Sexual revictimization, sexually exploited persons, and the Ecological Model: a transdisciplinary approach with mental health professionals

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Abstract

Sexual revictimization (SR) is relatively unexplored among victims of sexual exploitation, especially among those trafficked from low-income or conflict settings. This study uses an Ecological framework to form a contextualized understanding of SR and how it may be addressed by conducting interviews and focus groups with mental health professionals (MHPs) of diverse professional backgrounds. The study also aims to promote mutual learning and organizational change through these discussions. Qualitative data was analyzed using inductive thematic analysis. Results indicated that SR was a normalized behavioral pattern in patients whose sexual exploitation stemmed from childhood sexual abuse and abnormal psychosocial development. Many patients sought and maintained sexually abusive and unsupportive relationships, and came from impoverished communities where sexual violence was tolerated and sex was used as a survival resource. In comparisons between Dutch society and countries of origin, many of the social inequalities and gendered experiences of SR were shared. Refugees and asylum-seekers were socially disadvantaged in both the Dutch context and their countries of origin. MHPs exhibited enthusiasm in group discussions about conceptualizing and addressing SR. Findings contributed to a contextualized systems understanding of SR and indicated a need to engage the broader psychosocial health system and society in dialogues about SR.

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1. Introduction

With the United Nations' creation of the Sustainable Development Goals (SDGs) in 2015, the world is beginning to formally recognize psychosocial health as a human right and place greater priority on addressing the high global burden of mental illness (Patel et al., 2018). Experts in the field of global mental health argue for promoting and prioritizing "the welfare of people with mental disorders and those at risk of poor mental health, and to enable an environment that promotes mental health for all" by addressing social determinants of health (ibid). By paying special attention to inequities in mental health, such an approach is crucial for achieving the SDG vision of "leave no one behind" (ibid).

Despite formal recognition of the need to protect the mental health and rights of all, thousands fall victim to sexual exploitation each year and face a host of mental health problems and social inequalities, such as post-traumatic stress disorder (PTSD), depression, anxiety, sexual violence, social isolation, and poverty, even if they have relocated to "safe" host countries (United Nations Office on Drugs and Crime, 2020; Oram et al., 2012; Kygnaert et al., 2012). Sexual violence may be a pervasive theme throughout the life histories of many exploited individuals, as a systematic review found that one in three people who were trafficked for sexual exploitation had also been sexually abused as children (Oram et al., 2012). Such a finding aligns with a wealth of evidence linking childhood sexual abuse with a high likelihood of being sexually victimized in the future (a phenomenon known as sexual revictimization, or SR); however, existing literature on sexual victimhood and SR tends to focus almost exclusively on Western white populations and remains scarce regarding how and why SR occurs among disadvantaged groups living in Western contexts (Pittenger et al., 2016) and people originating from contexts where poverty, war, and conflict are pervasive (Ghafoerkhan et al., 2019). These are groups to which persons trafficked and exploited in the global West often belong. By not addressing how disadvantaged and understudied groups affected by SR are positioned within their environmental context, much of the literature is failing to capture the broader picture of how SR is produced and reproduced within systems of disadvantage, neglect, and oppression (Grauerholz, 2000; Pittenger et al., 2016).

Particularly for exploited women and children who originate from low-resource settings, highly patriarchal societies, and areas of conflict, context may play a key role in their experiences of childhood sexual abuse and SR (Ghafoerkhan et al., 2019). In contexts such as these, where systems may lack the resources, stability, or willpower to protect women and children from sexual violence, abusers and exploiters may go unpunished and thus undeterred (ibid). Traffickers may take advantage of a person's low socioeconomic status by approaching her with false opportunities to make money domestically or abroad, and when she agrees, she may be transported to an unfamiliar place, beaten, and coerced into selling sex in order to 'repay' her captors for travel fees, as well as ongoing food and accomodation costs (ibid).

Women and children may also be attacked in their homes by armed militants and forced into sexual acts, marriage, or slavery in order to save their own lives or the lives of their loved ones (ibid). Sexual violence may also persist even after exploited persons arrive in a relatively "safe" host country and apply for asylum; for refugees and asylum-seekers broadly, sexual violence and exploitation in the host country has been attributed to both individual and systemic problems, including a lack of knowledge about sexuality, difficulty reading social cues of other cultures, low self-confidence and other mental health problems, predatory targeting of women and children, lack of a supportive social environment, as well as socioeconomic hardship which forces them to live in unsafe conditions and take risks for money (Kygnaert et al., 2012). Psychosocial services that recognize and address the unique issues surrounding sexual violence that refugees and asylum-seekers face were seen as crucial to the promotion of health equity and human rights (ibid).

Despite an unmet need to address SR among sexually exploited persons of all backgrounds and the key role that psychosocial services are acknowledged to play, research has shown that health professionals across various disciplines, including mental health professionals (MHPs), often lack confidence and organizational support in identifying possible cases of trafficking, providing appropriate care, and making referrals when necessary (Ross et al., 2015; Domoney et al., 2015). Difficulties with recognizing and addressing the needs of sexual trauma patients may be attributed to a lack of formal education and training regarding issues stemming from past sexual trauma, and some researchers in recent years have called for greater integration of sexual abuse and trauma into trainings and educational curriculums (Kenny & Abreu, 2015). The lack of professional awareness and competency regarding human trafficking, sexual exploitation, and related issues such as SR, in combination with a lack of scientific literature which takes a holistic systems approach to understanding the SR of people with multicultural backgrounds, constitutes a knowledge gap that may have practical implications. Scientific and organizational efforts are needed to raise awareness of health professionals about SR and sexual exploitation as well as to support health professionals in responding appropriately to their patients' needs (Domoney et al., 2015). That being said, we feel that experienced MHPs who specialize in providing treatment for sexually exploited persons may be an untapped resource for both contributing a more holistic and multicultural systems understanding of SR among this population to the scientific literature as well as fostering real-life dialogue and awareness with other professionals in the health system about SR, since they play a dual role as both trusted confidants in the world of the patient as well as actors embedded within the health system.

Accordingly, this research has two main goals: (1) to tap into the knowledge of experienced and specialized MHPs in order to contribute to a contextualized, systems understanding of SR; and (2) to use the research process as a tool to foster awareness, dialogue, and mutual learning among MHPs regarding the SR of sexually exploited persons. With these aims in mind, the present study seeks to answer the following research questions:

1) How is SR of sexually exploited persons conceptualized within broader systemic contexts according to specialized MHPs?
    a) How do these professionals define victimhood and SR?
    b) What individual, interpersonal, community, and societal factors are seen as key drivers of SR?

    c) How do these spheres of influence interact as a system to produce and reproduce sexual violence?
2) What lessons can be learned from engaging MHPs in dialogues about SR among sexually exploited persons?
    a) What strategies and lessons have they learned during their past experience with treating and preventing SR?
    b) What are the challenges to engaging in these dialogues?
    c) How useful do MHPs find these conversations?
    d) In what ways can MHPs create sustainable change in their practice or organizational setting following these dialogues?

2. Conceptual Framework

Sexual Exploitation

The World Health Organization (WHO; 2017) defines sexual exploitation as “any actual or attempted abuse of a position of vulnerability, differential power, or trust, for sexual purposes, including, but not limited to, threatening or profiting monetarily, socially or politically from the sexual exploitation of another”. Examples of this can include sex trafficking, sexual slavery, and early or forced marriage (McAlpine et al., 2016). While the WHO conceptualization is used as a guideline when entering into conversations about sexual exploitation and SR, we acknowledge that the related concepts of power differentials, abuse, vulnerability, and profiting may lie on somewhat of a spectrum to be interpreted, rather than a binomial “yes or no” distribution.

Sexual Victimhood

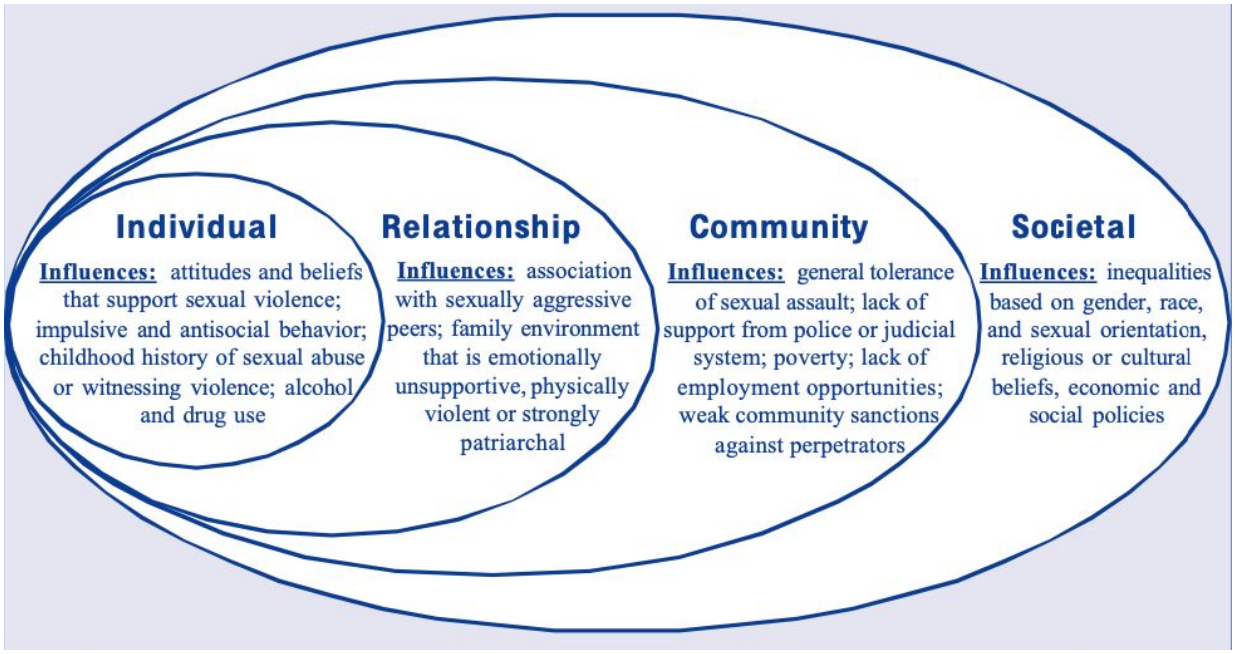
The point at which someone is understood to be sexually ‘victimized’ or ‘revictimized’ is not always clear and likely to be subjective (Hlavka, 2014). Acts that some may consider sexual violence may be disregarded or normalized by others acts as harmless flirting or just a part of daily life (ibid). Or, people may be blamed and receive no sympathetic victim status, even if they were forced or coerced (ibid). In some traditional cultures or conflict-affected settings where women and children are viewed as unworthy of consent or respect, the normalization of sexual violence may be especially pervasive, and these women and children may not view themselves as victims (Ghafoerkhan et al., 2019). Acts such as sex work may also be viewed in different ways, such as a case of (re)victimization, a moral failing, or a normal way to make a living (ibid). Due to the subjective nature of sexual victimhood, we do not seek to impose our own preconceived definition of victimhood and SR upon participants, and instead choose to explore how MHPs understand and identify SR among their patients through open-ended questioning.

