

# The Care of Sexual Assault Victims: the First Regional Center in Israel – 10 Years Experience

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**ABSTRACT:** **Background:** The management of sexual assault victims comprises complex medical, psychological, social and judicial care that was previously provided by various disciplines at several distant locations. This novel concept is the delivery of comprehensive care to victims of sexual assault at one location 24 hours a day.

**Objectives:** To describe the characteristics of sexual assault victims, their assailants, the assault and the treatment, and provide descriptive data on the evidentiary examination.

**Methods:** We performed a retrospective analysis of the charts of all sexual assault victims presenting to the Regional Center for Care of Sexual Assault Victims between October 2000 and July 2010. The center, the first in Israel, provides comprehensive care to victims of sexual assault in one location 24 hours a day using a multidisciplinary approach.

**Results:** The study group comprised 1992 subjects; 91.5% of the victims were females and 8.5% were males, and the age ranged from 1 to 88 years (mean age 22.3 years). Of the 1992 victims, 1635 were single (82.2%), 195 were divorced (9.8%), 141 were married (7.1%), 18 were widowed (0.9%) and 3 were unspecified. The assailant was a stranger in 794 (39.8%) of the cases, someone familiar to the victim in 786 cases (39.0%), a partner in 127 cases (6.4%), a family member in 117 cases (5.9%), someone met via the internet in 53 cases (2.7%), an authority figure in 39 cases (2.0%), and unspecified in 76 (3.9%). In the majority of cases the attack occurred either in the evening or at night (71.7%).

**Conclusions:** We identified several risk factors for sexual assault that can be used in prevention programs. The sexual assault victim in our study tended to be a young single woman who was attacked by a familiar assailant in the evening or at night. Our center provides comprehensive care to victims 24 hours a day at one location and includes a team of forensic, psychological, physical and legal specialists.

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**KEY WORDS:** sexual assault, rape, victimization, health services, drug-facilitated sexual assault

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The management of sexual assault victims comprises complex medical, psychological, social and judicial care [1]. Prior to the establishment of the Regional Center for Care of Sexual Assault Victims, management was provided by various disciplines at many distant locations. The victim had to file a police report on his or her assault at a police station, present evidence for persecution in a forensic institute or hospital emergency department, seek medical treatment in a gynecological care facility, and obtain psychosocial support in an appropriate health care setting. Such wanderings may contribute to negative sequelae such as post-traumatic stress disorder associated with the aftermath of sexual assault [2]. Previous studies suggested that sexual victims benefit from a single health care setting strategy since it results in a lesser psychological and physical impact of the sexual assault [3].

In October 2000, the first regional center for the care of sexual assault victims in Israel was established at the Department of Obstetrics and Gynecology, Wolfson Medical Center, Holon. The novel concept of the center was the provision of comprehensive care to victims of sexual assault at one location 24 hours a day. This multidisciplinary approach brings together the various care providers – police, forensic medicine expert, social worker, and gynecologist – in one location [Figure 1]. Gathering evidence for legal persecution is properly carried

**Figure 1.** Concept of the Regional Center for Care of Sexual Assault Victims: the victim is in the center with the other relevant service providers all gathered at one location



out at one location. The medical management comprises psychosocial support, medical treatment of injuries, prophylactic treatment for pregnancy prevention, and empiric treatment for sexually transmitted diseases (syphilis, gonorrhea, trichomoniasis, chlamydia), vaccination for hepatitis B, and preventive treatment for human immunodeficiency virus when indicated. Vaccination for hepatitis B is considered when the victim does not know the assailant and the status of vaccination is alleged as negative. Preventive treatment for HIV is administered when the index of suspicion that the assailant is an HIV carrier is high. Early psychological support is also available. The center is intended primarily for acute cases of sexual assault that occur up to one week prior to presentation at the center.

The aim of our study was to characterize the victims' background and his/her relationship with the assailant, the type of assault including place, day and hour of the attack, the use of force and violence, and involvement of alcohol or drugs.

### SUBJECTS AND METHODS

The study was based on data collected in a survey of cases seen at the Regional Center for Care of Sexual Assault Victims, located at the Wolfson Medical Center between October 2000 and July 2010. The center principally provides care for the central region of Israel (population about 2,000,000). The study protocol was approved by the Wolfson Institutional Review Board Committee.

Victims who arrived at the center were seen by a social worker, a gynecologist (preferably female), a forensic medicine specialist, and a policeman/woman [Figure 1]. Sometimes victims were accompanied by volunteers from the Association of Rape Crisis Centers in Israel. Each victim first provided her or his personal information and description of the sexual assault event to the emergency room's social workers who recorded the data. A gynecologist trained to treat victims of sexual assault examined each victim, administered the appropriate medications and treatment, and recorded the data in the medical file. A forensic medicine specialist collected evidence and completed the required documentation. In every case the data were documented in a special standardized data collection form by the gynecologist and the social worker who were specifically trained for this purpose. The form included personal and demographic data (gender, age, marital status), data relating to the attack (hour, location, number of assailants, relation to the assailant, type of sexual act, type and degree of violence or threat, use of a weapon, involvement of drugs or alcohol), medical and forensic information that included the type of injury, and the police report.

