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Research Paper

Reasons for contacting the consultation service of a Dutch assault centre

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ABSTRACT

A telephone and e-mail helpline known as the Consultation Service, open to all the public, was launched at a Dutch Centre for Sexual Violence to deal with non-acute sexual violence. The aim of this study was to gain insight into case characteristics, reasons for contacting the Consultation Service and whether these reasons differed for victims, their relatives and professionals. Using a mixed methods design, the study included all consultations handled at the Consultation Service in 2018 and 2019. Descriptive statistics described quantitatively the case characteristics, the themes and differences between victims, relatives and professionals. The themes of the reasons for contact were established from the qualitative analysis, using the method of content analysis. Cases were characterised by complexity. Three themes emerged: case complexity, decision-making on care options and reporting to the police, which differed for victims, relatives and professionals. The differences in reasons for contacting the helpline imply that approaches should be adapted and fitted to different clients. Specialised care is needed to guide clients through cases that are challenging and often complex. There is a widespread lack of knowledge of options in addition to the complex multifaceted aspects to decision making about actions post-assault. Assault centres should implement a Consultation Service in which integrated care is offered not only to the victims, but also to their relatives and professionals.

1. Introduction

Sexual violence is defined as forcing someone to perform or undergo sexual activity against one's will and without consent.[1] Sexual violence is a worldwide public health concern with a significant health impact, whose immediate consequences include physical injuries, unwanted pregnancies and sexually transmitted diseases.[2,3] In the long-term, victims suffer from lasting psychological issues such as anxiety, post-traumatic stress disorder (PTSD) and depression as well as from physical consequences, such as cardiovascular diseases and persistent physical symptoms.[2,3] To prevent adverse health outcomes, professional help at a multidisciplinary assault centre to improve care for victims of acute sexual violence is recommended.[4–6]

Sexual violence is not only significant and life-changing for victims, but it also puts a great burden on the victims' relatives and on professionals supporting victims. Relatives worry about the victims' well-being and often feel anger towards perpetrators, and they are, moreover, important facilitators in helping victims to contact an assault service.[7,8] For professionals in their turn, sexual violence is a difficult issue to discuss with clients and patients.[9–11]

At a regional Dutch sexual assault centre for victims of acute sexual violence, a telephone and e-mail helpline was launched for non-acute sexual violence, known as the Consultation Service (CS). This CS is open to all the public: victims, their relatives and professionals, such as doctors from all medical disciplines, psychologists, legal professionals, social workers and school counsellors. Adverse psychological or physical effects are known reasons for victims to contact such a service, and although research has been performed on the help-seeking behaviour of victims of sexual violence, reasons to specifically contact a CS have scarcely been studied, certainly not those of relatives or professionals.[12,13] Knowledge of these reasons and possible differences between victims, relatives and professionals will help caregivers of victims to offer more fitting and appropriate care, matching their advice to their clients' specific needs.

The aim of our study, therefore, is to gain insight into the reasons for contacting the CS. The following research questions were formulated: what are the characteristics of the victims who consult the CS? What are reasons for contacting the CS and do these reasons differ for victims, their relatives and professionals?

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Table 1
Definitions of victim, assault and perpetrator characteristics.

Characteristics	Definitions[1,7]
Cognitive disability	Based on the consultants' notes and files
Living situation	
Living alone	Victims living alone, victims living with minors and homeless victims
Living with others	Victims living together with others (partners, parents, roommates) and victims living in an assisted living residence
Type of psychosocial care	
Mental healthcare	Mental healthcare included youth services and social work. Mental healthcare provided by the GP and mental healthcare practice nurses were excluded.
Assisted living residency	A residence for people unable to live on their own, including psychiatric inpatients, people living in crisis relief and minors living in foster care homes.
Other	Care including neighbourhood services, victim support and school counsellors.
Type of sexual violence	
No penetration	Unwanted touching with sexual intention, including manual sex
Penetration	Unwanted sexual vaginal, anal and/or oral penetration
Suspicion of sexual violence	The client suspected rape or assault but was unable to establish complete certainty, for instance, due to the victim's age, a cognitive disability or loss of memory due to a drug- facilitated sexual assault (DFSA).
Incestuous sexual violence	Sexual violence by a family member, including stepfamily and members of a foster family
Intimate partner violence	Sexual violence taking place within an intimate (ex) relationship
Drug-facilitated sexual assault (DFSA)	(Suspicion of) sexual violence that was non-consensual due to the effect of drugs or alcohol
Frequency of violence	Sexual violence performed once or more than once by the same perpetrator
Previous violence	History of sexual or domestic violence
Victim-perpetrator relationship	
Family, (ex-)partner	The perpetrator is a (ex-)partner or family member, which also includes stepfamily or members of a foster home.
Friend, acquaintance, colleague	The perpetrator is a friend, acquaintance or colleague of the victim.
Recent contact (internet, prostitution)	The victim met the perpetrator less than 24 h ago (e.g., in a club, on the Internet).
Stranger	The victim never met the perpetrator before.

