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A record-based study from a sexual assault center and a police district

NTNU
Norwegian University of Science and Technology
Thesis for the Degree of
Philosophiae Doctor
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Doctoral thesis

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Sårbarhet blant fornærmede og gjerningsmenn ved voldtekt

For å øke kunnskapen om seksuelle overgrep mot voksne kvinner og om hvordan politiet etterforsker voldtektssaker mot kvinner, har målsetningen med dette arbeidet vært å sammenligne undergrupper av både ofre og gjerningsmenn ved voldtekt. Studien er basert på journalgjennomgang fra Overgrepsmottaket ved St. Olavs hospital i Trondheim, og fra Sør-Trøndelag Politidistrikt (STPD). Datagrunnlaget for de tre delarbeidene er fra perioden 2003 – 2010.

I det første delarbeidet brukte vi informasjon fra overgrepsmottaket, og ville se nærmere på de pasientene som hadde spesifikke psykososiale sårbarhetsfaktorer. Pasientene ble definert som såkalt sårbare dersom de hadde en eller flere av følgende karakteristika: Fysisk eller psykisk utviklingshemming, psykiske helseproblemer, rusavhengighet, eller tidligere opplevd seksuelle overgrep før den aktuelle henvendelsen som førte til kontakt med overgrepsmottaket. Vi fant at hele 59 % av pasientene hadde en eller flere slike sårbarhetsfaktorer. Vi sammenlignet opplysninger om overgrepet fra denne gruppen med gruppen av pasienter som ikke hadde en slik sårbarhet, og vi fant et klart mønster. Ofrene med sårbarhetsfaktorer var noe eldre enn de uten sårbarhet, og overgrepene var oftere begått av noe eldre menn, som kvinnene kjente fra før. De sårbare kvinnene var oftere arbeidsledige. Ofrene uten de nevnte sårbarhetsfaktorene var ofte unge og studenter som hadde blitt utsatt etter inntak av større mengder alkohol, gjerne av en tilfeldig bekjent overgriper. Tendensen var ellers at det var begått overgrep som involverte mer bruk av fysisk vold i sakene mot sårbare ofre enn mot de ikke-sårbare.

I det andre delarbeidet brukte vi informasjonen fra politiets arkiver (STPD), og undersøkte hvordan etterforskningen ble gjennomført i de anmeldte voldtektssakene. Her sammenliknet vi saker hvor offeret hadde en eller flere av de samme sårbarhetsfaktorene som i det første delarbeidet, og saker hvor offeret ikke hadde slik sårbarhet. Vi fant at politiet hadde gjennomført en etterforskning som så ut til å være av lavere kvalitet i de sakene hvor offeret hadde sårbarhet enn i sakene som involverte ofre uten sårbarhet.

I det tredje delarbeidet brukte vi også politidataene til å undersøke forskjeller mellom overgrep begått av tre ulike kategorier av mistenkte gjerningsmenn: Menn som var anmeldt for voldtekt eller annen voldskriminalitet for første gang (førstegangs-mistenkte), menn som var tidligere anmeldt for voldtekt eller annen voldskriminalitet (gjengangere), samt uidentifiserte gjerningsmenn. Vi fant at det var høyere arbeidsledighet og mer rusavhengighet blant gjengangerne enn hos de førstegangs-mistenkte. I forhold til de førstegangs-mistenkte hadde både gjengangerne og uidentifiserte gjerningsmenn utøvd mer fysisk vold ved overgrepet. Gjenganger-voldtektene var også noe oftere begått av offerets partner/eks-partner. I sakene med førstegangs-mistenkt gjerningsmann hadde voldtektene oftere funnet sted i festrelatert sammenheng hvor offeret ofte var ung. I sakene med uidentifisert gjerningsperson var det ofte oppgitt en gjerningsmann av utenlandsk (ikke-vestlig) opprinnelse. Da vi sammenlignet politietterforskningen i henhold til hvilken overgriper-kategori som var involvert, fant vi at politiet hadde gjort et grundigere etterforskningsarbeid i voldtekter der mistenkte var gjenganger enn i sakene med førstegangs-mistenkt. I sakene med gjenganger ble det også oftere tatt ut tiltale.

Det er et behov for mer kunnskap om og formidling av det vi vet om den høye forekomsten av seksuelle overgrep som begås mot kvinner som er spesielt sårbare. Slik ny kunnskap om omstendigheter rundt overgrep mot sårbare kvinner kan gi nyttig informasjon om både ofre og gjerningsmenn, og bidra i fremtidig arbeid med forebyggende strategier. Mer kunnskap trengs også om hvordan karakteristika hos ofre og gjerningsmenn kan påvirke politiets etterforskning og beslutningsprosesser i voldtektssaker.

Kandidat: Bjarte Frode Vik
Institutt: Institutt for Klinisk og Molekylær Medisin, NTNU
Veiledere: Cecilie Therese Hagemann, Kirsten Rasmussen og Berit Schei
Finansiering: St. Olavs Hospital, Universitetssykehuset i Trondheim, Divisjon Psykisk Helsevern, Avdeling for forskning og utvikling (AFFU).

Ovennevnte avhandling er funnet verdig til å forsvares offentlig for graden PhD i Medisin og helsevitenskap. Disputas finner sted ved St. Olavs hospital torsdag 5. november 2020, kl. 12.15. Grunnet pandemien med covid-19 blir disputasen tilgjengelig for publikum kun via digital overføring

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1. Acknowledgements

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Finally, I want to thank my family and friends for all your support and for never stopping believing in me. Cathrine, my lovely and clever wife, thank you for your love and encouragement, and thank you for your patience, especially during the last stressful months when you let me spend most of my time at the office finishing up the work with this thesis. To our three wonderful children, Nora, Anne, and Peder, thank you for bringing so much joy and for reminding me of what is most important in life.

2. List of papers

Paper I

Vik BF, Nøttestad JA, Schei B, Rasmussen K, Hagemann CT. Psychosocial Vulnerability Among Patients Contacting a Norwegian Sexual Assault Center. *J. Interpers Violence* 2016 Jul.
doi: 10.1177/0886260516659657

Paper II

Vik BF, Rasmussen K, Schei B, Hagemann CT. Is police investigation of rape biased by characteristics of victims? *Forensic Sci. Int.: Synergy* 2 (2020) Feb. 98-106.
doi: 10.1016/j.fsisyn.2020.02.003

Paper III

Vik BF, Rasmussen K, Schei B, Hagemann CT. Three groups of suspects in police reported rape cases: First-time suspects, recidivists, and unidentified suspects. A comparative study. *J. Forensic Leg. Med.* Available online 15 Feb. 2019.
doi: 10.1016/j.jflm.2019.02.004

3. Abbreviations

ASD: Acute Stress Disorder

CI: Confidence Interval

CRF: Case Report form

CJS: Criminal Justice System

DGPP: Director General of Public Prosecutions

df: degrees of freedom

DFSA: Drug-facilitated sexual assault

FCE: forensic clinical examination

ID: Intellectual Disability

IPV: Intimate Partner Violence

IQ: Intelligence quotient

IS: Police *Investigational Score*

OPD: Oslo Police District

OR: Odds ratio

PTSD: Post-Traumatic Stress Disorder

SA: Sexual Assault

SAC: Sexual Assault Center

SACC: Sexual Assault Care Center

SARC: Sexual Assault Referral Center

TI: Tonic Immobility

UK: United Kingdom

US: United States

4. Summary

To increase our knowledge about sexual violence against women, the three studies in this thesis aimed at analyzing and comparing subgroups of both victims and assailants, as evidence-based research on these topics is limited. This thesis examines how sexual assaults committed against women with certain vulnerability factors differ from assaults against women who do not have such vulnerability characteristics. Further, the quality of police investigations of these crimes is studied with regard to differences between the corresponding cases of victims with and without vulnerability. Finally, three categories of rape suspects are examined to detect differences in assault characteristics and police investigations depending on the category of the suspect involved.

The basis for Paper I was a relatively large collection of data from the Sexual Assault Center (SAC) at St. Olavs University Hospital in Trondheim, Norway, from the period 2003–2010. These SAC data (Paper I) were then merged with corresponding data from police files at the Sør-Trøndelag Police District (STPD), and Papers II and III were based on data from the merged data sources, but then with different perspectives. All three papers in the thesis have a retrospective and descriptive design, although Papers II and III could be seen as having qualities of a historical prospective cohort design.

There are four main themes: (a) the association between victim vulnerability and assault characteristics, (b) the association between victim vulnerability and police investigation, (c) the association between suspect category and assault characteristics, and d) the association between suspect category and police investigation.

Vulnerable groups of victims constituted the majority of women contacting the Trondheim SAC and the STPD after being sexually assaulted. There were obvious patterns of difference in characteristics of sexual assaults committed against women with vulnerability compared to those without vulnerability. Victims without any of the vulnerability factors were more often young students and assaulted during or after social settings where alcohol, and relatively large amounts of it, was served. In the cases of vulnerable victims, and presumably by the nature of these victims' inherent vulnerability, alcohol seemed to a lesser degree "to be needed" in order to attract, mislead, and abuse them.

We found a trend showing less thorough police investigation of rape cases if the victims had vulnerability than in cases where victims did not have vulnerability. The police less often interrogated witnesses other than the victim and suspect, and they also less often secured biological material from the crime scene in cases involving victims with vulnerability than in cases involving non-vulnerable victims. Patterns of rape were different depending on the categories of suspects involved. Cases

involving suspects who had a criminal record as a former suspect of a sexual/violent crime (recidivist suspects), were investigated more thoroughly by the police and were more often prosecuted than cases where suspects did not have a record of such crimes. More knowledge is needed in the future to improve preventive and protective means toward groups of women who are at increased risk of being sexually assaulted. Future research should explore the presence of eventual rape myth endorsement among law enforcement personnel, and whether such preconceived attitudes bias police investigations in rape cases depending on the characteristics of victims and suspects.

5. Introduction

From 1989, the Sexual Assault Center (SAC) at St. Olavs Hospital in Trondheim, Norway, has offered medical care to victims of sexual assault. The patients receive emergency medical treatment of injuries, and biological forensic trace evidence is collected. Also, the SAC offers supportive follow-up conversations with psychiatric nurses. In cases in which assaults are reported to the police, findings from the forensic medical examination are sometimes used as relevant information related to police investigations, and occasionally these results can be crucial in the decision-making in court.

As a consulting psychiatrist in an outpatient clinic which deals with habilitation of people with neuropsychiatric conditions, including many patients with intellectual disability (ID), I had some knowledge about the vulnerability for becoming victims of and assailants in sexual assault within the population of people with ID. Literature on these topics is scarce, but as my interest in especially victim vulnerability for sexual assault evolved, I had the privilege of contacting Senior Researcher and Psychologist Jim Aage Nøttestad (1948–2016) at the Forensic Research Unit Brøset at St. Olavs Hospital. Nøttestad had a special interest in research on sexual assailants and had through his work an established contact with the research environments at both the Department of Obstetrics and Gynecology at St. Olavs Hospital and the police at the Sør-Trøndelag Police District (STPD). He provided valuable help and advice regarding how to get started with the project. This was how I came into contact with Cecilie Therese Hagemann, a specialist in obstetrics and gynecology, who performed the dissertation for her PhD-degree in October 2014, based on data from the Trondheim SAC and the STPD. Hagemann became the main supervisor for my project.

During my research studies, I have had the opportunity to participate with oral presentations of my results on three occasions at the International Conferences on the Survivors of Rape (ICSoR 2014, 2016, and 2018 in Lisbon, Stockholm, and Helsinki, respectively). At two of these conferences, I presented results regarding vulnerability factors in women for being sexually assaulted, and both times I was confronted with questions and arguments from the audience which evidenced that I was dealing with a topic of controversy, especially when talking about sexual revictimization. Many researchers question the usefulness of focusing on victims rather than on the ones who commit the crimes, the assailants, because such a focus may be interpreted as blaming of sexually assaulted women for the assaults they have experienced. These are important considerations, but in my opinion, we need a broad focus in the search for knowledge about sexual assault, and with a balanced perspective on factors in both assailants and victims, in order to gain a better understanding of how to prevent these complex and hidden crimes

in the future. In two of the papers of this thesis, victim vulnerability factors for sexual assault are a main focus, whereas the third paper primarily deals with different groups of assailants.

Sexual assault is the overarching topic of this thesis, which contains a mixture of science from the disciplines of gynecology, psychiatry, forensic medicine, criminology, and law.

6. Background

6.1. Definitions

According to the first *World Report on Violence and Health* published by the World Health Organization (WHO) in 2002, sexual violence represents a human rights violation with severe negative impact on mental and physical health [1], and is defined broadly as "any sexual act, attempts to obtain a sexual act, or acts to traffic for sexual purposes, directed against a person´s sexuality using coercion, harassment or advances made by any person regardless of their relationship to the victim, in any setting, including but not limited to home or work" [2, 3]. Exact definitions of sexual violence against women outside the legal terms are complicated and involve many different forms, from sexual harassment to more severe cases involving the use of force, eventually evidenced by various degrees of physical injuries.

In the Norwegian penal code, a rape is defined as follows: "A person committing rape or attempted rape is defined as one who obtains sexual activity by means of violence or threats, or with any person who is unconscious or for any other reason incapable of resisting the act, or by means of violence or threats compels somebody to engage in sexual activity with another person, or to carry out similar acts with him- or herself. In addition to vaginal, anal and oral intercourse, touching of genitals, a man´s exposed genitals being rubbed between a woman´s thighs or buttocks or on her belly, masturbation, licking or sucking of genitals, or insertion of fingers or objects into the vagina or anus" [4]. The WHO refers a narrower definition of rape: "Physically forced or otherwise coerced penetration, even if slight, of the vulva or anus, using a penis, other body parts or an object. Attempts to do so are defined as attempted rape" [3]. The term "sexual assault" often refers to a single episode and is considered identical to "rape" or "attempted rape." The term "sexual assault" is often used in the health care system, whereas the more judicial terms "rape" and "attempted rape" are more commonly found in settings within the criminal justice system (CJS). The term "sexual violence" is often used when describing illegal sexual activity on a general basis, or in international literature as an overarching term comprising both the terms "rape" and sexual assault. The use of the terms "sexual assault," "rape," and

"sexual violence" have also been used interchangeably in the literature [5]. The term "sexual abuse" is more commonly used when discussing sexual violence against children and adolescents and reflects a situation of ongoing, repeated assaults over time. Repeated rapes, which also have been found to be common in cases of intimate partner rapes, has been termed "rape chronicity" [6]. In Paper I of this thesis, which is based only on SAC data, we used the term sexual assault consistently, while the term "rape" was used for the cases which were based on merged data from both police and SAC records (Papers II and III). Accordingly, the terms patient and assailant were used in Paper I, whereas victim and suspect were the terms used in Papers II and III, based on police data subsequently merged with SAC data. When referring from the literature, terms are used in accordance with each reference.

6.2. Prevalence of sexual assault in population surveys

Sexual violence represents a serious public health concern across the globe [2, 7], and the phenomenon has been broadly researched for decades [8, 9]. Women and girls are more likely to be victims of sexual violence, and men are more likely to be assailants [2]. Sexual violence against men/boys is also a significant problem worldwide [1, 10], but as this thesis is concentrated on sexual assault against women, male sexual assault is mentioned only on a few occasions.

The real prevalence of sexual violence is elusive, and a huge dark figure exists that is difficult to capture. Making comparisons of prevalence between countries is hard due to several methodological problems. Sexual violence is defined differently between cultures, and there are variations in legislation and organization of the CJSs around the world. Extensive underreporting, different questioning in surveys, variations in sampling, and in what countries studies are conducted are examples of challenges met by researchers when trying to determine the true prevalence [11]. Population-based data from the United States show that the lifetime prevalence of women for becoming a victim of rape is one in five [12]. According to the International Violence Against Women Study, 13 to 34% of women in high-income countries[1] reported ever having been raped during their lifetime [13, 14]. Research has shown that a majority of all sexual assaults occur within an intimate partner relationship. Estimates from low- and middle-income countries[2], conducted by the WHO, disclosed that between 6 and 59% of women reported lifetime experiences of intimate partner sexual violence, and that between 0.3 and 12% reported ever being subjected to non-partner sexual violence [15]. The worldwide prevalence of non-

[1] Germany, Italy, Switzerland, Denmark, Sweden, Australia
[2] Brazil, Ethiopia, Peru, Serbia and Montenegro, Tanzania, Bangladesh, Namibia, Japan, Thailand, Samoa

partner sexual violence after the age of 15 years was 7%, varying between 10–20% in sub-Saharan Africa, 7—10% in Europe, 5–13% in North-America, and 3–6% in Asia [16].

A national study of the prevalence of rape and sexual violence in Norway was conducted in 2013. Of the 2435 interviewed women aged 18 to 75 years, the lifetime prevalence of rape was reported by almost one in 10, and half of these had experienced being raped before the age of 18 years [17]. In this study, rape was described by a strict definition, which implies that the result has probably been an underestimate of the actual prevalence. In another Norwegian national survey, 16% of the women reported having experienced unwanted sexual intercourse after the age of 16 years [18]. A survey conducted in the capital of Norway, Oslo, in 2000 - 2001 showed that 9% of women reported having been subjected to rape or attempted rape at least once in their lifetime [19]. A Norwegian study of a randomly selected population aged 24—55 in Oslo found that 6% of their respondents had experienced sexual violence by a current or former intimate partner [20]. As most literature on the prevalence of sexual assault, these Norwegian studies also found that the risk of being assaulted was higher among young adults and adolescents than among older women [20, 21]. Lifetime experience of sexual assault among males was also registered in the Norwegian surveys, but at a significantly lower scale (1–3%) [17, 18, 21].

Population-based prevalence of sexual assault and rape in the other Nordic countries have been reported as follows: A report from Sweden published in 2014 showed that 20% of women and 5% of men reported having been sexually assaulted [22]. According to a survey on violence against women in the EU from 2012, 17% of women in Finland have experienced sexual violence during their lifetime [23]. A new report by Amnesty International refers to findings from 2014 by the Fundamental Rights Agency on violence against women across the EU, showing that the proportion of women aged 15 years and above in Denmark who reported having been raped at least once in their lifetime was 19% [24]. In conclusion, in spite of different definitions and populations, all these studies confirm the large scale of the serious problem of sexual violence against women.

6.3. Medical and judicial help-seeking after sexual assault

6.3.1. Sexual Assault Centers (SACs)

The first hospital unit specifically designed to treat patients after sexual assault was established in the US in the early 1970s. The purpose was to secure services with a high professional standard where specialists from different fields cooperated under a so-called multidisciplinary model. The idea of such

sexual assault centers (SACs) spread first to Australia [25] and later to Europe and the rest of the world [26-28]. The term sexual assault care center (SACC) has also been used in the literature [29]. St. Olavs University Hospital in Trondheim, Norway, established its SAC in 1989 [30, 31]. The service is accessible 24 hours a day, seven days a week, and offers emergency medical care provided by practiced gynecologist registrars, by pediatricians for minors, and by specially trained nurses. In addition to the treatment of injuries and other medical conditions, as well as psychosocial crisis intervention, the service offers a forensic clinical examination (FCE), including systematic documentation of injuries, laboratory testing, and collection of biological trace evidence. The forensic specimens are occasionally requested by the police for further investigations.

According to the organization of forensic medicine in Norway, the specialists who perform the medical examinations at the SAC may be summoned to assist in police investigations and sometimes as expert witnesses in court.

In accordance with other similar centers in the Nordic countries, the Trondheim SAC has experienced a steady increase in annual numbers of patients attending this health care service after sexual assault. We do not know the reasons for the increased attendance, but it could be due to a growing awareness of, and eventually, an increased trust in the available specialized service offered at the SAC. There are now a total of 23 SACs in Norway, and in all of the country´s 11 counties, offering low-threshold services to more than 2000 patients a year [32], and regardless of whether victims wish to go further with police-reporting or not. However, according to the NKVTS survey from 2013 mentioned above, one in three victims never tell anyone about an experience of sexual assault, but it has been communicated through the media that there should be no reasons not to contact a SAC [33]. The main principles of the service are primarily to offer medical and psychosocial help to victims, and to let the victims themselves take the decision about whether to police-report the assault. Research from the Nordic countries has shown that 50–70% of the patients who contact a SAC after sexual assault also report the incident to the police, and vice versa [34].