The Ecological Model of Sexual Violence

The Ecological Model of Sexual Violence (EMSV) (Centers for Disease Control, 2004), adapted from Bronfenbrenner’s Ecological Model (1979), is useful for understanding SR from a systems perspective because it takes into account individual, relationship, community, and societal factors that work together to drive sexual violence. Individual factors in this model concern sociodemographics or attitudes, behavior, and cognition that occur within a person. The

relationship sphere concerns interpersonal factors that may play a role in sexual (re)victimization, such as physically or emotionally abusive romantic relationships or friendships, or interpersonal discrimination. The community sphere deals with more structural factors that enable sexual abuse, such as lack of law enforcement or unemployment, while the societal sphere is more concerned with the overarching, shared cultural values, beliefs, and policies which may underlie discriminatory acts or prejudices in the other three spheres. While Ecological Models such as the EMSV cannot capture the full spectrum of factors that drive sexual violence in all circumstances, they can be used to structure findings in an organized and easy to digest manner that takes blame and shame away from the individual by placing sexual violence within its broader spheres of influence (Grauerholz, 2000). And, while the EMSV may include drivers that are specific to SR, it has not been contextualized to explore SR among a diversity of exploited persons before and after coming to high-income countries. In seeking to fulfill Aim 1, the present study will analyze and organize data about SR among exploited individuals that takes into account contexts prior to and after arriving in high-income countries, using the EMSV as a guide and the Netherlands as a case example.

Figure 1. *The Ecological Model of Sexual Violence Prevention (Centers for Disease Control, 2004).*



Transdisciplinary research

Aim 2 of the present study may be viewed as a transdisciplinary approach to knowledge generation and societal transformation through dialogue, reflection, and mutual learning. Transdisciplinary research is a concept that has existed in scientific literature for decades, yet its definition and boundaries are still contested by researchers (Pohl, 2010). It is generally agreed

that transdisciplinary research aims to address socially-relevant issues and transcend the boundaries and paradigms of different knowledge disciplines (ibid). However, it is still up for debate whether transdisciplinary research must include actors outside of academia (participatory research) or seek to "build a unity of knowledge" in which there is a general viewpoint on the issue at hand across scientific disciplines (ibid). Considering the potential value of including differing perspectives, and due to the exploratory and discursive nature of this study, building unity or consensus is not a study aim. For the purposes of this study, transdisciplinary research is understood as research which seeks to address socially-relevant issues by incorporating real-world experiential knowledge from MHPs into an iterative research process while also promoting change and mutual learning through the creation of dialogue spaces.

3. Methods

Setting and Context

This research is situated within the National Psychotrauma Center of the Netherlands (ARQ), which is a non-profit organization that conducts research and psychotherapy with survivors of one or more traumatic experiences. Within the organization, there are multidisciplinary expert teams that specialize in clientele with particular traumatic backgrounds. Members within these teams may include psychologists, psychiatrists, social workers, medical doctors, psychiatric nurses, and researchers, all of whom support each other in weekly meetings by giving their professional opinions and advice about research and treatment regimens. The primary team affiliated with this study is the Sexual Violence and Exploitation (SVE) Team, as these MHPs regularly see patients who have been trafficked for sexual exploitation and likely have ideas and perspectives that will be valuable for conceptualizing SR. This team consists of approximately 20-25 MHPs.

Many of the SVE Team's clientele are victims of trafficking. When sexually exploited persons come from low-resource and conflict-affected settings, repatriation is often not in their best interest as returning to their home country would place them at high risk of being re-trafficked, socially excluded, and/or otherwise harmed (Ghafoerkhan et al., 2019). Seeking a better life, these patients learn to adapt to the unfamiliar Dutch context and undergo the process of seeking asylum or other legal residence status (Kramer et al., 2018). Those in the Netherlands who have obtained refugee status or are in the official process of obtaining residence have a legal right to health insurance, (mental) health care, basic shelter, and access to the labor market (ibid). However, obtaining refugee or residence status is a stressful process that often spans months or years, involves crowded and frequently-changing living conditions, lengthy legal procedures, lack of familiarity with the Dutch political and health systems, and uncertainty about the outcome of their application (ibid). Taken together with difficulties regarding language barriers and non-Western idioms of distress that may complicate diagnosis and treatment, trafficked persons residing in the Netherlands may face exceptional challenges in accessing and benefitting from mental health interventions (ibid). The matter is further complicated for undocumented persons, who do not have a legal right to psychosocial services and are vulnerable to homelessness, which may make them especially vulnerable targets for further assault and sexual exploitation (Lahuis et al., 2019).

Research design

This study uses qualitative methods. Exploratory interviews and two focus group discussions (FDGs) were conducted with MHPs in order to reflect upon and contextualize SR of sexually exploited patients using an Ecological perspective, as well as to create spaces for dialogue and mutual learning among psychotherapists. FGD2 was not in the original research plan, but the psychotherapists from FGD1 felt that it was important to engage other colleagues in the organization of discussions about SR so that they could all learn and benefit, and the research team agreed to add FGD2 into the research design. Due to Dutch social distancing measures in light of the ongoing Covid-19 pandemic, all interviews and FGDs were conducted online via Zoom. For a full account of the changes made in light of the Covid-19 pandemic, see Appendix A. While conducting interviews and FGDs via videocall may involve technical difficulties and inability to see the interviewees' body language, it may also be advantageous because participants conveniently do not have to gather in one place, communicating through technology may offer some relative anonymity and encourage participants to share more of their ideas, and still allows the researcher to observe verbal and nonverbal cues (Janghorban et al., 2014).

Participants and procedure

Participants' pseudonyms, backgrounds, and participation in the research can be found in Table 1. All participants were female, as the SVE team had no male MHPs at the time of data collection.

The exploratory interviews were conducted by researcher "RB" with MHPs affiliated with the SVE team to inform and refine the discussions and designs of the FGDs. As the researchers are also ARQ employees, they had knowledge of psychotherapists' experience and access to the contact information of the SVE team. Four MHPs from ARQ were recruited purposively via email for individual exploratory interviews based on their varying levels of experience with working in the field of sexual violence. All 4 participants who were contacted expressed interest in interviewing and were emailed an informed consent form (Appendix B) via an online document signing platform, as well as a Zoom meeting ID and password.

FDG1 was designed to engage the more experienced psychotherapists from the SVE Team in co-reflection and dialogue about SR among exploited patients, with the intention of contextualizing SR and achieving knowledge co-production and awareness that can be used in their professional practice. By discussing SR in a group and listening to their colleagues' input, rather than discussing in individual interviews with the researchers, therapists may be able to clarify and better articulate their own views and experiences. Recruitment for FGD1 was done purposively with the advice and assistance of the SVE team leader in order to select participants from the SVE team who come from a variety of mental health professions and are considered by their colleagues to be experienced in providing treatment for sex trafficked patients. FGD1 participants were contacted by RB via email with information about the study and given an informed consent document (Appendix C) via an online document signing platform. Of the 7 psychotherapists invited, 5 were able to participate, 1 had a scheduling conflict, and 1 agreed to participate but was ill on the day of the FGD.

FGD2 was designed as an opportunity for MHPs on the SVE team to share their conceptualizations of SR among exploited patients, their experiences with recognizing and treating SR in their practice, and discussing sustainable ways to maintain attention for SR after the conclusion of the present study. Everyone from the SVE team (n = 17) was invited via email to participate in FGD2. All experience levels and professional backgrounds were encouraged to participate. All who expressed interest were emailed the informed consent document (Appendix C) and Zoom meeting ID and password, and asked to digitally sign consent prior to participating. In total, 9 participants joined FGD2, including 3 participants from FGD1.

