statistical correlation between nominal variables. In these analyses they are used to examine if the distribution of one variable depends on the group variable, whether you are revictimized or not. Specifically, we use Chi-square to examine the difference in the distribution of demographic variables such as gender, ethnicity, occupation, specified occupation and prostitution between revictimized and non-revictimized patients. Chi-square is also applied to vulnerability factors such as mental illness and daily alcohol consumption, as well as offence-specific variables such as resistance and relationship to abusers. For ordinal variables such as highest completed education, number of violent offences committed by the abuser, and drug use, Mann-Whitney U tests were conducted. When comparing the two groups’ age, an independent sample t-test was performed. Finally, 10 post-hoc Chi-square analyses were performed for each psychiatric diagnosis. To control for multiple comparisons and to maintain a low risk of false positives

between groups, Bonferroni correction was applied, yielding an adjusted significance threshold of $p < .005$ (Benjamini & Hochberg, 1995).

Effect sizes in the form of Cramer's V, Phi, Rosenthal's r and Cohen's d were also calculated for the corresponding analyses to highlight the strength of our findings.

5. Results (SØ)

This section provides a summary of the study's key results, beginning with a comparison to the background population, and continuing with findings on revictimization rates and associated risk factors.

In the comparisons with the background population extracted from Statistics Denmark, CSO patients differ significantly on a number of demographic parameters. On average, they are significantly younger (25.5 years vs. 40.8 years), more often women (95.4% vs. 51.3%) and more likely to be students (47.5% vs. 17%, Danmarks Statistik, 2023a). Ethnically, non-western immigrants and descendants as well as western immigrants and descendants are slightly underrepresented compared to the background population (8.5% vs. 14.99% and 5.3% vs. 8.54%, Danmarks Statistik, 2023b). Among the employed patients at CSO, high earners and managers are strongly underrepresented (4% vs 39.2%), while lower-income groups dominate (53% vs. 40.9%, Danmarks Statistik, 2023c). These comparisons suggest that there might be a social difference in who utilizes CSO services. But it may also suggest that there is a difference in who is more often exposed to abuse.

Frequency analyses within the sample revealed a revictimization prevalence of 34% in patients in CSO, meaning that more than ⅓ of the patients have experienced more than 1 assault after the age of 15. When examining how long ago the revictimized patients experienced their first victimization "over 3 years ago" was the most commonly reported timespan (43.2%).

Additionally, revictimized and non-revictimized patients differed significantly on a number of demographic characteristics. The group of revictimized participants had a significantly higher mean age ($p < .001$) and a lower percentage of men ($p < .001$) than the non-revictimized patients. Moreover, there was also a significant difference in the distribution of employment status in the two groups. There were approximately similar percentages of people in work (31.1% vs 31.6%), but fewer students in the revictimized group than in the non-revictimized group (38.4% vs 55%). This, in turn, means that the

percentage of unemployed in the revictimized group was larger compared to the non-revictimized (30.6% vs 13.4%).

Regarding psychological vulnerability, the analysis showed a significant difference in psychiatric disorders between the two groups. There was a significantly higher prevalence of PTSD, affective disorders, personality disorders, anxiety and ADHD in the revictimized group compared to the non-revictimized. Additionally, all types of substance abuse, including use of both alcohol and drugs, were significantly more prevalent in the group of revictimized patients than in the non-revictimized group.

The analysis also showed significant differences in some assault characteristics. The tests revealed a significant difference in perpetrator type between the revictimized and non-revictimized patients in regards to their most recent sexual assault. It was uncovered that the most common relationship between perpetrator and victim was non-intimate in both the revictimized (84.5%) and non-revictimized groups (90.3%). However, the revictimized patients were more likely to be assaulted by an intimate partner than the non-revictimized. There were no significant differences in the amount of violence experienced or whether the patients had exerted resistance.

6. Discussion (C)

The aim of this study was to investigate the prevalence of revictimization among adults exposed to sexual assault in adulthood, and to identify possible differences between those who experience revictimization and those who do not. The following section discusses the main findings of the study in light of previous research and theoretical perspectives. Methodological strengths and limitations will also be considered, as well as implications for practice and further research.

6.1 Revictimization Rates in Plural (SD)

In the total sample ($N = 4161$) we found that 34% of patients reported experiencing revictimization in adulthood. This result implies that almost one in three patients at CSO have experienced repeated abuse after the age of 15, indicating that revictimization is a significant problem among adult sexual assault victims. Comparing the prevalence rate to existing literature, it is relatively high (Table 1). Looking specifically at the prevalence rate of Walsh et al. (2023), whose sample was also from a rape center and above the age of 15, they found a revictimization rate of 21.7%. However, this may be due to the fact that they did a

longitudinal design with a follow-up only 6 months after the first assault. Here it is relevant to refer to one of the present study's findings. We examined whether there was a pattern in how much time passed between the initial sexual victimization and revictimization. The most frequent answer was ‘over 3 years’ followed by ‘1-3 years after’. Only 17.3% of those revictimized at CSO reported that they had experienced revictimization ‘within six months’ of the initial assault. This indicates that the risk of revictimization may increase as a result of the amount of years that pass, as other studies have suggested (Classen et al., 2005). The short follow-up interval in Walsh et al. (2023) may then be the reason why their revictimization rate is somewhat lower than in this study.

Several of the other studies (Cusack et al., 2021; Livingston et al., 2007; Relyea & Ullman, 2017; Anderson et al., 2022) find higher prevalence rates (Table 1). What they have in common is that their operationalization of sexual revictimization differs from the one used in present study. They refer to a broader form of sexual revictimization, which includes sexually abusive behaviour that is not necessarily described as assault or rape (e.g., unwanted sexual contact). As Katz et al. (2010) found, one of the most frequently reported forms of revictimization in their study was ‘unwanted sexual contact’ (56%) whereas only 26% experienced revictimization in the form of completed rape. This may explain why revictimization rates are higher in studies with a broader definition of sexual revictimization compared to the current study.

There are generally large differences in revictimization rates in Table 1. One reason may be that the majority of existing studies has focused their investigation on sexual revictimization among American college students and used self-report surveys as measurement tools (Angelone et al. 2018; Conley et al. 2017; Cusack et al., 2021; Fisher et al., 2010; Humphrey & White, 2000; Katz et al., 2010). They find varying revictimization rates from 11% to 69%, likely due to differences in whether it is longitudinal or cross-sectional, and due to differences in operationalization of sexual revictimization. However, several studies have also included or focused exclusively on adult women and have still found varying revictimization rates ranging from 21.7% to 50.3% (Littleton & Ullman, 2013; Livingston et al., 2007; Relyea & Ullman, 2017; Ullman & Najdowski, 2009; Walsh et al., 2023). The fact that there are such large differences in methodology, sample selection and operationalization across the research field consequently makes it complex to compare this study's findings with existing literature.

Comparing this study's prevalence of sexual revictimization in adults in adulthood with the rates of revictimization in adults with CSA, there are also notable differences. Meta-

analyses by Walker et al (2019) and Classen et al (2005) found average prevalence rates of 47.9% and 67% in victims of CSA. These are significantly higher than this study's 32.1%, which is explained by the literature as a result of childhood being a particularly sensitive period, where victimization and trauma can have long-lasting consequences on relational, emotional, as well as sexual development (López Alvarado et al., 2020; Messman-Moore et al., 2013; Walker et al., 2019). There is a tendency in the literature to not distinguish between adults exposed to CSA and adults exposed to sexual victimization in adulthood. However, the fact that there is also a significant prevalence of revictimization in adults who have been sexually victimized in adulthood provides an incentive to investigate it further as a separate phenomenon.

6.2 Psychological Vulnerability (SØ)

The results of this thesis's analysis have shown that over half of the revictimized patients have a mental disorder compared to about a third of the non-revictimized. Post-hoc analyses showed that there were significant differences in affective disorders, anxiety, PTSD, personality disorder and ADHD between the revictimized and non-revictimized patients. Based on these findings, it can be argued that there must be a link between some mental disorders and the risk of revictimization. It supports many of the findings that have already been made in the field, including associations between revictimization and PTSD (Conley et al., 2017; Cusack et al., 2021; Jouriles et al., 2017; Ullman, 2016) and depression (Christ et al., 2022; Cusack et al., 2021; Edwards & Banyard, 2022; Smith et al., 2022). Contrary to the findings of Cusack et al. (2021), the current study identified a significant difference in anxiety disorder between the two groups, with 38.1% of the revictimized and 29.4% of the non-revictimized reporting the disorder. One reason for this difference in findings may be that Cusack et al. (2021) investigated anxiety via self-reported symptoms on questionnaires, whereas our sample is categorized based on whether or not they have been diagnosed clinically. For this reason, it should be noted that several studies use non-clinical samples in which mental health issues are measured via self-reported symptoms rather than clinically diagnosed disorders. This may affect both the strength and reliability of the associations found with revictimization, as symptoms can be contextual and temporary, and there is a risk of both under- and overestimation of effects. Studies with clinically diagnosed participants (e.g., Christ et al., 2022) allow for a more robust assessment of mental illness as a risk factor, whereas it can be more difficult to encompass psychiatric disorders, such as clinical

depression, with a single-item scale like Edwards and Banyard (2022) did. Thus, it is important to take the variation in measurement methods and sample types into account when interpreting the current study's results.

A significant difference was also found between the prevalence of ADHD in the revictimized group compared to the non-revictimized group. This finding was somewhat unexpected, as our systematic literature search did not identify any studies that examined or suggested a link between ADHD and revictimization. However, a few authors have examined the influence of ADHD on risky behaviours and as a predictor of sexual assault in adolescence and early adulthood (Shoham et al., 2021; Wymbs & Gidycz, 2021). Shoham et al. (2021) found that ADHD, especially symptoms of hyperactivity, is strongly associated with a general tendency to engage in risky behaviours which can contribute to increased exposure to sexual assault. The association could not be explained by comorbid disorders like depression, PTSD, or substance abuse. One could therefore argue that our significant result may support a possible tendency. However, more studies are needed on the specific link between ADHD and revictimization.