6.3.2. Police-reporting of rape

During the last two decades, there has been a dramatic increase in the number of rapes reported to the Norwegian police, with the increase being especially significant over the last five years [35]. A similar development has been reported from other countries [22, 24, 36, 37]. In the early 1990s, approximately 400 cases were reported each year, a number which increased to almost 1700 cases in 2018, excluding rapes and attempted rapes against children < 14 years, which alone constituted more than 500 police-

reported cases in 2018 [35].[3] Still, rape is described as the most unreported crime of our time [38]. One category of rape which is relatively new is sexual assaults happening on the Internet. The extent of these rapes has obviously increased over the last years. Rape on the Internet occurs without physical contact between the assailant and the victim and often involves a victim being threatened or lured to carry out sexual activity with someone else or with him- or herself. Children are often the victims of these assaults, but adult victims are also reported [35]. As we did not have data about rape on the Internet, this topic is not discussed any further in this thesis, except for a short notice under the section "Suggestions for future research" regarding a need for new studies which investigate associations between rape on the Internet and populations of especially vulnerable victims. Explaining the vast increase in police-reporting of rape is complex, but it is hardly due to an increase in the true extent of sexual assaults happening in Norway [35, 39]. Types of reported sexual assaults have changed, and hence cases which were previously not acknowledged as rape or sexual assault are now being reported and subjected to police investigations [37, 39, 40]. A change in the general openness about sexual violence in society has been suggested as another important explanation [35]. More openness leads not only to a lower threshold for police-reporting of rape but also to more supportive attitudes from important others (friends/family) regarding the choice of reporting a rape incident to the police. Another likely explanation is that rape has been a highly prioritized type of crime in the Norwegian police in recent years, which has been clearly communicated toward society from the criminal justice authorities and from the media [41]. This may have contributed to an increased trust from the public in police handling of sexual crimes.

6.4. Victim vulnerability

In the World Health Organization report on violence and health from 2002, the WHO described several factors which had been shown to increase women´s risk/vulnerability for experiencing sexual violence [1]. Explaining sexual violence against women was emphasized as difficult by the "multiple forms it takes and contexts in which it occurs," implying that the construct of one single and fully completed list of vulnerability factors would be complicated. One of the most common forms of sexual violence worldwide is that which is perpetrated by an intimate partner, leading to the conclusion that one of the most important risk factors for women, in terms of their vulnerability to sexual assault, is having an intimate partner. Further, the following list of factors which are found to increase women´s

[3] After a revision in the Norwegian law on October 1, 2015, sexual intercourse with children under the age of 14 years was defined as rape. To keep updated rape crime statistics comparable with older results, numbers must be registered in two age categories; cases where the victim is either < 14 years or ≥ 14 years of age.

vulnerability to sexual assault was referred to in the WHO report: 1) being young; 2) consuming alcohol or drugs; 3) having previously been raped or sexually abused (revictimization); 4) having many sexual partners; 5) involvement in sex work; 6) becoming more educated and economically empowered, at least where sexual violence perpetrated by an intimate partner is concerned; 7) poverty. The WHO report suggests that the various vulnerability factors have an additive effect, so that the more factors present, the greater the likelihood of sexual violence [1]. According to the references that support these risk/vulnerability factors, it is likely that some of them are closely linked to the economic development and patriarchal norms in the countries from which they are referred. For example, risk factor 6, educational level, is based on references from South Africa and Zimbabwe, implying that it may be less applicable in countries where the general level of education among women, and gender equity, is higher. Regarding the use of the terms "risk factors" and "vulnerability factors," these have been used interchangeably by the WHO [1].

6.4.1. Rationale for a concept of victim vulnerability at the Trondheim SAC

Since we have regarded the understanding of our patients´ psychosocial history as crucial for being able to offer optimal medical care after rape, the Trondheim SAC has consequently and over many years collected information about such a history in the medical records. Patients´ psychosocial history has also been described in formerly published studies [29, 42, 43]. The concept of victim vulnerability described in these studies has provided the basis for continued research from the Trondheim SAC regarding victim vulnerability for sexual assault. According to our concept of victim vulnerability, which constitutes the basis of this thesis, a victim is considered vulnerable if at least one of the following features was present:

- Intellectual and/or physical disabilities
- History of present/former mental health problems
- History of present/former alcohol/substance abuse
- Former sexual assault

Although some of the risk factors referred by the WHO were not included among our vulnerability factors, we still regard these four chosen factors as being highly relevant and crucial in the sense that they both one by one and also on a compound level of co-occurrence diversely describe especially pervasive and inherent qualities of the victims in a long-term perspective. Our access to records from the Sør-Trøndelag Police District (STPD) in corresponding cases of police-reported rape, also contributed to a rich and varied data material for research purposes, although vulnerability information often was

scarcely documented in the police records.

The vulnerability factor *History of present/former alcohol/substance abuse* refers to a former or present clinical condition of alcohol or substance abuse/addiction. In this thesis, it is important to distinguish this vulnerability from the variable *victim alcohol intake prior to assault*, which refers to the situational intake of alcohol in victims before the incident of sexual assault. The latter is an acknowledged risk factor for sexual assault, especially in cases of excessive episodic drinking, or "binge drinking" [44], but is not necessarily equivalent to alcohol/drug addiction. In theory, other acknowledged vulnerability factors could have been added to our list, such as young age and acute assault-related alcohol intoxication ("binge drinking" behavior). However, we evaluated victim age and "binge drinking behavior" to be better suited for analyses as separate risk factors, already thoroughly explored by others in the sexual assault literature [1, 44, 45]. Another reason for excluding young age and "binge drinking behavior" was that most of the victims in our data actually were young, and a large majority had consumed alcohol before the assault, which would make almost all of the victims vulnerable in the construct of vulnerability as a single compound, dichotomized variable consisting of multiple vulnerability factors. Both victim age and alcohol intake before the assault are, however, included in several of the analyses in this thesis as independent and confounding variables, showing how these factors are intertwined when exploring the complexity of sexual assault cases.

Research shows that an overlap between different vulnerability factors is common [1, 46, 47]. The four vulnerability factors in this thesis and their internal co-occurrences are illustrated in Figure 1 in section 6.4.6. In the following subchapters (6.4.2. – 6.4.6.), each of the separate vulnerability factors will be described, as well as the frequent occurrences of more than one of the vulnerability factors. Prevalence in the community (population) and in SAC studies, associations with some assault characteristics (e.g., relationship to assailant), and an explanation of the over-representativity of vulnerability in SAC populations will be presented as well. Victim vulnerability, according to some aspects of police investigation, will be further discussed in section 6.5.4.

6.4.2. Intellectual and/or physical disabilities

The term intellectual disability (ID) refers to a highly heterogenous group of people who have in common evidence of some delay in reaching developmental milestones, a delay or failure to acquire living, educational, and social skills as expected for their age, and evidence, on standard psychological assessment, of significant intellectual impairment. Other terms found in the literature for ID are "mental retardation," "learning disability," and "developmental disability." The term ID says nothing about the

cause of the diagnosis, and biological explanations for the condition often remain unknown or undetected. For some people with ID, there is an identifiable and acknowledged explanation, such as a genetic or other congenital or early-acquired biological/neurological condition, which explains the impaired function. ID is not a psychiatric condition, although it can be coded as one according to the International Classification of Diseases 10th revision (ICD-10) [48]. To meet the criteria for the diagnosis of ID, an intelligence quotient (IQ) must be measured as < 70. It is, however, important to remember that IQ is only one of several diagnostic criteria for the diagnosis [49]. In a normal population, one would expect an IQ < 70 to be found in approximately 2–3% [50]. The majority are in the category mild ID (i.e., IQ 50–69), and many in this category are never diagnosed, which explains why official prevalence measures of ID are lower than the "true" number of people with IQ < 70 found in population studies [49]. This implies that there may be many unrecognized women and men in our society who struggle with many challenges in life, including a lack of protection against sexual offenders. The prevalence of people with a so-called administrative diagnosis of ID in Norway today is approximately 0.4- 0.5% (i.e., people with the diagnosis of ID who receive community services on a daily basis) [51, 52]. In contrast, the average "true" prevalence of ID in school children has been estimated at 3% worldwide [53]. A diagnosis of ID is commonly coded in medical records without any formal diagnostic assessments being performed. The assessment of the diagnosis ID is complicated and requires high competence within the discipline of neuropsychology. Frequencies of ID vary depending on the diagnostic criteria used and between countries [49, 54]. The term borderline ID is also used, and the definition of this is set at an IQ in the range 70–79 [49].

The incidence of sexual violence against people with ID seems to be significantly higher than in the general population [55, 56]. There is, though, limited evidence-based literature regarding sexual violence against people with disabilities, and studies often address the problem of physical and sexual violence against people with different categories of impairment without discriminating between either the types of disability or the types of violence [57].

The increased vulnerability for being sexually assaulted among people with ID can be explained by a number of reasons, one of them being a lack of sex education and understanding of normal sexual boundaries, leading to sexual violations where individuals may not acknowledge that they are being abused [55]. According to unpublished federal crime data from the U.S. Justice Department, people with ID are sexually assaulted at a rate seven times higher than those without disabilities, and this problem has been addressed as "the epidemic no one talks about" [58]. They are likely to be assaulted by someone they know and during daytime hours. They are targeted because they are easily manipulated

and will have difficulty testifying later. These crimes mostly go unrecognized, unprosecuted, and unpunished, and the abuser is free to abuse again. Police and prosecutors are often reluctant to take these cases because they are difficult to proceed and prove in court.

A physical disability is a somatic condition which limits one or more of a person´s major life activities, including mobility and self-care/home management [59]. An interview questionnaire study from the US showed that women with physical disabilities experience physical and sexual abuse at the same proportion as women without physical disabilities, but they were more likely to experience physical and sexual abuse by attendants and healthcare providers rather than more peripheral persons and friends [59]. A Norwegian review regarding sexual assault against women with disabilities showed that especially young women/girls who had the disabilities of impaired vision and hearing were more exposed to sexual assault than women without disabilities [60].

Research from SAC studies regarding any disability is scarce, and very few studies have specifically explored assault characteristics of SAC patients with disabilities. A Norwegian SAC study from Oslo showed that 3% had a mental disability [61]. A Canadian SAC study found that 11% were reported to have physical or cognitive disabilities [62], and a French study found that 7% of the victims were either physically or mentally handicapped [63].

6.4.3. History of present/former mental health problems

The literature on the prevalence of preexisting mental health issues in victims of rape and sexual assault is limited [64]. A study from Copenhagen, Denmark, found a higher prevalence of mental health problems among patients contacting a SAC than in a control group [65]. A study from England reports that 40% of those presenting at a SAC had a preexisting mental health problem [66], which is consistent with reports also from the Netherlands [67] and the United States [64]. One study from a US SAC referred that 27% of the victims had a registered psychiatric diagnosis [68]. Correspondingly, a study from a Danish SAC reported that 38% had given information about former psychiatric treatment [45]. Another SAC study from the UK found that two thirds of their sample of 269 adults had a preexisting mental health problem [69]. Affective disorders were disclosed in 49% (depression, anxiety and depression, bipolar affective disorder), deliberate self-harm was disclosed in 29%, and as many as 22% reported attempted suicide at least once in their lifetime. Only 3% had a diagnosis of psychotic illness. In summary, that study described occurrences of preexisting psychiatric diagnoses but did not relate the diagnoses to assault characteristics or other clinically relevant information.

Very little information is available with regard to why these women seem to be over-represented

among SAC patients. Vulnerability due to mental health is an area with substantial amounts of speculation and perceived understanding despite limited evidence [69]. A British government review from 2010, which was commissioned to examine how the public authorities in England and Wales handled rape complainants, emphasized that vulnerability, by any means, including mental health problems, decreases an individual's capacity to consent [6]. Other studies demonstrating the link between preexisting psychological problems and increased vulnerability for sexual assault are those showing that mental health problems such as post-traumatic stress disorder (PTSD) and depression, which commonly develop in the aftermath of sexual assault, lead to increased susceptibility to being re-victimized [70-74]. The phenomenon of revictimization is discussed further in section 6.4.5.

6.4.4. History of present/former alcohol/substance abuse

People who abuse or are addicted to alcohol and/or drugs have been shown to have an increased risk of being sexually assaulted [75]. Substance users may "find themselves" in "risky" situations that may increase the likelihood of becoming victims [76], especially while under the influence of psychotropic drugs. Alcohol and drugs lead to reduced abilities to make sensible and rational judgements, in addition to impairments of the users` sense of motor movements, which may make it difficult to identify a perpetrator and fight back during an assault.

Being highly intoxicated by alcohol or drugs contributes to increased vulnerability for being subjected to the phenomenon of drug-facilitated sexual assault (DFSA), both proactive DFSA (when the assailant actively administers drugs to an unsuspecting victim) and opportunistic DFSA (when the assailant takes advantage of someone already inebriated by voluntary intake). In both instances, the victim has a level of intoxication incompatible with giving consent to sexual advances [77]. Many women contacting SACs or the police have been involuntarily drugged and sexually assaulted, or sexually assaulted while asleep or in a state that rendered them unable to consent or resist [43, 61, 78]. Not uncommonly, the woman does not remember and is unable to relay details about the incident [42]. A recent SAC study from the US found that 40% reported a prior substance abuse history and that those with a history of substance abuse were less likely to report minority race/ethnicity than non-users. The study reported that, among victims with histories of substance abuse and sexual assault, the victim claimed that prior assault preceded substance onset in the majority of cases [79]. The authors suggested that substance use and associated impairment may serve as a rape tactic by assailants, and that assessment and intervention approaches should target alcohol, marijuana, and other illicit drug use and abuse [79]. A study from the Norwegian SAC in Oslo found that 17% of the victims reported an addiction problem [61]. Most of the

SAC studies in which different aspects of alcohol/substance abuse are discussed do not relate the condition of abuse with other assault characteristics.

One population-based study described the intertwining relationship between substance abuse and sexual assault and highlighted the reciprocal nature of the two phenomena, meaning that a sexual assault can increase the risk for substance abuse and vice versa [47].

6.4.5. Former sexual assault (revictimization)

There is increasing evidence documenting that having experienced sexual assault increases the vulnerability for experiencing new episodes of sexual offending, or so-called sexual revictimization [1]. A study which broadly reviewed the literature on the problem of sexual revictimization concluded that persons who have experienced sexual assaults in childhood have a doubled risk of being sexually assaulted as teenagers and young adults. Further, the study showed that two thirds of individuals who are sexually victimized, either as a child or later in life, will experience revictimization [80]. A special concern was also expressed regarding the problem of revictimization in the Stern Review cited above [6]. A typical trait in this category of "repeat victims" was that they often come from a "whole history of abuse" that becomes their norm or continuum of suffering [6].

Frequent occurrences of revictimization have also been documented in SAC reports from both the Scandinavian countries and the US [43, 45, 61, 79, 81]. One of these studies, from Sweden, found that women who were sexually assaulted by their partners more often had a history of earlier assaults, suggesting repetitive assaults are more common within the intimate relationship [81].

It has also been shown that women sexually assaulted by a partner have a high risk of being sexually assaulted in another relationship [80].

Explanations for sexual revictimization are scarce in the literature. However, research shows both a significant prevalence of PTSD among revictimized as compared to single-incident rape victims [82] and that psychological symptoms of PTSD and depression, caused by former episodes of sexual assault or rape, are risk factors for being revictimized [79, 83-85]. A study on psychological treatment of PTSD and depression after interpersonal violence showed that those who responded positively to the treatment in terms of fewer PTSD and depression symptoms had a reduced risk of subsequent revictimization [71]. One PTSD symptom which has been found to be an important risk factor is so-called "emotional numbness" [71, 86]. Symptoms of unemotional behavior in PTSD patients have been closely linked to feelings of fear, anger, shame, and self-blame [86]. Women with sexual victimization histories often engage in less direct verbal resistance, such as turning cold or freezing during an offence. This is a symptom described as being "switched off emotionally" or being in a state of limited contact with

emotions, where the person seems indifferent and lacks the ability to feel joy, anger, sadness, fear, or other affections. We don´t yet know why this “emotional numbness” is a risk factor, but one may think that a “shut off” emotional mind has a reduced capacity to sense and understand risky situations. It is also likely that such reactions represent the phenomenon of dissociation, which is a learned psychological defense mechanism helping victims to psychologically flee from frightening situations.

Dissociation is a common symptom in PTSD. The phenomenon of fear-freeze-responses has also been termed “tonic immobility” (TI) in the literature [87, 88], and a Swedish SAC recently reported that as many as 70% of its patients reported to have been in a state of TI during the assault [89]. TI has been described as an involuntary, temporary state of motor inhibition in response to situations involving intense fear [87]. TI has been shown to be associated with the development of PTSD, severe depression, a previous trauma history, and a psychiatric treatment history [89]. Researchers have described TI in animals as an evolved defense mechanism against predators [87]. The possible relationship between TI and human reactions to sexual assault is a topic of discussion, although most studies on TI in humans have focused on sexual assault victims. Studies have shown that TI scores, measured by the Tonic Immobility Scale form, are significantly higher (i.e., a higher degree of freeze reactions) in victims of sexual abuse compared with other types of trauma [90]. Knowledge about TI is important not only in the follow-up of traumatized victims of sexual assault but also in judicial matters related to how victims of rape and sexual assault are understood and treated through criminal justice systems around the world [88]. The phenomenon of revictimization in the view of victim-police interaction is presented and discussed in section 6.5.4. Among the intentions of early mental health interventions in the meeting with patients at the SAC is to reduce psychological symptoms of distress (for example PTSD) and thereby to strengthen the patients and help them avoid further revictimization [31]. More high-quality research is needed about sexual revictimization and how mental health interventions can contribute to treatment and prevention of the phenomenon in the future.

6.4.6. Co-occurrences of vulnerability factors

It is evidenced in the literature that many women who experience sexual assault have more than one vulnerability factor for being sexually assaulted and that the degree of vulnerability increases as a result of more vulnerability factors being present [1]. The British Stern Review cited above reported co-occurrence of three of “our” vulnerability factors since they found that “repeat victims” (that is, those subjected to revictimization) often have also been found to have mental health problems and/or learning disabilities (i.e., cognitive impairment or mild ID), which make them vulnerable to being taken advantage of [6]. In a study already mentioned, which described a prevalence of preexisting psychiatric

diagnoses among adult female sexual assault victims, the diagnosis of learning disability was included, although this is not strictly considered a mental health issue [69]. This shows how two of "our" vulnerability factors can be categorized as one by others, hence exemplifying the co-occurrence of these two vulnerability factors in victims experiencing sexual assault. PTSD and depression resulting from sexual assault constitute especially potent vulnerability for later assaults, describing the presence of both revictimization and mental health problems as being frequently co-occurring vulnerability factors for sexual assault [71]. Again, the US SAC study reported that a patient´s history of sexual assault before the new acute SAC consultation was associated with a history of drug abuse [79]. Hence, a first assault, resulting in PTSD, depression, drug abuse, and then new assaults (revictimization) might constitute a self-perpetuating cycle for some people unless they are met with appropriate preventive and treatment strategies.

A new study described the prevalence of intimate partner violence (IPV) against women in 46 low- and middle-income countries [91]. Huge inequalities were observed both between countries and within countries. The study highlighted certain sociodemographic variables as being associated with increased vulnerability for physical and/or sexual IPV: being poor, young, and less empowered, in addition to living in rural areas. Figure 1 illustrates the four vulnerability factors in this thesis and their internal co-occurrences.

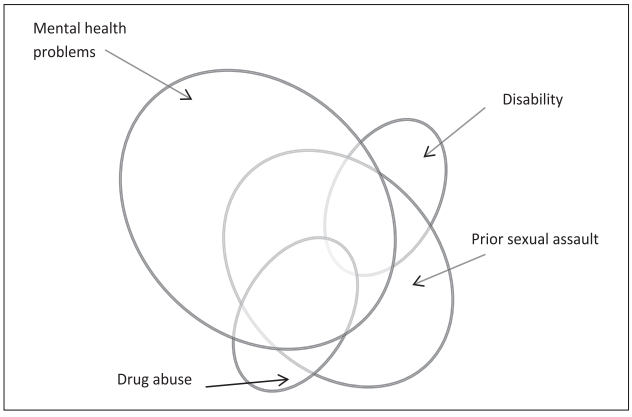

Figure 1. Theoretical model (Venn diagram) depicting the four vulnerability factors and their co-occurrence. Note (not drawn to scale).