Table 1. *Participant characteristics*

Pseudonym	Profession	Participation
Yara	Basic psychologist	Interview 1
Eline	Healthcare psychologist	Interview 2
Femke	Clinical psychologist and senior researcher	Interview 3
Charlotte	Healthcare psychologist	Interview 4
Esmee	Healthcare psychologist	FGD1
Zoe	Psychiatrist	FGD1
Mila	Healthcare psychologist	FGD1 & FGD2
Vera	Psychotherapist	FGD1 & FGD2
Annelies	Psychomotor therapist	FGD1 & FGD2
Olivia	Healthcare psychologist	FGD2
Jasmijn	Medical doctor	FGD2
Emily	Clinical psychologist and SVE team leader	FGD2
Benthe	Psychology intern	FGD2
Isabel	Healthcare psychologist	FGD2
Floortje	Healthcare psychologist	FGD2

Data collection & analysis

All exploratory interviews and FGDs were conducted by RB, and these meetings were audio-recorded and transcribed by RB within one week of recording. Audio files were deleted

immediately after transcription, personal information which could be used to identify participants was removed from the transcripts, and pseudonyms were used in place of real names. Only the research team had access to the transcripts, which were only shared through secure organization-issued email.

RB conducted inductive thematic analysis using Atlas.ti software in order to identify recurring themes throughout the transcripts of both the interviews and FGDs. This was done by reading and re-reading the transcripts, marking sections of text that addressed particular components of the Ecological Model or research questions, and considering how these sections could be grouped together and described as themes. In addition to their use in the analysis and structuring of results, themes from the interviews were also integrated into the designs and question prompts of FGD1 and FGD2 so that FGD participants could aid in the interpretation and analysis of these themes and discuss any interesting or unexpected findings. Themes that were not identified in the interviews but emerged during the FGDs were also included in the analysis. To enhance the validity of the qualitative analysis, RB performed member checking during the interviews and FGDs by asking clarifying questions and summarizing and verbally repeating participants' responses so that the participants could have the chance to correct misinterpretations.

Ethical considerations

According to Dutch law and the Ethical Committee of the Vrije University Faculty of Sciences, ethical approval was not needed to conduct psychosocial research with MHPs, who regularly discuss sensitive health topics in their practice, and were not expected to be at significant risk for any negative outcomes of the research. All participants were given detailed information about the study and asked to provide informed consent (Appendix B, Appendix C). Participants were told how their data would be used by the research team, asked to respect the privacy of their peers by not sharing their peers' information with others outside of the FGDs, and told that they may choose to not participate or to leave the discussions at any time, for any reason.

4. Results

Results from the inductive thematic analysis are shared in this section, where themes are organized into: (4.1) therapists' general conceptualizations of SR, (4.2) key factors underlying SR within an Ecological framework, (4.3) therapists' experiences with addressing SR in their practice with exploited patients, and (4.4) the mutual learning process and keeping the conversation about SR alive. In presenting the results, codes will be placed into quotation marks for easy identification. See Appendix G for more detail about the themes and coding scheme.

4.1 Conceptualization of sexual revictimization

In conceptualizing SR, it was also essential to reflect upon sexual victimhood generally. MHPs viewed sexual victimhood with a great deal of nuance. Rather than defining victimhood

by a particular kind of sexual act or relationship, MHPs were more concerned with how particular sexual acts were perceived and experienced by the individual. Therefore, sexual victimhood was understood to be highly "subjective" in nature. However, despite the "subjective" nature of sexual victimhood, the therapists did posit a few key elements that they believed to be generalizable to most instances of sexual victimhood. Namely, these elements were "power imbalances" between the victim and perpetrator, a lack of "choice or agency" over one's sexuality, and "human suffering" in response to being sexually violated. Particularly when discussing how certain "gray areas" with existing "power imbalances" fit in to the concept of sexual victimhood, such as sex work or early marriage, all interviewees and several focus group members expressed the opinion that these are not always instances of victimhood if there was still some degree of "choice or agency" and a lack of "human suffering".

> "*If [victimhood] is defined by something, it's defined by whether they had any interest in it at all originally, and also how they interpret it, and if they feel they have any control over it. You know, the less control they have over it and the less they want it, I think the more traumatic it becomes*" (Femke, clinical psychologist and senior researcher, Interview 3).

When turning the conversation towards SR, all of the interview and FGD participants primarily conceptualized SR as the phenomenon of falling into a "pattern" of sexual victimhood in which one may "actively seek or maintain" "unhealthy relationships" with abusive partners, despite the "human suffering" that these partners cause.

> *"You keep on getting into these situations where you're abused, you're exploited, you give things and someone else gets gratification from it ... you don't say 'okay we're going to have this kind of agreement', you just kind of think this is the only way to go ... unless there's an outside force that will help you realize it ... you're going to stay in that pattern"* (Yara, basic psychologist, Interview 1).

4.2 Contextualizing SR of Exploited Patients in an Ecological Framework

In accordance with the Ecological Model, MHPs in the interviews and FGDs identified contributing factors to SR that could be categorized within individual, relationship, community, and societal levels of influence (visualized in Figure 1). As community and societal factors can differ between the Dutch context and the patients' original contexts, shared factors and divergences between these different contexts are also noted in the model.

Individual factors.

In every interview and FGD, MHPs emphasized how a history of "childhood sexual abuse" plays a central role in cases where SR is most pervasive, as it leads to "abnormal psychosocial development" that has a strong, negative impact on their ability to function later on as healthy social and sexual beings. The foundation of their identity and existence, their "personal boundaries", sense of "self-worth", and what it means to be in a healthy relationship,

become distorted through experiences of “childhood sexual abuse”, wherein sexual abuse and SR become a “pattern”.

> *“They keep acting according to this imprint that they got when they were very young ... even sometimes when [male victims] are heterosexual and married, they’ll go somewhere just to get abused. It’s like this drive that they feel inside to go there, and they cannot explain it to anybody and they don’t understand it, because they’re unable to grow in their own sexuality”* (Femke, clinical psychologist and senior researcher, Interview 3).

Patients’ “internalized gender roles” were also believed to build upon this sense of low “self-worth” and “personal boundaries” when it comes to SR. Males talked about feeling demasculinized and weak in therapy. For female patients, this often meant going along with the “power imbalances” between women and men and taking on a “desire to please” where they put others’ needs above their own, even if this resulted in their own “human suffering”. Especially for lesbian patients at ARQ, internalized “gender roles” often also meant that they had to engage in loveless sexual relationships with men in order to fulfill their role in society, and therefore learned that it was normal for their own sexual wishes and “personal boundaries” to be disregarded by others.

> *“I see a lesbian patient with Isabel who comes from a forced marriage ... We asked questions like ‘but how did you feel about marrying a guy all of a sudden?’ she was like ‘I just had to’. And I think when she was in a prostitution situation, it was also a bit like that. Like, ‘okay, this is my new reality and I just have to get through it’”* (Benthe, psychology intern, FGD2).

Physiological drivers of SR were identified, as symptoms of PTSD such as “dissociation” and “hyper-arousal” may lead sexually traumatized people to “lack self-awareness” or misinterpret their own psychobiological signals, interfering with their ability to recognize or manage their gut feelings of “anxious arousal” in risky situations.

> *“The PTSD symptoms in themselves can make you more vulnerable for re-experiencing it because your alarm system is not working properly anymore. So when I might feel that this is a dangerous situation, it might be different for people whose alarm systems are either super sensitive or not working anymore at all”* (Mila, healthcare psychologist, FGD1).

When investigating further this relationship between bodily signals and risky situations, patient cases were discussed where this feeling of “anxious arousal” was intertwined and confused with feelings of “sexual arousal”.

> *“I think [my patient] felt a lot of arousal in her body ... My hypothesis is that that could be anxiety, but it could also be arousal of a sexual kind … From a young age, she had*

> *learned that being intimate and being violent were two things that could come together in one attachment relationship … So [her boyfriend] loved her and abused her and that was a normal thing, and that was how it was supposed to be"* (Emily, clinical psychologist, FGD2).

"Alcohol and substance abuse" also served as both a coping mechanism and a risk factor related to psychobiological signals.

> *"I think substance abuse is often a way to cope with all of these emotions that people go through, and I guess that is a way to not feel so much, but that also numbs the healthy inhibition or healthy anxiety that a person should feel when they're with someone who is perhaps not the right person to trust"* (Emily, clinical psychologist, FGD2).

Lastly, those with "low social and emotional intelligence", such as those who may be diagnosed with autism spectrum disorder, were also brought up as a vulnerable population for SR. This is because they may have trouble "reading social cues" that would alert them to danger of sexual abuse. A similar difficulty with "reading social cues" in dangerous situations was attributed to people who have been sex trafficked to the Netherlands from non-Western cultural contexts, as social behavior is often culture-bound.

> *"A lot has to do with confidence and knowing other people and being able to estimate if a person has good intentions with you or not. And that is very culturally-bound … People have different mimics, different nonverbal ways of expressing themselves, so it's harder to see if someone is joking or not joking"* (Eline, healthcare psychologist, Interview 2).

Relationship factors.

Just as SR was often attributed to "childhood sexual abuse", living in a "family environment which is emotionally unsupportive, sexually abusive, strongly patriarchal, or homophobic" was theorized to lead to "abnormal psychosocial development" in which those affected by sexual violence never learn what a "healthy relationship" means to them.

> *"I have a client from the middle east and she was raped as a little child, like 5 or 6 years old, and then the family blamed her for what happened, so she was really harshly punished by the family because the neighbor guy did it to her. So she doesn't feel protected at all, and that was how she developed [problems] later in life"* (Isabel, healthcare psychologist, FGD2).