Regarding the data acquisition, patients were asked whether they are currently being assessed for or if they are diagnosed with a mental health condition at CSO. The nurses have access to the patients' medical records, so it is reasonable to assume that there is some certainty about the patients' mental health status. However, it should be emphasized that CSO is not a diagnostic unit, and there is a risk that some patients with a mental disorder will not be identified during the process. Additionally, it is important to note that CSO operates under a policy whereby individuals with severe mental illness are primarily referred to psychiatric services, and patients with untreated mental disorders are not treated at the CSO (Center for Seksuelle Overgreb, n.d.). This also indicates that there must be patients who do not enter CSO because they are referred to other treatment programs. Therefore, it is possible that our analyses are not representative of all mental disorders, and that findings may not be generalizable to individuals with severe mental disorders, regardless if they are currently in treatment or are untreated. It is also worth mentioning that there may be a number of people with mental illness who are not included in the sample because they have an increased distrust of the healthcare system, either as a result of previous experiences or fear of stigmatization (Thornicroft et al., 2016).

Another important point of discussion is that we cannot say anything about whether the current study's sample had their mental disorders prior to the assault, or whether they were diagnosed post assault. Hence, It would make sense to do a longitudinal design with the

possibility of monitoring the patients' mental health long term. However, the analyses do show that there is a connection although it has only been examined univariately. As mentioned before, a great amount of the literature suggests that mental disorders are not necessarily the direct cause of revictimization, but that it may lead to maladaptive coping strategies or to negative social consequences that then increase the risk of revictimization (Relyea & Ullman, 2017; Smith et al., 2022). If this study were to investigate this further, there should have been performed multivariate analyses to see if other factors in combination with mental illness can predict revictimization.

6.3 Characteristics of Victimization (SØ)

Although much research has found a significant correlation between SRA and revictimization (Fisher et al, 2010; Oesterle et al, 2022), current analysis did not show a significant difference in resistance between the revictimized and non-revictimized patients.

A possible explanation for the lack of significant difference may reside in how sexual refusal assertiveness (SRA) is operationalized in this study compared to other research. As highlighted in the formerly mentioned literature, SRA is a multifaceted construct that encompasses not only resistance behaviors, but also risk perception, boundary awareness, and the ability to detect and avoid threats (López Alvarado et al., 2020). In this study, we focused specifically on the resistance strategy; whether or not patients exerted resistance during the assault. This is contrary to definitions and operationalizations other studies have applied. While many studies assess SRA through hypothetical scenarios or self-reported reliance on resisting unwanted sexual advances, such methods may not accurately reflect how individuals respond in real life situations. Thus, it is important to be aware of which aspect of SRA is being assessed. As Oesterle et al. (2021) argued, there is a conceptual and functional difference between general sexual refusal assertiveness and situational resistance strategy. An individual may have high SRA in terms of self-awareness, boundary setting, and verbal assertiveness in everyday situations, and yet respond passively during an acute threat due to fear, shock, or perceived danger. Thus, the absence of group differences in resistance behavior in this study does not necessarily contradict previous research linking low SRA with revictimization. It rather highlights the complexity of the phenomenon and the need to distinguish between general SRA and situational response. Importantly, our findings also raise the possibility that other factors, such as offender aggression, may play a more direct

role in shaping victims' ability and/or opportunity to resist. For instance, Gidycz et al. (2007) found that resistance is strongly influenced by offender aggression level.

Another possible explanation for the lack of a significant correlation between resistance and revictimization in our sample may be found in the type of perpetrators involved. The proportion of assaults perpetrated by intimate partners, i.e., current or former romantic partners, appears to be relatively low in our dataset. This may be important as Testa et al. (2007) argued that low SRA is more strongly associated with victimizations by intimate partners, while it may play a less crucial role in cases involving non-intimate perpetrators. Moreover, as suggested by Livingston et al., (2007) many existing studies on SRA have been conducted on college students, which also limits generalizability to more heterogeneous populations. Since SRA is largely developed during adolescence and early adulthood, it could be relevant to investigate whether SRA has a different impact on the risk of revictimization depending on age (López Alvarado et al., 2020). The CSO sample had an age average of 24 and 26 years, suggesting that some individuals may still be in a developmental phase regarding SRA. It is therefore possible that an initial assault in adolescence or early adulthood may disrupt the normative development of SRA and increase vulnerability to later revictimization. Nevertheless, the age range of our sample is relatively broad, complicating interpretation and suggesting the need for future age-stratified analyses.

It is also important to point out that it is difficult to derive a causal explanation for how patients react during their first assault, and their reaction during the subsequent one. Due to the study’s methodology, it has not been possible to retrieve more details about the revictimized patients' first assault, which means that the second assault of revictimized patients has been compared to the first assault of non-revictimized patients. This skewness may obscure group differences, especially if resistance patterns differ between first and subsequent assaults. However, based on previous research one would expect revictimized individuals to show less resistance during subsequent assaults, making the lack of observed difference an unexpected finding (Livingston et al., 2007; Oesterle et al., 2022).

Overall, the results suggest that the relationship between sexual refusal assertiveness and revictimization is more complex than assumed. The lack of effect in the current study may be due to methodological differences, sample composition, and other contextual factors such as offender aggression and/or relationship with the victim. This highlights the need for more nuanced measurements, and a broader understanding of what mechanisms actually influence the risk of revictimization.

In contrast to the findings on SRA, our study partially replicated previous research on victim–perpetrator relationships by identifying a significant difference in the type of relationship revictimized and non-revictimized individuals had with their perpetrator (Testa et al., 2007; Anderson et al., 2020). As mentioned earlier in the thesis, Testa et al. (2007) found that a majority in their sample had been assaulted by intimately known perpetrators. The findings of our study surprisingly contradicted these results. There are many possible explanations for why this happened. Firstly, when filling out the registration form at CSO, multiple experiences of sexual assaults by the same perpetrator are not reported, and therefore were not included as instances of revictimization in our analysis. This was either included or not specified in many of the existing studies (Fisher et al., 2010; Johnson et al., 2020; Testa et al., 2007). If we had classified these as revictimizations, the percentage of intimate perpetrators would possibly be larger in the revictimized sample. However, since the percentage of intimate perpetrators is even smaller in the non-revictimized sample (9.7%) it can be argued that this doesn't explain the entire difference in findings.

Because we find that the majority of our sample has been subjected to abuse in a non-intimate relationship, it could have been relevant and interesting to further subdivide this category within the study's measurements. We have chosen to divide the victim-perpetrator relationships like Testa et al. (2007) to test their theory about the separation of intimate and non-intimate relationships. This provided us with a basis for comparison. However, because there was a clear majority of our sample who had experienced abuse in non-intimate relationships (83.7% and 90.3%), one could also argue that it would have been more meaningful if this category had been subdivided. An investigation of different types of non-intimate relationships might have revealed a more unexpected distribution of perpetrator–victim relationships. Given the way the analysis is conducted in this paper, the proportion of abuse committed by intimate partners may appear relatively modest, but if it could be compared with other specific relationships such as friends, it would potentially have been clearer how prevalent this type of abuse is in the population.

Consistent with Testa et al. (2007), we find that the percentage of intimate partner abuse is higher within the revictimized group compared to the non-revictimized group. However, the interpretation of this finding is not completely straightforward. Unlike Testa et al. (2007) victims in our study were compared according to their most recent victimization, as opposed to their first. It is therefore more difficult to determine whether the results indicate that one is more likely to be revictimized within an intimate relationship, or whether it indicates that those who are revictimized are more likely to be abused, both the first and

subsequent time, by intimate partners. Because patients at CSO are asked to record all previous abusers without specifying their order, it was not possible to isolate the initial abusers for subsequent analysis.

Although it can be argued that the group difference should then be interpreted with caution, the results of the frequency analysis on this variable may contribute to the understanding of the remaining findings of the study. As mentioned earlier in the paper, previous empirical research has indicated that a skewed distribution of offender types may control which risk factors end up being significantly tied to victimization (Depireux & Glowacz 2024; Fisher et al., 2010; Testa et al., 2007). In accordance with what Testa et al. (2007) found to be significant predictors of revictimization by non-intimate perpetrators, we found that alcohol use significantly predicted revictimization within our sample while low SRA did not. However, contrary to Testa et al. (2007) we also found that drug use was a risk factor for revictimization which suggests that this risk factor might not be limited to victims of intimate partner violence. To further support the hypothesis of dependent risk profiles, it would be relevant for future research to carry out analyses in which the same factors and characteristics are compared across offender types in the group of revictimized patients. This would indicate whether risk factors are distributed as expected.

It is possible that the unexpected findings regarding perpetrator type can be explained by CSO having a narrower definition of sexual abuse compared to existing literature (Relyea & Ullman, 2017). As mentioned earlier, there is evidence indicating that victims of sexual assault in intimate partner relationships are more likely than others to experience sexual coercion (Testa et al., 2007; Willis et al., 2019). Assaults of this kind are not always violent and victims can be left with doubts about whether or not they qualify as victims of assault (Bagwell-Gray, 2021; Depireux & glowacz 2024). When an individual does not meet the criteria for a stereotypical rape scenario, seeking help from both professionals and acquaintances may be more challenging, as they may question whether their experience qualifies as legitimate reasons for support (Friis-Rødel et al., 2021). Our results may thus reflect how this victim group systematically seeks less help than other victims of sexual assault. In support of this hypothesis, other research projects at Danish rape centers have also found that only 8% of their sample had been victimized by an intimate partner (Friis-Rødel et al., 2021). They pointed out that this finding was surprising, because previous population surveys in Denmark had found that between 32% and 38% of victims had known their perpetrator intimately.

Additional barriers to seeking help may arise when the perpetrator is an intimate partner, for example, due to ongoing emotional attachment, shared parenting responsibilities, or fear of escalating an existing conflict (Hansen et al., 2019). Intimate partner violence is a complex phenomenon where the primary concern is not always sexual abuse. As pointed out in much of the existing research, sexual assault in relationships rarely stands alone and can be followed by stalking, physical violence, psychological violence etc. (Bagwell-Gray, 2021). It is possible that these victims do not prioritize approaching CSO because there are services that specifically target IPV. For this reason, CSO also refers some victims of IPV to more suited treatment centers which explains why they have not been registered in our sample.