6.5. Police investigation of rape

6.5.1. Police investigations of rape cases in Norway

An evaluation by the National Criminal Investigation Service in Norway (Kripos) published in 2015 showed that four out of 10 investigations of reported rapes were of low or very low quality and effectiveness [92]. The most common insufficiencies were that crime scene investigations had not been carried out, a DNA profile from the alleged perpetrator had not been collected, and electronic evidence had not been fully secured. Also, cases with a low- or very low-quality investigation were characterized by inefficient case processing and disorganized written materials. Police investigations of rape are complex and demanding, and although there are examples in the literature of accessible research results based on sensitive police data [93], a British author claimed that there are few research opportunities with unfettered access to police case files regarding rape [40]. The STPD in Norway was criticized by the district attorney[4] after delivering a report on 50 recently investigated rape cases in 2014 [94]. The STPD did not release the report publicly, but the chief inspector admitted that the number of investigational steps conducted had been too low, and hence, that the general quality of the investigations had been poor. Further, he expressed that they should have conducted more and better interrogations and that biological trace evidence should have been collected and secured more often. However, nothing was mentioned about eventual insufficiencies regarding the investigation in cases with especially vulnerable victims. This topic is discussed further in sections 6.5.3 and 6.5.4 as Paper II in this thesis is a comparative analysis of how police investigations differ between cases involving vulnerable and non-vulnerable victims. One consequence of the disclosures described above was the establishment of a specialized unit for the investigation and prosecution of rape and other sexual crimes in the STPD [94]. Time will show whether this may contribute to improved police investigation quality in the future. A survey conducted in Norway in 2017 showed that 18% of women with blindness or impaired vision reported having been exposed to sexual assault some time in their life [95]. When the newspaper VG contacted the Norwegian Police Directorate about this, they were informed that the Norwegian police do not have any statistics regarding the prevalence of sexual assault against people with disabilities. This is an indicator of a topic of low priority within the Norwegian police, the research community, and among politicians in Norway [95]. There is generally a lack of knowledge and research about rape against groups of especially vulnerable victims, and about how these victims are handled by the police, compared with victims who

[4] Statsadvokat

do not have increased vulnerability. One example of progress in the judicial rights for people with ID, however, was when the Norwegian government changed the legislation in 2015. After that, when children and other especially vulnerable groups, such as people with ID, police-report sexual crimes, they are assured interrogations and handling of legal procedures especially facilitated and adapted according to their needs [96].

6.5.2. The attrition problem

Along with the increase in police-reporting of rape, concern has been expressed from Norway and other countries about the low proportion of reported cases actually taken to trial and ending with conviction [24, 36-38, 97, 98]. In Norway, the prosecution rate in rape cases declined from 30% in 1990 to only 14% in 2001 [99]. Norway was criticized by the United Nations Convention on the Elimination of all forms of Discrimination Against Women (CEDAW) in 2003. The convention noted: "It is concerned that an extremely low percentage of rapes results in trials and convictions and that the police and public prosecutors dismiss an increasing number of such cases" [99]. Political authorities have for many years aimed at improving this picture, but nevertheless, recent statistics show that the percentage of police-reported rape cases going to trial in Norway remains low, with 21% being prosecuted in 2017 [100]. After a review of reports from the Norwegian Police service and rape crime statistics from Statistics Norway[5] in 2015, the Norwegian newspaper Aftenposten reported that 80% of all police-reported rape cases end with case closure by the police [101]. Further, among the 20% of cases which are prosecuted and taken to court, three out of four end with conviction [101]. Correspondingly, statistics from England and Wales in 2009 noted that only 6% of police-reported rapes resulted in a conviction [97]. Accordingly, recent statistics from the US disclosed that 99% of perpetrators of sexual violence will walk free [102]. In the literature, this growing gap between reported cases and criminal justice responses has been termed the "attrition problem" or "justice gap" [103]. In a report from 2019, Amnesty International expressed concerns about the high rates of attrition also in all the Nordic countries [24].

According to a British study, one problem which contributes substantially to the high rates of attrition is that many victims apparently decide to withdraw their complaints in the aftermath of police-reporting and that such victim withdrawals account for almost half of the attrition [40]. Similar results have been found in older British studies [104, 105], but none of the studies described whether the propensity to withdraw was linked to any specific subgroups of vulnerable victims. In Norway, as a

[5] Statistisk sentralbyrå (SSB) 2015

consequence of the system of so-called public prosecution, when the police only "become aware of" a rape complaint, they are obliged to establish a formal investigation [78]. Sometimes, however, the police meet victim-related "challenges" during investigation proceedings, which makes further investigation especially complicated. This has been described in a report by the Oslo Police District (OPD) [78]. They used an example similar to that in the British studies: rape complainants wanting the police to close their cases and not continue investigations. Other examples stated in the report were when victims did not show up for interrogations, due either to a lack of memory of the assault because of intoxication at the time of the assault or when victims for other reasons lack the will, courage, or social support to be able to cooperate. The private and sensitive nature of many rape cases were hypothesized as important explanations for why many cases were closed due to the sort of challenges described here [78].

6.5.3. Rape myths

Researchers have for 30 to 40 years claimed that we live in a rape-prone culture that propagates messages that the victim is to blame for her assault, that she caused it and indeed deserved it [106-109]. Rape myths is a term which was first used in the 1970s to explain false beliefs and misconceptions about how and why women are sexually assaulted [110]. Such attitudes exist not specifically among police officers or others who provide services to sexual assault victims but represent inherent sociocultural norms which can be seen in the society as a whole [111]. An understanding of what constitutes a "real rape" was proposed by Estrich in 1987 [112]. According to this myth, a rape should be perpetrated by a stranger in an outdoors setting, involving the use of force, which is met with resistance and evidenced in visible injuries. Another feature of the "real rape" myth is that victims will report the rape to police immediately and, because of the seriousness of the assault, have a clear and detailed memory of the incident. Contrary to this rape myth, experience suggests that victims of sexual assault often will delay reporting for a variety of reasons [113-115] and that traumatic events such as rape often impair rather than enhance memory performance. However, the latter notion is a theme of controversy discussed among forensic phycologists performing evaluations of credibility in criminal cases [116]. Empirical evidence has shown that "real rapes" are not typical at all, considering that the majority of assailants are known to their victims [43, 117-120]. The theories of rape myths have led us to question whether such attitudes could influence how the CJS approaches victims with specific vulnerabilities.

6.5.4. A vicious cycle of rape myth endorsement, victim vulnerability and attrition

The acknowledged fact that the majority of rape cases are closed during the police investigation [36, 38, 98, 121, 122] has contributed to an increased interest among researchers in studying police officers´

involvement in the decision-making process [121]. It is poorly understood what informs police decisions regarding how to go forward after a complaint of rape. There is, however, evidence showing that police officers possess significant and unfettered discretion in their decision-making in terms of suspect apprehension, investigative progress, and case-processing outcomes [121]. One study reported that 45% of rape complaints in the UK were not recorded in official statistics by some police authorities [97]. Other studies have described decision-making surrounding rape cases as often influenced by individual attitudes and cognitions in police officers, also termed "rape myth endorsement" [123, 124]. It has been argued that the answer to high attrition lies in attitudes and stereotypical ideas among those working within the CJS [40]. The police are the critical gatekeepers of the CJS and the first point of contact with the criminal justice process for women who have been raped and seek formal justice [40].

One study assessing official police records in rape cases found police notes which suggested that reported incidents were not "a real rape" because the victim was either a regular drug user, a sex worker, had reported rape before, was "mental", or promiscous [125]. An Australian criminological report described myths and misconceptions about sexual offending and was written to provide an evidence-based resource for police and legal practitioners to improve future practices [126]. In this report, some of the common rape myths presented were highly relevant with regard to the vulnerability factors which have been presented in this thesis: "People with disabilities are rarely victims of rape, and if subjected to rape they are not capable of relaying details about the incident;" "People with mental health problems often fabricate reports of rape;" "Intoxicated victims consent to sex but regret it afterwards and allege rape." A British study showed that rape cases which involved victims with mental health problems or learning disabilities were less likely to progress through the criminal justice system [37]. A higher rate of early dismissal was also found in cases in which victims had previously reported one or more episodes of rape or sexual assault. Sexual crimes seem to elicit a unique response from the surrounding community compared to other crimes. The credibility and responsibility of victims of robberies are rarely questioned, but victims of sexual crimes often experience not being believed in situations of police-reporting [127].

Without blaming victims, it is important not to overlook that psychological reactions and consequences following rape may affect a victim in a way that can negatively influence interaction with the support system, for example, in a setting of police interrogations. Research has shown that victims presenting with typical symptoms of acute stress syndrome (ASD) or PTSD, such as avoidance behavior and unemotional behavior, and behaviors associated with shame and self-blame can be interpreted by the police as lying or irrationality on the victim's part [86]. Also, a study found that police empathy

toward the victim is negatively correlated with these symptoms and behaviors [128]. A Norwegian study found that if victims of rape do not present with the "expected emotional response" following rape (being upset or showing negative emotions), the victim is deemed less credible by the police [129]. These findings suggest that some police officers may be unaware of the diversity of trauma reactions following interpersonal violence; hence hindering the proper progress of the investigation [5]. Studies have, however, noted that rape myth endorsement is dependent on occupational characteristics in police officers, such as officer sex, level of specialized education, and experience within the field of sexual crimes [130].

Some argue that the influence of rape myths on rape investigations may not be as pronounced as previously assumed [131]. They explain this through an increased public awareness of rape myths and the implementation of multidisciplinary rape response teams throughout the US and in many European countries [25, 132]. In accordance with this, a UK study has shown increased likelihood of case progression in police districts which adhered tightly to a so-called "victim-focused approach," This approach emphasizes believing victims when they report and supporting them to remain in the criminal justice system [37]. The idea is also actively to involve multidisciplinary links along with the ongoing police investigation, such as sexual assault referral centers (SARCs), independent sexual violence advisors (ISVAs), specialist sexual violence services, and the health sector [37]. In many Norwegian towns, so-called support centers have been established within the police systems for victims of crimes, where a *counsel for the aggrieved party*[6] offers consultations free of charge to help victims endure through the investigative and legal process. This is an example of progress and enhancement for the support of rape victims in recent years, regardless of whether victims have specific vulnerabilities.

6.5.5. The role of forensic evidence and its use in the investigation of rape cases

The service of the Trondheim SAC was introduced in section 6.3.1. The forensic medical examination includes documentation of injuries, forensic specimen collection, and toxicological laboratory testing. Few studies have investigated the impact of forensic and medico-legal findings obtained at a SAC on case progression and legal outcomes in cases of rape [133]. Some older studies concluded that there was no impact on charges and convictions resulting from the forensic medical examination findings [134, 135]. Contrary to this, there are more recent studies, one of them conducted at the Trondheim SAC, which

[6] Bistandsadvokat

have found that the analysis of collected swabs at the national forensic laboratory was significantly associated with charge filing [136]. The other, from a Danish SAC, concluded that documentation from the forensic clinical examination (FCE) influenced the decision-making process at all stages of the judicial process [133]. These studies highlight the importance of thoroughly documenting injuries and collecting and analyzing biological trace evidence even in non-stranger rape and sexual assault cases [133, 136].

When a rape is reported to the police in Norway, the police decide in each case whether to request a FCE report from the SAC. After having received the medical information from the SAC, the police still have the choice of whether to submit the collected forensic swabs for analyses at the National forensic genetic lab in Oslo [136]. Concern has been expressed about the fact that a substantial proportion of collected forensic specimens are never submitted for analyses at a crime laboratory in rape cases even in high-income countries [29, 137, 138]. There is, however, limited literature explaining why so many swabs are never submitted [137-140]. In a new study from Michigan, some explanations were found to be related to resource constraints, like staffing cuts in the police or insufficient capacity in crime labs [137]. The authors also mentioned that one explanation was found to be the presence of victim-blaming beliefs and rape myths among police officers. Improvements in training and education of police in order to obtain more utility of collected evidence were suggested as future implementions. We have, however, not found any studies which have analyzed eventual differences in the police´s utilization of forensic specimens depending on whether rape victims have vulnerability or not.

6.6. Assailants of sexual violence

6.6.1. An introduction to the topic

The research focus in Paper III in this thesis is on different characteristics of male sexual assailants as opposed to the focus on victims´ vulnerability factors in Papers I and II. An overarching topic between Papers II and III is, however, the descriptions of the police investigation in rape cases and how this relates to victim characteristics (in Paper II) and suspect characteristics (in Paper III).

In recent years, there has been a growing demand, reflected through the media, for more studies specifically on sexual assailants, as this is a topic about which the literature gives only limited answers [21, 78, 141-143]. Despite the deficiency of information on sexually violent men, research has evidenced that sexual violence is found in almost all countries, in all socioeconomic classes, and in all age groups from childhood onwards. Data on sexually violent men also show that most direct their acts at women whom they already know [1]. There has been a long tradition in research on sexual recidivists and the

prevention of sexual recidivism [141, 143]. The information which has been published on this topic has, however, raised concerns because it does not necessarily reflect an accurate picture of the larger population of male sexual assailants. Most research from Norway and other countries has been conducted on men who have been identified, sentenced through lawsuits, or eventually received treatment for their committed violations [144]. One example is a UK study from 2005 on the topic of sexual offenders with intellectual disabilities (ID), which showed that the sexual recidivism rate of offenders with ID is 6.8 times and 3.5 times that of non-disabled sexual offenders at 2- and 4-years´ follow-up, respectively. Further, the study showed that sex offenders with ID are also at greater risk of re-offending in a shorter period [145].

A researcher from the US suggested that we have knowledge about only a minority of sex assailants (less than 10%), simply because most of them are never identified [146]. New research has emphasized that the strong focus on recidivist sex offenders over the last 30 years, and with a punitive approach, has had only a limited effect, if any, on the prevention of sex crimes in a long-term perspective, and calls for more studies, which can lead to a better understanding of the origin and the development of sex offending over time, and the factors responsible for it [147]. It has also been emphasized that the attention to research on the prevention of sexual assault and offender treatment should be drawn toward youths who commit sexual crimes, as all data point to the origin of sexual offending in the early adolescent years [146]. As for primary preventive measures against rape and sexual assault, there are descriptions of positive results based on experiences with teaching programs aimed both at young women and men, but further development of the methods is needed [148].

6.6.2. Assailant characteristics and risk factors

Studies reveal that the majority of rape assailants are men [12, 17, 21]. Based on a summary of theory and research on rape, it has been shown that adult rape assailants tend to have a diverse criminal history [149]. In contrast, those convicted for sex crimes against children tend to engage exclusively in sex offences and may appear to be well-functioning and recognized community members [143, 150]. One study showed that convicted assailants in sex crimes are as versatile in offending behavior as other violent offenders in general [151]. Further, assailants convicted for adult rape tend to be characterized by high levels of antisocial personality traits, hostility, and aggressiveness [149]. Limitations of traditional theories on sex offender typologies are also addressed in the literature. Crossover-offending is described to be common, meaning that many offenders tend to admit to multiple victims and offences atypical of criminal classification, which underlines the complexity in the attempts to categorize sex offenders into typologies [143].

Some possible risk factors associated with rape perpetration in general were examined in a literature review [152]. Key findings revealed five groups of risk factors based on studies from North America and South Africa, examining different populations of incarcerated sex offenders, naval recruits, and college men, in addition to some community-based studies. Groups of risk factors considered important included adverse childhood exposure (such as being sexually abused and witnessing intimate partner violence), attachment and personality disorders, social learning of delinquency (e.g., associating with delinquent peers), gender-inequitable masculinities (e.g., the impact of social norms related to gender and the perception of sexual entitlement over women), and substance abuse [152]. Regarding risk factors for intimate partner rape, studies indicate that non-sexual aggression and marital dissatisfaction are among factors found to be strongly correlated with rape in marriage [153]. Furthermore, individual characteristics such as unemployment, hyper-masculinity, alcohol and drug abuse, and also sexually coercive fantasies are some indicated risk factors [153]. It was claimed in a Norwegian master's thesis in psychology that, despite the large amount of existing literature about sex assailant typologies and risk factors for becoming a rapist, there are still few characteristics, traits, or patterns of human behavior (modus operandum) which can be used to generalize hallmarks in a population of male sex assailants [142]. A comprehensive Norwegian literature review on men who have committed sex offences also concluded that there are no certain or satisfactory answers to the question of similarities or differences between men who commit rape or sexual assault and men who do not. Still, it was concluded that committing sexual assault is not normal behavior as most men never commit such violations [21]. A group of researchers from the US reported that, like many of the convicted and sentenced sex offenders, a large proportion of undetected rapists also report having committed other types of violent offences. This implies that sex offenders who are not identified and convicted have, in some ways, similarities with assailants who have been convicted and sentenced [154]. Research is, however, limited regarding unidentified sexual assailants, and more studies should focus on this in the future. A report published by the Oslo Police District (OPD) in Norway concluded that a sample of sex offenders are significantly different from the general male population in several ways: They have risk factors (or vulnerability) in the way that they are far more victimized, they have more mental health problems and far more often have a criminal record [78]. Two thirds of the persons reported to the OPD for rape in 2010 had formerly registered some criminal activity in police files. An especially disturbing finding was that among those reported for intimate partner rape only 16% did not have former crimes registered in the police files [78].

6.6.3. The influence of sexual assailant characteristics on police decision-making

Little is known about how the police prioritize in investigations of sexual assault cases, or how decision-making is influenced by characteristics of assailants. In section 6.5.4, theories and research were presented about rape myths among police officers with the perspective of how victim characteristics may eventually influence police decision-making in rape cases. The concept of what constitutes a "real rape" also involves suspects, and research has correspondingly shown that existing myths and misconceptions in the police environment regarding suspects in rape crimes also influence how suspects are treated by the police and how their cases are progressed in the criminal justice system depending on their characteristics [40, 98]. Although the literature on this matter is limited, there is research describing that stereotypes about sexual offenders have led to the term "the credible criminal," which is in line with the rape myth of "real rape." One British study showed that suspects with a criminal record, especially as former sex offenders, and those of non-white skin color, had an increased risk of being convicted [40]. A Danish study later found that rape suspects with one or more prior sexual assault charges were more likely to be both charged and convicted of a rape offense than those who did not have such criminal histories [98]. A Norwegian criminologist described that suspects who have a criminal record, regardless of the types of crimes previously committed, tend to get a higher priority in criminal investigations than those who do not [155]. It seems as though priorities made by the police in the investigation of sexual assault is tailored to a great extent to a limited amount of both human and financial resources available within the field of sex crimes, resulting in a rationalized approach of prioritizing primarily those cases that, based on experience, have the potential to result in convictions. It is important to study whether police investigation of sexual assault is conducted differently depending on characteristics of both victims and suspects, in order to disclose eventual biases which may systematically reduce the possibilities of reaching justice in some groups of cases compared to others.

7. Final comments on the aims of the studies

7.1. Paper I

Before designing Paper I, we acknowledged that there was little published research from the SACs on the topic of victim vulnerability for sexual assault, and to our knowledge there were no previous studies which had analyzed differences in characteristics of sexual assaults committed against women with specific vulnerability factors compared with sexual assaults against women without such factors. We also noted that literature describing multiple vulnerability factors as a pooled phenomenon was scarce. Increasing our understanding of victim vulnerability and characteristics in assaults committed against

women who are more susceptible to being sexually assaulted than others, is important as it can pave the way for improved preventive measures, specialized counselling services, and follow-up in the future.

7.2. Paper II

Research regarding the impact of vulnerability characteristics of victims in police investigations of rape is limited. In the process of designing Paper II and being aware that approximately 60% of the patients described in Paper I who had visited the SAC had also reported the assault to the police, we wanted to find out more about the course of the proceedings of these women´s cases in the CJS. We had knowledge about the low rates of prosecution and conviction of rape cases in general in Norway and Sør-Trøndelag county. However, we knew from the victims´ stories that they had various experiences with the process of reporting the rape to the police and from being part of an investigation. While some experienced their case to be proceeded in court, others, unfortunately and too often, experienced their case being dismissed. We wanted to find out if the vulnerability factors described in Paper I could also possibly imply vulnerability for the victims in their meetings with the police. Paper II was, therefore, designed to compare the thoroughness and the quality with which police investigations had been conducted between cases involving vulnerable and non-vulnerable victims. We wanted to look for and describe eventual patterns of differences in police investigations between rape cases with vulnerable and non-vulnerable victims, based on the hypothesis that rape myth endorsement among law enforcement personnel could systematically bias police investigations in favor of the non-vulnerable victims. Through our analyses in Paper II, we wanted to begin addressing some important research questions about which there is so far a dearth of evidence-based answers.