LGBT+ trafficked persons were not discussed in the interviews or FGD1, but participants of FGD2 discussed how having a homophobic family sometimes meant that they were kicked out of their homes and forced to live in a state of "unstable housing or

homelessness". This lack of protection and "low socio-economic status" rendered them highly vulnerable to sexual abuse and human trafficking.

Associations with "sexually aggressive peers" was also a relationship-level contributing factor for SR. In addition to being directly physically and sexually abused by these peers, some patients were prostituted by their partners for financial gain.

> *"Many of the stories go from being exploited to falling in love or being rescued by a client, and then having an affair with that client, and then from that going into another exploitation situation ... He can say 'I'm going to help you escape', and afterwards in that situation maybe there's no money, no way to pay for the apartment, so then it's 'maybe can you start doing [prostitution] again for money?', and then they're back in that situation again"* (Emily, clinical psychologist FGD2).

Community factors.

Community factors were explored within both the original context (when relevant) as well as the Dutch context for exploited persons in relation to SR.

Specifically in their patients' communities within their countries of origin, MHPs pointed to a "general tolerance of sexual violence" in which community members knowingly did not hold perpetrators accountable for their misdeeds. In areas of "war and conflict", where there was a lack of top-down social order and "lack of support from police and the judicial system", communities had to take it upon themselves to prosecute criminals.

> *"I got a message from a friend of mine from Congo, who sent me a newspaper clip that said they burned a burglar to death, and that is what happens very often ... Since there is impunity, the population will do something about it to punish you ... But, that doesn't happen with rapists … theft is higher in the hierarchy than sexual violence"* (Eline, healthcare psychologist, Interview 2).

However, a "lack of support from police and the judicial system" was not unique to conflict-affected contexts. MHPs from Interview 2, FGD1, and FGD2 discussed how perpetrators go undetected and unpunished in the Dutch context.

> "*I don't think they have enough police on the streets … If there's something that I'm really, really annoyed about, it's that we hear so little about exploiters being caught … I have never heard a patient say 'they caught him'. Never.*" (Eline, healthcare psychologist, Interview 2).

Furthermore, in both contexts, living in a community with widespread "poverty and lack of economic opportunities" as well as accompanying "unstable housing and homelessness"

meant that communities may view “sex as a resource”, where sex work or enduring abuse is their only option for survival.

> “*I’m thinking of a woman from Eastern Europe who has been in several exploitation situations, and every time that she got into a situation again with a new pimp or exploiter, it was because she had no shelter, no money, no way to go back home, so there was this person who said “okay you can come and live in my apartment and I can help you” ... She thought ‘okay well let’s try it, it’s worthless anyway, my life in the bushes or in the train station or under the bridge is not bringing me much, so let’s go with this guy and hope for the best*’” (Emily, clinical psychologist, FGD2).

Specifically in the Dutch context, a “lack of social inclusion of refugees and asylum-seekers”, wherein trafficked persons and other asylum-seekers must go through a period of time living in the asylum centers, could trap trafficked persons within communities where they are exposed to prostitution networks and face a higher risk of re-entering into risky sexual encounters.

> “*[Traffickers] can be sometimes in the community … one person in the shelter gets a text from someone else outside who was previously in the shelter with a photo of a previous exploiter ... So then [re-entering into unregulated sex work] is very easy*” (Mila, healthcare psychologist, FGD1).

Societal factors.

Many of the previously listed factors at the other levels of the Ecological Model were attributed to overarching norms, values, beliefs, and inequalities that exist at the societal level.

The majority of patient cases that were discussed in the interviews and FGDs were trafficked from low-income countries where they faced significant social “inequalities based on gender, age, and sexual orientation”. For women and girls, this sometimes meant that “gender roles” at the societal level reinforced “power imbalances” in which they are seen by themselves and others as objects to be used by men. “Policy about sexual violence and gender equality” may reflect both the values and cultural norms within a society while actively shaping the way in which sexual violence is addressed.

> *“I think in different cultures there are different role patterns, how you are expected to behave as a woman, for example, in your relationship to a man … Women feel ‘less than’ or that they have less the right to protect their own rights”* (Olivia, healthcare psychologist, FGD1).

“War and conflict” was discussed in the interviews and FGDs as a societal driver of sexual violence and revictimization. For the perpetrators, rape was a tool of war by soldiers in order to assert dominance over another society. For the victims, who faced a risk of death and

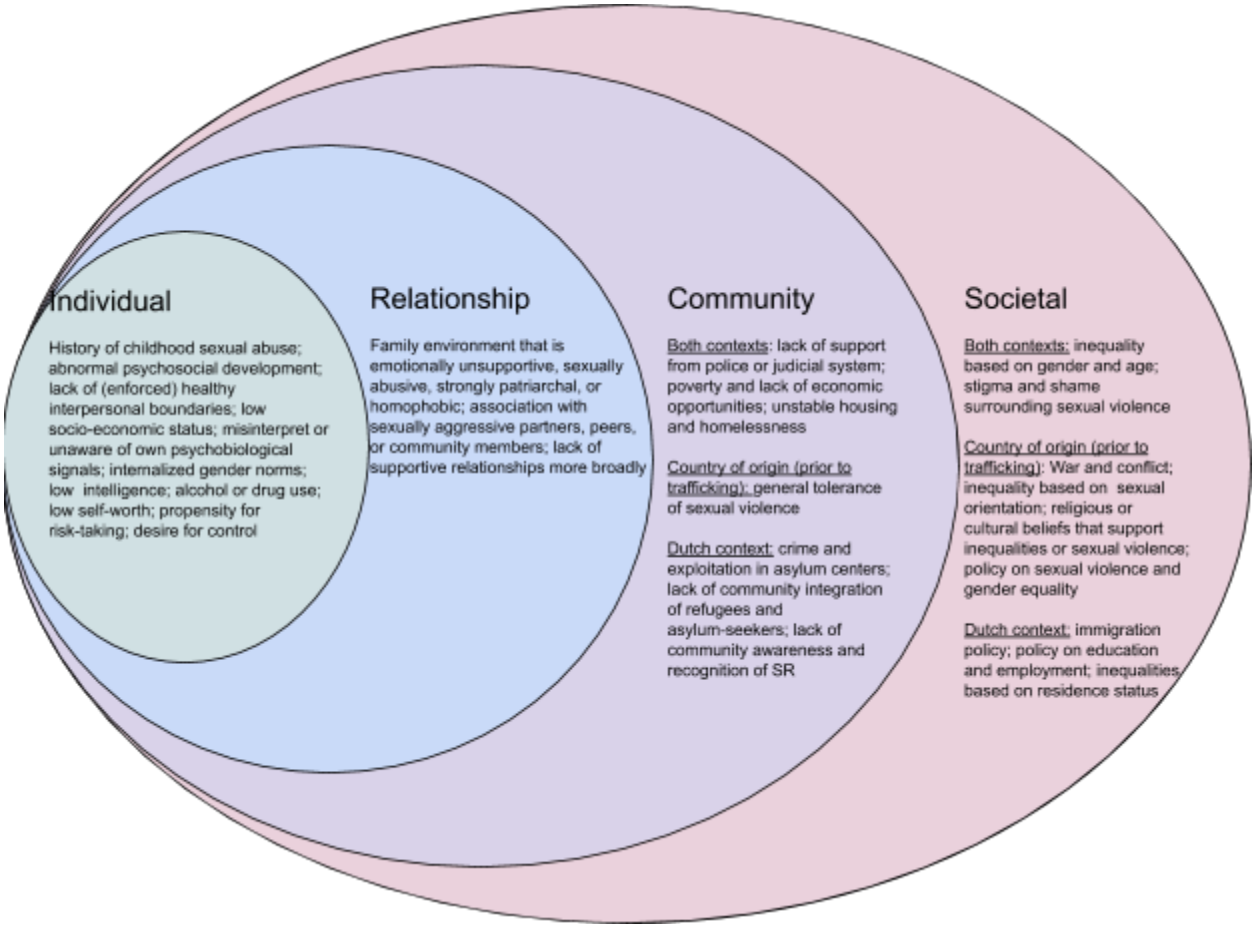
"unstable housing and homelessness" due to violence and destruction, using "sex as a resource" and entering into trafficking situations or other risky sexual situations seems like the only option.

> *"One of my patients ... was a lady who survived the concentration camps at Auschwitz by using her body for the officers of Hitler ... She said, 'I'm not happy about what happened, but it was my way to survive'"* (Charlotte, healthcare psychologist, Interview 4).

Societal "stigma and shame" surrounding sexual assault was also mentioned in relation to SR, as those who have been abused may be unwilling to seek help out of fear that they will be shamed or ostracized. This societal "shame and stigma" may be especially pertinent for males who have been sexually abused or revictimized and who come from societies with patriarchal "gender norms" where men are expected to be strong and dominant.

> *"We see a lot of patients who were sexually abused in childhood, but most of them are women ... I think there is a lot of shame among the population of men to speak about sexual abuse ... It is more on a macro level of society that women are seen as more vulnerable for it, and boys, 'no no no that's not possible' That's masculinity in our society, it's bigger, it's more repressive"* (Charlotte, healthcare psychologist, Interview 4).

Figure 1. *Factors organized according to the Ecological Model*



4.3 Therapists' experiences with addressing SR with exploited patients

When MHPs discussed their professional experiences and strategies with breaking the "pattern" of SR in their practice, all interviewees and the FGD participants found it was important to have a "nonjudgmental attitude" regardless of differences in opinion and background with their patients in order to "empathize". Rather than seeking to tell patients what is or is not normal, or to push their own socio-cultural values upon patients who come from different backgrounds, the MHPs tried to "ask questions" and explore together what a healthy relationship might look like for the patient and provide "psychoeducation" along the way about topics such as psychobiological signals and functioning to foster patients' "self-awareness".