6.4 Methodological Considerations (SD)

While this study offers valuable insights on revictimization, it is important to weigh these findings against its methodological strengths and potential limitations. A considerable limitation of this study is that it is a cross-sectional design, which enables the estimation of prevalence and associations but does not account for temporality. This makes it difficult to determine whether the included variables contribute to revictimization or if they have appeared after. This may be particularly relevant for the analysis of the connection between psychiatric disorders and revictimization, where it can be difficult to determine if it is a vulnerability factor or instead a result of the assault. Additionally, the current thesis suggests that revictimization often occurs several years after the initial assault, which indicates that individuals classified as non-revictimized may still be at risk. Thus, it would be necessary to conduct a longitudinal examination of the patients to establish such temporal relationships.

Another limitation of the chosen study design is that data is collected retrospectively, which can lead to recall bias (Fairbrother et al., 2025). This is particularly relevant when investigating sensitive and complex phenomena such as sexual assault and revictimization. The patients in this study may potentially remember the assault differently than it happened, either because it happened a long time ago or because they are in an acute state that prevents them from remembering the event accurately. According to Walker et al (2019), women who have experienced sexual assault may also find it difficult to acknowledge it as an assault, especially if the assault does not fit into stereotypical understandings of what constitutes one, or especially if it was committed by a boyfriend or friend.

Methodologically, this study is strengthened by the use of clinical registry data collected shortly after the assault through structured interviews with professionals specialized

in trauma and sexual assault. This increases the probability of valid and detailed information compared to retrospective self-report studies. However, this method also comes with a risk of interpretation bias, as the information is not collected directly from the patients but communicated through the clinical interviewers. Although the use of a standardized documentation form ensures systematics, it places demands on the interviewer's memory and judgment. Data was collected by several different nurses, which may have led to variations in interview depth and accuracy, contributing to missing or unsystematic records. Despite these limitations, the clinical setting allows for follow-up questions and trust building, potentially promoting more open and honest disclosure of sensitive information.

Yet another limitation of collecting data via conversation is that the patient may experience social desirability, which can cause them to underreport important details (Hall & Farber, 2001). Thus, a patient may underreport sensitive or stigmatized information, especially regarding past trauma, substance abuse, or mental health concerns, in fear of being judged or to avoid feelings of shame. This means that there may be patients in the non-revictimization group who have experienced previous assaults but have chosen not to disclose it in the conversation with the professionals. Furthermore, it is important to note that the data only represents individuals who have sought help from the CSO. Therefore, the results do not capture the characteristics or experiences of those who have been victimized but have not sought or accessed support services, potentially limiting the generalizability of the findings.

Finally, it is important to reflect on our choice of statistical correction for multiple comparisons. Performing many hypothesis tests increases the risk of type I errors and thereby mistakenly finding an effect that does not exist (Benjamini & Hochberg, 1995). In this thesis, we wanted to specify differences in the prevalence of 10 psychiatric disorders between revictimized and non-revictimized patients. To reduce the overall probability of at least one false positive (family-wise error rate, FWER), we applied a Bonferroni correction (Benjamini & Hochberg, 1995). Without correction, the overall probability of error for ten independent tests with a significance level of 0.05 would correspond to approximately 40%, which we considered unacceptable given the potential implications that the results might have. By dividing the overall significance level (.05) with the number of tests performed we lowered the critical level to .005 per test.

One advantage of using Bonferroni is that we protect the results from false positives and thus increase the credibility of the significant findings (Benjamini & Hochberg, 1995). On the other hand, the method is conservative and there is a risk of type II error, i.e. overlooking real effects, especially with small or moderate effect sizes like those in our

analyses. In this study, it excluded the otherwise significant effect of schizophrenia. It is therefore noteworthy to weigh the consequences between false certainty and loss of sensitivity in the results. In our case, we considered it necessary to be cautious, as we were dealing with psychiatric diagnoses with high clinical significance.

Sample representativeness (SØ). To assess the generalizability of our findings, it is important to consider the diversity of the sample in relation to the population of the Capital Region. There are no questions about sexual orientation in the registration sheets, and gender was analyzed binary due to too few registrations, limiting the ability to examine groups known to be particularly vulnerable to sexual assault and revictimization (Balsam et al., 2011; Macy, 2008; Teasdale et al., 2014). Women were disproportionately represented in the sample, which may reflect both higher exposure to abuse but also gender differences in recognizing or seeking help after abuse (Jeffrey & Senn, 2024). The sample possibly also underrepresents people with both Western and non-Western immigrant backgrounds compared to the background population, which may also explain the lack of ethnic differences between the revictimized and non-revictimized patients at CSO (Macy, 2008). This could potentially be because immigrants and descendants do not have the same opportunities to get help due to language barriers, stigmatization, or structural inequalities (Littleton & Ullman, 2013; Relyea & Ullman, 2017; Weist et al., 2014).

Despite these limitations, the CSO sample is still relatively representative of the population in the region. Its size exceeds much of the existing literature and its use of population-based samples instead of convenience samples improves representativeness (Friis-Rødel et al., 2021; Macy, 2008; Walsh et al., 2014).

6.5 Broader Perspectives and Implications

Individualizing the Problem (SD). This study investigated the prevalence of revictimization in adults who were sexually assaulted in adulthood, with the aim of estimating some risk factors that could explain why certain people are re-offended. This means that this study had a more individual-centered focus on revictimization, which necessitates a discussion of what producing research like this might imply.

In her methodological research review, Macy (2008) has pointed out that there is a lack of research that contextualizes revictimization. Existing research mainly focuses on individual factors such as alcohol consumption and sexual refusal assertiveness, which can

lead to overlooking other important factors such as offender actions, social and cultural norms, and the role of systems and institutions. For example, several studies have found significant correlations between revictimization and offender factors. Both Gidycz et al. (2007) and Park and Monaghan (2022) emphasize the critical role of perpetrator aggression in understanding revictimization. Gidycz et al. (2007) show that women's resistance strategies are highly dependent on the level of aggression used during the assault, while Park and Monaghan (2020) argue that research has historically overemphasized victim-related risk behaviours at the expense of offender-related factors. By integrating both perspectives, they demonstrate that perpetrator aggression holds independent explanatory power and is a central predictor of revictimization risk.

Some authors have argued that revictimization is better understood through an ecological framework where individual, relational, institutional, and cultural factors come into consideration (Decker & Littleton, 2018; Relyea & Ullman, 2017). The demographic differences that emerged in our analyses, such as higher age and unemployment among the revictimized, could, according to those perspectives, be seen as indicators of broader structural and contextual vulnerabilities. An ecological approach allows for interpreting such findings in light of social differences such as access to resources and position in society, rather than solely on individual characteristics (Decker & Littleton, 2018; Relyea & Ullman, 2017). Nonetheless, it must be recognized that this thesis has not had the opportunity to consider comprehensive meso-level factors, such as the social and relational context in which the abuse takes place. Decker and Littleton (2018) point out that young people are often abused in environments characterized by party culture and alcohol, where the abuser is not necessarily an intimate partner, but not a stranger either. Such environments, where norms of boundary setting, peer support and institutional responses play a crucial role, are central to the understanding of revictimization, but unfortunately it has not been possible to investigate this in the current data set.

Yet, the thesis has not directly addressed the influence of the macro level either, such as cultural narratives, rape myths, societal sexual norms and legal frameworks, which Wager et al. (2021) have shown can contribute to a systemic devaluation of victims, especially those who have been revictimized. These macrostructures can be internalized in the form of self-blame or low sexual refusal assertiveness and thus affect the individual's actions in risky situations. Relyea and Ullman (2017) described how these structural factors can be understood through a meta-perspective where individual factors, such as coping and emotional regulation are both influenced by and interact with social and cultural processes.

Researching in a Danish Context (SØ). As argued by Macy (2008), revictimization should be contextualized to include societal factors in understanding the phenomenon. When comparing our findings to international research, it is important to consider that our study was conducted in a Danish context. A relevant example could be our finding that the participants' specific type of employment, and thereby also their level of income, does not increase the risk of revictimization, while many American studies have found income to be a significant indicator of revictimization. It may be because the relative difference between rich and poor is smaller in Scandinavia than it is in the United States (Bendixen et al., 2014). Healthcare, including the CSO, is also completely free in Denmark, which presumably makes it more accessible to people with limited financial means. This may mean that this population group is better represented in our analysis compared to other countries where one has to pay for both emergency examination and psychological treatment afterwards. However, as pointed out in the report, there are still barriers preventing people with fewer resources from seeking help in the public system in Denmark (Friis-Rødel et al., 2021).

A cultural difference that could potentially also have influenced our results is the high consumption of alcohol in Denmark (Cooke et al., 2019). The alcohol culture in Denmark differs significantly from that of countries like the United States and may partly explain why our findings on alcohol consumption as a risk factor for revictimization differ from those of other studies' (Angelone et al., 2018; DeCou & Skewes, 2021). According to some of the studies that examined alcohol consumption among college students, it was argued that sampling from a group that generally had a higher alcohol consumption than the background population potentially skewed their results (Angelone et al., 2018). When designing our study, we have considered that the participants in our sample probably drink alcohol more frequently than participants in many of the international studies with which we compare results. Anderson et al. (2020) divided their "frequency of alcohol consumption" variable dichotomously into drinking/not drinking categories. We have leaned on this measure, but have chosen to divide the responses more conservatively into "does not drink or only drinks regularly" and "drinks daily" to hopefully only highlight those victims who drink excessively.

The social and sexual gender roles that prevail in a given country can also be assumed to increase the vulnerability of survivors of sexual assault to future revictimization (Macy, 2008). According to research on rape myths and stereotypes, a society has a dominant narrative about what characterizes the "real" rape and the "real" rape victim (Friis-Rødel et

al., 2021). These discourses/beliefs are internalized by the individual, including the rape victims, and can affect whether they identify as a victim and thus believe that they deserve help. This in turn might affect who chooses to seek help at CSO and thus are included in our study (van Mastrigt & Hartmann, 2021). As the study relies on individuals from the target population actively seeking help at the CSO, it may be subject to selection bias, particularly if certain subgroups within the population are less likely to seek support. The Nordic countries, including Denmark, have over the years ranked among the most gender equal nations worldwide (Bendixen et al., 2014; Hansen et al., 2019). This may have had an impact on how accepted rape myths are in the population. A Danish study of young people's attitudes towards rape and rape myths found that there is a generally low acceptance of myths (van Mastrigt & Hartmann, 2021). Existing research shows that there are generally fewer rape myths in Denmark compared to other European countries. However, myths still exist, e.g., that abuse can not be perpetrated by one's partner. Previous studies have also found similar results when comparing Norwegians' attitudes towards rape with those of American youths. Despite a difference in equality between cultures, it is therefore still possible that the difference is not as big as one might think.