The attacker was designated accordingly as a stranger, an acquaintance, a partner (spouse/boyfriend), a family member, an authority figure (employer, teacher, coach, etc.) or someone

met via the internet. Severe violence was defined if the victim suffered from physical injuries that required additional medical treatment. Use of alcohol and/or drugs was based on the victim's descriptive data and their answers to a specific question included in the sexual assault data collection form regarding the use of alcohol or drug shortly before or during the sexual assault. The timing of the assault was stratified into four categories: morning (6 a.m. to noon), afternoon (noon to 6 p.m.), evening (6 p.m. to midnight), and night (midnight to 6 a.m.).

Analysis of the data was carried out using SPSS 9.0 statistical analysis software (SPSS Inc., Chicago, IL, USA, 1999).

### RESULTS

A total of 2064 sexual assault victims presented to the Regional Center for Care of Sexual Assault Victims between October 2000 and July 2010. The data collection form was unavailable for 72 patients, thus the study group comprised 1992 subjects (96.5%): 1823 females (91.5%) and 169 males (8.5%). The ages ranged from 1 year to 88 years (mean age 22.3 years), with about one-third (n=652, 33.1%) younger than 18. The parents were notified in the majority of cases (n=609, 85.4%) where minors were involved. There were 61 (3.1%) retarded and 80 (4.0%) mentally ill subjects. Of the 1992 subjects 1635 (82.2%) were single, 195 (9.8%) were divorced, 141 (7.1%) were married, 18 (0.9%) were widowed and 3 were unspecified. A total of 536 women (26.9%) reported that they were virgins at the time of the assault. Incest occurred in 70 (3.5%) of the attacks.

The majority of victims (n=781, 39.2%) immediately sought help at the center, while 635 (31.9%) presented within 24 hours of the assault, 286 (14.4%) within 3 days, 196 (9.8%) within 1 week, 89 (4.5%) at or after 1 week, and in 5 cases (0.3%) it was not specified. In most cases the victim first turned to the police for help (n=1159, 58.2%), followed by 346 (17.4%) who turned to the emergency department of our hospital, 139 (7.0%) who turned to the emergency department of another hospital, 136 (6.8%) who presented directly to our center, and 212 (10.7%) who turned for help to various other sources.

**Table 1.** The place where the assaults occurred

	No.	%
Public place	611	30.7
Assailant's home	495	24.8
Victim's home	342	17.2
Car	156	7.8
Bar or club	115	5.8
At work	36	1.8
Other or unspecified	237	19.1
Total	1992	100.0

HIV = human immunodeficiency virus

**Table 2.** Nature of the acquaintance with the assailant

	No.	%
Complete stranger	794	39.8
Familiar to the victim	786	39.0
Partner	127	6.4
Family member	117	5.9
Met via the internet	53	2.7
Authority figure	39	2.0
Unspecified	76	3.9
Total	1992	100.0

**Table 3.** How the victims were subdued

	No.	%
Physical force	1166	58.5
Incapability for judgment	487	24.4
Paralysis	215	10.8
Social pressure	40	2.3
Use of weapon	39	2.0
Unspecified	76	3.9
Total	1992	100.0

The timing of the assault was documented in 1830 cases (91.8%). In 36.3% (n=664) the assault occurred in the evening, in 35.4% (n=647) at night, in 19.5% (n=357) in the afternoon and in 8.8% (n=162) in the morning. A description of the place of assault is presented in Table 1. The nature of the acquaintance with the assailant is summarized in Table 2. Table 3 designates how the victims were subdued. Significant violence was encountered in 553 cases (27.8%), while extreme violence was reported in 125 (6.3%).

For female victims, in cases where the type of sexual act was specified (n=1609), vaginal assault was most commonly reported, occurring in 1245 victims (77.4%), followed by anal assault in 169 (10.5%), oral assault in 29 (1.8%) and combined assault in 166 (10.3%).

Involvement of alcohol was reported in 602 (30.2%) of the cases and involvement of drugs in 147 (7.4%). Since 2005 we began to observe that victims described a temporary memory loss and the suspicion that they had been sexually assaulted without awareness; thus drug-facilitated sexual assault was added to our Sexual Assault Data Collection form. DFSA is denoted as a rape drug (nitrazepam, rohypnol, gamma-hydroxybutyrate, or ketamine). The suspicion of the use of DFSA was recorded in 181 cases (9.1%). In 91.3% of the suspected cases of DFSA, involvement of alcohol or drugs was

also recorded. In only 80 cases of suspected DFSA did we test for the presence of a rape drug. We do not have any positive evidence of a rape drug since all the laboratory tests for rape drugs were negative. Furthermore, the substantial use of alcohol in these cases precluded distinguishing between the use of voluntary alcohol or drugs and the use of a covert drug.