2. Methods

2.1. Setting

The study was set at the CS of a Dutch Centre for Sexual Violence Gelderland-Zuid en- Midden (CSG-GZM) in the eastern part of the Netherlands. This Centre offers acute care for victims who were assaulted less than eight days ago. These victims receive interdisciplinary care at an emergency department to treat and prevent diseases and to offer psychological and legal support. Next to acute care, a CS was established to meet the needs of victims who require advice or care outside of the eight-day window. Callers can reach the CS by e-mail or telephone to submit their requests or questions. Consultants at the CS either mail, call or meet face-to-face with callers for a consultation. During this consultation, callers and consultants explore the problems and discuss specific advice or possible care solutions. The consultants are one experienced general practitioner (GP) and two mental health nurses, all with special expertise on sexual violence and consultation.

2.2. Study design and study population

This study has a mixed methods design. The study population consists of all consultations handled at the CS in 2018 and 2019.

2.3. Data collection

All data was retrieved from digitally written and anonymous case reports. Case reports described the problems the callers experienced and their reasons for contacting the CS, as well as background information on the victim, the assault and the perpetrator. All data retrieved from the case reports was added to an SPSS database.

2.4. Measurements and definitions

The following characteristics of the consultations were registered in the SPSS database: type of client, the client's gender, type of contact and time between the sexual assault and CS contact. As background characteristics of the victim, the following items were registered: gender, age categories, ethnicity, living situation, family composition, existing psychosocial care and the presence of a cognitive disability. Details of the assault and the perpetrator were noted: the type of sexual violence, the frequency of the violence, previous violence, the number of perpetrators, whether it was a drug facilitated sexual assault (DFSA) and the relationship with the perpetrator. Several characteristics are explained in greater detail in Table 1.

The callers were divided into three categories: victims, relatives and professionals. Relatives also included friends, acquaintances and colleagues. Professionals included medical, psychological, social, legal and educational professionals.

Some callers mentioned multiple reasons for contact. In this study, the most important reason was defined as the reason for contact, based on the degree of attention this reason received in the case reports.

2.5. Data analysis

Descriptive statistics in SPSS were used to describe background characteristics, to quantitatively display the themes and to describe the differences between victims, relatives and professionals. To establish the themes for reasons to contact the CS a qualitative document analysis was performed. In this analysis, the case reports were analysed using the content analysis method. First, the researcher (JM) familiarised with the data by reading all case reports. Suitable codes were selected in discussion with a second experienced qualitative researcher (TLJ). Next, a category list was made of reasons for contacting the CS. The reasons for contact were then categorised by the two researchers (JM and TLJ)

Table 2
Example of theme generation.

Reason for contact	Code	Category	Theme
A professional calls about a male victim, who is 17, and has been absent from school. The victim is stuck in prostitution. The professional and the victim's parents have tried to get him out of prostitution, but without success. The victim avoids discussions. The professional feels helpless and does not know what steps to take.	Prostitution, male victim, minor, communicative problem, emotional call for help	Fragile victim, multiple problems, burdensome for client	Case complexity
A medical professional calls about a 16-year-old girl, who was raped by her brother last year. The family tries to hide the incident. The girl is now suffering from PTSD symptoms. When the professional decided to report the incident to a child protection service, the victim's parents were very angry and wanted to sever all contact with the professional. He wonders how he can help the victim but also how he can rekindle the professional bond with the family.	Incestuous assault, closed family system, PTSD symptoms, worrying, conflicting problems, dealing with anger	Fragile victim, fragile family situation, burdensome for client, multiple and conflicting problems	Case complexity

independently and discussed in the supervising committee. When the categories differed, the researchers discussed until consensus was reached. Finally, themes were identified based on the categories by the two researchers and discussed in the supervising committee. An example of this coding, categorising and theming process is provided in Table 2.

Once the themes had been formed, all case reports were assigned to the applicable theme. In this way, the frequency of themes and differences in themes between different callers were analysed. A comprehensive overview of the data analysis is shown in Fig. 1.