How the national police handle rape cases and decisions on when to investigate them can also have an impact on who people consider to be real victims (Friis-Rødel, 2021; Hansen et al., 2019; Murphy et al., 2022). Especially if there is a clear investigative bias that aligns with the prevailing rape myths, such as if police reported assaults are more likely to be investigated if the victim was sober while victimized compared to intoxicated. In recent years, there have been a number of policy initiatives in both the United States and Europe aimed at changing this bias (Hansen et al., 2019; Murphy et al., 2022). Research has indicated that the Danish police, are guided less by the prevailing myths than before, which has potentially empowered more victims of sexual assault to seek help. In addition, rape laws in Denmark, among other countries, have also recently been changed so that an absence of consent is now central to the understanding of the crime (Depireux & glowacz 2024). Based on this, it could be considered whether our selection bias might not be influenced by the same cultural rape myths as in other countries where less attention has been paid to how sexual assault victims are treated.

Both the arguments about a reduction of investigative bias in the Danish police and the consent legislation in Denmark, further emphasize how the handling and understanding of sexual assault has evolved on a societal level in the past few years. This

emphasizes the relevance of continuous research on this phenomenon to depict how it is developing (Hansen et al., 2019; Friis-Rødel et al., 2020).

Practical Implications (SD). Several critics have pointed out that an individual-centered focus, for example, in the form of prevalence of risk factors in research, can have consequences for how victims of sexual revictimization are met in clinical practice (Curchin, 2019; Decker & Littleton, 2018; Relyea & Ullman, 2017; Thapar-Björkert & Morgan, 2010)

According to Bedera and Nordmeyer (2015), women often bear the burden of rape prevention. In their analysis of American universities' prevention content, they found that 80% were directed at women, while only 14% addressed men. Women were typically instructed to set boundaries, avoid wandering alone, and refrain from drinking, while men were simply encouraged to respect a “no”. This mainly places the responsibility for assault on women and maintains rape prevention as an individual, female responsibility, while marginalizing the role of the perpetrator. The authors argue that this contributes to a culture where women's vulnerability is normalized and blame is displaced. Relevant to the previous section, rape myths also exist in a Danish context which can influence the understanding of who is responsible for preventing sexual assault. When such understandings of responsibility and rape myths exist in a society, it is important to consider how these can also contribute to certain discourses in treatment centers, such as CSO.

A study by Thapar-Björkert and Morgan (2010) examined how blame and responsibility for violence and abuse is often unconsciously placed on the victim, even in institutions and support programs with declared anti-blame policies. Through interviews with volunteers in a UK victim support group, they demonstrated how cultural and institutional discourses still found their way into practice. They found that some volunteers maintained a belief that women should change their behaviour to avoid abuse. This was reflected in comments about women's responsibility to avoid risky situations or to dress “challenging”. Thapar-Björkert and Morgan (2010) warn that such notions risk reproducing a culture of violence where responsibility is shifted from the perpetrator to the victim and societal challenges are reduced to individual actions. Risk factors, such as the ones discussed in the present thesis, can thus quickly be understood in the light of existing rape myths, which can have implications for how patients are received by health care professionals. When discussing individual risk factors, clinicians risk planting self-blame in the victim by telling them that some characteristic of their actions or psychological vulnerability caused it to happen. Miller et al. (2007) argue that self-blame can often be exacerbated by how victims of

sexual assault are perceived in society and not least by the public agencies they encounter in their search for help, which in turn actually increases the risk of revictimization. This suggests that research of this kind may inadvertently reinforce the notion that victims are responsible for their own abuse, a notion that, through mechanisms such as self-blame and reduced social support, can help maintain or increase the risk of revictimization.

This raises a key question for us on how to prevent knowledge about risk factors from being used to stigmatize victims, rather than addressing the societal conditions that make abuse possible. Curchin (2019) has handled this subject of counselling and treating women to prevent them from being abused or revictimized, without blaming them. She explains it with following quote, *"Women have the potential capacity to prevent and resist rape, yet are not responsible for rape on account of this potential capacity"* (Stringer, 2014 In Curchin, 2019, p.5). She presents two important concepts that are relevant when arguing in favour of prevention in vulnerable groups; *strategic interest*, which is the aim for society and the perpetrators to change, versus *practical interest*, meaning that victims need tools here and now to protect themselves. Ideally a therapist can have a strategic interest in society changing and in disproving rape myths, while in reality still be obligated to try to protect their patients by addressing risk behaviors or maladaptive patterns. Since changing society's handling of abuse is extensive and complex, and it is more difficult to access offender investigations, practical interests should be kept in mind and address victims' capacities without removing the perpetrator's responsibility. However, there is merely a fine line in the communication and treatment of these findings. Our research places a great responsibility on clinicians and therefore we encourage it to be handled responsibly and with caution. Inspired by Curhin (2019), we encourage clinicians to be careful in communicating advice and prevention to the patient. The clinician should ask themselves whether it creates unreasonable sacrifices in terms of freedom of the patient and then the clinician should be mindful of not judging the victims for not adhering to the advice, as it is after all the perpetrators' responsibility that the assault is committed.

7. Conclusion and Future Directions (C)

This thesis' findings indicate that sexual revictimization in adulthood is a frequent and pressing concern. At the Center of Sexual Assault (CSO) more than one in three patients reported having experienced multiple assaults. This underscores the need to expand our understanding of the mechanisms driving revictimization, not only to improve theoretical models but also to inform preventive strategies in clinical practice.

The results showed that revictimized individuals were significantly older and more likely to be unemployed compared to those who had experienced a single assault. These demographic differences suggest that certain societal groups may be more vulnerable, an insight that, through an ecological lens, points to the potential impact of structural and socioeconomic inequalities on victimization risk. Furthermore, our analysis replicated several associations between revictimization and psychological vulnerability, previously established in the research literature. Particularly it seems that certain psychiatric disorders as well as substance abuse, increase the risk of being sexually assaulted again. Characteristics of the assault itself may also play a role. In particular, the relationship to the perpetrator was significant. Interestingly, no association was found between revictimization and assault severity or resistance strategies, which diverges from previous research findings.

Although this study provides important insights, it also has limitations. The analysis focused on individual risk factors and did not explore potential interactions or cumulative effects between them. Hence, future research should adopt multivariate designs and consider integrating meso- and macrolevel influences such as rape myths, societal norms, and cultural factors, for example, how victims are perceived, especially in the culture in which the victimizations take place.

Despite the limitations, the study contributes to the literature by highlighting clinical and demographic risk profiles that may otherwise be overlooked. It also calls for greater clinical awareness of revictimization as a recurrent and structurally embedded problem. For practitioners, this means not only screening for known individual risk factors such as psychiatric vulnerability and substance use, but also being mindful of the broader social and relational contexts in which patients live. By doing so, clinical settings like CSO can play a key role in both support and prevention.

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Prevalence and Risk Factors of Sexual Revictimization in Adult Sexual Assault Victims

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Data availability

Data is not publicly available

Abstract (C)

Objective. While repeated sexual victimization is known to worsen trauma outcomes, research on revictimization following an initial assault in adulthood remains limited. This study sought to answer the research question, "*what is the prevalence and risk factors of revictimization among adult sexual assault survivors?".* **Method.** The objective of this study was to conduct a cross-sectional analysis of the registered data (recorded between 2018 - 2024) from The Center of Sexual Assault (CSO) in Copenhagen. All patients in the defined period who had experienced their first sexual assault after the age of 15 were included (N = 4161). The sample consisted of predominantly female, ethnically Danish, young adult victims. Additionally, specific risk factors guided by the literature were investigated such as psychological vulnerability factors, including psychiatric disorders and substance abuse, and assault characteristics, including severity, sexual refusal assertiveness (SRA), and victim-perpetrator relationship. **Findings.** A prevalence rate of 34% was found in the sample meaning that more than one third of the patients at CSO experience multiple assaults during adulthood. Significant differences between groups indicated relevant risk factors including psychological vulnerability, specific psychiatric disorders and substance abuse, as well as the relation to the perpetrator ($p < .001$). **Conclusions.** Despite its limitations, the use of registry-based clinical data from a large, population-based sample offers a contribution to the literature by identifying clinical and demographic risk profiles that may otherwise be overlooked while also underscoring the need for greater clinical awareness of revictimization as a recurrent and structurally embedded issue. However, the cross-sectional and retrospective design, combined with underrepresentation of minorities, limits causal inference and generalizability underscoring the need for future prospective, longitudinal, and more inclusive research designs.

Keywords: sexual revictimization, sexual assault, psychological vulnerability, assault characteristics

Introduction (C)

Sexual assault is a widespread global issue with profound consequences for the victim's physical and mental health (World Health Organization, 2013). Having experienced a sexual assault is considered one of the main risk factors of experiencing a subsequent one (Relyea & Ullman, 2017). Furthermore, research has shown that experiencing revictimization, repeated sexual assault, can further worsen mental health effects of earlier abuse and significantly increase the risk of PTSD (Arata, 2002; Cividanes et al., 2019; Macy, 2008). Thus, understanding what precedes revictimization is essential to improving prevention efforts.

Research on sexual revictimization has previously been dominated by studies on child sexual abuse (CSA) and subsequent sexual assault in adulthood (Walker et al., 2019). Since childhood is a particularly sensitive developmental period, there is reason to believe that sexual revictimization of adults whose initial sexual victimization happened in adulthood is a distinct phenomenon (Humphrey & White, 2000). Adolescents and adults whose first experiences of sexual assault occur later in life also appear to face a heightened risk of repeated victimization (Angelone et al., 2018; Cusack et al., 2021; Edwards & Banyard, 2022; Humphrey & White, 2000). Despite this, research on revictimization among individuals whose first assault occurred in adolescence or adulthood remains relatively scarce and methodologically heterogeneous leaving important questions unanswered about risk patterns and relevant factors in this population (Macy, 2008).