All victims consented to antibiotic prophylaxis for sexually transmitted diseases, 1166 (58.5%) received postcoital contraception, 804 (40.4%) received hepatitis B vaccine, and 272 (13.7%) needed HIV prophylaxis.

## DISCUSSION

This report presents, for the first time, evidence from a single regional center for the care of sexual assault victims as well as data collected from a significant cohort of subjects (n=1992) over a 10 year period. The distinctive concept of this center is the provision of necessary care in one location that brings together all the relevant elements: police, forensic medicine expert, social worker, and gynecologist [Figure 1]. This concept allows efficiency in all the five previously described domains of sexual assault examiner programs [4] with minimal mobilization of the victim, minimalization of testimonial mistakes and discrepancies, and avoidance of unnecessary additional stress. The center promotes the psychological recovery of sexual assault survivors, comprehensive post-rape medical care (e.g., emergency contraception, sexually transmitted disease prophylaxis), documentation of the forensic evidence of the crime in a complete and optimal manner (thereby improving the judicial process by providing better forensics and expert testimony), and enables continuation of proper follow-up in the community by bringing all relevant service providers together to deliver comprehensive care to survivors of sexual assault. A minority of the victims (6.8%) presented directly to our center, whereas most sexual assault victims were brought to us by the police (58.2%).

Our study revealed several key demographic characteristics of sexual assault victims. Similar to previous reports [5-8], the sexual victim in our study was typically a young and single woman. These demographic characteristics can be explained not only by their lifestyle and their higher vulnerability to sexual attack, but also because younger women tend to report sexual assault more than do older women [8]. Also, individuals who have never been married or are separated or divorced were more likely to experience unwanted sexual activity [9].

As previously reported [6,10], sexual assaults are more often carried out by someone familiar to the victim. About 56% of the victims were assaulted by someone who they previously knew or had some type of relationship with, including spouse or boyfriend, acquaintance, parents or other family member, or someone with authority (such as boss, teacher,

DFSA = drug-facilitated sexual assault

coach, etc.). Only in 39.8% of the cases was the assailant a complete stranger, e.g., a random meeting in a public place. In 2.7% of the cases, the assailant was someone “met” via the internet. The internet is a rapidly expanding and frequently used facility today; this is a new and important fact to note, remember and educate youth about accordingly.

Similar to previously reported data [6], 42% of the assaults occurred in either the assailant’s or the victim’s home. About one-third of the attacks (30.7%) occurred in a public place. In the majority of cases the attack occurred either in the evening or at night (71.7%). This probably reflects the lifestyle of adolescents and young people who spend more time in nightclubs, pubs, and at social events and other forms of entertainment in public places on the weekends. The hour of attack supports the above assumption since most sexual attacks of adolescents and young adults occur in the evening or night – the time for social activity and entertainment compared to the morning and afternoon which is dedicated to work and study.

This study revealed that the use of alcohol increased the victim’s vulnerability to sexual assault. This is in agreement with other studies suggesting that alcohol and drugs are associated with sexual assault and have long been recognized as important risk factors for both acquaintance and stranger rape [10,11]. It is important to note that our study had scant data on drug involvement, which can be attributed to the fact that some victims probably avoided reporting the use of drugs. We suggest that the increased involvement of alcohol in sexual assault victims is due to the growing exposure to alcohol in Israel, mainly among adolescents [12] and young adults. On the other hand, growing awareness as well as media coverage have emphasized the health risk facing intoxicated women or males and have identified the risk of rape as an additional hazard.

Beynon and colleagues [11] recently reviewed the role of alcohol and drugs in the risk of being a victim of sexual assault. Only one study of the 11 included in the review addressed covert drugs and estimated that about 2% of instances of alleged drug and alcohol in DFSA sexual assault were due to covert drug administration. The other 10 studies did not exclude voluntary drug or alcohol consumption from their analysis and the results were therefore biased. Our results agree with the conclusion of that review. Although victims described temporary memory loss and suspected they were sexually assaulted without their awareness, we were not able to support the involvement of rape drugs by laboratory testing. Furthermore, in most of the suspected cases (91.3%), alcohol consumption shortly before the temporary loss of memory was reported, which makes it difficult to distinguish between voluntary alcohol use and use of a rape drug.

Our regional center provides comprehensive care for victims of sexual assault, day and night, at one location. They are treated by a professional team of forensic, psychological, physical and legal experts. We carry out a more accurate collection

of forensic evidence that has resulted in improvement of the prosecution process. This activity at the center has increased the awareness of the medical profession and the general public to the special needs in caring for sexual assault victims, specifically regarding the potential use of rape drugs in Israel. Above all, we contributed to the welfare of the victims and to a more gentle and humane approach in their management, significantly benefiting their future recovery. Since prevention is the optimal way to deal with the problem of sexual assault, our unique and large database is a crucial tool that can be used by government authorities for introducing educational programs in schools and health facilities in an attempt to minimize the phenomenon of sexual assault and its sequelae.

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