Examples of the reasons for contact are used to illustrate the themes formed. The examples are displayed with an identifying case report number, type of client, and the victim's sex and age category. To guarantee the anonymity of the cases, identifiable case-specific information was deleted or altered.

2.6. Ethical aspects

The CMO Radboudumc declared that this study was not subject to the law on Dutch Medical Research Involving Human Subjects (WMO) (file number 2018-4661). All data was anonymised prior to analysis. To guarantee the complete privacy of the case reports, the victims' names and dates of birth of were fully deleted. Secondly, a confidentiality agreement relating to the content of the reports was made with the researcher. Lastly, the reports were not copied or taken outside the CS.

3. Results

3.1. Study population

The CS was contacted by callers 340 times: 25% of callers were victims, 25% were relatives and 50% were professionals (Table 3). Around 80% of callers were female. Most contacts were conducted by telephone. Callers predominantly reached out to the CS one week to one year after the incident.

Most victims were female and 40% of victims were minors (Table 4). A cognitive disability was present in 10% of the victims. In minors, 43% of parents were divorced. Psychosocial care was present in over half of all cases, with over 40% of victims receiving mental healthcare and 12% of victims living in assisted living residency. Over 45% of victims suffered from sexual violence more than once by the same perpetrator. The perpetrator was most often a family member or a (ex-)partner, with over 29% of victims suffering from incestuous sexual violence.

3.2. Reasons for contact

The case reports varied in scope and style: some gave detailed information, while others were short and straightforward. Three themes covering the most important reasons for contact emerged from these case reports: case complexity, decision-making on care options and reporting to the police. Over 44% of cases concerned callers who were confronted with a complex case (Table 5). Around 40% of callers contacted the CS as they were unaware of options for care. Reporting to the police was mentioned by 15% of callers. Illustrative reasons for contact are shown with a case report number per theme in Tables 7–9.

3.2.1. Differences in reasons for contacting themes per type of client

In 75% of cases, victims sought help at the CS to explore care options (Table 6). Over half the relatives contacted the CS to make decisions on care options for victims and one-third felt entangled in a complex case. Most professionals reached out as they were confronted with complex cases.

3.2.2. Theme 1: case complexity

Most consultations concerned complex cases in which victims often suffered from psychiatric morbidities and were embedded in a fragile social environment. Table 4 shows that 10% of victims suffered from a mental disability and 43% of victims had already received mental healthcare. In minors, over 43% of children came from divorced families, and 29% experienced incest by a family member.

Complex cases were characterised by multiple, sometimes conflicting problems, which made it challenging for callers to find a fitting approach (C1, C2 Table 7). The multiple problems in complex cases caused callers to struggle with elucidating the main problem (C3 Table 7), which was noticeable as consultations often revealed new topics, which proved to be crucial for discovering the main problem. Complex cases were burdensome to callers as victims were often vulnerable and mentally unstable, and their misjudgement of the situation might cause harm to victims (C4 Table 7). This increased their need to discuss a case with an expert. Sometimes callers were looking for reassurance about their approach and the work they had already done. As complex cases were characterised by the great number of caregivers involved, it was hard to decide whether extra care was needed or whether current care levels would suffice, with adaptations or not (C5 Table 7). All cases in which victims suffered from sexual violence within an intimate partner relationship could be categorised as complex. Victims mentioned being socially isolated, scared, trapped and anxious to

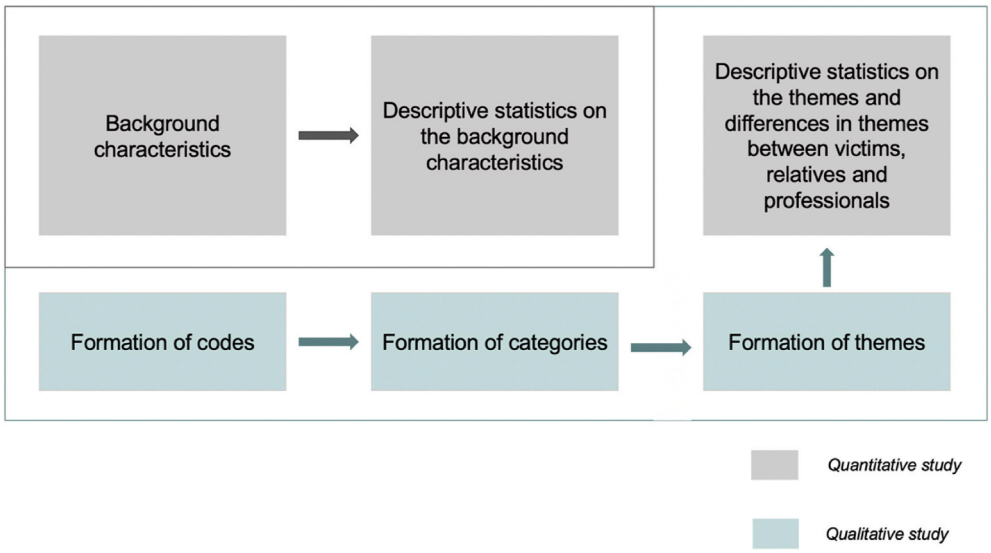

Fig. 1. Overview of the data analysis.