Existing Research on Sexual Revictimization (SD)

Research shows that revictimization is prevalent across populations and contexts. Among young women, Walsh et al. (2023) found that 21.7% experienced sexual or physical revictimization within six months of their initial rape. In a broader dataset, Walsh et al. (2014) found a 50% revictimization rate among women who had previously experienced

rape. High rates have also been found in studies of college students with Cusack et al. (2021) reporting that 39.5% of those who had previously experienced sexual assault were revictimized during college. The risk was higher if the first offence occurred early in adolescence. Similar trends were also found in a smaller study by Katz et al. (2010) where 31% of women experienced revictimization within six months.

Long-term studies support the pattern. Relyea and Ullman (2017) found that 49% of women who had previously experienced sexual assault in adulthood were revictimized over a three-year period. Ullman and Najdowski (2009) and Livingston et al. (2007) also reported revictimization rates of 45% and 50%, with a higher risk among women who had previously experienced severe abuse such as rape.

Findings of high revictimization rates within 1–2 years of the initial assault have led to investigations into whether the time elapsed since the first assault influences the risk of subsequent victimization. The fact that abuse in adolescence appears to increase risk more than abuse in childhood may either be due to developmental vulnerability, but it could also be due to a recency effect where risk is highest shortly after the first sexual assault (Angelone et al., 2018; Classen et al., 2005).

There are studies that support this idea. Ullman (2016) and Walsh et al. (2023) found high revictimization rates within the first year of the initial assault, especially the first six months. However, other results are more contradictory. Walsh et al. (2014) found that adults in their 40s on average had higher rates compared to younger participants, which may be because they have had more years to be exposed. Furthermore, Relyea and Ullman (2017) found no effect of ‘time since most severe abuse’ and instead suggest that factors such as coping, symptom severity, and social support may be more important explanations for the association.

Although studies in the field of revictimization vary in design and operationalization, they indicate that the risk of recurrent abuse is significant, also among people exposed in adolescence or adulthood. This makes it interesting to further investigate this, and whether there is a recency effect in the risk of revictimization.

Existing Research on Risk Factors

Demographics (SØ). Research has indicated that socioeconomic factors such as limited education, low income, and partaking in risky professions, such as prostitution or drug-dealing, increase the risk of revictimization (Loya, 2014; Relyea & Ullman, 2017; Walsh et al., 2023). With fewer financial resources one might be more likely to live in areas with higher crime rates which could increase the exposure to possible perpetrators (Loya, 2014; Walsh, 2023). Lacking a resourceful network or the financial means to take a break from work after experiencing an initial assault may also hinder recovery, increasing vulnerability to future victimizations (Loya, 2014).

Being part of an ethnic minority has also been shown to increase the risk of sexual victimizations (Caamano-Isorna et al., 2021; Littleton & Ullman, 2013; Macy, 2008; Relyea & Ullman, 2017). With roots in culture and historical inequalities, having low socioeconomic status can be more frequent in minority groups, potentially putting them at risk. Ethnic minorities might also face barriers when seeking help after assaults, such as linguistic difficulties or discrimination (Littleton & Ullman, 2013; Relyea & Ullman, 2017).

Psychological vulnerability (SD). Several studies have examined how mental health issues influence the risk of being sexually victimized and later revictimized (Christ et al., 2022; Cusack et al., 2021; Jouriles et al., 2017; Policastro et al., 2016; Smith et al., 2022). In particular, depression, PTSD, and excessive alcohol use have repeatedly been identified as risk factors. Psychiatric disorders and substance abuse are often investigated in extension or

in interaction with each other. In this case, both are treated as psychological vulnerability factors. In a large longitudinal study, Cusack et al (2021) found that symptoms of depression, trauma reactions, and alcohol abuse increased the risk of revictimization while anxiety did not. Edwards and Banyard (2022) found similar patterns among adolescents, with depression and suicidal ideation being more common among revictimized than among non-revictimized and non-victims. They argue that mental health symptoms and disorders can impair the ability to exercise assertive resistance in revictimization situations, thus increasing the risk of revictimization.

Several studies have highlighted PTSD as a key vulnerability factor. According to research, PTSD symptoms can impair risk perception, lead to maladaptive coping strategies, and thus increase vulnerability to further abuse (Littleton & Ullman, 2013; Ullman, 2016). At the same time, research indicates that PTSD is a consequence of, as well as a mediator between, earlier and later abuse (Jouriles et al., 2017; Relyea & Ullman, 2017).

Smith et al. (2022) has explained how depression and anxiety can contribute to revictimization based on the Stress Generation Model. According to the model, individuals with depression and anxiety are at higher risk of revictimization because the disorders can generate interpersonal stress in the form of internalized negative cognitions about self-worth and feelings of helplessness. This in turn may lead them into riskier situations, for example by using maladaptive coping-strategies such as substance abuse, which weakens their ability to protect themselves (Smith et al., 2022).

As aforementioned, substance abuse is also a frequent focus of sexual assault research (DeCou & Skewes, 2021; Park & Monaghan, 2022; Testa et al., 2007; Walsh et al., 2014). While most evidence indicates a significant correlation between drug use and revictimization, the research on alcohol use is more mixed with some evidence indicating a significant difference between single and recurrent victims (Anderson et al., 2020; Angelone et al., 2018;

DeCou & Skewes, 2021; Littleton & Ullman, 2013). Several of the studies that find a link between substance abuse and revictimization subsequently discuss whether alcohol consumption or drug use is a coping strategy for dealing with psychological distress such as PTSD (Anderson et al., 2020; Angelone et al., 2018; DeCou & Skewes, 2021; Littleton & Ullman, 2013). In line with the self-medication hypothesis, it can be argued that victims who have developed PTSD after their first assault will tend to use alcohol to relieve their psychological distress, increasing their overall consumption (Littleton & Ullman, 2013; Messman-Moore et al., 2013; Walsh et al., 2014). Being under the influence of alcohol or drugs can make it more difficult to avert dangerous situations and to resist unwanted sexual advances, increasing the likelihood of being targeted by a possible perpetrator (Littleton and Ullman, 2013; Testa et al., 2007).

Assault characteristics (SØ). As Fisher et al. (2010) has noted, state dependence, also known as incident characteristics, may be a factor in determining who experiences subsequent sexual assaults.

Sexual refusal assertiveness (SRA) refers to the ability to refuse a sexual activity, express sexual boundaries, and resist in potentially abusive situations. According to López Alvarado et al. (2020), high SRA is associated with safer and more respectful sexual relationships while low SRA may reflect an uncertainty about boundaries and an inability to resist sexual assault. SRA typically develops during adolescence and is influenced by factors such as self-esteem, sexual experiences, cultural norms, and coping strategies.

Several studies have identified low SRA as a risk factor for sexual revictimization, particularly among college women (Katz et al., 2010; Kearns & Calhoun, 2010; Kelley et al., 2016; Kirwan et al., 2022).

Oesterle et al. (2022) have chosen to separate assertive resistance strategy from sexual refusal assertiveness. They showed that low SRA and the use of non-assertive coping

strategies in hypothetical scenarios (e.g., ignoring or joking about the situation) reinforced the association between past and new victimization. Further evidence supporting this association was found in a national study by Fisher et al. (2010) where women who attempted to resist the first assault had a lower risk of later revictimization. This indicates that the ability to respond assertively in stressful situations has a protective effect.

Research explains the association between SRA and sexual victimization as reciprocal, more specifically by suggesting that low sexual refusal assertiveness (SRA) may increase the risk of revictimization because it reduces the ability to set boundaries, recognize risky behavior, and respond assertively in sexual situations which makes individuals more vulnerable to assault. Prior victimization can further reinforce this vulnerability by undermining self-esteem, risk perception, and belief in one's own agency, contributing to a circular dynamic in which sexual victimization and low SRA mutually reinforce one another (Edwards & Banyard, 2022; Livingston et al., 2007; Smith et al., 2022).

Another relevant characteristic may be the relationship between the perpetrator and the victim (Fisher et al., 2010; Friis-Rødel et al., 2021; Johnson et al., 2020; Park & Monaghan, 2022; Testa et al., 2007). A type of perpetrator, that may be relevant for closer inspection, is the intimate partner, as this type of relationship is often found to be most prevalent among victims of sexual assault (Park & Monaghan, 2022; Testa et al., 2007). Intimate relationships can be characterized as involving previous instances of consensual sex, such as the relationship with a current or previous romantic partner (Testa et al., 2007; Willis & Jozkowski, 2019). It has been argued that this relationship might hold a greater risk of victimization because closer proximity to a motivated perpetrator and sexual precedence in a relationship can increase the risk of sexual coercion (Fisher et al., 2010; Park & Monaghan, 2022; Testa et al., 2007; Willis & Jozkowski, 2019). While research on college students has also found that victimizations by acquaintances, such as partners, are most frequent in their

sample, only assaults by strangers was shown to increase the risk of revictimization (Anderson et al., 2020). Besides being a potential risk factor for revictimization, the distribution of perpetrator-relationships within a sample might also influence which other risk factors emerge as significant predictors of revictimization (Fisher et al., 2010; Testa et al., 2007). Revictimizations by non-intimate perpetrators can be predicted by frequent episodes of heavy drinking and a high number of sexual partners while assaults by intimate perpetrators can be predicted by low SRA, frequency of drug use, and previous sexual assaults by intimate partners (Depireux & Glowacz, 2024; Johnson et al., 2020; Park & Monaghan, 2022; Testa et al., 2007; Willis & Jozkowski, 2019). If assaults committed in intimate and non-intimate relationships can be understood as different constructs, some researchers recommend separating them when investigating revictimization (Depireux & Glowacz 2024; Fisher et al., 2010; Testa et al., 2007). If a sample is dominated by a certain type of victim-perpetrator relationship it might influence which risk factors emerge as significant. This could explain the contradictory findings in research on substance abuse, among other things.