> *"I would start with accepting all kinds of sexuality ... I don't have a judgment about what they are doing. If they want to be a sex worker, it's okay ... we discuss, 'what if people do it like this? Or do it like that?' So then it becomes more their own choice … the only*

thing I think as a therapist you can do is provide other options, and question the choices" (Zoe, psychiatrist, FGD1).

While a "nonjudgmental attitude" and "empathy" appeared to be at the heart of addressing SR, no one particular therapeutic approach was identified by the MHPs as the "golden standard". A range of techniques were described by the MHPs as useful. Several did not name a specific therapy or approach, but described more general "talk therapy" in which they practiced "active listening" and "asking questions" in a way to prompt self-reflection among their patients. One of the healthcare psychologists and the psychomotor therapist from the FGDs described how they worked together on a particular case using techniques from eye movement desensitization and reprocessing ("EMDR") therapy in order to help patients recognize and distinguish between "sexual arousal" and "anxious arousal". One healthcare psychologist and one clinical psychologist discussed the use of "rescripting" therapy in order to help patients reflect on their past and to retrospectively prescribe the kind of love, protection, or other things that they would have needed in the past. By doing this, patients could explore what a healthy relationship means to them and reduce feelings of self-blame. "Schema therapy" was mentioned in Interview 3, FGD1, and FGD2. Participants of FGD2 especially backed the use of "schema therapy":

Isabel (healthcare psychologist): I think the schema therapy that we do is a good way of breaking the patterns ... It's about self-value, and how you can be intimate with others in a more self-worthy way

Emily (clinical psychologist): Completely agree. By focusing on patterns we can-- oh, Olivia also says agree! -- ... it helps people to realize that from early youth already that they've been in patterns in relationships, and looking at themselves in another way may also help them to find out how a healthy relationship could work.

The psychomotor therapist also described using "exposure" techniques using hypothetical scenarios to help patients become more comfortable with how they can respond to both risky situations and opportunities for building physical intimacy that feels safe and pleasurable.

"I see [my patient] now with her partner because she wants to do exposure in being physical with him … There is this part that knows that she is safe, but it's still so difficult to change. The autonomic nervous system gets so active immediately ... there's the kind of defensive part of 'let's stay at a distance, when I give a hug, it will lead to sex'. And even though she knows she is not thinking rational thoughts, that is immediately what comes up" (Annelies, psychomotor therapist, FGD2)

The general consensus among participants was that breaking these "patterns" was quite "challenging". Furthermore, breaking the "pattern" of SR may require a long-term approach even after the patient has completed one or more rounds of trauma-focused therapy and "exposure".

> *"I feel like with EMDR or something, you can't stake out all of the information in there, and I think there is a part needing exposure, but sometimes that is not possible. So it stays with you for a longer time, and then you enter into a new phase in your life, and then you have to deal with it again. That's how I notice it often"* (Mila, healthcare psychologist, FGD2).

The "challenging" care requirements that SR presents may also be a barrier to accessing adequate psychosocial care. One of the interview participants mentioned that within the broader mental health system, some MHPs were not always able or willing to address SR and other issues stemming from sexual trauma.

> "*I've perceived colleagues in the mental health care system here in the Netherlands, and I think a lot of therapists turn their heads away when they hear [about SR]. It's terrible, because a patient has at that moment quite a lot of trust in your relationship to tell about the abuse, and then to go 'yeah yeah okay, now we're going on to talk about something else, this is not the goal of our treatment', or they say 'I'm not going to treat this, it's too difficult, I'm going to refer you', I see it a lot. So, I think for a lot of therapists, it's heavy to do therapy with this kind of patient, but I think every therapist can do it*" (Charlotte, healthcare psychologist, Interview 4).

Even when MHPs who are highly experienced and specialized in sexual trauma are the ones providing treatment and prevention efforts, some patients may still re-enter into their old "pattern" of sexual abuse.

> *"I was seeing a lady who had a very abusive relationship with her boyfriend, and he had forced her to prostitute herself … We were in the middle of the trauma treatment, and she told me all about all of these times where he was completely aggressive and would beat her up … Somewhere along the path she didn't come back to any of her appointments, and she actually had met him again on the street and went off with him ... I thought we were working on her realizing what was going wrong in that relationship … so it was really hard to understand"* (Emily, clinical psychologist, FGD2).

With challenging patient cases such as these, it is valuable for the MHPs to be able to discuss their challenges and doubts with their colleagues in the SVE team, and they hold weekly meetings to do so. In the next section, we explore MHPs' perceptions and experiences with discussing SR as a specific challenge in therapeutic practice.

4.4 The mutual learning process and keeping the conversation about SR alive

When taking notes and reflecting on the challenges of engaging MHPs in dialogues, something that RB noted was that the interviewees that had been part of the SVE team for a relatively short time (Yara, Interview 1 and Charlotte, Interview 4) had expressed some "self-doubt" in

regards to how knowledgeable and meaningful their contributions would be to dialogues about SR or how comfortable they would be discussing SR with colleagues.

> *"It's very valuable to talk with your colleagues about [SR]. But in a bigger team? No, only maybe in an intervision or a supervision when you are with two or three people, but in a big group I really don't know if I dare to"* (Charlotte, healthcare psychologist, Interview 4).

Yet, these participants were able to engage with the topic for the full 45-60 minutes of the interviews and identified many factors and themes that aligned with their colleagues, and their mention of "lack of awareness" and cultural misunderstandings at the community and societal levels were incorporated into later FGD designs for sparking discussion. "Self-doubt" may be a barrier to engaging young and useful perspectives in group dialogue spaces and mutual learning.

In FGD2, self-doubt was not explicitly expressed. The two newest members (Benthe and Floortje) talked the least, but still expressed active engagement through nodding, smiling, asking questions, and expressing verbal agreement with others. Thus, while spoken participation from newer members was noted as a challenge to engaging MHPs during TDR, other forms of participation and engagement within the learning process still occurred.

The creation of dialogue spaces for "reflection and mutual learning" through interviews and focus groups generated "enthusiasm" among participants because of their "utility in professional and scientific practice". Participants of Interviews 1, 2, and 4 explicitly mentioned that discussing SR in the interview was useful for them to reflect upon and "verbalize their thoughts" and professional experiences. Interviewee 3, while not explicit, frequently cited what she had learned from colleagues' presentations and literary works in the field of trauma research when formulating her answers to interview questions, also exemplifying the utility of dialogue spaces and "reflection and mutual learning".

Echoing this sentiment, participants from FGD1 found the dialogue spaces and "reflection and mutual learning" to have utility in professional and scientific practice. By having a space to "verbalize their thoughts" and hear the input of colleagues, they felt they were also able to "compare and sharpen" their own perspectives:

> *Annelies: I love to share about [SR] and that keeps things more in my frontal lobe. It's more accessible again and helps me to look a bit more clearly at what I see or what I experience when I'm in contact with clients.*
>
> *...*
>
> *Vera: For me it's the same … I like that you ask questions, because most of the time you think on your own pathway ... I think we can do it more often like this. It's inspiring.*

Participants of FGD1 also expressed enthusiasm for "reflection and mutual learning" through dialogue spaces by coming up with the idea to do a second FGD for the rest of the SVE team

so that others could benefit. Agreeing with the value of engaging more participants in “dialogue spaces” as well as including participant input into the research design, FGD2 was added.

Participants in the FGDs were asked about whether they had any ideas for keeping sustainable attention for SR after the conclusion of the FGDs. In FGD1, a few suggestions were given: promotion of a pilot “module training” for the prevention of SR, making an effort to “engage other MHPs” in discussions with colleagues about SR, and “incorporating SR into protocols and procedures” done at the organization. The ideas suggested by FGD2 participants were: “publishing” the present study in the scientific literature, promotion of using “schema therapy” to address SR, promotion of a pilot “module training” for the prevention of SR, “engage other MHPs” in conversations about SR, and “partnerships with local community organizations” that provide social and vocational support.

5. Discussion

To the best of our knowledge, this study was the first to tap into the knowledge of MHPs specialized in treating sexually exploited persons in order to contribute to a contextualized understanding of SR, while also using the research process as a tool to foster dialogue and mutual learning among MHPs regarding the SR of sexually exploited persons. Results indicated that sexually exploited patients’ experiences of SR usually stemmed from childhood sexual abuse, and from there, one’s psychosocial developmental trajectory towards becoming a healthy sexual being was blown off course by harmful environmental factors in the relationship, community, and societal socio-ecological spheres. Discussions with multidisciplinary MHPs were met with a high level of enthusiasm and engagement, and highlighted that SR is a topic that garners little attention from the psychosocial health system and does not yet have an established “golden standard” for prevention. Selections from key findings, future directions, limitations, and strengths are discussed below.