Table 3
Characteristics of 340 cases presented at the CS in 2018 and 2019.

Characteristics	% Cases (n = 340)
Type of client	
Victim	24.4% (83)
Relative	26.2% (89)
Professional	49.4% (168)
Caller's gender	
Female	79.1% (269)
Male	18.8% (64)
Unknown	2.1% (7)
Type of contact	
Telephone	91.2% (310)
E-mail	2.6% (9)
Face-to-face	6.2% (21)
Time between sexual assault and contact	
≤ 7 days	16.5% (56)
>7 days–1 year	37.9% (129)
1 year–5 years	10.9% (37)
>5 years	10.9% (37)
Unknown[a]	23.8% (81)

[a] Unknown due to a registration error.

disclose to anyone. Most victims were unable to leave their alarming home situation, as they were dependent on the perpetrator. Relatives and professionals mentioned that it was difficult to help victims as they felt powerless and perceived the case as a burden due to the severe concerns for the victims' safety (C6 Table 7).

3.2.3. Theme 2: decision-making on care options

Many victims reached out to the CS just to tell their story and to be heard, without formulating a concrete problem or question. Victims had little notion of what they were actually in need of and were unaware of options for care. Victims told how they felt, mentioning their emotions, symptoms and worries (C2 Table 8). Most victims wanted someone to listen and acknowledge their feelings. Some victims mentioned they were unsure whether their feelings and emotions were normal and reasonable; they reached out to gain support and recognition, as they felt lonely and lacked a supportive social system. A few victims sought acknowledgement of what had happened to them because they were unsure if what had happened to them actually constituted sexual violence. When sexual violence occurred within a friendship, victims experienced conflicting emotions about whether the incident was acceptable or not (C2 Table 8). Moreover, victims wished to receive psychosocial support for problems such as anxiety, depressive feelings, sleeping problems and other psychological problems related to the incident. Psychosocial support was requested in particular when victims suffered from problems in day-to-day life such as not daring to go outside, attending school or resuming work (C3 Table 8).

When victims themselves did not dare to contact the CS, relatives took over (C4 Table 8). They contacted the Centre to explore what care victims needed and subsequently helped them arrange such care (C5 Table 8). Relatives often worried about the victims' mental wellbeing. As they considered the victims fragile, they wanted advice on what approach to take and how best to support them (C6 Table 8).

Medical professionals contacted the Centre if they had little experience with victims of acute rape. They felt incompetent and lacked knowledge, which made them unable to decide what care victims needed (C7 Table 8). Relatives and professionals more often asked for a specific type of psychosocial support as they already had fitting type of care in mind but wanted to be reassured about their ideas (C8 Table 8).

3.2.4. Theme 3: reporting to the police

Medicolegal issues were common across all types of callers. Sometimes, these problems required a straight-forward answer, such as questions about STD and drug testing, medical examinations or regulations (C1, C2 Table 9). Most legal questions, however, were diverse and intricate for callers and often required extensive consultation. Callers were mainly hesitant about the decision whether to report to the police or not, especially when the perpetrator was a friend, family member or a partner, which gave rise to conflicting emotions in the victim, complicating the decision to report even further. Callers contacted the Centre in order to gain information on reporting, but even more so to discuss their feelings and ideas about reporting (C3 Table 9).

Some callers suspected that someone had been the victim of sexual violence but were unable to confirm this as the victim was drugged, a minor or suffered from a severe mental disability. A suspicion of sexual violence also involved difficult legal problems, such as the decision whether to confront the offender or whether to press charges or not. Many callers wanted to know what symptoms indicated that sexual violence had indeed occurred so as to be able to determine if their suspicion was grounded (C4 Table 9). Callers sought affirmation that their evidence was hard and that their legal case would be strong. Suspicion of sexual violence often occurred among children during or after a divorce and in broken family relationships, and in such cases, lengthy

Table 4
Victim, assault and perpetrator characteristics as presented at the CS in 2018 and 2019.