Additionally, research has found that individuals who experienced life-threatening danger during an assault were 5.5 times more likely to be revictimized within six months than those who did not (Walsh et al., 2023). A systematic review of 15 longitudinal studies similarly found that both frequency and severity of past partner violence predicted later sexual or physical revictimization (Kuijpers et al., 2011). More recently, Neilson et al. (2018) also found that women with more severe assault experiences responded more slowly to a hypothetical sexual threat situation, suggesting that prior severe assault may reduce one's risk perception.

Although severity, including the use of physical violence, threats, or perceived danger to life, often appears as a risk factor, the link is not necessarily direct. Several authors,

including Littleton and Ullman (2013) and Walsh et al. (2023), have suggested that it is not the nature of the violence per se, but rather the psychological consequences, particularly PTSD symptoms, that mediate the influence on revictimization. In addition, there are methodological conditions, such as the risk of bias in follow-up studies, where people with the most traumatic experiences are often underrepresented due to higher drop-out rates (Walsh et al., 2023). Despite such ambiguities, the existing literature provides a basis for examining whether abuse severity is an independent risk factor for sexual revictimization.

Present Study (C)

This study aims to estimate the prevalence of revictimization in a sample of adult victims of sexual assault in adulthood. Secondly, the study seeks to test for a number of risk factors such as demographics, psychological vulnerability factors, including mental disorders and substance abuse, as well as characteristics of the first assault, such as degree of violence, resistance strategy, and the relationship to the abuser (Fisher et al., 2010).

Method

Participants and Procedure (SØ)

Participants were drawn from The Centre of Sexual Assaults (CSO) and consisted of all registered patients in Copenhagen between 2018 and 2024. The full dataset consisted of 4581 patients. To avoid mixing CSA with adult revictimization, patients whose first assault occurred before the age of 15 were excluded (n = 393). Patients who reported an additional assault, but one that occurred after the one they sought help for, were also excluded to ensure that responses about previous assaults were only based on assaults prior to current ones (n = 27). Thus the full sample in this study was N = 4161 patients.

CSO is a unit at Rigshospitalet in Copenhagen where patients can receive multidisciplinary sexual assault treatment from nurses, doctors, psychologists and social workers. The unit accepts patients who have been victims of, "sexual acts in the form of vaginal, anal or oral penetration, or attempted penetration without their consent" (Center for Seksuelle Overgreb, n.d.). As the center includes an urgent care unit, victims from the entire Capital Region of Denmark and Region Zealand are accepted if they seek help within 7 days of their assault occurring. If the referral occurs more than 7 days after the assault, the patient will be assessed at their local hospital.

An interview-based survey was completed by trained professionals upon arrival at the center. In 2022, CSO changed their registration form, and the analysis will thus be based on merged data from 2 different measurement tools.

Measures (SD)

Sexual Revictimization. Multiple experiences of sexual assault was measured as: "*Has the patient been sexually assaulted by another offender prior to the reason for referral?*". Answers were coded into a binary response option: "Yes, prior to [the current assault]" or "No". Multiple assaults by the same perpetrator were considered one reason for referral at CSO, and these patients have therefore been registered as non-revictimized. Patients who recorded previous sexual assaults were additionally asked, "*How long before contacting CSO did the previous assault/last previous assault take place?"*, which was measured as 1 = "Less than half a year ago", 2 = "½-1 year ago", 3 = "1-3 years ago", 4 = "More than 3 years ago".

Demographics. Participants' age, gender, ethnicity, education and employment was recorded. Ethnicity was organized as either 1 = "Danish", 2 = "Immigrant/descendant from a western country", or 3 = "immigrant/descendant from a non-western country". Education was

measured as the patient's highest level of completed education and could be answered as follows, 1 = "Completed less education than ninth grade", 2 = "Primary school", 3 = "High school", 4 = "Vocational education", 5 = "Short-cycle higher education (less than three years)", 6 = "medium-cycle higher education (three-four years)", 7 = "Long-cycle higher education (more than four years)". Employment status was recorded as 1 = "Student", 2 = "In employment" or 3 = "Not in employment". If the patient answered 2 = "In employment", another question was asked where the type of work could be specified as either 1 = "Self-employed", 2 = "Top executive, employee of highest paylevel", 3 = "Employee of medium paylevel" or 4 = "Employee of lowest paylevel or other". Both editions of the registration scheme also had an item where it could be logged if a patient identified as a sex worker.

Psychological Vulnerability. Mental illnesses that have been diagnosed or are currently being assessed, are measured in an independent item that can be dichotomously answered with "Yes" or "No". For the patients experiencing mental illness, their specific disorders can be recorded in predefined categories. Due to different recording practices between the previous and new registration sheet, it was decided to only utilize data from the new scheme during the investigation of this measure.

Substance abuse was measured by frequency of alcohol and drug use. The patient's general alcohol intake was registered as either 1 = "No use", 2 = "Regular use, not daily", 3 = "Daily use" or 4 = "Has been or is in recovery and/or doesn't use any longer". In line with existing literature, items were dichotomized into 1 = "No alcohol use or regular, but not daily, use", or 2 = "Daily use or in/has been in recovery from substance abuse" (Anderson et al., 2020). Usage of non-prescription drugs was initially measured according to the type of drug. Patients were asked separately about their intake of mild (marijuana), intermediate (cocaine, pills and ecstasy) and hard drugs (Heroin and morphine). Response options were equal to those of the question on alcohol use. The measures were merged to a singular, ordinal

variable in which only the participants' most severe form of drug use was registered. Drug use was in the final analysis measured as 1 = "No drug use or only tried mild drugs a few times", 2 = "Any current or previous use of mild drugs", 3 = "Any current or previous use of intermediate drugs", and 4 = "Any current or previous use of hard drugs".

Assault Characteristics. The victim's relationship with the perpetrator at the time of the assault was selected from a list of possible types of relationships, such as *boyfriend, family member, Scout leader, classmate* etc. As suggested by the existing literature, we categorized relationships according to whether they were "Intimate" or "Non-intimate" to have a basis for comparison (Testa et al., 2007).

The degree of violence experienced during the most recent assault was recorded with a list of possible forms of violence such as *restraint, blunt violence e.g. blows with a flat hand, sharp violence e.g. stabbing, strangulation* etc. For analytical purposes, answers were tallied and registered as the total number of violent elements answered. The answers were coded in line with Neilson et al.'s (2018) paper, and the final variable was therefore a sum of experienced violence. An upper category of 5 or more types of violence was created.

Assertive resistance strategy during the most recent assault was also recorded as displayed resistance, such as verbal resistance (e.g. saying no directly or saying no by mentioning obstacles) and physical resistance (e.g. crying, running, pushing, etc.). As coded by Fisher et al. (2010) we created a binary variable where answers were dichotomized as either "No type of resistance was performed" or "Any type of resistance was performed".

Data Analysis (SØ)

To assess the representativeness of the sample, frequencies on key demographic characteristics (e.g., age, gender, and ethnicity) were compared to data on the population in region H from Statistics Denmark.

In order to examine the prevalence and risk factors of revictimization, the data was analyzed using SPSS version 29.0.2.0 (20). Frequency analyses were used to identify trends and differences between revictimized and non-revictimized which were then tested with inferential statistics, including Chi-square tests, Mann-Whitney U tests, and an independent-samples t-test. To ensure anonymity of data, all analyses with $n < 5$ will not be reported in the results.

As the variable for psychiatric disorders was only available in the most recent part of the dataset (n = 1.522), both the main analysis and the subsequent post-hoc analyses on specific diagnoses were limited to this sub-sample. 10 post-hoc Chi-square analyses were executed to identify which specific psychiatric diagnoses might contribute to a possible connection between revictimization and psychiatric disorders. To control for multiple comparisons, Bonferroni correction was applied yielding an adjusted significance threshold of $p < .005$ (Benjamini & Hochberg, 1995). Effect sizes in the form of Cramer's V, Phi, Rosenthal's r and Cohen's d were calculated for the corresponding analyses.

Results

Sample Characteristics and Background Analysis (SD)

The registered sample of 4.161 corresponds to an average annual incidence rate of approximately 37.05 people per 100.000 inhabitants over the age of 15 in the region, based on the population in the Capital Region in 2023 (N = 1.604.409, Danmarks Statistik, 2023a).

Compared to the background population, participants in this study differ significantly on several demographic parameters. On average, they are significantly younger (25.5 years vs. 40.8 years) and far more often women (95.4% vs. 51.3%, Danmarks Statistik, 2023a). Ethnically, non-western immigrants and descendants as well as western immigrants and

descendants were slightly underrepresented compared to the background population (8.5% vs. 14.99% and 5.3% vs. 8.54%, Danmarks Statistik, 2023b). In addition, people in employment are significantly underrepresented in the CSO group (31.3% vs. 63.6%) while the proportion outside the labour force is higher (68.7% vs. 32.8%, Danmarks Statistik, 2023c). Although it should be noted that students make up a large proportion of the "outside of labour force" group in the CSO dataset. In the CSO sample, 30% had primary school as their highest completed education and 30.9% had reported high school while 11.3% had medium and 7% long higher education. In comparison, data on the background population shows that 34.4% had primary school as their highest level of education while 20.1% and 15.3% had medium and long higher education (Danmarks Statistik, 2023d). Thus, there is an overrepresentation of lower levels of completed education in the CSO group compared to the background population. In regards to employment status, high earners and managers are strongly underrepresented in the sample (4% vs 39.2%) while lower-income groups dominate (53% vs. 40.9%, Danmarks Statistik, 2023c).

The Extent of Revictimization (SD)

Table 1 presents the count and percentage of CSO patients who have been sexually victimized once and the number and percentage of patients who have experienced sexual revictimization. The prevalence of victimization among patients in CSO is 34%, meaning that more than ⅓ of the patients have experienced more than 1 assault after the age of 15.

The percentage distribution of "time since first sexual assault" is depicted in Table 2. When examining how long ago the revictimized patients experienced their first victimization, "over 3 years ago" was the most commonly reported timespan (43.2%). Furthermore, 17.2% had been revictimized less than a half year after their most recent victimization.