7.3. Paper III

Paper III was based on our knowledge about men who have previously been police-reported and/or sentenced for rape (recidivists) and the association between having a violent criminal record and the susceptibility to rape women. We wanted to use information from the criminal records of the rape suspects in our police district and see if we could find any patterns of difference between the assaults committed by recidivist suspects and those suspects who had been police-reported for rape for the first time (first-time suspects). Since one in five suspects were in a category of suspects who were never identified, we also decided to include this group as a third category of suspects in our comparisons. Further, based on previous research which evidences the existence of preconceived attitudes in the

police environment against groups of suspects, we wanted to examine whether there were differences in police investigation and decision-making in our police district, depending on suspect characteristics. Addressing this understudied problem can lead to increased awareness of eventual rape myth endorsement among police officers and suggest important directions for future research on the topic.

8. Aims

Paper 1

1. To describe the occurrences of four specific vulnerability factors among adult and adolescent female patients seeking health care after sexual assault.

2. To investigate whether there were different patterns of sexual assaults committed against the group of patients with vulnerability factors compared with assaults against the group without these factors.

3. To describe the assault characteristics for each separate vulnerability factor, in addition to describing those with more than one vulnerability factor.

Paper 2

This study aimed to describe police investigations of rape and assess differences in the investigations between cases in which the victims were characterized as being vulnerable and cases involving victims who did not have such characteristics.

Paper 3

1. To describe and to compare the following three groups of suspects of rape or attempted rape in a police district in the period 2003–2010: 1) first-time suspects, 2) recidivist suspects, and 3) unidentified suspects. Comparisons were conducted with regard to suspect, victim, and assault characteristics.
2. To describe differences in police investigations and prosecution rates of rape cases depending on the group of suspects involved.

9. Material and Methods

9.1. Design and settings

This thesis is based on studies from three different samples of women reporting sexual assault either to the police, to a hospital SAC, or both. Our studies are all retrospective (cross-sectional) and descriptive, thereby not allowing us to conclude on causal relationships. However, for Papers II and III, even if we retrospectively collected and then merged information from medical and police records, these studies could be regarded as having some qualities otherwise belonging to a prospective cohort design, since in both these studies we compared groups regarding police investigations from the time of reporting until decision-making. The data for all the three studies have been extracted from records at the main hospital and/or from files in the regional police district in the county of Sør-Trøndelag in central Norway. This area had a population of approximately 280 000 during the observation period for the studies [156], including the city of Trondheim with about 160 000 inhabitants.

The SAC is located at the Department of Obstetrics and Gynecology/Department of Pediatrics at St. Olavs Hospital, Trondheim University Hospital, Norway, and offers 24/7 low-threshold health care to patients who have been subjected to sexual assault. The SAC provides acute medical and forensic examinations conducted by consultant specialists/residents in gynecology or pediatrics and by specifically trained nurses. If patients present more than 72 hours after the assault, a consultation may be offered during office hours, but an evaluation of the need for immediate attention is done in each case. All patients are offered follow-up psychosocial support, which is conducted in terms of supportive conversations, psychoeducation, and counselling ("watchful waiting") with psychiatric nurses.

During the first consultation at the SAC, injuries are treated, and if the patient consents, biological trace evidence and laboratory tests are collected. The SAC stores the forensic specimens for up to six months, after which it is discarded if not requested by the police.

During the study period for the three studies in this thesis, the Sør-Trøndelag Police District (STPD) covered 23 municipalities. In addition to the district´s largest police station in Trondheim, it included 20 smaller police offices in the region. (However, in a police reform conducted by the Norwegian government in 2016, the number of police districts in Norway was reduced from 27 to 12. The Sør-Trøndelag Police District was merged with the Nord-Trøndelag Police District into Trøndelag Police District. Likewise, Sør-Trøndelag and Nord-Trøndelag counties were merged in 2018 into Trøndelag county.)

9.2. Study samples

The written materials which were initially noted by routine medical and police documentation in the SAC and police records, respectively, were later collected and registered into two different data sets for research use (one dataset for SAC data and one for police data). The study groups for the different analyses were identified from these datasets.

9.2.1. Sample for Paper I (based on SAC data)

This study sample originates from the SAC consultations. In Paper I, we included female patients ≥ 12 years of age who were examined at the SAC between July 1, 2003, and December 31, 2010. Figure 2 depicts the exclusion and inclusion of patients in this study. During the study period, 730 individual consultations were performed for patients ≥ 12 years. Males (n=20) and those not medically examined (n=68) were first excluded from the study. Also, in some cases, it was evaluated as unlikely that a sexual assault had happened (n =21), and these were excluded based on criteria stated in a Canadian study [62]. All patients eligible for inclusion (n=623, involved in a total of 667 visits) received a letter of information, with instructions on how to withdraw their records from the study. Those who did not want their medical records to be used for this research were excluded (n=9), as well as duplicate registrations, that is, attending the SAC more than once (revictimized) (n=39). A total of 573 patients were thus finally eligible for the study (Figure 2).

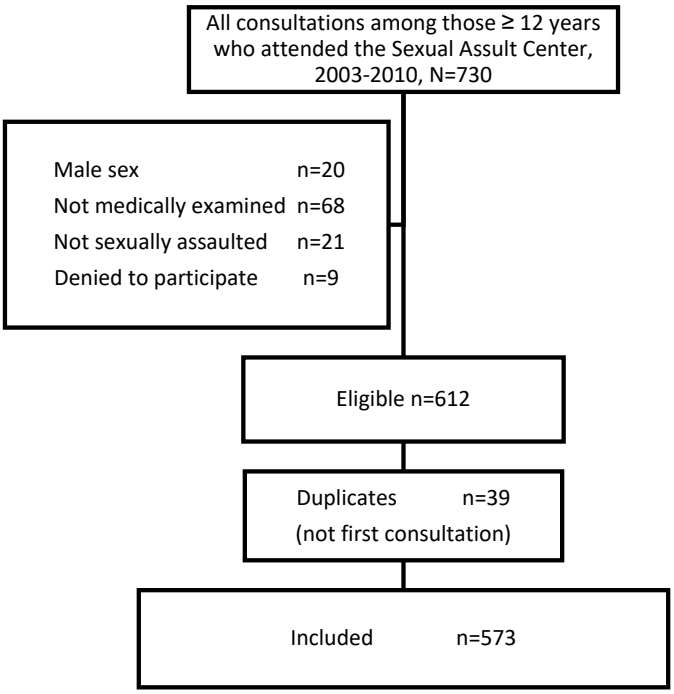

Figure 2. Flow chart for patients included in Paper I. Cases based on patients attending the Trondheim Sexual Assault Center during the period July 2003 through 2010.

9.2.2. Samples for Papers II and III (police data merged with SAC data)

The samples of Papers II and III originate from police-reported sexual assault cases. We identified all police-reported cases of rape and attempted rape of female victims ≥ 16 years of age in the Sør-Trøndelag Police District (STPD) in Norway during the period from July 1, 2003, to December 31, 2010. Cases were identified according to the former Norwegian penal code, § 192, which was applicable until revisions were made in September 2015 [4]. According to this law, a person committing rape or attempted rape is defined as "one who obtains sexual activity by means of violence or threats, or with any person who is unconscious or for any other reason incapable of resisting the act, or by means of violence or threats compels somebody to engage in sexual activity with another person, or to carry out similar acts with him- or herself. In addition to vaginal, anal, and oral intercourse, touching of genitals, a man´s exposed genitals being rubbed between a woman´s thighs or buttocks or on her belly, masturbation, licking or sucking of genitals, or insertion of fingers or objects into the vagina or anus is

defined as rape." The following specific crime denominations were included, as described by the same former penal code, §192: Sections 1 and 2 (rape), section 3 (aggravated rape), and section 4 (grossly negligent rape). Most of the cases included in Papers II and III were reported under sections 1 and 2 (rape). Cases of attempted rape were also included and coded by §192 and §49 in the same penal code.

For Papers II and III, 475 cases were identified. These were then merged with data from corresponding cases at the Trondheim SAC based on a key code (the personal identification code). Some victims had reported more than one rape incident. To avoid duplication, as in Paper I, these cases were explored specifically to confirm a matching date of assault in the police file and the SAC file. The merged file was then de-identified. Figure 3 shows the flow charts for Papers II and III, according to different exclusion criteria for the two studies. First, we excluded the following cases from both Paper II and Paper III: cases in which victims were < 16 years of age (age of sexual consent) (n=49), cases with male victims (n=18), unidentified victims (n=3), and duplicate registrations (n=21). After the merging of the data, we had a total of 384 victims. Of these, only 223 had visited the SAC.

9.2.2.1. Study sample Paper II (Figure 3)

For Paper II, we included only patients who had both reported to the police and visited the SAC. Therefore, all victims who had not been to the SAC were excluded (n=161), leaving a total of 223 cases eligible for the study. The sample was further divided into two study groups: In study group 1, all 223 cases were included. However, since some of the analyses of the police´s investigative steps in study group 2 were relevant only in cases where the suspect had been identified (police interview of suspect, DNA reference test of suspect, collection of forensic specimen from suspect), we excluded all cases with an unidentified suspect (n=47), leaving 176 cases eligible for study group 2.

9.2.2.2. Study sample Paper III (Figure 3)

For Paper III, which was also based on merged data from police files and SAC records, we included both cases where victims had only police-reported (n=161) the rape and the cases where victims also had medical records from the SAC (n=223). Since this study was about recidivist suspects, we excluded the cases in which there was uncertainty as to whether the suspect was a former suspect (n=28), leaving 356 cases eligible for the study. Of these, there was SAC data in 212 cases and only police data in 144 cases. The merging of the data is described in section 9.4.5.

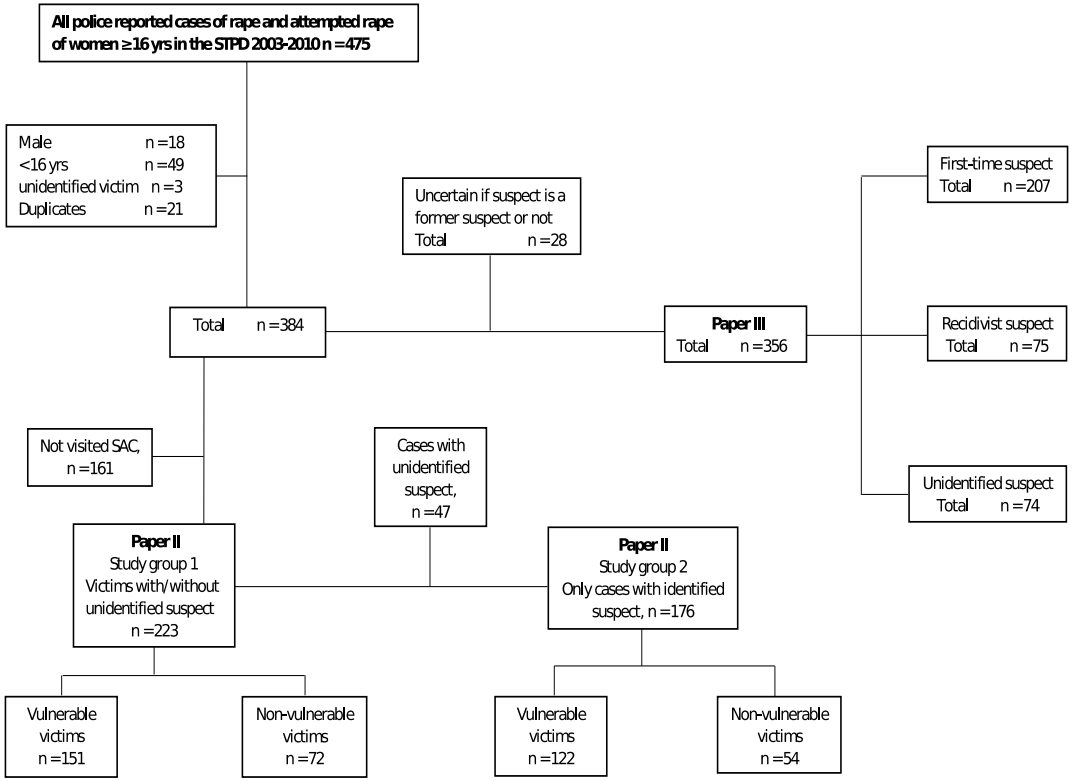

Figure 3. Flow chart for Papers II and III. All included and excluded police-reported cases of rape and attempted rape of women ≥16 years in the Sør-Trøndelag police district (STPD) from July 1, 2003 to December 31, 2010.

9.3. Data collection and storage

9.3.1. From medical records (all studies)

Sociodemographic, clinical, forensic, and laboratory information was gathered from the patients´ medical records and registered through a web-based data collection system (case report form, CRF) developed and administered by the Unit of Applied Clinical Research at the Norwegian University of Science and Technology (see Appendix 1). Through this system, all information was encrypted and de-identified. To ensure accuracy, the different collectors of data cross-checked with the record. If necessary, specific cases were discussed and consensus reached between all authors.

9.3.2. From police files (Papers II and III)

For Papers II and III, data from police files were registered through a web-based data collection system (web-CRF, police, see Appendix 2) similar to that for the hospital data (see section 9.3.1). In Papers II and III, the judicial terms victim and suspect have been used as corresponding to patient and assailant, which were used in Paper I.

9.3.3. Data storage

The SAC data, including the identifiable list of patients who received the letter of information about the study (for Paper I), as well as the merged data of police and medical records (for Papers II and III) are stored in a separate limited-access research file area provided from the *Data Protection Official*[7] at St. Olavs Hospital, Trondheim.

[7] Personvernombud

9.4. Variables

Table 1 presents the variables used for the different papers.

Table 1.

Variables used in Papers I–III. The variables are grouped into four categories: Victims´ (patients´) characteristics, Assailant/suspect and assault characteristics, Clinical documentation, and Police investigation variables.

Variables	Paper I	Paper II	Paper III
Victims´ (patients´) characteristics			
Age	x	x	x
Origin (Western vs. non-Western)		x	x
Occupation	x	x	x
Alcohol intake before assault	x	x	x
Vulnerability factors	x	x	
Assailant/suspect and assault characteristics			
Age	x		x
Origin (Western vs. non-Western)		x	x
Occupation			x
Education			x
Alcohol intake			x
Intake of drugs other than alcohol			x
Patients'/victims' suspicious of being drugged		x	
Victim-assailant relationship	x	x	x
Venue	x	x	x
Time of day of assault	x		

Variables	Paper I	Paper II	Paper III
Physical violence	x	x	x
More than one assailant/suspect	x		x
Penetration	x	x	x
Clinical documentation from SAC			
Time from assault to medical examination		x	x
Patient/victim bodily/extragenital injury	x		x
Patient/victim anogenital injuries			x
Patient/victim toxicology		x	x
Assault reported to police	x		
Police investigation variables			
Reported incident (rape/attempted rape)		x	
Suspect identified		x	x
Suspect a former suspect (recidivist)			x
Victim a former victim of a crime		x	
Victim a former suspect of a crime		x	
Suspect interrogation		x	x
Victim interrogation		x	x
Interrogation of other witnesses		x	x
Suspect arrested		x	x
Police investigation of crime scene		x	x
Police requested medical record from SAC		x	x
Analysis of swabs and/or clothes from victim		x	x

Variables	Paper I	Paper II	Paper III
Collection of swabs/or clothes from suspect		x	
Collection of biol. material from crime scene		x	
Suspect DNA profile taken		x	
Suspect admits sexual contact		x	x
Suspect admits rape		x	x
Time from police-reporting to legal decision		x	
SAC physician summoned as witness in court			x
Prosecution		x	x
Police investigation score		x	
Police investigation quality		x	

9.4.1. Victims´/patients´ characteristics

Patient/victim vulnerability factors

This thesis is built upon four psychosocial vulnerability factors in victims, which have been introduced and described in detail in section 6.4. A victim was considered vulnerable if at least one of the following four features was present:

1) Intellectual and/or physical disabilities
2) History of present/former mental health problems
3) History of present/former alcohol/substance abuse
4) Former sexual assault

Most of the analyses in Papers I and II were conducted using the presence of at least one of the vulnerability factors as the criterion for vulnerability. In Paper I, we compared assault characteristics between patients with and without each vulnerability factor, as well as comparing victims with 1 or > 1 vulnerability with those without any vulnerability.

In Paper II, we conducted analyses comparing police investigation scores (IS) as well as police investigation quality between vulnerable and non-vulnerable victims. We also compared police investigation quality between cases involving each of the vulnerability factors.

The concept of victim vulnerability according to the four factors was not used in Paper III.

Patient/victim occupation

In Paper I, patient occupation was classified by three categories; employed, student, and unemployed. In Papers II and III, this variable was dichotomized into; employed/student, and unemployed.

Patient/victim alcohol intake prior to assault

Self-reported intake of alcohol in victims before the assault was classified in three categories: "no intake," "intake of < 5 units of alcohol," and "intake of ≥ 5 units of alcohol." One alcohol unit was defined as corresponding to 12 g ethanol, which equals approximately a 33 cl can of beer, a 12 cl glass of table wine, or a 4 cl drink of spirits [157].

9.4.2. Assailant/suspect and assault characteristics

Assailant/suspect age

In Paper I, the age of assailant/suspect was assumed and reported by the patient and classified by the following three categories: < 18 years, 18–24 years, and > 24 years. Due to a different suspect age distribution in the police records, in Paper III, the age of an identified suspect was classified by the following three categories: ≤ 24 years, 25–34 years, and ≥ 35 years. In Paper III, we also described the mean age of both identified and unidentified suspects. For the cases of unidentified suspects, age was assumed and reported by victims.

Assailant/suspect origin

Suspect origin was classified as Western if stated as Western Europe, North America, or Oceania (Australia or New-Zealand) and otherwise classified as non-Western in Papers II and III.

Assailant/suspect occupation

Suspect occupation was registered among identified suspects in Paper III and dichotomized to either employed/student or unemployed.

Assailant/suspect education

Suspect education among identified suspects was registered in Paper III and dichotomized to either < 13 years or university/college.

Assailant/suspect intake of alcohol

Self-reported intake of alcohol before assault was described among identified suspects in Paper III, dichotomized to yes and no.

Assailant/suspect intake of drugs other than alcohol

Self-reported intake of drugs other than alcohol was described among identified suspects in Paper III, dichotomized to yes and no.

Patients/victims suspicious of being drugged

A patient/victim was classified as suspecting a proactive drug-facilitated sexual assault (DFSA) when she raised a suspicion of being involuntarily drugged and assaulted, in combination with at least one of 16 associated symptoms, for example, total or partial amnesia, blackout, hangover, or symptoms inconsistent with the amount of alcohol or drugs voluntarily ingested [62]. Table 1 of Paper II describes the results of this variable. The concept of DFSA has also been described more thoroughly in a previous study from the Trondheim SAC [42].

Relationship between victim and assailant

The relationship between the victim and suspect was categorized into four categories: 1. Partner (current or previous partner/husband/boyfriend), 2. Friend/family, 3. Casual contact (assailant known < 24 hours), and 4. Stranger (assailant not previously known).

Venue

The venue (place of the assault) was defined as private if in the patient´s/victim´s, the assailant´s/ suspect´s or other person´s residence, or public if in any public indoor or outdoor location or a vehicle.

Physical violence

Physical violence was graded as severe (presence of weapon, attempted strangulation, fracture, or internal injuries), moderate to light (as in holding, punching, kicking), or none/verbal threats. If more than one category of violence was described, the answers were stated according to the above-mentioned order.

More than one assailant/suspect

Information regarding the presence of more than one assailant/suspect was described in Papers I and III. In cases where more than one assailant/suspect was reported, information regarding the presumably most active one was used.

Penetration

In Paper I, Table 3 described information regarding penetration under the variable sexual acts and classified by four categories: 1. No penetration, 2. Penile penetration in one orifice, 3. Penile penetration in more than one orifice, and 4. No recollection. In Papers II and III, the variable penetration was dichotomized to "no penetration" or "penetration by penis or foreign object."