Characteristics	% Victims (n = 340)
Gender	
Female	80.9% (275)
Male	18.2% (62)
Unknown	0.9% (3)
Age	
<12 years	20.6% (70)
12 – 17 years	22.1% (75)
18 – 25 years	27.9% (95)
> 25 years	25.3% (86)
Unknown	4.1% (14)
Ethnicity	
Western	78.8% (268)
Non-western	7.6% (26)
Unknown	13.5% (46)
Cognitive disability	10.0% (34)
Living situation	
Living alone	12.1% (41)
Living with others	73.8% (251)
Unknown	14.1% (48)
Family structure (n = 145)[a]	
Parents divorced	42.8% (62)
Parents not divorced	57.2% (83)
Psychosocial care present	53.2% (181)
Type of psychosocial care	
Mental healthcare	42.9% (146)
Assisted living residency	12.1% (41)
Other	27.1% (92)
Intimate partner violence	5.3% (18)
Type of sexual violence	
Penetration	71.8% (244)
No penetration	19.1% (65)
Violence presumed	7.6% (26)
Unknown	1.5% (5)
Incestuous sexual violence	28.5% (97)
DFSA	9.4% (32)
Frequency of violence	
Once	46.8% (159)
More than once	46.2% (157)
Unknown[b]	7.1% (24)
Previous violence	14.1% (48)
Number of perpetrators	
1 perpetrator	77.9% (265)
> 1 perpetrator	12.6% (43)
Unknown[b]	9.4% (32)
Victim-perpetrator relationship	
Family, (ex-)partner	37.1% (126)
Friend, acquaintance, colleague	39.7% (135)
Recent contact (Internet, prostitution)	14.7% (50)
Stranger	2.1% (7)
Unknown	6.5% (22)

[a] Only registered for minors (<18 yrs).
[b] Unknown due to DFSA.

Table 5
Frequency of reasons for contacting themes.

Themes	% cases (n = 340)
Case complexity	44.1% (150)
Decision-making on care options	40.9% (139)
Reporting to the police	15.0% (51)

Table 6
Differences in reasons for contacting themes per type of client.

Type of Client	Reasons for contact	% cases (n = 340)
Victims	Case complexity	11.9% (10)
	Decision-making on care options	75.0% (63)
	Reporting to the police	13.1% (11)
Relatives	Case complexity	33.0% (29)
	Decision-making on care options	52.3% (46)
	Reporting to the police	14.8% (13)
Professionals	Case complexity	66.1% (111)
	Decision-making on care options	17.9% (30)
	Reporting to the police	16.1% (27)

Table 7
Theme 1: Case complexity.

C1, 315	A 21-year-old male victim called. Due to childhood abuse, he suffered from PTSD for which he was visiting a therapist. A year ago, the victim started to have a sexual relationship with his therapist. He recently attempted to discontinue the therapy, but the therapist constantly tried to contact him. He felt lost without psychological help and had suicidal thoughts. He did not know what to do anymore.
C2, 238	A social professional sought advice in a case in which an 11-year-old mentally disabled boy was forced to have sex with a male classmate. The victim's mother already confronted the suspect and the suspect's mother. The perpetrator denied the incident, but the victim was constantly crying and restless. The victim's school was not doing anything, and they thought it would be best to keep the boys in the same class and not cause any further hassle. The mother was very sad and angry with the perpetrator and the school. The professional did not have the slightest idea where to start.
C3, 100	A psychologist called about a 14-year-old girl who had had voluntary sex with multiple men. The psychologist doubted whether these contacts were actually voluntary. The girl had been abused by her stepdad when she was eight years old and received therapy by the psychologist. The victim did not seem upset about her sexual activities and talked openly about them. The psychologist arranged to meet the victim the week after and wondered what she should do.
C4, 235	A psychosocial professional reached out to the Centre as she felt depressed and discouraged about a 16-year-old girl she had been assisting over the past two years. The underage girl was entrapped by a lover-boy gang and unable to get out. The victim's father now blamed the caregivers, including the professional, of not doing their job properly. The professional felt depressed and wondered whether she should indeed have acted differently.
C5, 318	A relative called about a 28-year-old victim. Last year, the victim disclosed to her relatives that she had been abused by her neighbour for several years during her childhood. After the disclosure, the relatives consulted a psychologist and enrolled the victim in therapy. The victim was now also visiting a psychiatrist, and neighbourhood services were also involved. The victim recently quit her work, broke up with her long-term partner and severed contacts with several relatives. The relative felt desperate but remained heavily involved in trying to care for the victim. The relative, emotionally drained but unable to let go, questioned whether the current therapy was actually sufficient.
C6, 150	A medical professional sought advice about a 45-year-old female who confessed to him that she had been suffering from intimate partner violence over the past 20 years. Her husband recently tried to rape her in front of the children. The victim was ambivalent about whether she should leave him, as she had neither a job nor money, barely spoke Dutch and was scared to report. She was socially isolated: no one knew, and no one was allowed to help. The physician was unsure what was good practice and how she could build trust.

legal proceedings might serve to feed the clients' suspicion (C5 Table 9).