While there was substantial overlap between the factors listed on the Ecological Model of Sexual Violence Prevention (CDC, 2004) and those identified by the MHPs in relation to SR, the MHPs were able to specify and expand upon the previous model in a number of ways to suit the purpose of examining SR within systemic contexts; their depth of knowledge and expertise was impressive to the researchers, especially considering how issues such as childhood sexual abuse, sexual exploitation, and SR often go unrecognized and unaddressed in the education and practice of MHPs (Domoney et al., 2015; Ross et al., 2015; Kenny & Abreu, 2015). In the individual sphere, abnormal psychosocial development, lack of (enforced) healthy interpersonal boundaries, misinterpretation or lack of awareness of psychobiological signals, internalized gender norms, low intelligence, propensity for risk-taking, and low self-worth were all added on top of the CDC framework. While some of these factors may also render one vulnerable to an initial act of sexual violence, many were described by the MHPs as mediators between initial childhood sexual abuse and later experiences of SR, and may explain a divergence between the study model specific to SR and a more general model for all forms of sexual violence. This idea of a mediating role is well-supported by theoretical and mathematical

models published in past studies, which tend to posit (childhood) sexual abuse as the initial causative factor, with a range of different abnormalities having to do with psychosocial development and psychosocial difficulties (e.g. depression, PTSD) as mediators, and SR as the outcome variable (Classen et al., 2005; Lalor et al., 2010; Auslander et al., 2018; Gold et al., 1999; Arata et al., 2000; Ullman & Vasquez, 2015).

The relationship sphere was largely the same between the two models, with the present model of SR including the new elements of a homophobic family environment and a more general lack of loving, supportive relationships outside of the family relationship context. Discussions surrounding homophobia in the family context highlighted the substantial problems and risks that the exploited LGBT+ patient population face. While the LGBT+ trafficking cases that were discussed all happened to come from non-Western cultures, it should be noted that LGBT+ youth in Western contexts (e.g. the USA) also have a higher risk of becoming homeless, those presenting at shelters are twice as likely to have been sex trafficked than their heterosexual and cisgender co-residents, and roughly half of homeless LGBT+ youth had engaged in sex trade at some point (Murphy, 2016). While the Dutch Central Bureau of Statistics (CBS) reports that homelessness in the Netherlands has more than doubled in the past 10 years and is disproportionately increasing among youths and non-Western migrants, LGBT+ sexual orientation was not included as a variable (Centraal Bureau voor de Statistiek, 2019). Official information on homelessness and the unique psychosocial health problems that the general LGBT+ population in the Netherlands is insufficient (COC, 2019). Future research on the relationship between sexual orientation, homelessness, and sexual exploitation and SR in the Dutch context is needed to clarify uncertainties. Furthermore, as the theory of intersectionality posits that certain groups with multiple, intersecting identities have unique experiences and needs (Crenshaw, 1990), the authors urge this future research to use an intersectional framework.

The community and societal segments of the study model differed from the CDC model in that they considered factors in both the Dutch context and patients' countries of origin so that the different contexts could be compared and contrasted. While the 'country of origin' sections admittedly had to remain general in order to pertain to a range of origin contexts (e.g. subsaharan Africa and the Middle East), the MHPs were still able to observe some patterns and make comparisons. War and conflict was a distinct risk for SR in some origin contexts, while in the Dutch context, the poor social integration of the asylum shelter community 'bubble' and the socio-economic positioning of refugees and asylum seekers of a sexual exploitation background in Dutch society were identified. As the present study did not explore the conditions and risks of SR in refugee camps and asylum centers located in low- and middle-income contexts, meanwhile the vast majority of refugees and asylum-seekers are hosted by low- and middle-income countries (World Bank, 2020) and there is clear evidence of sexual violence taking place en route to Europe (Freedman, 2016), this presents a blind spot in the current study that is worth exploring in future research so that the study model of SR can be validated and expanded upon.

Conversations about cultural and religious norms in relation to SR tended to center on societal inequalities faced by women and girls. While psychosocial health interventions targeted at these vulnerable populations are certainly warranted and have been receiving increased attention worldwide in recent years (Patel et al., 2018), it was noted as a discussion point during interviews 3 and 4 that gender-based inequalities and a gendered understanding

of sexual violence could be a double-edged sword: on one hand, women and girls are harmed when repeatedly treated as objects for the sexual gratification of men; on the other hand, through the sociocultural gendering of sexual violence and SR, men and boys are also shamed and made to feel 'weak' in their masculinity if they fall victim to sexual violence, and therefore may be less likely to come forward to seek the psychosocial care that they need. Calls to scientific action in the literature align with these interviewees' critical reflections on gendered experiences of SR and psychosocial care, arguing that masculine gender norms and expectations are neglected in conversations surrounding sexual violence (e.g. Javaid, 2016a; Kiss et al., 2020), and that sexual violence is perpetuated for both males and females through this omission (Javaid, 2016a; Javaid, 2016b). Further exploration of how experiences of SR and psychosocial care needs may be gendered for male victims are needed to address and expand upon this gap in the scientific literature.

Conversations with multidisciplinary MHPs revealed that there is not an approach that is considered to be the "golden standard" for addressing and preventing SR. MHPs took a pragmatic approach by applying a variety of techniques from schema therapy, trauma-focused treatments (TFT) such as exposure therapy, talk therapy more generally, mindfulness, and "rescripting" when trying to help their patients break learned behavioral patterns of SR. The creativity and pragmatism of the MHPs in adapting existing therapeutic techniques to address SR likely comes from necessity; there is a paucity of scientific studies that give clear support the use of any particular therapeutic approach in breaking the pattern of SR (Classen et al., 2005; Lalor & McElvany, 2010). For example, while a review of different therapeutic approaches to treating and preventing SR was published approximately 15 years ago and indicated that piloted trauma-focused treatments and group interventions may be promising (Classen et al., 2005), a randomized control trial stemming from that pilot found no significant improvements in revictimization following TFT or group therapy (Classen et al., 2010). Another review, albeit not systematic, also found that a wide range of therapies and community interventions to reduce SR among youth may work, but due to methodological limitations in the extant literature, they would not endorse any particular therapy or intervention (Lalor & McElvany, 2010). There is also some evidence to suggest that interventions focusing on emotion regulation (Walsh et al., 2012), experiential and somatic-based treatment (Hopper et al., 2018) and early interventions in which parents are involved in healing and prevention (Scoglio et al., 2019) may help to address SR, though more trials and evaluation studies are needed to build an evidence base. We urge future research to continue the search and evaluation of therapeutic approaches that can be used to effectively address and prevent SR.

In notes and reflections about mutual learning in FGD1 and FGD2, RB observed difficulties with drawing distinctions between the viewpoints of the different types of mental health professions because there was considerable overlap of knowledge and experiences between the different professions. For example, one of the healthcare psychologists and the psychomotor therapist talked about how they worked together on a case to provide holistic care for their patients; the health psychologist and psychomotor therapist were both well-versed in describing techniques from talk therapy and psychobiological concepts, and used the same terms and theories. While it was difficult to analyze the unique contributions of each profession to the discussions, it also evinced the mutual learning and multidisciplinarity that can be achieved within diverse and collaborative team settings, helping professionals to develop a more holistic understanding of the health and needs of their patients. Future efforts to capture differences in approach and opinions between different mental health professions, as well as

foster mutual learning, may go more smoothly if they bring together various MHPs who do not already work within multidisciplinary teams.

Limitations and strengths

This study has several methodological and circumstantial limitations. First, as this study used only qualitative methods, it would have benefitted from the addition of a quantitative component to create a sequential exploratory design, as the results could have been brought to a larger and more diverse study sample, including patient samples and non-Western MHPs, in order to validate and expand upon the findings. Furthermore, as the research was done only with the perspectives of MHPs, it did not give other key stakeholders a say in the research, a chance to learn, or a chance to help their communities. It also did not draw regional or cultural distinctions between patients' countries of origin, which inhibited a deeper contextual analysis and inclusion of more specific community and societal-level results. While the contextualization of SR within broader socio-ecological systems is likely to take away some of the individual blame of sexually victimized persons by highlighting broader environmental risks and failings (Grauerholz, 2000; Pittenger et al., 2016), the present study could have taken this idea of systemic disenfranchisement and inequality one step further by involving patients and other stakeholders in an intersectional feminist approach. Unfortunately, as this study stems from a master's thesis that had a strict time limit and was conducted at the height of the Covid-19 pandemic while the psychosocial health care system was facing unforeseen challenges with providing care to patients, efforts to recruit patients in an ethical and pragmatic way failed, and the research design was subsequently adapted to fit only the MHP perspectives.

This study also has a number of strengths. The inductive thematic approach facilitated a thorough, detailed, and iterative qualitative analysis of the data. Its iterative and transdisciplinary design allowed for flexibility and adaptation in the face of unforeseen Covid-19 challenges, while its recruitment of a multidisciplinary, engaged, and sexual trauma-focused team of MHPs led to a wealth of relevant professional experience and patient cases for the researchers to draw from. By seeking to promote mutual learning and discussion among participants through dialogue spaces, as well as building off of MHPs interests and enthusiasm, there may also have been a more equitable exchange of benefits between the research team and its participants. This was particularly the case when the SVE team asked for further discussion of SR in a second FGD and the research team obliged, which benefited the SVE team by giving them an additional learning opportunity and benefited the research by enriching the data and giving a greater variety of perspectives.

Conclusion

The findings presented in this study contribute to a more contextualized and systems understanding of SR among sexually exploited patient populations. Its involvement of a multidisciplinary team of MHPs specialized in sexual violence and exploitation tapped into a wealth of professional knowledge and experiences regarding SR and how to break the pattern of sexual violence, while also stimulating dialogue, reflection, mutual learning, and enthusiasm for giving SR the attention that it deserves. The enthusiasm and demand for a second FGD evinced the value and importance of engaging MHPs outside of academia in the process of exploring and addressing SR. Future efforts are needed to further examine SR using mixed

methods and ecological and intersectional frameworks, build an evidence base for effective therapeutic approaches, and involve key stakeholder groups in the research process.