9.4.3. Clinical SAC documentation of the patient/victim

Patient/victim extragenital injury

When determining bodily (extragenital) injuries, we used the classification described in a previous Canadian study [158]. Injuries were classified as **serious** when evidence of attempted strangulation, head injury with concussion, and stab/incision wounds were present; **moderate** when bruising of the head and neck could be expected to result in significant headache, lacerations requiring suture/dressing, bite marks and/or injection marks were present; and **minor** when erythema, swelling, bruises, abrasions, lacerations, and/or suction marks were present. In Paper I, we used the following three categories based on the criteria described: No injuries, minor injuries, and moderate/serious injuries. For Paper III, extragenital injuries were only dichotomized (yes/no).

Patient/victim anogenital injury

For Paper III, the variable anogenital injury was included and dichotomized (yes/no) in descriptions of medico-legal findings. The criteria for such injuries were described in a previously published study from the Trondheim SAC and included only tears, abrasions, and bruises (ecchymoses/petechiae) [136].

Patient/victim toxicology

The variable toxicological samples from a victim in Paper III´s Table 3 describes the proportion of the victims in the study who attended the SAC and were tested with toxicological screening. This involved urine and/or blood sample analyses for alcohol and other predefined substances likely to be used in DFSA (benzodiazepines, z-hypnotics, opioids, cannabinoids, central stimulants) [42]. The variable toxicological results from a victim were used in Papers II and III and dichotomized to "no toxicological agent" or "≥ 1 toxicological agent".

Assault reported to police

In Paper I, we had information about whether the patients had reported the assault to the police. We estimated the proportions of patients who had police-reported between vulnerable and non-

vulnerable patients. We also estimated proportions of those who had police-reported in each vulnerability group.

9.4.4. Police investigation variables

Analyses regarding police investigation variables were conducted for Papers II and III (see Table 1, Variables). Most of the police investigation variables were only dichotomized into "yes" and "no," and are, therefore, not described any further here.

Reported incident

The reported incident was dichotomized into "rape" or "attempted rape."

Police investigation score

The initial process of choosing relevant police investigational variables to collect into the CRF registration forms (see Appendix II) consisted of meetings with a group of police analysts from the STPD, SAC physicians, and researchers from other parts of Norway, as well as a forensic psychologist with a special interest in suspect matters. When planning for Paper II, we reached a consensus on some central variables to include, based on professionals` experiences of what would be most useful. Our gynecologist specialists from the SAC had a special interest in variables related to the forensic medical examination; hence, some of the variables were included from that category. Then, with help from the group of police officers and investigators, we added some other variables as well, which were evaluated as central steps in the early investigation process in any rape case. For Paper II, we selected 10 investigation variables for **police *investigational score* (IS),** each of the 10 variables counting a value of one score point (see Table 2 above and Paper II`s Table 2).

High vs. low police investigation quality

We constructed an index for measuring police investigation quality based on the 10 variables described above. To our knowledge, there is no validated, standardized method designed to evaluate the quality of police investigations in rape cases. Our rationale was to construct a score with neither too many nor too few variables in order to create a comprehensive score based on relevant investigation variables. We defined "high-quality investigation" for those cases where ≥ 7 of the 10 chosen investigation variables had been conducted (see Paper II, Table 3). Proportions of cases in which the police had conducted investigations of "high" vs. "low" quality, according to our definition, were compared between cases involving victims with and without vulnerability. Also, we made comparisons of

high and low police investigation quality between victims with and without each of the separate vulnerability factors (see Paper II, Table 3).

Time from police-reporting to legal decision

In Paper II, we compared the mean time (number of months) used by the police to reach a legal decision, between cases with vulnerable vs. non-vulnerable victims. The variable legal decision was dichotomized into *prosecution* or *case closure/dismissal*.

9.4.5. The merging of the data (Papers II and III)

The data were merged by the following procedure. The collected police data were merged with the collected medical record data based on a key code (the personal identification code). Victims reporting more than one incident of rape were specifically explored to avoid duplication of the cases, and the merged dataset was checked for mismatching date of assault in the police file as compared to the SAC-file. The merged file was then de-identified.

9.5. Statistical analyses

Table 2 shows an overview of the statistical methods used in the three papers. For all analyses, descriptive characteristics were reported as frequencies and proportions for the categorical variables, and as mean, median, and ranges for the continuous variables. Statistical significance was assumed when $p < 0.05$. Missing data were calculated but excluded when statistical tests were performed. Data analysis was performed with SPSS[8] for Windows, version 21.0 (Paper I), version 25.0 (Paper II), and version 22.0 (Paper III).

[8] IBM Statistical Package for the Social Sciences (SPSS Inc., Chicago, IL, U.S.)

Table 2.

Overview of statistics in the respective papers.

Statistics		Paper I	Paper II	Paper III
Method	Pearson chi-square test	x	x	x
	Fisher exact test	x	x	
	Exact unconditional test			x
	Binary and multivariable logistic regression	x	x	
	Student`s t-test	x	x	x
	Mann Whitney U test		x	
Outcome measure	Vulnerability (dichotomous)	x	x	
	Disability (dichotomous)	x		
	Present/former mental health problems (dichotomous)	x		
	Present/former alcohol/substance abuse (dichotomous)	x		
	Former sexual assault (dichotomous)	x		
	Vulnerability (3-categorical: 0, 1 or > 1 vulnerability)	x		
	Police investigation quality (dichotomous, “low” or “high”)		x	
	Groups of suspects (3-categorical)			x
	Groups of suspects (dichotomous)			x

9.5.1. Analyses for Paper I

We compared patient´s and assailant´s mean age, respectively, between cases with and without patient vulnerability by using the student´s t-test. We used Pearson chi-square tests to find differences in the categorical assault characteristics between vulnerable and non-vulnerable patients. We also compared the vulnerability group versus those without vulnerability by using logistic regression analyses, calculating crude and adjusted odds ratios (ORs) with corresponding 95% confidence intervals (CIs). For the adjusted analyses, we used two separate models; first, we adjusted for patient age and then for both patient age and alcohol intake. When comparing assault characteristics between non-vulnerable patients and patients with each separate vulnerability factor, we almost exclusively used chi-square tests, except

on two occasions where the sample size was insufficient for using the chi-square: when comparing women with and without disabilities regarding the relationship to the assailant and when comparing women with and without substance abuse regarding bodily injury. We then got valid results by running Fisher´s exact tests.

9.5.2. Analyses for Paper II

For study group 1 (n = 223) (also including the unidentified suspects), we explored differences in victim and assault characteristics between vulnerable and non-vulnerable victims by using Pearson chi-square and Fisher´s exact tests as appropriate for the categorical variables. For the continuous variable victim age, we used Student´s t-test and Mann Whitney U test. Since four of our 10 police investigation variables were relevant only in cases where suspects were identified (n = 176, study group 2), the 47 cases with an unidentified suspect were excluded when exploring differences in police investigation (police investigation score and high vs. low investigation quality). Pearson chi-square and Fisher´s exact tests were used to compare vulnerable and non-vulnerable victims with regard to each of the 10 police investigation variables (Table 2, Paper II). To calculate mean and median of the police investigation score (IS), Student´s t-test and Mann Whitney U test were used. For comparing high and low quality of police investigation between vulnerable and non-vulnerable victims, we used logistic regression analyses, calculating crude odds ratios (cOR) and adjusted odds ratios (aOR) with corresponding 95% confidence intervals (CIs). We had three statistical models: 1) adjusting for victim age (three-categorical); 2) adjusting for victim age, victim alcohol intake, and whether suspect was registered as a former suspect in the police files; and 3) adjusting for victim age, victim/suspect relationship (four categories), and reported penetration or not (by penis or object). We used the same logistic regression models when examining the differences in the quality of police investigations in cases with each of the vulnerability factors separately and for those with more than one vulnerability factor (Table 3, Paper II).

9.5.3. Analyses for Paper III

We compared suspect-, victim-, and assault characteristics as well as police investigation variables between three groups of rape suspects: First-time suspects, recidivist suspects, and unidentified suspects. The analyses of suspect characteristics regarding sociodemographics and police investigations were, in many cases, relevant only when there was an identified suspect. For these analyses, the 74 cases with unidentified suspect were, therefor, excluded from the total of 356 cases in the sample, and the outcome variable of suspect categories was reduced from three to two (see Table 2, Paper III). For

the comparisons, Pearson chi-square and Exact unconditional tests were used as appropriate for the categorical variables, and Student´s t-test for age as a continuous variable.

9.6. Study approval

The studies were approved by the Regional Committee for Medical Research Ethics (REK-Midt).

9.6.1. Study approval for Paper I

All eligible patients for participation (n=623) received a letter with general information about the study (see Appendix 3), and after further evaluations of inclusion and exclusion, we ended up including 573 participants (see Figure 2, flowchart for Paper I). Study approval reference number from REK-Midt): 2010/1941/REK midt (see Appendix 4).

9.6.2. Study approval for Papers II and III

For Papers II and III, the samples were recruited from police-reported rapes, and an additional approval was obtained from the Norwegian Director General of Public Prosecutions (DGPP),[9] through the Advisory Board on Secrecy and Research.[10] Study approval reference number from DGPP: 2014/00471 – 016 AGR/ggr 639.2 (see Appendix 6). Additional approval was also obtained from REK-Midt for the access to use data from police files, with a new study approval reference number: 2011/276/REK midt (see Appendix 5).

The Norwegian Directorate of Health[11] was informed of the study, and the Norwegian Data Inspectorate[12] provided a license allowing for the study to be conducted with an exception from the principle of informed consent. The merging of data was also approved by the Norwegian Data Inspectorate.[11] Also, the study was approved by the Data Protection Officer[13] at the Norwegian Social Science Data Services[14].

9.7. Ethical considerations

The ethical issues in the project are mainly related to handling and storing sensitive data about patients/victims, and in the case of police data, about a third party, the suspects. All studies were

[9] Riksadvokaten
[10] Rådet for taushetsplikt og forskning
[11] Helsedirektoratet
[12] Datatilsynet
[13] Personvernombudet for forskning
[14] Norsk samfunnsvitenskapelig datatjeneste AS, NSD

conducted in accordance with the Helsinki Declaration, and approvals for the different studies are described under section 9.6.

Only a minority of sexual assaults and rapes which are being committed are ever reported to health care and/or police. It is, therefore, important to utilize data from the limited sources available to increase our knowledge about these hidden and harmful crimes. It is also important to distribute and communicate research results about sexual assault to provide for future preventive measures and contribute to lowering the threshold for openness on this sensitive topic in our society.

There are ethical dilemmas related to contacting former patients/victims of sexual assault and rape for the purpose of collecting information to be used in research. The Regional Committee for Medical Research Ethics instructed us regarding how to contact patients by mail, and the letter of information was formulated in general and neutral ways and with a strong emphasis on the high level of discretion in which hospital record data would be handled (see Appendix 3). Prior patient´s safety must be taken into consideration in research. Hypothetically, a prior patient may suffer physical harm if a violent partner or family member finds out that she has reported information on violence.

Some women could experience the topic of victim vulnerability for sexual assault and rape as provocative and humiliating, as it places the focus on the characteristics of assaulted women rather than on the assailants who actually commit these crimes. Also, the exclusion of men as victims may be perceived as ethically problematic, as it is recommended to strive for gender equity in research. However, since we perform quantitative research, the power and study sample size would be too small for proper comparisons regarding male victims. Likewise, our ethical committee approvals regarded only women.

10. Results/Overview of papers

10.1. Paper I

10.1.1. Results according to aim 1

Occurrences of vulnerability

A total of 335 (59%) of the 573 patients had at least one of the four vulnerability factors: 54 patients (9%) had intellectual and/or physical disability; 234 patients (41%) reported to have a mental health problem; 51 patients (9%) had present or former alcohol or drug abuse, and 200 patients (35%) reported one or more prior incidents of sexual assault. Patients having more than one of the vulnerability factors

numbered 164 (29%), which means that half of the vulnerable patients had more than one of the vulnerability factors present. Figure 1 in section 6.4.6 illustrates the co-occurrence of the four vulnerability factors.

10.1.2. Results according to aim 2

Patients with vulnerability vs. those without

The patients' mean age was 24 years in the vulnerability group and 21 years among those without vulnerability ($p < 0.001$), and crude odds ratio (OR) for having a vulnerability was 2.5 for those ≥ 25 years of age compared to those younger than 18 years (95% CI [1.0 – 4.4]) (Table 2, Paper 1). The assailant mean age was 30 years in the vulnerability group and 26 years among those without vulnerability ($p = 0.012$). Of the patients in the vulnerability group, 25% were unemployed, compared to 8% of those without vulnerability. Half of the patients with vulnerability were students, whereas 68% of the non-vulnerable were students. The patients in the vulnerability group were more often assaulted by a known assailant (friend/family), while the patients without vulnerability more often were assaulted by casual contacts and strangers. Of all the patients, 67% reported alcohol intake before the assault; however, those without vulnerability reported significantly more alcohol consumption than those with vulnerability (79%), and they were more often assaulted during nighttime (between midnight and 7 a.m.) than the vulnerable. Patients with vulnerability were more frequently exposed to light/moderate physical violence than the ones without vulnerability. Correspondingly, medical findings of minor body injury were documented more often in the vulnerability group.

10.1.3. Results according to aim 3

Patients with disability vs. those without disability

Among the 54 patients with intellectual and/or physical disabilities, 30 patients (5%) had intellectual disability, 22 patients had physical disability, and two patients had both intellectual and physical disability. In 61% of the assaults against those having a disability, the assailant was reported to be a family member or an acquaintance, but none of the assailants in this group was a partner ($p = 0.002$, FET). Having a disability was associated with assault during daytime/evening (between 7 a.m. and midnight) ($X^2 = 9.8$, $df = 1$, $p < 0.01$). The disability group reported less alcohol intake before the assault (41%) ($X^2 = 19.9$, $df = 2$, $p < 0.01$).

Patients with mental health problems vs. those without mental health problems

Having a history of mental health problems increased with age, but patients under 18 years also had a high proportion of this vulnerability (31%). Mental health problems were associated with patient unemployment ($X^2 = 38.4$, df = 2, $p < 0.01$), assault during daytime/evening ($X^2 = 13.3$, df = 1, $p < 0.01$), physical violence, and bodily injury related to the assault ($X^2 = 7.2$, df = 2, $p = 0.03$).

Patients with substance abuse vs. those with no substance abuse

As many as 63% of the patients with a history of present/former alcohol/ substance abuse (referred to as substance abuse) were older than 25 years ($X^2 = 45$, df = 2, $p < 0.01$). This vulnerability group also had a higher unemployment rate (63%) ($X^2 = 94.4$, df = 2, $p < 0.01$), and a higher frequency of assaults performed by more than one assailant (26%) ($X^2 = 9.9$, df = 1, $p < 0.01$) compared to those without. They had higher frequencies of bodily injury related to the assault ($p = 0.023$, FET) than non-substance-abusers. Police-reporting rate was low (49%), although the latter finding was not statistically significantly different from non-abusers. Most of these patients also reported having mental health problems.

Patients with prior sexual assault vs. those with no prior assault

Prior sexual assault was strongly associated with known assailants (53%) ($X^2 = 13.2$, df = 3, $p < 0.01$), and older assailants ($X^2 = 19.8$, df = 2, $p < 0.01$). A quarter of the patients who reported prior sexual assault(s) were under the age of 18 years. The unemployment rate among these patients was 27% vs. 11% among those without this vulnerability ($X^2 = 24$, df = 2, $p < 0.01$). Reported alcohol intake before the assault was lower than in the rest of the sample ($X2 = 13.4$, df = 2, $p < 0.01$).

Patients with more than one vulnerability factor vs. those with no or only one vulnerability factor

We found that those patients who reported more than one vulnerability factor were older ($X^2 = 31.4$, df = 2, $p < 0.01$) and reported older assailants ($X^2 = 19.2$, df = 2, $p < 0.01$) than those reporting one or fewer than one vulnerability. Also, we found that those with more than one vulnerability were significantly more often unemployed than those with only one vulnerability (36% vs. 14%) ($X^2 = 63$, df = 2, $p < 0.01$). Among the assault characteristics, those with more than one vulnerability more often reported penile penetration in more than one orifice ($X^2 = 16.4$, df = 2, $p = 0.012$) (see Table 3 in Paper I).

10.2. Paper II

10.2.1. Results according to victim and assault characteristics

Among the 223 victims police-reporting the rape, after merging the data with SAC data, we found that 151 (68%) had at least one of the four vulnerability factors present (Figure 3, flow chart, Paper II, study group 1): 22 (10%) had intellectual and/or physical disability, 117 (53%) had a mental health problem, 29 (13%) had present or former alcohol or drug abuse, and 98 (44%) reported one or more prior incidents of sexual assault. Reporting more than one vulnerability factor occurred among 87 victims (39%).

When comparing vulnerable vs. non-vulnerable victims in this material (Table 1, Paper II), the mean age of victims was 24.9 (SD 8.5) years among the vulnerable and 22.2 (SD 7.2) years among the non-vulnerable ($p = 0.02$). The victim was more frequently registered as a former victim of a crime in the police files, when she was vulnerable compared with the non-vulnerable cases (72% vs. 46%, $X^2 = 14.3$, df = 1, $p < 0.001$). Also, a vulnerable victim was more often registered as a former suspect of a crime than a non-vulnerable victim (48% vs. 21%, $X^2 = 14.3$, df = 1, $p < 0.001$).

10.2.2. Results according to investigational variables

Investigational actions performed and police investigation score (IS)

Among the 176 cases with only identified suspects by vulnerability (Figure 3, flow chart, Paper II, study group 2), the police had interrogated the suspects in 106 (89%) cases with vulnerable victims and in 49 (94%) cases where victims were non-vulnerable ($p = 0.4$, FET) (Table 2, Paper II). All but five of the 176 victims were interrogated; here, four of those not interrogated were vulnerable. In cases where the victim was vulnerable, the police interrogated witnesses other than the victim and suspect marginally less often than in cases where the victim was non-vulnerable (73% vs. 83%, $X^2 = 2.4$, df = 1, $p = 0.1$). In 47% of all cases, a forensic medical SAC report was requested by the police, and 41% of the available forensic evidence kits were submitted for further analyses at the National Institute of Public Health in Oslo.

When computing the investigation score points (IS) (with a maximum of 10 points) for each reported rape case, we found a mean and median IS of 5.3 (SD 2.3) and 5.0, respectively, in cases with vulnerable victims vs. 5.9 (SD 2.4) and 6.0, respectively, in cases with non-vulnerable victims, the difference was borderline significant ($p = 0.13$ and $p = 0.16$, resp.).

High and low quality of police investigation

After dichotomizing the IS into low-quality and high-quality police investigations, we found that a low-quality police investigation had been performed in 65% of the cases with vulnerable victims vs. in 52% of the cases involving non-vulnerable victims (p = 0.1) (Table 3, Paper II). The aOR for a low-quality police investigation was 2.1 (95% CI [1.0–4.4]) in cases with vulnerable victims, compared with cases with non-vulnerable victims.

When comparing cases of victims with mental health problems to cases of victims without such problems, the aOR for having a low-quality police investigation was 1.8 (95% CI [0.9–3.6]) (Table 3, Paper II). For those with only one vulnerability factor and those with more than one vulnerability factor, the aORs for a low-quality investigation were 2.4 and 1.9, respectively, compared to those with no vulnerability (aOR = 2.4, 95% CI [0.9–5.9]) and aOR = 1.9, 95% CI [0.9–4.4]).

Investigational results

The mean time from police-reporting until legal decision-making was nine months (278 days) in the vulnerability group and eight months (246 days) in the non-vulnerability group (p = 0.29). Investigations led to prosecution in 10% of the cases, regardless of victim vulnerability (p = 0.8, FET) (Figure 3, flow chart, Paper II, study group 1).

Among the 176 suspects who were identified, 75% admitted sexual contact, and this phenomenon was less common if the victim was vulnerable than if she was non-vulnerable (69% vs. 88%, $X^2 = 5.8$, df = 1, p = 0.03). Only two suspects admitted rape, and five admitted culpability (study group 2).