4. Discussion and conclusion

4.1. Discussion

Our study shows that victims often came from a problematic environment, with high incest and divorce rates and psychosocial care being already involved, causing callers to feel the need to contact the CS and

Table 8
Theme 2: Decision-making on care options.

C1, 168	A 16-year-old girl called the Centre whilst crying. She recently told a group of friends that a classmate had raped her. Her friends confronted the classmate. He denied the incident. The entire school rallied behind the perpetrator online. She really struggled with this, felt isolated and lonely and wanted to talk to someone.
C2, 33	A 21-year-old female victim wondered if she was at fault. Her date raped her on their second date. She liked him but was not ready to have sex. She expressed to him that she did not want sex but wondered afterwards if she had said it clearly enough. She was afraid to tell people what had happened, felt nervous, tired and had flashbacks. She partially blamed herself, as she should have not let him into her house anyway. She just wanted to tell her story, wanted to know if this was rape, felt nervous about the flashbacks and wanted to know what she could do now.
C3, 27	A 21-year-old victim who had previously received help at the ED met face-to-face with a consultant to discuss her upcoming trip to a city where she had been raped last year. She was scared to run into the perpetrator and wanted tips on how to deal with her fear.
C4, 240	A 19-year-old female victim was raped three months ago and called the CS together with a close friend. The victim had been very confused for months and unable to reach out for help. Last week, she told her friend, who thought her friend's feelings and thoughts were not normal and indicated that she should go to a centre to get help and get some sort of tests. What should they do?
C5, 322	A father contacted the Centre. His 18-year-old daughter was on holiday abroad and had been raped three days ago. She was now very scared and wanted to come home as soon as possible. What should he advise his daughter and what could and should they do when she arrives back home?
C6, 88	A father called to say that his daughter told him that one of her friends, a 15-year-old girl, had been abused by her father. The daughter was very worried about her friend's safety and so were her parents as the victim had said she felt very lonely and depressed. They wanted to invite the girl over for dinner and they wanted to help her with her feelings and emotions. They were wondering how they should discuss the incident and what care would be fitting for the victim.
C7, 209	A medical professional contacted the Centre. That morning, a 27-year-old patient told her she had been raped two weeks ago. This was the first time she had encountered a victim who had been raped. The professional did not feel well-equipped to deal with sexual violence and did not have the slightest idea what needed to be done.
C8, 190	A professional asked about her patient, a 21-year-old woman, who was raped last year and suffered from PTSD. The victim saw a trauma psychologist for treatment and was getting better for a while. Nevertheless, she was now having trouble sleeping and seemed distracted at school. Was there a specific approach for sleeping disorders in trauma patients?

Table 9
Theme 3: Reporting to the police.

C1, 66	A medical professional called as one of his patients, a 21 year-old woman, had presumably been raped eight days ago. The victim went out and took psychedelic drugs. The next morning, she woke up with vaginal pain and a spot of blood in her underwear. She was too ashamed to contact the medical professional right away as she blamed her own drug use for the rape. The professional wondered if there was a way to prove that rape actually took place, in order to build a case.
C2, 10	A father asked if he could report to the police on behalf of his 16-year-old daughter, who definitely did not want to report. The daughter had been a rape victim the year before.
C3, 21	A 19-year-old female victim met with the consultant at the Centre. She was unsure if she should report a sexual incident that had occurred several months ago to the police. The perpetrator was a family member. There was a lot of conflict already in this family and the victim did not want to contribute to that. She wanted information and consultation on what to do. She particularly wanted to know whether the consultant thought the case was a criminal offence.
C4, 289	A mother called about her 3-year-old child, a boy, who started acting differently when he returned from day-care one day, being very withdrawn and quiet and crying. Whereas he used to love day-care up until just two weeks before, the boy was now crying when his mother dropped him off. The mother suspected something had happened. She wanted to know if her assumption was fair and wanted to know what signs would indicate that sexual violence had indeed taken place.
C5, 225	A mother called the Centre. She found that her 2-year-old daughter acted differently when she returned from her ex-partner. She divorced her ex-partner at the beginning of the year as he was physically violent. She was trying to get full custody of her daughter and was so angry because of what had happened to her. The little girl was anxious and did not want her diaper to be changed. The mother wanted to know if sexual violence had taken place.