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Appendix A. Reflection on research design changes and Covid-19

Considering the host of challenges that the Covid-19 pandemic raised, including substantial difficulties with recruiting patients for the study, we had to make several methodological changes to the original plan. Originally, the idea was to do exploratory interviews with patients seen by the SVE team on their ideas about healthy vs. unhealthy relationships, their confidence in protecting themselves, and other topics related to SR. Then, we had a focus group lined up to have a group discussion about healthy vs. unhealthy relationships, how patients navigated their social positioning in the Dutch context, and strategies they could think of to avoid or protect themselves in risky situations. After that, we would have conducted a FGD with MHPs similar to the present FGD1, but with more joint analysis of findings from the interviews and the patient FGD and how this could be incorporated into practice. Intersectional feminism was the intended theoretical framework. Still wanting to contextualize SR within larger systems of influence and inequality, but realizing it would go against the ethical ideals of inclusion and empowerment underpinning intersectionality by not speaking with patients, we chose instead to use the Ecological Model as a general framework for discussing and analyzing professionals' opinions and experiences. The shortcomings of having to make this change to the design are discussed further in the discussion section of the article, as well as other methodological and circumstantial limitations resulting from the Covid-19 pandemic.

To try to incorporate more transdisciplinary elements, the MHPs from the interviews were asked what they thought was most important to bring up in the FGDs, and this advice was taken in mind when creating the FGD guides. An example of this is how Eline (Interview 2) emphasized her outrage and disappointment about ongoing exploitation in and around the Dutch asylum centers, which was then brought to FGD1 and FGD2 for further discussion. I also tried to make a case in the introduction for how MHPs are still a useful stakeholder group to discuss SR with, arguing that they are uniquely positioned as both trusted confidants in the worlds and life histories of their patients and actors embedded within the health care system.

Appendix B. Informed Consent - Interviews

Thank you for your interest in participating in our study! We are researchers at ARQ National Psychotrauma Center, and we are doing this study to learn about how and why some people may be sexually abused or exploited more than once (sexual revictimization). We believe that your thoughts and ideas are important, and that we can learn a lot from you. We hope that this study will give you a safe space to share your thoughts, learn from yourself and others, and develop your critical thinking skills. We also hope that the information you provide will inform and strengthen future efforts to prevent sexual victimization and revictimization from happening to people.

If you decide to participate, you will join either 1 interview or 1 group discussion where you can share your ideas about sexual revictimization, and this discussion will take approximately 1 hour. Participation is completely your choice, and your decision will not have any good or bad consequences for you or your work or therapy. If you wish, you are free to either take a break or completely stop with the discussion at any time, for any reason. The discussions will be recorded, and then written down as text to be used for our research. Once the discussion is written down, the video and/or audio files will be deleted and names and other personal information will be removed from the text. We do this to protect your privacy and make sure that nobody will be able to trace what has been said back to you (or your group mates if you participate in the focus group). Any research papers which are published from this study will not contain any personal information that can identify you. We also ask that you do not share the personal information of your group mates with others in order to protect their privacy.

Do you consent to participating in the study and letting us use your answers in the discussion in our research? [ ] Yes [ ] No

Name: _____ Date:_____

Signature: _____

If you have questions or concerns, please contact:

Rachel Brenner (master's student & facilitator): r.brenner@arq.org, +31636417697

Pim Scholte (supervisor): p.scholte@equatorfoundation.org

Appendix C. Informed consent - FGDs

Thank you for your interest in participating in our study! We are researchers at ARQ National Psychotrauma Center, and we are doing this study to learn about how and why some people may be sexually abused more than once (sexual revictimization). We believe that your thoughts and ideas are important, and that we can learn a lot from you. We hope that this study will give you a safe space to share your thoughts, learn from yourself and others, and develop your critical thinking skills. We also hope that the information you provide will inform and strengthen future efforts to prevent sexual revictimization from happening to people.

If you decide to participate, you will join 1 group discussion where you can share your ideas about sexual revictimization, and this discussion will take around 60 minutes. Participation is completely your choice, and your decision will not have any good or bad consequences for you or your relationship with ARQ. Since sexual revictimization can be a sensitive topic, it is possible that you may feel uncomfortable during the discussion. If you wish, you are free to either take a break or completely stop with the discussion at any time, for any reason. The discussions will be recorded as an audio file, and then transcribed within 7 days so that the research team can carefully study what has been said. Once the discussion is transcribed, the audio file will be deleted and names and other personal information will be removed from the text. We do this to protect your privacy and make sure that nobody outside of the group discussion will be able to trace what has been said back to you or your group mates. Any research papers which are published from this study will not contain any personal information that can identify you. We also ask that you do not share the personal information of your group mates with others in order to protect their privacy.

Do you consent to participating in the study and letting us use this discussion in our research?

Yes [ ] No [ ]

Name and date: _____

Signature: _____

If you have questions or concerns, please contact:

Rachel Brenner (master's student & facilitator): r.brenner@arq.org, +31636417697

Pim Scholte (supervisor): p.scholte@equatorfoundation.org

Appendix D. Interview Guide

Greet and thank participant, remind them of study purpose, ask if anything was unclear on the informed consent.

The interview will last somewhere around 45 minutes, and with your permission, I will record our conversation as a video or audio file so that I can listen to it later and type it out as text. If you feel uncomfortable at any point and wish to take a break or stop with the interview, just let me know and we will stop. Also, your responses will be confidential between us, and I will keep your answers anonymous by deleting the recordings after I have typed out our conversation, and I will use a fake name for you on any papers that are published from this study.

Do I have your permission to record our conversation and use it for my research?

1) Great. So, first could you please tell me a bit about your role here at ARQ and what motivated you to work here?

a) Probing/clarifying questions: how does your profession differ from that of other mental health professions? What do you like about your job?

2) Next I'd like to shift the conversation towards your ideas about sexual victimhood. At what point would you consider someone to be a victim of sexual abuse or exploitation? Where do you draw the line between 'normal' and 'victimhood'?

a) Can you think of any 'gray areas' or situations where there is not always a clear distinction? Please explain.

I. is marriage before age 18 sexual victimization?

II. Is someone a victim if they agree to sexual acts even though they do not want to or are having doubts?

III. Are sex workers victims?

IV. If someone enters into a marriage or intimate partnership mainly for economic reasons to survive, is this victimization?

b) What do you think of the term 'victim'? Are there consequences to using this term? How does it make you feel to use it?

c) Do you find that you and your patients have similar or different opinions on whether they/others are victims? Why?

3) What comes to mind when you think of "sexual **re**victimization"? There are no right or wrong answers.

a) E.g. they could be words, images, a definition, emotions, just anything that comes up when you think about sexual revictimization.

4) Do you think that someone who has been sexually victimized in the past is more or less likely to experience sexual victimization again in the future? Why?

a) Do you think these experiences change depending on whether that person is also male/female, non-Dutch, religious, seeking asylum, LGBT+, etc? Why?

5) Do you think your patients are safe from being sexually revictimized here in the Netherlands? Why or why not?

a) In what situations might they be unsafe against sexual revictimization? In what situations are they protected?

b) Do you think they are safer from sexual revictimization here in the Netherlands than in other places they have lived? Why or why not?

c) Do you feel that your patients have the services and tools they need to be able to stay safe? Why or why not?

6) I'm planning to discuss these points with other therapists and also patients. Do you think there are important questions or topics that we haven't covered today that I should be discussing with them? Anything else you'd like to talk about?

Conclude and thank the participant.

"If you have any questions for me or any new ideas pop up that you'd like to share, please feel free to get in touch with me and I'd be happy to discuss. If you want to stay informed about the status of the paper or see the final product, Rina and I will continue to work on it in the coming months and we'll be happy to give you updates. Thanks again, and I hope you enjoy the rest of your day!"

Appendix E. FGD1 Guide

Hi everyone, welcome and thank you so much for participating in my study!

- Master's thesis about sexual revictimization
- Interested in how this phenomenon can be understood and addressed from various perspectives
- perspectives of psychotherapists such as yourselves will be hugely valuable in shedding light on the issues and nuances surrounding sexual revictimization, since sexuality and victimhood are likely to come up when you are working with patients who have a sexual trauma background.
- One hour
- Open and honest conversation, encouraged to interact with each other and react to what others have said
- My own role here is to make sure we stay on topic, ask questions here and there to spark discussion between you all, and keep an eye on the time.
- Questions before we get started?
- PRESS RECORD

1) What do you love most about your job? Please all write your answers using the chat box feature (5 minutes)
2) What comes to mind when you hear the words 'sexual revictimization'? Take a minute to think about any words or phrases, then write them in the chat box. Then we'll do a round so that each person can explain what they've shared (10 minutes)
3) Why do you think sexual revictimization happens to people? (10-15 minutes)
    a) Are there differences in how revictimization happens here in NL vs in patients' home countries?
    b) I learned something interesting in one of the interviews about how there are quite a few people who go missing from the shelters here in NL because exploiters hang around near the shelters and lure people into sex work. It was shocking for me to hear. Do you all know anything about that? Why do you think it's not prevented by the police or other responsible parties?
4) So, when I was doing interviews to prepare this focus group, something that often came up was that therapists found it tough and sometimes uncomfortable to challenge their

clients' understanding of unhealthy relationships and sexuality, especially as a Western 'outsider'. So my next question for you all is: (20-25 minutes)

a) How do you as therapists achieve a shift in your clients' understanding of healthy vs. unhealthy sexuality in a way that is sensitive and understanding of their backgrounds?

b) What therapies or techniques were helpful?

c) How can you help other therapists navigate this challenge (especially less-experienced therapists)? How can you all help each other to learn from everyone's experiences?