10.3. Paper III

10.3.1. Results according to aim 1

Suspect characteristics

Among the 356 suspects included in this study (Figure 3, flow chart, Paper III), 207 were first-time suspects (58%), 75 were recidivists (21%), and 74 were unidentified (21%). The mean age of the identified suspects, that is, first-time suspects and recidivists (Figure 3, flow chart, Paper III) was 30.4 years (SD=10.9), ranging from 16 to 84 years. The mean age of unidentified suspects, based on victims´ self-reporting, was 29.5 years, ranging from 18 to 58 years. (SD=8.2). Among unidentified suspects, 35% were reported as non-Western, whereas the corresponding percentages were 27% and 23% among first-time suspects and recidivists, respectively. ($X^2 = 11.3$, df = 2, p = 0.004) (Table 1, Paper III).

Among the identified suspects, the unemployment rate among first-time suspects was 10%, versus

28% among recidivists (X^2 = 11.1, df = 1, p = 0.004) (Table 2, Paper III). One third of the identified suspects had fewer than 13 years of education, regardless of suspect category. However, information on suspect education was often missing in the police records. Suspect alcohol consumption before the assault was reported by 60% of the first-time suspects and 53% of the recidivists (X^2 = 2.8, df = 1, p = 0.09). Use of drugs other than alcohol in relation to the assault was reported by 6% of the first-time suspects and 15% of the recidivists (X^2 = 6.4, df = 1, p = 0.015) (Table 2, Paper III).

Victim and assault characteristics

Victims in the youngest age category (16–17 years) more often reported a first-time suspect, whereas older victims more often reported recidivists (X^2 = 12.0, df = 4, p = 0.02) (Table 1, Paper III). Victim unemployment was more prevalent in cases with a recidivist suspect than in cases with a first-time suspect (27 vs. 16%, X^2 = 4.6, df = 2, p = 0.1). Victim alcohol consumption was associated with unidentified suspect (X^2 = 5.4, df = 4, p = 0.07). Although the percentages of victims who reported having consumed alcohol before the assault were about the same in the two groups of identified suspects (first-time suspects and recidivist suspects), there was an association between the victim being highly intoxicated by alcohol (consumed > 5 units) and recidivist suspect.

The victim knew the suspect in almost two thirds of the cases with identified suspect, regardless of whether the suspect was a first-time or a recidivist suspect (Table 1, Paper III). Being a first-time suspect was associated with cases where the victim was a casual contact (known < 24 hours), while recidivist suspect was associated with partner rape. There was also a higher occurrence of stranger rapes among the group of recidivist suspects than among first-time suspects (X^2 = 138, df = 6, p < 0.001). Among the 74 unidentified suspects, 22 were classified as casual contact and 41 as strangers.

Among the identified suspects (Figure 3, flow chart, Paper III, two upper right boxes, i.e., first-time suspects and recidivists), 210 (75%) were accused of a penetrative assault, whereas penetration was reported in 39 (53%) of the unidentified suspects, (X^2 = 10.2, df = 2, p = 0.006). The victims of recidivists more often reported to be exposed to physical violence than victims of first-time suspects (83% versus 68%) (X^2 = 12.6, df = 4, p = 0.01). Unidentified suspects were associated with a public venue, while three of four assaults committed by identified suspects occurred in a private place (X^2 = 52, df = 2, p < 0.001).

Victim injury and laboratory findings

Among the 212 victims who had been examined at the SAC (Table 3, Paper III), extragenital injury was registered in 126 victims (59%), while anogenital injury was disclosed in 53 (25%). There was no significant association between injury and suspect category.

Half of the victims who attended the SAC had a toxicological blood sample collected; in 58% of victims of first-time suspects, in 35% of victims of recidivists, and in 44% of victims of unidentified suspect ($X^2 = 7.6$, df = 2, p = 0.02). Samples disclosed ≥ 1 toxicological agent in 39% of victims of first-time suspects, in 21% of victims of recidivists, and in 39% of victims of unidentified suspects ($X^2 = 5.0$, df = 2, p = 0.08).

About 70% of the victims at the SAC were examined within 24 h after the assault when the suspect was identified, this in contrast to when the suspect was unidentified where 83% of the victims were examined within 24 h ($X^2 = 2.8$, df = 2, p = 0.24).

10.3.2. Results according to aim 2

Comparisons of police investigations and results of these between the three groups of suspects

The police requested a forensic medical record from the SAC in half of the cases in which victims had been medically examined, and there were no differences between the groups of suspects regarding that variable (Table 3, Paper III). Analysis of swabs and/or clothes collected from victims was conducted in 70% of the cases with an unidentified suspect, whereas only in 41% and 35% of first-time suspect cases and recidivist cases, respectively ($X^2 = 13.8$, df = 2, p = 0.001) (Table 3, Paper III).

In cases in which the suspect was identified, the police interrogated witnesses other than the victim more often than in cases where the suspect was unidentified (75 vs. 61%, $X^2 = 5.1$, df = 2, p = 0.08) (Table 1, Paper III). Interrogations of suspects were conducted in a significantly higher proportion of recidivists than among first-time suspects (96 vs. 85%, $X^2 = 5.1$, df = 1, p = 0.03) (Table 2, Paper III). Among recidivists, 71% admitted sexual contact with the victim, whereas 54% of the first-time suspects admitted sexual contact ($X^2 = 3.0$, df = 1, p = 0.09).

A DNA profile of the suspect was secured during investigations in somewhat more of the recidivist cases than in the first-time suspect cases (45 vs. 34%, $X^2 = 1.2$, df = 1, p = 0.27) (Table 2, Paper III).

Prosecution happened in 32 of the 282 cases where suspects had been identified, and was associated with recidivist suspects, of which 17% of the cases were prosecuted in court, whereas only 9% of the first-time suspect cases were prosecuted (Exact unconditional test, p = 0.06) (Table 2, Paper III). A medical doctor from the SAC was summoned as an expert witness in only five of the 32 cases.

11. Discussion

11.1. Discussion of the results

11.1.1. Psychosocial vulnerability among SAC patients

We found that 59% of the patients who sought medical care at the SAC after being sexually assaulted had preexisting vulnerability: 9% had an intellectual or physical disability, 41% had a history of present or former mental health problems, 9% had present or former alcohol/substance abuse, and 35% had experienced one or more prior sexual assaults. Nearly one third had more than one of the vulnerability factors present (see Figure 1 in section 6.4.6), and an especially frequent co-occurrence of vulnerability was the finding that almost all of the patients with alcohol/substance abuse also had a mental health problem.

The major finding of the study was that it confirmed the hypothesis that characteristics of sexual assaults committed against women having specific vulnerability factors differed from characteristics of sexual assaults against women without these factors. Those who had at least one of the vulnerability factors were older, more often unemployed, and in a majority of cases, they knew the assailant. They had been exposed to more physical violence in relation to the assault than those who were not vulnerable. Body injuries post assault were more frequently evidenced by the medical examinations of these patients compared to the non-vulnerable. Vulnerability was also associated with assault at a private place, during daytime hours, and with significantly less alcohol intake before the assault than what was found in the cases of those without vulnerability. The analyses in this study were focused on vulnerability factors being present on a compound level in one group of patients, as compared to another group of patients who did not have vulnerability in accordance with our definition of the concept. To our knowledge, this makes our results new and unique, considering that we have not found any previous studies from a SAC which describe patients with different vulnerability factors as a pooled phenomenon, and sexual assault characteristics related to the presence of vulnerability. In the general population, people with vulnerability, as described in this thesis, represent a marginalized minority. The high prevalence of victims from marginalized populations who seek help at a SAC should be a “wake-up call” for decision-makers for future prevention policies. The occurrence of one or more vulnerability factors in as many as 59% of our patients, and the high occurrences of each vulnerability factor separately, are findings which also call for increased awareness and reflexion among SAC personnel.

One important pattern of difference in assault characteristics between the two groups studied is that those without any of the vulnerability factors seem to a greater extent to have been assaulted during or

after social settings where alcohol, and relatively large amounts of it, has been part of the setting. This is equivalent with a population study concluding that sexual assault against young women who are too drunk to consent seems to be prevalent in Norway [44], and probably also in other Nordic countries with similar binge-drinking behavior. As a consequence of these results, one may claim that young female students in Norway who do not necessarily have any specific predefined vulnerability for being sexually assaulted tend to become "vulnerable" and more prone to sexual exploitation as a result of episodic excessive drinking. In the case of vulnerable victims on the other hand, and presumably by the nature of these victims´ inherent vulnerability, alcohol has to a lesser degree been "needed" in order to attract, mislead, and abuse them.

The vulnerability factors defined in our studies are different, and they influence vulnerability in different ways. Our finding of intellectual and/or physical disability in 9% of the patients corresponds with separate Canadian and French SAC studies from a little more than 10 years back, where 11% and 9%, respectively, reported physical or cognitive disabilities [62, 63]. Neither of these studies analyzed associations between assault characteristics and disabilities. We found that 5% of the patients attending the SAC had the subcategory of intellectual disability (ID). This prevalence is more than 10 times that of the general population in Norway with a registered (administrative) diagnosis of ID [51, 52] and should be noted as an especially disturbing result. We do not know how the diagnosis of ID was registered in these patients. In some cases, family members, friends, or professional personnel following them to the SAC could have informed us about it, in other cases we have been informed through the course of treatment and follow-up that they lived and received special care in, for example, public residencies. Still, we can assume that many of these patients represented a category with a formally registered diagnosis of ID in medical records, which implies that they represented the acknowledged minority of people with ID who receive necessary care from the public. However, our data did not provide sufficient information about whether those with ID had been properly diagnosed by valid assessment tools. Our study showed that having disabilities was associated with sexual assault during the daytime, by a known non-partner assailant, and with less intake of alcohol before the assault, circumstances which are in line with previous studies from settings other than SACs [55, 58, 59]. Hence, sexual assaults against people with disability show many similarities with assaults committed against children, such as adult assailants from whom the victims should expect protection rather than abuse.

A history of present/former mental health problems was found in 41% of the patients. A British study cited in the Background section found an even higher level of preexisting mental health problems among the SAC victims than we found [69]. Here, as many as two thirds of a sample of 269 adults demonstrated

psychiatric illness. That study described occurrences of specified psychiatric diagnoses but did not relate the conditions to assault characteristics or other clinically relevant information. In a report from a Danish SAC, information on former psychiatric treatment was found in 38% of the patients [45]. Our study confirms findings from the other SAC studies cited, highlighting the concerning level of mental health problems among victims attending SACs. We found that SAC patients having mental health problems were older than those without, although a high proportion of the youngest patients also reported this vulnerability. Also, they more frequently reported a known assailant, physical violence, and bodily injuries than other SAC patients.

We found that 9% had a history of alcohol/drug abuse. A SAC study from a larger city in the US described that as many as 40% of female victims reported a history of substance abuse [79]. That study aimed specifically at describing factors related to substance abuse histories in SAC patients and may have conducted a more thorough registration of substance abuse details and used other criteria than we did in our sample. Most other SAC studies which discuss different aspects of alcohol/substance abuse do not relate the condition of abuse to other assault characteristics. In our study, almost all of the patients with alcohol/substance abuse also reported having a mental health problem (see Figure 1 in section 6.4.6). More disturbing, even if those with drug abuse seemed to be more seriously assaulted, they still had a lower police-reporting rate, which may be a sign of resignation or lost trust in eventual gains from reporting rape to the police. It could be that drug abusers seek help only when assaulted more seriously, for example, when they need medical care for injuries, and that we see only the tip of an iceberg when offering services to victims with this vulnerability. It is reasonable to believe that dark figures are high regarding victims with alcohol/drug abuse who contact SACs or the police after sexual assault.

One or more episodes of former sexual assault were reported by 35% of the patients, which corresponds with previously reported occurrences of revictimization from other SAC studies [43, 45, 61, 79, 81]. Even among those aged 12–18 years, a quarter reported having previously been exposed to sexual assault, whereas this was reported by almost half of those older than 18 years, which corresponds with the prevalence found in a Danish SAC study [45]. The revictimized patients were assaulted by a known assailant in 60% of the cases and consumed less alcohol before the assault than those who did not have this vulnerability factor. Sexual revictimization is a controversial topic, and more high-quality research is needed about this phenomenon in future studies.

In Figure 1 in section 6.4.6, we illustrated that many of the patients in the sample had more than one vulnerability factor present pre-assault. To our knowledge, no previous SAC studies have explored patient vulnerability factors as a graded or dose-response phenomenon depending on the number of

vulnerability factors present in patients. Not surprisingly, we found that having more than one vulnerability factor was associated with older patient age and unemployment. The assaults against those reporting more than one vulnerability factor also showed a tendency of being especially violent, exemplified by the strong association with penile penetration in more than one orifice in this group. Hence, our results are in line with the statement by WHO, saying that the various risk factors have an additive impact on vulnerability, as referred to in the background chapter [1].

11.1.2. Victim psychosocial vulnerability and police rape investigation

We found a borderline significant tendency that the police less often interrogated witnesses other than the victim and suspect, less often arrested the suspect, less often collected biological material from the crime scene, and also less often collected a suspect DNA profile in cases with vulnerable victims than what they did in cases involving non-vulnerable victims (see Table 2, Paper II). According to our definition, we found that 65% of the police investigations had been of "low quality" in the cases where vulnerable victims were involved; this in contrast to the cases involving non-vulnerable victims, where 52% of the police investigations had been of low quality. The odds for getting a police investigation of low quality was more than doubled in cases with vulnerable victims compared with cases involving non-vulnerable victims. In the sample of 176 investigated cases where a suspect was identified, the estimated median investigation score points (IS) in cases involving vulnerable and non-vulnerable victims were 5.0 and 6.0 of 10, respectively. This also indicates the difference in the thoroughness of police investigations in favor of the non-vulnerable. Although the evaluation of police investigations of sexual assault is complex with many variables influencing differently from one case to another, we may claim that a median IS of only 5 or 6 of 10 reveals a potential for improvement for both groups of cases. This notion finds support in recent publications from Amnesty International [24] and other sources, which conclude that police investigations of rape cases in Norway are far from optimal [35, 94]. Hence, our findings confirm, to a certain degree, our hypothesis that police investigations of rape were biased by victim vulnerability. However, we cannot conclude regarding the causal explanations of why police investigations in cases where victims had vulnerability seem to have been less thorough than in cases where they did not have these characteristics. In this discussion, we emphasize the theories of rape myth endorsement among police officers in a theoretical model of interpreting and understanding our findings. To our knowledge, no previous studies have conducted a comprehensive comparison of police investigation in rape cases based on such differences in victim vulnerability.

Regarding the subgroups of vulnerable victims, we did not find any significant risk for low-quality police investigation among those cases where victims had the vulnerability factor *alcohol/substance abuse* nor regarding those with *former sexual assault* when compared to cases without those vulnerability factors. Others have, however, shown an association between re-reporting of rape and early dismissal from police investigation [37]. When we explored the investigation regarding cases with victims with mental health problems, we found a borderline significant aOR of almost 2 for low-quality police investigation compared to cases with victims without recorded mental health problems. This finding could be interpreted as a consequence of possible rape myths among investigating police officers toward victims with this specific vulnerability, but again, finding causal explanations for these differences is beyond the scope of the thesis.

Regardless of victim vulnerability, we found that the police had requested a report from the forensic medical examination in only half of the cases where this was available at the SAC. Although this result did not disclose any difference in the way the police handled cases involving vulnerable and non-vulnerable victims, we still find reason to discuss it as concerning. Only 41% of the forensic kits were analyzed at the national forensic genetic laboratory in Oslo, and this finding is supported by a substantial amount of literature from different countries expressing concern on the topic of untested sexual assault kits [29, 137, 138]. The argument of limited economic resources in the police was noted as one among other explanations of the problem in a Norwegian PhD thesis from 10 years back [159], but in Norway, this should be less relevant now since the forensic tests are no longer financed directly from police budgets but from other government sources. Regarding the influence of biological trace evidence in eventual court cases, the argument of consensual sexual activity is relevant, as a positive sperm finding or a DNA match is often of no value as legal evidence as long as the suspect/defendant claims that sexual activity occurred but was consensual. Some researchers claim that the perpetrator seldom denies sexual contact when swabs with forensic specimens already have been collected from the victim (with a potential of being analyzed) [135, 160]. More recent research has found a strong influence of forensic clinical documentation on legal decisions through the criminal justice system [133, 136]. When the police decide to collect only half of the forensic medical reports, this may indicate a loss of crucial evidence with a potential to illuminate several aspects of the reported rape, including the history and the documentation of the victim´s mental reactions after the incident. In the study cited in the Background chapter section 6.5.5, regarding why so many sexual assault kits are never submitted for testing, one reason discussed was victim-blaming beliefs and rape myths among investigating police officers. If such negative attitudes among investigating police officers have influenced the frequency of forensic kit

analysis in our data, this has discriminated the whole group of rape victims in the sample and not just victims with vulnerabilities specifically.

Despite the differences described in police investigations between cases with vulnerable and non-vulnerable victims, we found an equal prosecution rate of 10% in the two groups of victims we compared. This corresponds with the many studies showing that the majority of cases are dismissed early in the legal process [36, 38, 98, 122]. We did not have complete information on conviction rates in our police data, but estimates from Statistics Norway from 2015 showed that 75% of prosecuted cases in Norway ended with a conviction. Applied on our prosecution rate, this percentage would give a theoretical conviction rate of approximately 7-8% [101]. Correspondingly, statistics from England and Wales in 2009 noted that only 6% of police-reported rapes resulted in a conviction [97]. Our findings show that the prosecution rates in cases with vulnerable vs. non-vulnerable victims have not been influenced by what we described as less thorough police investigations in the one group when compared to the other. This is, after all, a positive finding, which shows that the victims with vulnerabilities were not exposed to a systematically lower priority by the police than the group of non-vulnerable victims.

When pointing to rape myth endorsement among police officers as a possible explanation for our findings of differences in investigation thoroughness between the two groups of cases, we may meet contrary arguments. A group of Danish researchers recently investigated whether stereotypical characteristics of "the real rape" influenced the likelihood of cases going to prosecution and found no evident indicators of an investigative bias in favor of cases meeting characteristics of rape stereotypes [161]. The study was, however, conducted in a Danish police district which participated in a multidisciplinary rape response team, and an emphasized limitation was that the findings had not been compared with police districts that did not apply the same multidisciplinary principles. The results are promising and in line with a UK study which showed an increased likelihood of case progression in police districts that adhere tightly to the multidisciplinary model of handling sexual assault cases [37]. The idea of the multidisciplinary rape response teams is based on the principles of believing victims from when they report and supporting them to remain in the criminal justice system. A proactive involvement of different professional service providers is also part of this model, such as sexual assault referral centers (SARCs), independent sexual violence advisors (ISVAs), and the health sector. The referred studies reveal that this updated and promising model of handling rape has not been implemented in all the police districts of the countries where the studies have been conducted [37, 161]. The model of a multidisciplinary handling of rape victims is, to a certain degree, implemented also in our region in Trøndelag, Norway, although probably not with the same organization of coordinated services as

described in the Danish model of the multidisciplinary rape response teams. As described in section 6.5.4, so-called support centers for victims of crimes have been established within police systems in many places in Norway in recent years, where a *counsel for the aggrieved party*[15] offers three consultations free of charge to help rape victims remain through the exhausting processes in the CJS. Future research should explore the existing coordinated services for victims of sexual assault in different parts of Norway and strive for improvements in follow-up according to the positive results described from multidisciplinary approaches in other countries. Furthermore, it is natural to think of non-vulnerable victims as having a stronger ability than the vulnerable to stand up for their rights and advocate for themselves in their meetings with the police investigation process. Hence, this may contribute to a higher quality of investigations among the cases of the more resourceful group of non-vulnerable victims.

11.1.3. The three groups of suspects in police-reported rape cases

Among the three categories of suspects described in this study, 58% were first-time suspects, 21% were recidivists, and 21% were unidentified suspects. We found that the mean age of suspects was around 30 years, regardless of whether identified or not. Correspondingly, the study from the OPD which had observed sexual assailants for 10 years found a mean age of suspects to be approximately 30 years [78]. The mean age of victims was 25 years. In a Danish study which also included merged data from police files and a SAC, victim mean age was 26 years [135]. In our study, the suspect and the victim knew each other in two thirds of the cases where a suspect was identified.