discuss the case with a professional. Three major reasons for contacting the CS emerged: case complexity, decision-making on care options and reporting to the police. There were notable differences between victims, relatives and professionals in reasons for contact. The most important reason for professionals to contact the CS was that they felt entangled in a complex case, characterised by multiple, sometimes conflicting problems, which made it difficult for them to elucidate what was the main issue and decide on appropriate care. For victims and their relatives, lacking knowledge of what steps to take, their main reason for contact was that they wanted to discuss a case in order to make decisions on options for care. The issue of whether to report to the police or not, finally, arose for professionals, victims and their relatives alike.

Many cases were characterised by complexity. Almost half the cases involved minors from broken families. A divorced family background, sometimes complicated by family feuds, is a known risk factor for sexual violence.[14–16] Another notable complexity was that over half the victims had already received psychosocial care by multiple professionals from different disciplines as victims experienced problems in many different areas, such as psychological problems, social problems or practical problems at school or work. The complexity of these problems often made callers feel powerless.

Professionals felt particularly challenged by the complexity of sexual violence cases, reinforcing their need to consult an expert. As violence is often too complex to handle alone and is often beyond a professional's own competence, this high need to discuss a case with an expert suggests that professionals may feel incompetent in dealing with sexual violence on their own, which previous literature has also shown.[11,17,18] It is recommended, therefore, to discuss complex cases in interprofessional teams.[14]

Our study found that professionals had difficulty identifying, and hence prioritising, the main problem in a case. Consultation with an expert, therefore, helped them to shift their understanding from the reason for contact that was initially given to the actual pivotal problem. The new insights and appropriate problem definition gained during such a consultation reveal the added value of expert discussion, which ultimately serves to improve care for victims.

Complex cases were also emotionally burdensome for professionals, even more so if the caller's feelings and struggles proved to be conflicting. Many professionals appeared to feel insecure about their handling of the intricacy involved and the care they should propose. As caring for victims of sexual violence is a highly demanding, responsible and mentally draining task, it may also affect many professionals' private life and even put them at risk of secondary traumatization.[15,16] Talking to another professional, in this case an experienced consultant, helps to reassure professionals and boost their confidence and strength.

Most victims reached out to the CS to tell their story and share their feelings without putting forward a concrete problem or question: they needed to tell their story to someone who would listen without judging. Previous studies showed that it is hard enough for victims to tell a professional what has happened, let alone to arrange care, and victims, therefore, needed help deciding what care would actually be appropriate to them.[19]

Victims often need someone to guide them through the process as they are too confused and distraught to do so alone.[19,20] Victims who contacted the CS often experienced negative psychological effects after sexual violence, including anxiety, social isolation and a sense of unsafety wearing them down. These negative mental health issues are a known facilitator in help-seeking.[21] Our study showed, moreover, that many victims only started to seek professional help for these negative psychological effects months (or years) after the event had taken place. This reveals the added benefit of offering CS care to victims, in addition

to acute care, regardless of the actual time of the event.

More than 95% of victims who disclose, do so to an informal source, such as friends and family, whereas only one in four discloses to a professional.[22] This highlights the importance of supportive relatives, who play an important role for victims to seek help, report to the police and complete care and therapy, especially when they respond positively to the victims' disclosure.[19,23] Our study also showed that relatives often take on the job of helping victims in seeking professional help and taking practical steps, which is in line with the literature.[7] Positive social reactions prevent the development of PTSD.[24] This again reveals the importance of relatives supporting victims and helping them heal from the traumatic incident.

Although it was mostly victims and relatives who needed help with exploring options for care, it became clear that many professionals lack knowledge of appropriate post-sexual-violence care and options for care. Studies reveal that professionals have difficulty talking to patients about sexual violence and that they also lack fundamental knowledge of sexual violence.[25] This lack of knowledge could be due to the topic of sexual violence not being sufficiently profiled in medical education, which approximately half the Dutch GPs mention as being an issue.[17] Many professionals, therefore, have difficulty recognising symptoms of patients as signals of sexual violence.[26,27] This underdiagnosis of violence makes professionals inexperienced in dealing with sexual violence.