5) Closing question: Finally, I'd like to ask all of you to take a minute to reflect on our discussion today. Then, I'll have each of you share what you will take away from this conversation. (10 minutes)

a) E.g. Did you learn anything new? Did anything surprise you? How do you feel about our discussion? Will you change anything in your own practice as a result of this discussion?

Appendix F. FGD2 Guide

Hi everyone, welcome and thank you so much for participating in my study!

- Master's thesis about sexual revictimization
- One hour
- Open and honest conversation, encouraged to interact with each other and react to what others have said
- My own role here is to make sure we stay on topic, ask questions here and there to spark discussion between you all, and keep an eye on the time.
- Questions before we get started?
- PRESS RECORD

Brief round of introductions

1) What is sexual revictimization and why does it happen?
    a) What about substance abuse? LGBT+?
    b) For those who are revictimized here in NL, who are the perpetrators?
    c) If someone goes into a marriage or prostitution purely for survival, do you think they are being victimized or exploited?

2) Several colleagues have described revictimization as a sort of pattern of abuse that their patients can get stuck in. Have you ever had a case where you felt like you succeeded in helping them to break this pattern?
    a) Could you describe this case?
    b) What helped you to succeed?
    c) What did you find challenging?

3) Would you say that Dutch society is doing a good or bad job at preventing revictimization from happening?
    a) Are there any shortcomings in communities, the health system, legal system, or police force?
    b) From my understanding, it happens quite a lot in and around the ACZs. Why do you think that is?

4) The therapists that I've talked to about revictimization have been really interested and engaged in the topic, but they also said that revictimization is not really "on the map", in the sense that it's not something they often think or talk about. Do you all have any ideas about how to keep these conversations alive and further address SR in a way that is feasible and sustainable?
    a) Any protocols or trainings that it could be integrated into?

Appendix G. Coding Scheme

Theme	Code	Explanation	Int1	Int2	Int3	Int4	FGD1	FGD 2
Conceptualize								
	Actively seek or maintain	Describes how patients may seek out or maintain unhealthy relationships, even in cases where they know the relationship is unhealthy	X	X	X	X	X	X
	Personal boundaries	Recognizing and letting others know when one feels uncomfortable with a particular act or situation	X	X	X	X	X	X
	Choice or agency	Having options or acting from one's own desire, rather than out of necessity	X	X	X		X	
	Gray areas	Acts or situations in which it is not immediately clear if it is victimization; requires interpretation	X	X	X	X	X	

	Human Suffering	Physical, mental, or social problems as a result of SR	X	X	X	X	X	X
	Pattern	Habitual behaviors, cognitions, or experiences of victimization	X	X	X	X	X	X
	Power Imbalance	There is a difference in agency between two individuals in a relationship; unequal distribution of costs and benefits	X	X	X	X	X	X
	Subjective	Requires interpretation; not universal	X	X	X	X	X	X
	Unhealthy relationships	Relationships in which one or more individuals experience(s) some form of human suffering	X	X`	X	X	X	X
Individual Level								
	Abnormal psychosocial development	Adoption of maladaptive coping strategies, behavioral patterns, or psychobiological tendencies over time	X	X	X	X	X	X

	Anxious arousal	Anxiety and its accompanying psychobiological signals			X	X	X	X
	Hyper-arousal	Fight-or-flight response is occurring at extreme level or during unnecessary times			X		X	X
	Personal boundaries	Recognizing and letting others know when one feels uncomfortable with a particular act or situation	X	X	X	X	X	X
	Childhood sexual abuse	Describes situations where a child is subjected to sexual interactions by a person in relative power	X	X	X	X	X	X
	Desire to please	Wanting to make others happy, giving in to their wishes	X	X			X	
	Difficulty reading social cues	When body language and tone are unfamiliar, hard to read, or do not match one's expectations		X		X		X
	Dissociation	Disconnection or 'blanking out' from one's		X	X	X	X	X

		thoughts, feelings, or what is happening in the present						
	Alcohol and substance abuse	(Over)use of substances that have a psychoactive effect			X		X	X
	Lack of self awareness	Capacity to know and connect with one's self	X	X	X	X	X	X
	Low social intelligence	Capacity to know and connect with others		X	X		X	X
	Low self-worth	Feeling as though one is less valuable or worthy as a person than others	X	X	X	X	X	X
	Internalized gender roles	Own beliefs about men's and women's place in society, the family, how they should act and present themselves	X	X	X	X	X	X
	Sexual arousal	Feelings of sexual desire and accompanying psychobiological signals			X		X	X
Relationship Level								

	Association with sexually aggressive partners, peers, or community members	Being in contact or associated with people who act in sexually aggressive and abusive ways	X	X	X	X	X	X
	Family environment that is unsupportive, abusive, highly patriarchal, or homophobic	Growing up in a family that does not properly care for the child's needs, safety, healthy sexual development and independence	X	X	X	X	X	X
Community Level								
	Exploitation in the asylum centers	Members within and around the asylum centers engage in or facilitate trafficking rings and other forms of sexual exploitation		X			X	X
	General tolerance of sexual violence	Downplaying or disregarding the seriousness of sexual violence		X	X	X	X	X
	Lack support from police or judicial system	Police or judicial system fail to protect victims by not adequately prosecuting and deterring exploiters		X			X	
	Lack awareness of SR	People do not know what SR is or if/how it exists	X	X		X	X	X

		in their community						
	Poverty and lack of economic opportunities	Communities are living with not enough resources, businesses/employers in the community are unable/unwilling to provide economic opportunities	X	X	X	X	X	X
	Sexuality as a resource	Using sex as payment to secure safety or a livelihood	X	X	X	X	X	X
	Lack societal inclusion of refugees and asylum-seekers	Refugees and asylum-seekers live apart from general population, lack opportunities to participate actively in society (e.g. job opportunities, integrated recreational activities)	X	X			X	X
	Unstable housing and homelessness	Uncertainty over being able to afford shelter, not having a place to call home, sleeping outside or 'couch surfing'	X			X	X	X
Societal Level								
	Gender norms	Societal beliefs about men's and	X	X	X	X	X	X

		women's place in society, the family, how they should act and present themselves						
	Inequalities based on gender	Denial of agency, support, or resources based on one's gender identity	X	X	X	X	X	X
	Inequalities based on sexual orientation	Denial of agency, support, or resources based on one's sexual orientation						X
	Inequalities based on age	Denial of agency, support, or resources based on one's age	X	X	X		X	X
	Inequalities based on residence status	Denial of agency, support, or resources based on one's residence status in a given country	X	X			X	X
	Policy on sexual violence and gender equality	Policies adopted by a society to address sexual violence and gender equality		X		X	X	X
	Stigma and shame	Societal devaluing, ridiculing, or ostracizing of someone for going through a particular experience or	X	X	X	X	X	X

		having a particular quality (e.g. being sexually assaulted)						
	War & Conflict	Violence and warfare between societies or major subgroups within a society	X	X		X	X	X
Prevention & Treatment								
	Break the pattern	Finding ways to help patients change maladaptive patterns in coping and other behaviors	X	X	X	X	X	X
	Challenging	Treatment is not always successful, takes significant time and resources, and is emotionally taxing on therapist and/or patient	X	X	X	X	X	X
	Exposure therapy	Engaging patient in conversations and hypothetical scenarios about past traumas so that they can process the experience under guidance			X	X	X	X

	Raise awareness	Teaching others about SR and alerting them to its existence in communities and societies	X	X		X	X	X
	Golden standard	(Lack of) established and evidence-based treatment and prevention protocols					X	X
	Integrate SR into protocols and procedures	E.g. include conversations about sexual (re)victimization in intake interviews or questionnaires					X	
	Module training	Short training courses that teach MHPs and patients new information and skills					X	X
	Psychoeducation	Teaching patients about psychological phenomena; giving patients the tools they need to better understand themselves and others		X	X	X	X	X
	Rescription	Recalling past relationships and experiences and retroactively prescribing the love, attention, or						X

		other things that the patient needed in the past; a tool to help patients formulate for themselves what a healthy relationship means to them						
	Schema therapy	A therapy focused on helping patients recognize and understand patterns in thought and behavior, how they respond to these patterns, and how this shapes facets of their identity/being					X	X
	Talk therapy	An umbrella term; can include techniques from schema therapy, cognitive behavior therapy, and other conversation based approaches			X	X	X	X
Role of the Therapist								
	Active listening	Demonstrating engagement during a conversation (e.g. taking notes,	X	X	X	X	X	X

		expressing sympathy)						
	Ask questions	Demonstrating engagement and commitment to learning during a conversation through probing questions	X	X	X	X	X	X
	Empathize	Being able to understand and acknowledge the feelings and experiences of others	X	X	X	X	X	X
	Non-judgmental	Listening and asking questions without asserting one's own values or preconceptions (passing judgments)	X	X		X	X	X
Reflection and mutual Learning								
	Engage other MHPs	Start conversations or put forth educational materials				X	X	X
	Enthusiasm	Excitement, engagement, desire for more	X	X	X	X	X	X
	Learn from colleagues	Openness to others' ideas and experiences so that they can	X	X	X	X	X	X

		sharpen and improve their own ideas and practices						
	Self-doubt	Lack of confidence in one's own abilities or expertise (e.g. 'I don't know if I will be very helpful for your study')	X			X		
	Verbalize thoughts	Make implicit thoughts explicit through dialogue	X	X		X	X	
	Partnerships with local community organizations	Pooling of resources, networks, expertise in order to provide more comprehensive care (e.g. communicating and cooperating with asylum centers)						X
	Publishing	Dissemination of scientific findings in journals, blog posts, or other mediums						X