Our findings of only 21% of the suspects being recidivists is in contrast to results from a Danish study, which reported up to two thirds as recidivists [98]. However, the registration routines in Denmark at the time of the study were different from those in Norway, registering basically only those cases which were charged. Estimates of recidivism rates is complicated partly due to the problem of underreporting. Still, the US Department of Justice concluded in 2015 that there is universal agreement in the scientific community that the observed recidivism rates of sex offenders are underestimates of actual reoffending [143]. This indicates that the percentage of reported recidivists in our study may also have been too low. It is reasonable to believe that many cases of first-time assailants are never reported to the police.

We found that being a first-time suspect was associated with the victim being < 18 years of age and an acquaintance of the suspect. It was also associated with high alcohol intake before the assault in both

[15] Bistandsadvokat

victim and suspect. Rape cases with first-time suspects also seemed to involve less physical violence than in other rape cases. The Norwegian police use the term *party-related rapes* to describe a category of rapes which are linked to parties and nightlife with the consumption of alcohol (often significant amounts of it), and especially happening on weekends [78]. Our results show that a first-time suspect most typically commits rape in the setting of a party at nighttime, where alcohol consumption is involved. This is in line with the OPD report showing a high prevalence of first-time suspects being involved in the category of *party-related rapes* [78]. Episodic excessive drinking behavior is a phenomenon which, regardless of gender, is an integrated and, to a certain degree, socially accepted part of the Norwegian (Nordic) culture. This may be intertwined in societal preconceptions which disclaim assailants from responsibility in situations of sexual coercion where both the assailant and the victim are under the influence of large amounts of alcohol. Attitudes like these may contribute to trivializing the seriousness of party-related rapes, and maybe even partly explain why the police seem to put less investigational effort into first-time suspect cases compared with recidivist cases. An Australian criminological report quoted the following victim-blaming rape myth: "Intoxicated victims consent to sex but regret it afterwards and allege rape" [126]. Such attitudes among police officers may be related to our findings of lower prosecution rates in first-time suspect cases compared to cases with recidivist suspects. Finding proof in cases of sexual assault is complicated as many cases have only two witnesses, one victim and one assailant, who present different versions of what happened. When, in addition, both have been under the influence of large amounts of alcohol at the time of the alleged assault, police investigations are not easy. There is research describing preconceived attitudes in society toward both victims and assailants of sexual offences, which can contribute to explaining how law enforcement prioritize when investigating sex crimes [40, 98]. Evidence-based literature is, however, insufficient on this topic and more research is needed.

We found that rapes committed by recidivist suspects had certain patterns of characteristics. The suspects had lower levels of education, were more often unemployed, and had an intake of drugs other than alcohol before the event. Hence, from a socioeconomic perspective, the recidivist suspects appear to represent a generally more vulnerable group than the first-time suspects. The recidivists were more often accused of partner rape, and used physical violence more often. This corresponds with a study from Sweden where intimate partner rapes were found to be more violent than stranger rapes and other acquaintance rapes [81]. Despite this, we found that there also was a higher occurrence of "stranger rapes" (although the suspect was later identified by the police) among the group of recidivist suspects than among first-time suspects. Based on our findings, we can also speculate whether it is possible that

some men who are in intimate relationships, occasionally attack not only their partner/spouse but also other random women. According to a research group from Finland, this scenario is not uncommon [162]. However, others have questioned whether it is likely that some cases of partner and stranger rapes were committed by the same assailant [21]. Theories about sex offender typologies have limitations, which have been described by the frequent occurrences of men who commit sexual assaults against multiple victims, atypical of traditional criminal classification [143].

Our results show that the police have been somewhat more thorough in their investigational work regarding recidivist suspects than in cases of first-time suspects. Interrogations of suspects were more often done, a DNA profile was more often secured, and the venue was more often investigated in the recidivist cases. Almost none of the suspects, regardless of group, admitted rape, but recidivist suspects more often admitted sexual contact with the victim. A striking, but maybe not a surprising finding, was that recidivist cases more often ended with a prosecution. Others have pointed out that, in most societies, a small group of people commit a large proportion of the crimes, the so-called "acquaintances of the police" [155]. A Norwegian criminologist describes how law enforcement systematically goes after citizens who frequently violate the law. From a law enforcement viewpoint, she discusses why police investigations in the cases of recidivist rape suspects may be of higher quality compared with cases involving the two other groups of suspects [155]. It may be more uncomfortable, time-consuming, and stressful for police officers to initiate full sexual assault investigations of suspects who do not have a criminal record, than chasing those whom they know as criminals, especially considering the fact that sexual assault cases are so often dismissed due to a lack of evidence. The explanations could justify the higher prosecution rate in recidivist rape cases than in the two other groups, but it does not necessarily seem fair. It is still important to communicate this finding to the public for the purpose of helping victims of possible recidivist sexual assailants realize that police-reporting has a relatively larger potential of bringing their assailants to court. Even if their case alone is not enough to get the case to court, others may have experienced assault from the same assailant. Perhaps there is even some sense of logic in basing judicial decision-making on the accumulation of crimes committed by the same person, especially if it serves to prevent recidivism? In 1994, California voters enacted the "Three Strikes and You`re Out" law in response to two tragic murders. The law imposed a life sentence for almost any crime, no matter how minor, if the defendant had two prior convictions for serious or violent crimes. The intention of this sentencing principle was to "keep murders and rapists behind bars, where they belong". Today criminologists in the US agree that life sentences for non-violent repeat offenders does nothing to improve public safety, and the law has been modified through the Three Strikes Reform Act [163].

Suspects registered as unidentified were either classified as a stranger to the victim or a casual contact (known less than 24 hours). Most victims in the police sample reported alcohol intake before the assault (63%), but this was even more prevalent in the cases with unidentified suspects (71%). Our results show that unidentified assailants seem to have taken advantage of women who were incapacitated by alcohol. In the aftermath, these women have presumably been unable to remember the assailants and details of the incident due to the condition they were in at the time of the assault. Previous research has concluded that sexual assault against women who are too intoxicated to resist, due to heavy episodic drinking, is a prevalent problem in Norway [44]. A previous study from the US supports our result describing that sexual exploitation of highly intoxicated women is associated with suspects who are never identified [164].

Despite the frequent analyses of swabs and/or clothes collected from the victims in cases of unidentified suspects, a relatively large group of these suspects remained unidentified with subsequent dismissals of the cases. Still, there is a potential for the use of collected and stored forensic evidence containing DNA from previously closed cases as definite evidence in future investigations. However, the registered crime code in police files of unidentified suspects was also relatively often *attempt of rape* rather than *rape*, and penetration was less often reported in these cases, making forensic specimens harder to detect [165]. This result is in line with previous research concluding that stranger rapists more seldom complete the rape with penetration and ejaculation [142]. This complicates the detection of a DNA profile and further limits the possibilities of solving the cases.

According to victims´ self-report, our results showed an association between unidentified suspect and non-Western suspect, which was also a finding in the OPD report, confirming similar patterns in another Norwegian city [78]. This may partly be explained as in a British study stating that the threshold for seeking help and police-reporting a rape is lower when the suspect is a stranger to the victim. [166]. It could also be possible that reporting a stranger rapist of non-white skin color may be experienced as easier for the victim, as this kind of attack rape may instantly imply a more credible victim. In Norway, the question of race is not a large issue in the debate of sexual assault compared to what is seen in literature from other countries such as the US and UK, where different aspects of race are emphasized much more strongly. We have used the categories Western vs. non-Western origin and kept out the term race since there is a high barrier in Nordic countries for separating people into groups based on race. We have reasons to believe that the emphasis on rapists of non-Norwegian/non-European origin results from a strong focus on this topic in the media in recent years [78]. An example of how a Western society can react to disclosures of sexual assaults committed by immigrants from non-Western countries

was demonstrated when the federal criminal police in Germany leaked a report showing that around 2000 men of non-Western origin allegedly had been involved in sexual harassments and assaults against about 1200 women in several of the largest cities in Germany on New Year's Eve in 2016 [167]. The news led to massive demonstrations organized by opponents of immigration and resulted in a "political earthquake" in the country. The assaults were difficult to solve and only 120 of the men were investigated by the police, most of them originating from Algeria and Morocco. Due to insufficient results of police investigation and probably also due to a general dissatisfaction in the population, the chief inspector of the police in Cologne was dismissed from his position as one of the consequences [167].

11.2. Methodological limitations and strengths

In addition to the limitations and strengths already discussed in the three papers, some more general methodological issues will be considered in the following section. The limitations and strengths of the study design will be explored, as well as the different types of research errors. These research errors are separated into random and systematic errors (or biases), the latter categorized into selection bias, information bias, and confounding [168]. Finally, validity and generalizability will be discussed.

11.2.1 Study design and data collection

Our studies are all retrospective (cross-sectional) and descriptive, thereby not allowing us to conclude on causal relationships. However, for Papers II and III, even if we retrospectively collected and then merged information from medical and police records, these studies could be regarded as having some qualities otherwise belonging to a prospective cohort design, since in both these studies, we compared groups regarding police investigations from the time of reporting until decision-making. Most of the medical information was documented shortly after the patients contacted the SAC. The legal decision-making, on the other hand, was often documented many months after the police-reporting. We collected the information about legal outcome almost two years after the assault was first registered in the police files, thereby optimizing the information on final legal outcomes.

11.2.2 Random error

Research errors can be classified as random or systematic [168]. Random error stands for the variability in the data that we cannot explain. Variation may reflect hidden biases that may not have been measured or discovered. The larger the study, the more this kind of error is reduced. It affects the precision of the point estimate represented by the width of the CI: Wide CIs represent less precision. In

our studies, many of the outcome groups were small, resulting in wide CIs and imprecise effect estimates. However, since police and medical record data altogether had been collected over a period of more than seven years, the relatively large sample size increases our studies´ credibility.

An example of considerations made regarding the influence of type II statistical error could be drawn from Paper I. The study sample was relatively large with 573 patients included, but when we performed subgroup analyses, in this example where we compared proportions of assaults committed by a partner between vulnerable and non-vulnerable patients, sample sizes became small resulting in a wide CI (see Table 2, Paper I). A larger sample would have resulted in a more precise estimate.

11.2.3 Systematic error (bias)

Systematic errors (or biases) distort the estimates in a given direction and are generally a greater threat than random errors in epidemiological studies. Unlike random errors, they are not reduced by increasing sample size. The systematic errors can be caused by how subjects were selected (selection bias), how the study variables are measured (information bias), and by confusion or mixing of effects (confounders) [168].

11.2.3.1. Selection bias

Several levels of selection bias exist in all three studies presented in this thesis. Only a minority of victims contact SACs and/or police after a sexual assault [30, 61, 169, 170], which means that those attending SACs or those filing a rape complaint to the police are not representative of all raped women. Women experiencing fear of injury or death, assaulted by a stranger, and concerned about contracting sexually transmitted infections might be overrepresented in the present studies [117, 171, 172]. Also, those attending SACs more often than the general population could be familiar with seeking health care for other reasons [173]. Similarly, those attending the police after a rape seem more often to be registered in the criminal records [78]. In line with our findings from Paper II, studies have also shown that women of non-Western origin seem to be underrepresented among Norwegian SAC patients [174, 175], a finding which we have interpreted as resulting from underreporting and distrust or disbelief in public Norwegian health care rather than reflecting the real prevalence of sexual assaults against women of non-Western origin living in Norway. For Paper III, we selected three groups of suspects based on certain criteria. Research shows that we have knowledge about only a minority of male sexual assailants (less than 10%), simply because most of them are never police-reported or otherwise identified [146]. However, since such a large proportion of suspects already were classified as recidivists, we have reason to believe that recidivists were over-represented in the police files as suspects and that first-time

suspects could be more representative regarding assailants in the community. As stated in section 11.1.3, there is a lower threshold for police-reporting a rape when the suspect is a stranger to the victim than if he is someone she knows [166]. This lowers the likelihood of police-reporting in cases where the victim and assailant know each other, which leads to a skewed selection of study participants because the majority of sexual assaults reported from the general population are committed by an assailant who is known to the victim. If we had access to information about a larger part of the population of male sexual assailants and not only the minority which has been police-reported and identified, our research results would probably look different. Since sufficient information on victim vulnerability was accessible only through the SAC records, for Paper II, police-reported cases where the victims had not also visited the SAC were excluded. A previous study from the same SAC showed, however, that one third of the police-reported rapes had occurred in rural areas, whereas the remainder had taken place in or near the city of Trondheim [29]. Among the former, 42% had attended the SAC vs. 61% among the latter. This implies that our exclusion of those who had not visited the SAC probably reduced the representability of rural rapes, compared to cases from the urban area. The low SAC attendance of victims of rapes perpetrated outside the urban area may be explained partly by geographical reasons; the large distances in Norway may feel disconcerting. The geographical differences in forensic examination raises the question of whether health services, and consequently also police investigations in rape cases, are less adequate for rural citizens than for those living in Norwegian cities.

11.2.3.2. Information bias

Information bias refers to the accuracy of the collected data and may also be described as misclassification for discrete variables [168]. The retrospective design did not allow us to collect more information than already present in the medical and police records. Information was gathered in clinical and police investigational settings, not in a research-designed context using standardized CRFs. Due to haste or to other urgent duties, some questions may not have been asked, for example, regarding former alcohol/drug problems in victims, resulting in underreporting of those variables. Also, even if the police nowadays, as a rule, use audio-recorded interrogations in rape cases, there is a possibility that especially SAC staff but even the police may not always write into the records exactly the information as given but instead may have recorded an abbreviated or “edited” version. For example, our criteria for categorizing suspects as recidivists in Paper III was based on the findings of former episodes of violent or sexual offences being recorded in the STPD police files. Likewise, inaccurate recordings in police files regarding former rape complaints in reported suspects could have biased the prevalence of recidivist suspects in Paper III. We were originally looking for information about mental health problems in

suspects in the police files, but this was described only sporadically, and we ended up with insufficient data for this category to be described. Further, insufficiencies in our information could partly be explained by us not being allowed access to the original recordings in police logs, only to official police records from the STPD. Neither did we have access to the national register of accused offending, which could have added significantly to our data. Hence, there are obvious limitations in our access to information regarding police investigations for this thesis. Especially disappointing was that education and employment data of identified suspects had not been documented in the records. This could have given us a more complementary picture of the suspects´ sociodemographic background. Another information bias to be aware of is that information occasionally could have been erroneously collected and registered into the database by the researchers (see section 9.3).

A substantial proportion of the data for all the papers was based on victims´ self-reporting to health care and/or police. This is especially evident in cases with unidentified suspects. It is questionable how reliable it is to collect data at a SAC within a context of medical forensic examination shortly after a sexual assault. It is likely that some information about, for example, a history of penetration or physical violence has been lost due to amnesia resulting from victim intoxication and/or psychological distress. Whether our data regarding alcohol intake is reliable is questionable, as many patients may hesitate to give such information. However, a prior study from our SAC found that patient´s self-reported history of alcohol intake corresponded well with a positive ethanol urine test collected within 12 h of the assault, confirming their history as quite reliable. Some may overreport the use of violence, penile penetration, stranger assailant, and more than one assailant, to satisfy the “rape myth criteria” [176] or to obtain sympathy/attention. The OPD claims that dark-skinned Norwegians could be wrongly classified by the victim as non-Western, and non-Western men are more likely to be police-reported than rapists of Norwegian/Western origin [78, 142].

11.2.3.3. Confounding and mediation

The concept of confounding expresses that the observed association between the independent variable and the outcome actually represents an association between another variable and the outcome, a confusion of effects, or that the effect of the independent variable is mixed with the effect of another variable [168]. Mediation refers to the mechanism of a causal relationship: The independent variable influences an intermediary factor which, in turn, influences the outcome. In multivariable models, it is possible to adjust for some potentially confounding factors, for example, by using logistic regression, which we used in this thesis.

In Paper I, we wanted to show the effect size of the differences and chose logistic regression

analyzes for the comparisons of the vulnerability group vs. those without vulnerability. In the logistic regression analyses, we adjusted for age and intake of alcohol (see Table 2, Paper I). Choosing age as a confounder is common in epidemiological science. For example, age is known to influence both the relationship to the assailant and the outcome variable vulnerability. Regarding acute (situational) intake of alcohol, our clinical view and experience make us consider this as a confounder. For example, alcohol intake could influence both where the place of assault is (independent variable) and the presence of one or more vulnerability (the outcome variable). However, we cannot exclude this as being a mediator instead. We entered the variables (patient age and alcohol intake) into the logistic regression models without stepwise selection. We considered entering even more variables into the model. However, because of limited sample size and clinical judgement, only these two variables were included in the final logistic regression model.

Examples in Paper I (see Table 2, Paper I): Assailant being > 24 years old was strongly associated with patient vulnerability in the unadjusted analysis (OR of 2.4 for having vulnerability). After adjustment for patient age, this association was reduced somewhat (OR of 1.8 for having vulnerability), and after adjustment for patient age and alcohol intake, the association was reduced even more (OR of 1.5 for having vulnerability). That is, the "effect" of an assailant being > 24 years on patient vulnerability was through the effects of both patient age and alcohol intake. Hence, patient age and alcohol intake were both confounders in this example. In contrast, the effect of a patient being ≥ 25 years old on vulnerability increased when we adjusted for patient alcohol intake. Alcohol intake is here a special type of confounder called suppresser [177].

11.2.4. Validity

11.2.4.1. Vulnerability factors

Our definition of victim vulnerability for sexual assault and our selection of the four vulnerability factors in this thesis has been described in section 6.4.1. In this section, some additional considerations are discussed regarding the validity in our concept of victim vulnerability. The retrospective design did not allow us to collect more information than what was already present in the records. This may have excluded some victim characteristics which could have been included in our pooled vulnerability variable. However, within each of the four selected vulnerability factors, there are some common features which make it natural to compound them, especially in the sense that they imply vulnerability in a long-term perspective: They are all inherent, pervasive, and "permanent," as opposed to other vulnerability factors such as excessive alcohol consumption before the assault or DFSA, which are more

situational characteristics, directly linked to the specific time when an assault occurs. In our opinion, the construct of one compound vulnerability variable consisting of four separate vulnerability factors with some similar long-term qualities made it possible to describe and comprehend vulnerability for sexual assault from a new perspective. People with our four selected vulnerability factors are often included in the category of "marginalized" populations, who typically represent a minority in population studies [178]. Our results show that 59% of the patients who contacted the Trondheim SAC had at least one of the four vulnerability factors present. Thinking of what vulnerability means in our construct of the concept, this should be a wakeup call for people responsible for designing future prevention campaigns and management strategies. The fact that the approval of the study was based on an information letter being sent out to patients by postal mail, without a mandatory written consent, probably has contributed to a more valid study than what would be possible to obtain in a written-consent study, as the latter usually implies a very low response rate, especially from vulnerable patients.

As a consequence of the dichotomizing of the samples for Papers I and II into victims with and without vulnerability, we have come to use the term "non-vulnerable" as opposed to vulnerable victims throughout the thesis. This may seem strange as it implies an absolute absence of all other forms of eventual vulnerability than the characteristics included in our definition of the phenomenon. We assume that there may have been various other alternative factors, apart from our four vulnerability factors, which could have influenced, in one way or another, on the victims´ vulnerability in our samples. Hence, the term "non-vulnerable" has been used as a means of concisely referring to a large number of comparative results, to exclusively distinguish between two groups: victims with and victims without the presence of our specific vulnerability factors, respectively.

11.2.4.2. The distinction between present/former alcohol/drug abuse and the phenomenon of episodic excessive drinking behavior before the assault

The question of how to define alcohol abuse is controversial and whether a patient was registered as having the vulnerability factor *History of present/former alcohol/substance abuse* was based on self-report, as well as information from medical records. In contrast, we found that 58% of the patients who were categorized as non-vulnerable had been drinking ≥ 5 units of alcohol before the assault. Some readers may juxtapose the propensity of consuming such amounts of alcohol with having an alcohol abuse problem and, as a consequence, question why these women were not categorized to the vulnerability group. In section 6.4.3, there is a description of how the vulnerability factor *History of present/former alcohol/substance abuse* is defined in this thesis. As stated there, our studies distinguish between two different sorts of problematic drinking behavior in our society: one pattern which we

define as alcohol abuse and the other as a pattern of episodic excessive drinking (binge drinking) among young people, which seems to be more of a problem linked to our Nordic culture. A question is whether episodic excessive drinking (binge drinking) ought to be defined as alcohol abuse as well. In this study, we have chosen not to, implying that this kind of behavior is quite normal in Norway, although a significant problem. In line with previous Norwegian research stating that excessive alcohol consumption is a risk factor for sexual assault [44], our results of probable over-representativity of patients reporting such drinking behavior in SAC contexts seem valid.