A minority of consultation reasons concerned the dilemma of whether or not to report to the police. This is in accordance with the finding that only 11% of Dutch female victims and 4% of male victims report to the police.[13] The main reason for not reporting is conflict of emotions.[28] While victims feel that the assault is wrong and want the perpetrator be prosecuted, they also feel shame, ambivalence and confusion.[19,28] Ambivalence is mostly due to self-blame, which is often boosted by victim-blaming.[29] This illustrates the importance for both professionals and for relatives to listen without judging and to acknowledge emotions. Beside conflict of emotions another reason for not reporting in our data was the risk of losing social support or friends because of the relationship to the assailant, mostly friends, colleagues or partners. Our study also found that many callers had questions about what counts as legal evidence in a case. Callers questioned whether they had sufficient hard evidence to support their case and what would be the likelihood of success in court. The fear of not having sufficient evidence and, therefore, of having an unsuccessful case is an important factor in victims deciding not to report.

4.1.1. Strengths and limitations

A strength of this study is that, to our knowledge, it is the first study investigating the reasons for victims, their relatives and professionals to contact a telephone and e-mail help service. Moreover, it is the first study exploring differences in reasons for contact between these different types of callers. The mixed-methods design produced rich results, enhancing our insight into both quantitative and qualitative aspects. The coding was done by two researchers independently, and all coding, category and theme formation decisions were discussed in detail. The documents analysed yielded robust material and carefully noted the victims' stories. A limitation is that all case reports that were analysed were recapitulations; these documents, therefore, may have contained subjective interpretations made by the consultant. Although the coding, categorising and theming tasks were executed carefully and thoroughly, qualitative research involves a certain level of interpretation by default.

4.2. Conclusion

This study shows a widespread lack of knowledge of option in addition to the complex multifaceted aspects to decision making about actions post-assault. Our study also underscores the fact that it is not only the victims who requires help and assistance, but also the victim's relatives and the professionals involved. Due to the complexity of many cases and the common inexperience with sexual violence, the specialised care a CS can offer has proved to be of great value and importance. The notable differences in reasons for contact imply that there is need for a fitting approach that is tailored to each type of caller. Linking a CS to sexual assault centres will help to reach out to all victims, regardless of the problem or the time of the event, which will help more victims to overcome or prevent trauma.

4.3. Practice implications

Victims who contact the CS are in need of someone who will listen without judging and take time. It is important to offer psychoeducation as this helps to normalise their reactions. Victims need to be guided through the decision-making process of options on care and assisted in arranging care. As our findings show that victims are often unaware of medicolegal procedures, it is crucial to educate victims on these procedures. Reporting helps to process trauma.[28,30] Therefore, victims should be told about the possibility of having an informative conversation with a police officer or with a lawyer.

Relatives generally do not know how to react and how best to support victims. It is crucial to tell relatives about victim blaming, which impedes recovery and significantly increases the victim's chance of developing PTSD. A non-judgemental attitude, therefore, should be advised. As therapy is often tough and confronting, many victims also need support to successfully complete therapy. Moreover, victims often require practical aid, which relatives in particular are able to give. As relatives play such an important role in supporting victims, it is essential that they do so to their best ability. This reinforces the value of a CS, where relatives too can be informed about options for care and medicolegal procedures and receive the advice they need.

Professionals feel a need to discuss complex cases with an expert. The CS helps them prioritising and elucidating the main problem, ultimately leading to the most appropriate care for victims. It is important, moreover, for professionals to share a case when it is becoming too burdensome to them, preventing secondary traumatization and compassion fatigue. It was also apparent that professionals from all disciplines want to be informed about the long-term medical and psychosocial consequences of sexual assault, what coping style might be ineffective and harmful after an assault, and how to discuss the victims' self-blame and feelings of guilt.

To further elaborate on our study, it would be worthwhile to investigate the callers' experiences with the CS. Improving our understanding of these experiences could enhance our knowledge of the functioning of the CS, which would ultimately help to improve the quality of care for victims of sexual violence.

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CRediT authorship contribution statement

J. Mulder: Conceptualization, Methodology, Formal analysis, Investigation, Data curation, Writing – original draft, Visualization, Project administration. **T.A.M. Teunissen:** Conceptualization, Methodology, Validation, Writing – review & editing, Supervision. **A.L.M. Lagro-Janssen:** Conceptualization, Methodology, Validation, Investigation, Resources, Writing – review & editing, Supervision.

Declaration of competing interest

The authors have stated explicitly that there are no conflicts of interest in connection with this article.

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