Table 1

Prevalence of Revictimization

	Patients at CSO (N = 4161)	
	%	n
Revictimized	34.0	1078
Non-Revictimized	66.0	2096
Missing data		987

Table 2

Time Since First Victimization

	Revictimized Patients (n = 905)	
	%	n
Less than a half year	17.2	156
0.5 – 1 year	13.3	120
1 – 3 years ago	26.3	238
Over 3 years ago	43.2	391

Comparing Revictimized and non-Revictimized Patients

Demographics (SØ). As shown in Table 3, the two groups differed significantly on a number of demographic characteristics. The group of revictimized participants had a significantly higher mean age ($M = 26.38$) than the non-revictimized participants ($M = 24.10$, $p < .001$, $d = 0.25$). A Chi-Square test also showed that gender was significantly associated with revictimization ($p < .001$, $\varphi = .08$). When looking at the frequency analysis, the percentage of men in the revictimized sample was smaller (2.3%) than in the non-revictimized sample (5.7%).

There is also a significant difference in the distribution of employment status in the two groups ($p < .001$, V = .22). There were approximately similar percentages of people in work (31.1% vs 31.6%), but there were fewer students in the revictimized group than in the non-revictimized group (38.4% vs 55%). This, in turn, means that the percentage of unemployed in the revictimized group was larger compared to the non-revictimized (30.6% vs 13.4%).

Psychological Vulnerability (SD). A Chi-Square test showed a significant difference between the prevalence of psychiatric disorders in the two groups ($p < .001$, $\varphi = .22$). As depicted in Table 3, 55.3% of the revictimized had a psychiatric disorder which differed significantly from the 33.4% of the non-revictimized patients. The post-hoc analyses showed significant differences on certain diagnoses as depicted in Table 4 ($\varphi < .22$). The largest difference was observed in PTSD with 13% of the revictimized reporting PTSD compared to 2.2% of the non-revictimized. This was followed by affective disorders (19% vs. 12%), personality disorder (8.1% vs. 3%), anxiety (19.5% vs. 12%) and ADHD (15.9% vs 9.8%). There were no significant differences for autism, schizophrenia, eating disorder or OCD after the Bonferroni correction.

All types of substance abuse were significantly more prevalent in the group of revictimized patients than in the non-revictimized group ($p < .001$). Of the revictimized patients 5.9% reported "drinking alcohol daily or being in recovery from alcohol use". Only 1.7% of the non-revictimized patients reported the same frequency of alcohol use, which was significantly less than the revictimized patients ($p < .001$, $\varphi = -.11$). Of the non-revictimized patients 89.7% reported using no drugs compared to 72.3% of the revictimized patients. Frequency analysis showed that the revictimized patients were more likely to consume both mild (12.3% vs 6.3%), intermediate (10.8% vs 3.3%) and hard drugs (4.6% vs 0.7%).

Assault characteristics (SØ). As depicted in Table 3, A Mann-Whitney U test showed no significant difference between the amount of violence each group reported ($p = .166$, $r = -0.03$). Likewise, a Chi-Square test showed no significant association between resistance and revictimization either ($p = .643$, $\varphi = -.01$). Of the revictimized patients 76.3% reported either verbal or physical resistance which is similar to the non-revictimized group where 75.5% reported having exerted resistance.

A Chi-Square test revealed a significant difference in perpetrator type between the revictimized and non-revictimized patients in regard to their most recent sexual assault ($p < .001$, $\varphi = .09$). It was uncovered that the most common relationship between perpetrator and victim was non-intimate in both the revictimized (84.5%) and non-revictimized groups (90.3%). However, the revictimized patients were more likely to be assaulted by an intimate partner (15.5%) than the non-revictimized (9.7%).

Table 3

Frequencies Distributed Across Variables, [%(n)], and Group Differences

Variables	Revictimized	Non-Revictimized	Test Value	*p*
Age	*M* = 26.38 (*SD* = 9.26)	*M* = 24.10 (*SD* = 9.13)	$t_{.05}(3172) = 6.64$	**< .001**
Gender			$X^2(1, n = 3168) = 18.82$	**< .001**
Male	2.3% (25)	5.7% (120)		
Female	97.7% (1049)	94.3% (1974)		
Ethnicity			X^2 (2, n = 3055) = 2.21	.331
Danish	86.3% (893)	87.5% (1767)		
Immigrant/descendant western	5.3% (55)	5.6% (113)		
Immigrant/descendant non-western	8.4% (87)	6.9% (140)		
Employment			X^2 (2, n = 3104) = 145.82	**< .001**
Student	38.4% (398)	55% (1137)		
Employed	31.1% (322)	31.6% (654)		
Unemployed	30.6% (317)	13.4% (276)		
Specified Employment			X^2 (3, n = 956) = 5.51	.138
Self-employed	7% (22)	4.7% (30)		
Top executive, Employee of highest pay level	2.9% (9)	5.5% (35)		
Employee of middle pay level	35.6% (112)	37.3% (239)		
Employee of lowest pay level or other	54.6% (172)	52.6% (337)		
Education	Mdn (3)	Mdn (3)	*U* = 702774.00, (n = 2603)	.814

Less than ninth grade	9.8% (76)	10.7% (196)		
Primary school	31.3% (242)	30.5% (558)		
High school	31.6% (244)	31.8% (582)		
Vocational education	5.1% (39)	5.7% (105)		
Short-cycle higher education	4.0% (31)	3.1% (57)		
medium-cycle higher education	10.9% (84)	11.4% (209)		
Long-cycle higher education	7.3% (56)	6.8 % (124)		
Prostitution	1.8% (19)	0.6 (12)	X^2 (1, n = 3115) = 10.69	**.002**
Psychiatric disorder[a]	55.3% (202)	33.4% (198)	X^2 (1, n = 958) = 44.77	**< .001**
Daily alcohol use	5.9% (55)	1.7% (32)	X^2 (1, n = 2800) = 36.55	**< .001**
Drug use	Mdn (1)	Mdn (1)	U = 635802.50, (n = 2653)	**< .001**
No drug use	72.3% (628)	89.7% (1600)		
Mild drug use	12.3% (107)	6.3% (113)		
Medium drug use	10.8% (94)	3.3% (58)		
Hard drug use	4.6% (40)	0.7% (13)		
Degree of violence by perpetrator	Mdn (1)	Mdn (1)	U = 463515.00, (n = 2036)	.166
No violence	25.2% (187)	26.8% (346)		
1 act of violence	41.3% (307)	41.5% (537)		
2 acts of violence	16.0% (119)	17.7% (229)		
3 acts of violence	8.5% (63)	7.9% (102)		
4 acts of violence	4.7% (35)	3.7% (48)		
5 or more acts of violence	4.3% (32)	2.4% (31)		
Resistance			X^2 (1, n = 2384) = 0.21	.643
No resistance	23.7% (193)	24.5% (385)		
Physical or verbal resistance	76.3% (622)	75.5% (1184)		
Victim-perpetrator relationship (Most Recent Assault)			X^2 (1, n = 2869) = 21.33	**<.001**
Intimate relationship	15.5% (153)	9.7% (183)		
Non-intimate relationship	84.5% (831)	90.3% (1702)		

[a]Includes data from only the new dataset.

Table 4

Prevalence of Psychiatric Disorders, [%(n)], and Group Differences

	Revictimized	Non-revictimized	Test Value	*p*
Affective disorders	19% (73)	12% (72)	X^2 (1, n = 984) = 9.16	**.002**
Anxiety	19.5% (75)	12% (72)	X^2 (1, n = 984) = 10.45	**.001**
PTSD	13% (50)	2.2% (13)	X^2 (1, n = 984) = 46.03	**<.001**
OCD	3.4% (13)	2.2% (13)	X^2 (1, n = 984) = 1.35	.245
Personality disorder	8.1% (31)	3.0% (18)	X^2 (1, n = 984) = 12.74	**<.001**
Eating disorder	3.6% (14)	2.2% (13)	X^2 (1, n = 984) = 1.92	.166
Schizophrenia	8.6% (33)	4.3% (26)	X^2 (1, n = 984) = 7.54	**.**006
Autism	3.9% (15)	3.3% (20)	X^2 (1, n = 984) = 0.22	.636
ADHD	15.9% (61)	9.8% (59)	X^2 (1, n = 984) = 8.01	**.005**
Other disorders	1.8% (7)	1.7% (10)	X^2 (1, n = 984) = 0.03	.854

Note. Data from the old registration scheme were excluded from the post-hoc tests. Bonferroni correction was applied, yielding an adjusted significance threshold of p < .005.

Discussion (C)

This study aimed to estimate the prevalence of sexual revictimizations among adults whos initial sexual assault also occurred in adulthood as well as predicting different risk factors based on group differences between single-assault patients and revictimized patients. We found that more than a third of the patients at CSO had experienced previous sexual assaults, classifying them as revictimized. These patients were significantly older and they were more likely to be unemployed than the single-assault patients. Further, we found that both psychological vulnerability and some characteristics of the sexual assault can predict future sexual victimizations. Although the existing literature was torn, our research supports the claim that substance abuse, both frequency of alcohol intake and drug use, is connected to revictimization.

The Prevalence of Revictimization (SD)

The prevalence rate highlights that revictimization is also common among adults exposed to sexual abuse in adulthood. Compared to Walsh et al. (2023), who found a revictimization rate of 21.7% in a similar sample from a rape center, our findings appear

high. However, a significant methodological difference is that Walsh et al. (2023) used a longitudinal design and only had six months of follow-up, while this study used data from hospital records. Our data indicates that revictimization often occurs several years after the first assault, which does not support a recency risk that is otherwise found in the literature (Classen et al., 2005). This may explain why a shorter follow-up period can lead to underestimation of prevalence in Walsh et al. (2023).

Other studies report higher prevalence rates (e.g. Anderson et al., 2020; Cusack et al., 2021; Relyea & Ullman, 2017) which is likely related to their broader definitions of sexual revictimization. Unlike the present study, which focuses on rape and severe assault, many other studies include unwanted sexual contact and verbal abuse. In line with this, it is relevant to point out that Katz et al. (2010) found that "unwanted sexual contact" was the most frequently reported form of revictimization (56%) while only 26% reported completed assault or rape. Therefore, it makes sense that studies with a broader definition of abuse would also find higher prevalences than the present study.

Many studies in the revictimization field focus on American college students. Their revictimization rates vary significantly from 11% to 69% often due to differences in study design (longitudinal vs. cross-sectional) and how revictimization is defined (Angelone et al., 2018; Cusack et al., 2021; Katz et al., 2010). Studies on adult women show similar variations in revictimization rates between 21.7% and 50.3% which can also be attributed to differences in methodology (Littleton et al., 2025; Relyea & Ullman, 2017).

Comparing our prevalence rate of 34% to studies of adults with childhood abuse (CSA), our rate is lower than the 47.9-67% found in previous meta-analyses (Classen et al., 2005; Walker et al., 2019). This is likely related to the particular vulnerability of childhood, where many experiences are formed, but it also highlights that revictimization in adulthood is a widespread and independent problem that deserves attention.

The Effect of Psychological Vulnerability (SØ)

The results of this study's analysis have shown that over half of the revictimized have a mental disorder compared to about a third of the non-revictimized. Post-hoc analyses showed that there were significant differences in affective disorders, anxiety, PTSD, personality disorder and ADHD between the revictimized and non-revictimized patients (Table 4). It supports many of the findings that have already been made in the field, including associations between revictimization and PTSD (Conley et al., 2017; Cusack et al., 2021; Jouriles et al., 2017; Ullman, 2016) and depression (Christ et al., 2022; Cusack et al., 2021; Edwards & Banyard, 2022; Smith et al., 2022). Contrary to what Cusack et al. (2021) found, there is a significant difference in anxiety disorder between the two groups in the current study with 38.1% of the revictimized and 29.4% of the non-revictimized reporting having the disorder. One reason for this difference may be that Cusack et al (2021) investigate anxiety via self-reported symptoms on questionnaires, whereas our sample is categorized based on whether or not they have the clinical diagnosis.

When comparing studies, it is important to note that many of them rely on non-clinical samples and self-reported symptoms which can lead to both under- and overestimation of the relationship between mental illness and revictimization. In contrast, studies that use clinically diagnosed participants (e.g. Christ et al., 2022) provide more credible results regarding mental illness. For example, the score on a single-item symptom scale, as employed by Edwards and Banyard (2022), is not directly comparable to a clinical diagnosis. However, it should be emphasized that despite nurses having access to patient records the CSO is not a diagnostic unit, and there is a risk that some patients with mental disorders will not be identified during the process. Furthermore, according to the CSO's policy, patients with untreated severe mental illness are referred to psychiatric services as they are considered to receive more appropriate care there. Additionally, it should be noted

that some patients who report being under assessment for a diagnosis may not ultimately meet the criteria, which means they could be misclassified.

It is important to point out that it has not been possible to determine whether the patients' mental disorders preceded or occurred after the assault. Although the results of the analyses show a univariate association between mental illness and revictimization, this does not mean that a direct causal relationship can be established. However, the literature suggests that mental disorders can often develop after an assault and then have an indirect effect on victimization such as through reduced risk perception, self-efficacy, or maladaptive coping strategies (Littleton et al., 2025; Smith et al., 2022; Ullman, 2016). In accordance with this argument, all types of substance abuse were significantly more prevalent in the revictimized group than the non-revictimized.

The Victim-Perpetrator Relationship (SD)

Our finding that intimately known perpetrators were not the most prevalent, contradicts existing research on samples similar to ours (Testa et al., 2007). Surprisingly, it does support findings within college samples (Anderson et al., 2020; Johnson et al., 2020). Because the vast majority of abusers in our sample were known non-intimately, this should, according to the literature, be reflected in which factors significantly predict revictimization in our analyses (Johnson et al., 2020; Park & Monaghan, 2022; Testa et al., 2007). In accordance with what Testa et al. (2007) found to be significant predictors of revictimization by non-intimate perpetrators, we found that alcohol use significantly predicted revictimization while low SRA did not. However, contrary to Testa et al. (2007) we also found that drug use was a risk factor for revictimization which suggests that this risk factor might not be limited to victims of intimate partner violence. To support the hypothesis of

dependent risk profiles, future research should conduct analyses comparing the same factors and characteristics across offender types within the group of revictimized patients only. This would indicate whether risk factors are distributed as expected on the basis of current research (Testa et al., 2007).

Our study replicates existing research to some extent by indicating that revictimized patients were significantly more likely to be victims of intimate partner abuse than non-revictimized victims (Anderson et al., 2020; Fisher et al., 2010; Park & Monaghan, 2022; Testa et al., 2007). But because intimate relationships made up a very small percentage of the victim-offender relationships examined, this should be understood as one of many risk pathways to revictimization in our sample. It is possible that intimately known perpetrators were less prevalent in our study because victims of intimate partner violence are less likely to acknowledge themselves as victims and to seek help from the public systems (Bagwell-Gray, 2021; Depireux & Glowacz, 2024; Friis-Rødel et al., 2021; Hansen et al., 2019). Our results may indicate that this victim group is less likely to seek help at CSO than other victims of sexual assault, perhaps making our conclusions around this characteristic less reliable.

Lack of SRA-Effect **(SD)**

According to the literature, the results should have replicated that patients with previous victimization also showed less resistance during revictimization, than patients for whom it was their first assault (Fisher et al, 2010; Oesterle et al, 2022). One explanation for not finding the same results as in the literature may be that sexual refusal assertiveness (SRA) is operationalized differently in this study compared to other studies (López Alvarado et al., 2020). Many researchers also measure SRA based on how participants' report that they would react in hypothetical scenarios. In this study, our focus was on the latter part of the

phenomenon by comparing the resistance of revictimized victims with that of non-revictimized victims. Moreover, it is important to emphasize that there can be a big difference between how you think you would react in a risky situation compared to how you actually react in a critical situation (Oesterle et al., 2022).

There may also not be an effect of SRA because few in the sample have experienced abuse from "intimate" partners, where low SRA typically has the greatest impact (Testa et al., 2019). In addition, there is a lack of detail on first assaults from the revictimized individuals, which complicates causal interpretations. This can lead to skewness because their second offence is compared to the first offence of the non-revictimized. Nevertheless, it should still have been possible to detect that those who have been revictimized are less resistant during their second assault, as the literature suggests (Livingston et al., 2007; Oesterle et al., 2022).

Strengths and Limitations **(SØ)**

The first notable consideration is that the data used to inform the present study was cross-sectional. Although, this method is effective in estimating prevalences and correlations across a large sample it does not take temporality into account, making it difficult to determine the order of different factors, e.g. whether a mental disorder may cause revictimization or whether a mental disorder is a result of it (Walsh et al., 2014). As our study has replicated, the majority of patients experience revictimization 3 years or more after their initial assault. Thus, it is possible that individuals classified as non-revictimized may still be at risk.

Another limitation of the study design is that data is collected retrospectively, which can lead to recall bias (Fairbrother et al., 2025). This is particularly relevant when investigating sensitive and complex phenomena such as sexual assault and revictimization. The patients in this study may potentially remember the assault differently than it happened

either because it happened a long time ago or because they are in an acute state (shortly after the assault has occurred). According to Walker et al. (2019) women who have experienced sexual assault may also find it difficult to acknowledge it as an assault, especially if the assault does not fit into stereotypical understandings of what constitutes one or if it was committed by a boyfriend or friend.

However, this study is also strengthened by its use of hospital registry data which allows the information to be collected as close to the event as possible. Unfortunately, it limits our opportunity to tailor questions or obtain data according to our specific hypotheses. Because data was collected by professionals trained in talking to traumatized patients and with specific knowledge of abuse, it likely ensured more accurate and nuanced data than self-report surveys, which the majority of papers in the research field have conducted (Conley et al., 2017; Cusack et al., 2021). However, this method also comes with a risk of interpretation bias, as the information is not collected directly from the patients but communicated through the clinical interviewers. On the other hand, the method allows professionals to ask follow-up questions, interpret uncertainty and validate answers during the conversation with patients, while at the same time building trust, which increases the possibility of honest and open sharing of sensitive information (Insua-Summerhays et al., 2018).

Yet another limitation of collecting data via conversation is that the patient may experience social desirability or shame, which can cause them to underreport important information, for example about substances, previous abuse, or their relationship with the perpetrator (Hall & Farber, 2001).

It is important to consider the diversity of the sample in terms of representativeness to the population of the capital region. Here it is relevant to highlight that sexual orientation was not registered in the database. This, combined with the gender analyses being limited to the binary, prevents analysis of groups that research otherwise has shown to be particularly

vulnerable to sexual assault and revictimization (Balsam et al., 2011; Macy, 2008; Teasdale et al., 2014). However, It is important to point out the large overrepresentation of women in the data. This may be because research indicates that more women are exposed to sexual assault than men, but it may also be a result of gendered patterns in experiences of abuse, realisations about the abuse and differences in whether and how people seek help (Wingender & Olesen, 2024).

As aforementioned, the sample does not fully reflect the composition of the population when it comes to ethnic origin. Immigrants and descendants of both western and non-western origin were underrepresented in this study which may limit representativeness and thus generalisability of the indicated risk factors in this study. This lack of ethnic representativity could also explain why ethnicity did not emerge as a significant risk factor for revictimization despite evidence indicating this connection (Caamano-Isorna et al., 2021; Littleton et al., 2025; Macy, 2008; Relyea & Ullman, 2017).

However, given how difficult victims of sexual assault can be to encompass adequately, the patients at CSO in the Capital Region of Denmark is still a sample with a high degree of representativeness. Both because of the sample size, which exceeds much of the existing literature, and because population sampling was used rather than convenience sampling, which much of the existing literature has been forced to use (Friis-Rødel et al., 2021; Macy, 2008; Walsh et al., 2014).

In conclusion, this study demonstrated that sexual revictimization in adulthood is a prevalent issue, affecting over one-third of patients at the Center of Sexual Assault (CSO) in Copenhagen. Significant associations were found between revictimization and factors such as age, employment status, psychiatric vulnerability, substance use, and perpetrator relationship. These findings underscore the need for clinical attention to both individual and structural risk factors. However, the cross-sectional and retrospective design, combined with

underrepresentation of minorities, limits causal inference and generalizability underscoring the need for future prospective, longitudinal, and more inclusive research designs.

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