11.2.4.3. Validity in choice of independent variables

Many of the independent variables in the three papers, some of them categorized, were based on prior studies from our SAC [29, 42] and from other SAC studies, for example, the categorization of bodily injury [158]. Although there may be limitations in using variables from other studies in this way, we still regard the variables chosen as being valid and representative by making it possible to compare and contrast our findings from what has previously been found in similar SAC studies.

11.2.4.4. Justification for choosing the index of police investigation quality

We, the authors of Paper II, are the ones who both selected the 10 variables for police investigation and thereafter constructed the police investigation index as described in section 9.4.4. This has also been communicated in the methods section of Paper II. Our choice of the 10 investigation variables upon which we based our index for quality of investigation was, however, not chosen wholly at random. Before planning our police studies, we had meetings with a group of police analysts, SAC physicians, and researchers from other parts of Norway, as well as a forensic psychologist. Together we reached a consensus on some central variables to include, based on professionals´ experiences of what would be possible and most useful to collect from the files. As two of the co-authors are specialists in gynecology and represent the SAC and medico-legal care, we had a special interest in variables related to the forensic medical examination; hence, some of the variables were included from that category. Then, with help from the group of police officers and investigators, we added some other variables as well, which were evaluated as central steps in the early investigation process in any rape case. The chosen variables could seem randomly picked. However, based on the process of their selection and the fact that our data are collected retrospectively, we regard them as adequate and valid for the purpose of our studies.

To our knowledge, there is no validated questionnaire or tool designed to evaluate police investigation quality in a standardized, quantitative way. Hence, there has been no scientific evaluation of a possible validity in choosing these exact variables for the purpose of making an index describing

police investigation quality, and we can see that our index has limitations. However, considering that a study like this has never been done before, the design should be interesting and represent something new. There is a dearth of literature that explores police decision-making in relation to rape cases. With this index, we have created a unique opportunity to begin addressing these understudied topics, and we hope that future research can validate, adjust, and improve this score in order to standardize our research on crime and police investigation. Some relevant and up-dated variables could, for example, have been electronic and digital evidence, which we did not include.

In our evaluation of the process of police investigation of sexual assault, we have strongly emphasized how victims are treated and handled according to their emotional needs. This aspect has not been specifically included among our 10 selected variables for police investigation. Research has shown that the inclusion of victim advocates during police investigations increases the likelihood of case progression [179]. This would, therefore, seem to be an important variable in high-quality police investigation. We did not have the opportunity to study the use of victim advocates in a Norwegian setting during police investigations as we did not have information describing this in our dataset. The right to a *counsel for the aggrieved party*[16] free of charge is secured by law for anyone reporting rape to the police in Norway. Once the police receive a rape complaint, they are obliged to inform the victim about this right. The *counsel* is available for three hours before victims decide to file a formal rape complaint to the police, which provides for judicial counselling in a stressful situation. After police-reporting, the *counsel* follows the victim through interrogations and other judicial proceedings, which is believed to contribute to both judicial and psychological support. This may seem like a description of the ideal model for victim support in a rape case. However, as we know, at least when it comes to prosecution and conviction rates, Norway has not achieved any more impressive results than any other developed country in the world [24].

11.2.4.5. A compound variable for disability

Regarding the disability variable, we used a compounded variable of intellectual and/or physical disability. This is not ideal, but intellectual and physical disability have some common features, and many patients have both intellectual and physical disability. However, our sample size regarding the different categories of disability (intellectual and physical disability) was insufficient for performing statistically valid comparisons for each disability, separated. Therefore, although we originally planned for a separate

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analysis, we chose the compound disability variable. Also, except for the prevalence of ID, there was limited information regarding details of the disabilities separated, which has been described and discussed in the thesis.

11.2.5. Generalizability

Our accessible data sources from the police for Papers II and III represented only one out of the 27 police districts in Norway. This limits the national generalizability of our findings and possible identification of victims being a former victim/suspect in another district.

As stated in section 11.2.3.1, many victims of sexual assault do not seek help from health care and/or police, and our results are, therefore, not necessarily applicable to victims of sexual assault in general. Moreover, generalization of our findings to other countries should be done with caution. Both the populations subjected to sexual assault and those seeking help may differ considerably between countries, and the medical indications for performing the different examinations and laboratory tests may vary. Differences in the organization and financing of health care and law enforcement may reduce the validity of our findings in countries with lower income and lower access to expensive technology.

12. Conclusions and implications

Women with what we defined as vulnerability represented a majority of those seeking help at the Trondheim SAC and the STPD in our studies. The high SAC prevalence of victims from marginalized populations is an important finding which should be taken into account by those responsible for future prevention strategies and improved victim services.

Characteristics of sexual assaults committed against women having specific vulnerability factors differed from characteristics of the assaults against women without these factors. Victims without any of the vulnerability factors were, to a greater extent, young students and assaulted during or after social settings where alcohol, and relatively large amounts of it, was served. On the other hand, in the cases of vulnerable victims, and presumably by the nature of these victims´ inherent vulnerability, alcohol seemed to a lesser degree “to be needed” in order to attract, mislead, and abuse them. They were somewhat older, often unemployed, and assaulted in a private setting. Awareness of how assaults against vulnerable groups of victims differ from assaults against those not in the vulnerability category is informative because there are women who are vulnerable and men who take advantage of this vulnerability. Our findings could, in the future, influence the design and initiation of prevention campaigns, management strategies, and planning of both healthcare and policing to target the specific

needs of the community of especially vulnerable individuals.

There is a high prevalence of both mental illness and substance abuse as well as the co-occurrence of these two vulnerability factors among patients attending a SAC. This supports the importance of sexual assault centers not only providing medical help and forensic examinations, but also facilitating mental health follow-up. The pursuit of a more optimized and integrated cooperation between the SAC and the mental health care system in the future could be appropriate, but this should be based on future studies exploring best practice alternatives regarding the issue. Victims should have a say in all evaluation processes of the services from SACs and the police.

Our findings indicate that vulnerable victims were less prioritized compared to non-vulnerable victims with regard to police investigations of rape. Our results do not prove any causal explanations for this finding, but in this thesis, we have discussed the phenomenon of rape myth endorsement among police officers as a theoretical model of explaining our findings. This was based on previous research describing that rape myth endorsement in the police environment can have a negative impact on rape case progressions through the criminal justice system. Police decision-making in sexual assault is complex, but despite an obvious need for more studies on the presence of rape myth endorsement among police officers in our police district, our findings call for an increased focus on objective approaches by the police when rape complaints are being filed, regardless of individual differences in victim characteristics.

Sexual assaults involving first-time suspects seem to have occurred during or after social settings involving the serving of alcohol, and where victim and suspect were acquainted. In these assaults, the victims were often under the age of 18 years, hence, possibly corresponding to those sexual assault settings we defined as for “non-vulnerable” victims. Our findings indicate that the recidivists and their victims seem to represent relatively more “vulnerable” populations in society. This is implied in our detection of a high unemployment rate and a possible drug abuse problem among recidivist suspects, in contrast to what was found in the first-time suspects. The recidivists´ assaults were also more physically violent, despite a known relationship between victim and suspect. The police seemed to be more thorough in their investigations of rape committed by recidivist suspects than in cases involving other groups of suspects, and possibly, therefore, recidivist suspect cases more often ended with a prosecution. This seems unfair, considering that the others may be just as guilty, but it is still a finding which is important to communicate to the public for the purpose of helping victims of possible recidivist assailants realize that police-reporting has a relatively larger potential for bringing their assailants to court.

Findings regarding sexual assaults committed by unidentified suspects were limited, but these assaults more often involved physical violence than cases committed by first-time suspects. These men were also more often reported to be of non-Western origin, and in our study, they exploited women who were highly intoxicated by alcohol. It is important to take attack rapes seriously and to believe victims in their descriptions of unknown and unidentified assailants, but at the same time, to be aware of the limitations in these results regarding suspect descriptions, especially through the fact that the data regarding unidentified suspects was based on victims' self-reporting.

The low reporting rates of sexual assault to both health care and the police imply that most assaults go unrecorded. We claim that it is important to report sexual assault to the police and to health care. Firstly, reporting to a SAC alone can give the victims access to help and health care important for them to heal after the traumatic event. Secondly, when more of these crimes are publicly reported (via the police), more cases will possibly be taken to court if investigated thoroughly. This will send a message to victims that reporting leads to more prosecution and conviction. It will also send a message to potential assailants that rape is taken seriously, and the risk of getting caught is increasing.

13. Suggestions for future research

Our specified concept of vulnerability, consisting of the four factors discussed in this thesis, has never been described before, neither from a SAC nor from other settings of research. Direct complete comparisons and contrasts of our findings in Papers I and II with similar studies would, therefore, not be possible. Still, new studies, based either on our vulnerability concept or with the inclusion of other vulnerability variables, could contribute to a continuation of the highlighting and publication of a problem in our society which is vastly under-communicated. Vulnerability factors among female sexual assault victims is a complex area which is sparsely investigated, and more knowledge is needed in the future to improve preventive and protective means toward individuals who are especially vulnerable for being sexually assaulted.

The high prevalence of women with physical and/or intellectual disability presenting at the SAC should be considered in future planning of protective follow-up measures. The patterns of assaults committed against people with disabilities resemble those committed against children, and our findings imply a need for research that can promote public health programs to protect people with disabilities from being sexually assaulted by their caregivers. Future research should investigate sexual assaults against people with specific types of disability, differentiating between different forms of physical and intellectual disabilities, since knowledge on these topics is sparse. For example, information could be

collected through qualitative studies by interviews of women with disabilities, of their family members or close friends, and of professionals who provide care in the community social service systems.

There is still a great need for research regarding sexual assault against victims with mental health problems. There is a lack of knowledge about what sorts of specified psychiatric/psychological diagnoses may be more closely linked than others to vulnerability for sexual assault. This should be a focus in future research. New studies should evaluate how mental health follow-up of SAC patients could be best conducted: as an integrated part of the SAC itself or by direct and free-of-charge referrals to, for example, psychiatric outpatient clinics. Considering potential problems with high drop-out rates from psychiatric appointments in former SAC patients, researchers could investigate the effects of offering consultations with the patients via the Internet or eventually on skype.

The high prevalence of co-occurring substance abuse and mental illness among patients attending SACs calls for specialized mental health follow-up. Future studies should facilitate research-based therapy aimed at the group of SAC patients with the combination of psychiatric problems and alcohol/drug addiction in order to measure long-term effects. The study implies a need for research on how mental health treatment of women with alcohol/substance abuse could improve protection against sexual assaults of patients with substance abuse in the future. The principle of treating the addiction problem first should preferably be continued also in the future.

The prevalence of revictimized women in both police and SAC settings is concerningly high, which is in line with previous findings [43, 45, 61, 79, 81]. Sexual revictimization is poorly understood and is also a topic about which more evidence-based support is warranted. Our findings were confined to some patterns of characteristics of revictimizing assaults, such as known and older assailants and private settings, in addition to a high frequency of victim unemployment. We did not, however, have access to data for studying eventual mental health challenges related to being a “repeat victim.” Studies should aim at increasing our knowledge about specific psychological and behavioral problems associated with sexual revictimization. We believe future studies could contribute to important preventive measures if focused on associations between sexual revictimization and mental health issues, especially related to PTSD and personality disorders. It is reasonable to believe that preventing PTSD through early interventional programs also could prevent revictimization, and future RCTs on the best possible interventions in Nordic settings are urgently needed. Sexual revictimization is a controversial topic, and more high-quality research is needed about how mental health interventions can contribute to treatment and prevention of the phenomenon in the future.

We did not have data describing sexual assaults happening on the Internet. This has become a

steadily increasing problem in recent years, and considering that children are especially targeted, future studies should investigate how this category of assault associates with other vulnerable populations.

Paper II addresses an important topic in relation to the progression of rape cases through the criminal justice system. There is little published research on the impact of the vulnerability of victims on police investigations, and our findings, which indicate that police investigations of rape could be biased by victim characteristics, should be backed up by future studies. To obtain more accurate knowledge of how police officers think regarding different groups of rape victims, more qualitative studies of the topic based on interviews with police investigators and attorneys should be conducted in the future. Likewise, as Paper III suggests that the police have been more thorough in the investigations of recidivist suspects than in cases involving the other two groups of suspects, future qualitative studies of police officers´ eventual preconceived attitudes should also include perceptions of different groups of rape suspects. There is not enough knowledge regarding rape myth endorsement among law enforcement personnel in Norway or other countries, and our findings call for future qualitative studies based on interviews of police officers in order to find out more about this in the future. Also, perhaps our self-composed index for police investigation in Paper II, which may be the first of its kind, could be an example of how to evaluate the quality of policing in the future. We would greet eventual proposals for revisions, further development, and validation of this method with enthusiasm and an open mind. There is even less literature that explores police decision-making in relation to forensic processes, and this topic should also be further explored. A new study could investigate whether more specialized education of police officers regarding the importance of analyzing forensic evidence kits could influence future practices.

The data of this study are more than a decade old, and there is a need for new data collections regarding how the police investigate rape, in order to disclose eventual improvements in practices in recent years. In order to be able to improve the validity and reliability of research regarding policing in the future, research must be based on more detailed and sensitive police data than what was possible to obtain in this study. Having access to unfettered police data for research is, however, rare, which should be a justifying reason for utilizing the data we had. It has been complicated to get the approvals needed for conducting studies on policing data in the past, and with the new Data Protection Impact Assessment (DPIA), this will not necessarily be easier in the future, considering ethical dilemmas such as, for example, research on a third party (suspects) without consent, and other challenges. We believe there is a great need for planning future studies on how rape cases are handled by the police. This should be based on a multidisciplinary approach with a strong focus on victims´ emotional needs in all the phases of their help-seeking.

As mentioned, there have been recent changes in the Norwegian legislation with adaptions regarding methods of facilitated interrogations when victims of sexual assault are minors and/or have intellectual disability [96]. Perhaps similar principles of adapted interrogations and handling of victims could have been suggested and implemented by law, not only regarding victims with ID but also regarding other vulnerable groups of rape victims, for example, those with mental health problems and/or alcohol or substance abuse. Future studies could have explored associations between increased education about mental health problems in police academies, and the satisfaction of rape victims in their meeting with the police.

Our studies show that evaluations of how the victims experience and evaluate their meetings with both SACs and the police are warranted. Qualitative study designs based on in-depth interviewing of patients/victims would be the best way to obtaining such knowledge.

The promising research results from many countries on the effects of handling victims of sexual assault by the so-called victim-focused multidisciplinary approach [25, 131, 132] call for follow-up studies on this topic also here in Norway. Studies refer that the degree to which this approach has been implemented varies between both countries and different regions within countries [25, 132]. Future planning and prevention programs should strive for more widespread implementation of this model aimed at obtaining equal and high-quality services. Such implementations could, for example, be done and evaluated by research projects in a large Nordic multi-center study. The development of optimized routines for both health care to victims and handling of their judicial rights must be built upon research.

Like most studies on sexual assailants, our thesis lacks suspect information from all the cases that are never reported. Future research should aim at gaining more knowledge of the population level among male sexual assailants who are not police-reported, as our knowledge about who these men are and how they differ from those who are reported is limited. More studies are needed also on sex offender typologies as this field of research is scarce and has limitations.

As Paper III showed that there was a high prevalence of assaults committed by unidentified suspects with a possible non-Western origin, and considering the limitations of this finding, it is important that future research aims at looking behind the surface of the immigrant over-representation among sexual offenders, in search for nuanced and diverse explanations, which can contribute to diminish rather than increase stereotypical misconceptions.

As the rates of reporting sexual assault to both police and health care are very low, there is an obvious need for research on how to reach people at a broader scale with information and education about these hidden crimes and their negative consequences for society. There are studies showing

promising preventive results of programs aimed at educating youths of both genders about the topic of sexual violence [21, 148]. Future longitudinal research should investigate the preventive effects of the implementation of more general education about sexual violence in both primary and secondary schools. There is a need for teaching not only girls/women about how not to be sexually assaulted, but also for teaching boys/men about how not to become sexual offenders.

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Paper I

Article

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Psychosocial Vulnerability Among Patients Contacting a Norwegian Sexual Assault Center

Bjarte Frode Vik, MD,[1,2] Jim Aage Nöttestad, PhD,[1,2] Berit Schei, MD, PhD,[1,2] Kirsten Rasmussen, PhD,[1,2] and Cecilie Therese Hagemann, MD, PhD[1,2]

Abstract

In this study, the objective was to assess the occurrence of specific vulnerability factors among adult and adolescent females attending a Norwegian sexual assault center (SAC). We also explored assault characteristics and investigated whether these characteristics differed between the group of patients with vulnerability factors compared with the group without such factors. We conducted a retrospective descriptive study of 573 women ≥ 12 years of age attending the SAC at St. Olavs Hospital, Trondheim, Norway, between July 1, 2003 and December 31, 2010. A patient was considered vulnerable if at least one of the following features was present: intellectual or physical disability; history of present/former mental health problems; history of present/former alcohol/substance abuse; or former sexual assault. At least one vulnerability factor was present in 59% of the cases. More than one vulnerability factor was present in 29%. Reporting at least one vulnerability factor was associated with a higher patient age, unemployment, a higher frequency of reported light/moderate physical violence, and the

[1]Norwegian University of Science and Technology (NTNU), Trondheim, Norway
[2]St. Olavs University Hospital, Trondheim, Norway

Corresponding Author:
Bjarte Frode Vik, Department of Neuropsychiatry, St. Olavs University Hospital, P.O. 1803 Lade, Trondheim N-7440, Norway.
Email: bjarte.vik@ntnu.no

Paper II

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Is police investigation of rape biased by characteristics of victims?

Bjarte Frode Vik [a, b, c, *], Kirsten Rasmussen [d, e, f], Berit Schei [g, h], Cecilie Therese Hagemann [a, h]

[a] Norwegian University of Science and Technology (NTNU), Department of Clinical and Molecular Medicine, P.B. 8905, N-7491, Trondheim, Norway
[b] Department of Research and Development, Psychiatry, St. Olavs Hospital, Trondheim University Hospital, Trondheim, Norway
[c] St. Olavs Hospital, Department of Neuropsychiatry, P.B. 3250 Torgarden, N-7006, Trondheim, Norway
[d] Norwegian University of Science and Technology (NTNU), Department of Psychology, 7491, Trondheim, Norway
[e] Norwegian University of Science and Technology (NTNU), Department of Mental Health, Faculty of Medicine and Health Sciences, Trondheim, Norway
[f] St. Olavs Hospital, Forensic Research Unit, Brøset, P.B. 1803 Lade, 7440, Trondheim, Norway
[g] Department of Public Health and Nursing, Norwegian University of Science and Technology, P.B. 8905, N-7491, Trondheim, Norway
[h] Department of Obstetrics and Gynecology St. Olavs Hospital, P.B. 3250 Sluppen, N-7006, Trondheim, Norway

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ABSTRACT

Aim: To explore differences in police investigations between cases of rape against women with and without vulnerability factors.
Methods: Retrospective, descriptive study of cases of rape against women ≥16 years of age. Cases involving victims with and without vulnerability factors were compared regarding the quality of police investigation.
Results: Vulnerability was present among 68% of the victims. Cases with vulnerable victims had an adjusted odds ratio for a low-quality police investigation of 2.1 (95% CI [1.0–4.4]) compared to cases where victims were non-vulnerable.
Conclusions: Our results do not prove that rape myths existed among police officers. Our findings show a trend indicating that vulnerable victims may have been less prioritized compared to non-vulnerable victims. More studies are needed regarding how the police respond to rape complaints and to what degree police investigations are influenced by different characteristics of victims.

1. Introduction

A marked increase in police reported rapes has occurred in Norway over the past 25 years, from 400 cases per year in the 1990s to more than 1700 cases in 2017 [1]. The proportion of reported cases taken to trial and ending with conviction has decreased both nationally and internationally [2–6]. Several factors may be operating when attempting to understand this attrition of cases. Types of reported rapes have changed, and hence cases which were previously not acknowledged as rape are now being reported and subjected to police investigations [1,4,7]. This poses increased and updated demands regarding how the police respond in cases of rape [3,8,9]. As many studies have shown that the majority of cases are closed in the initial phase of the legal process [3,5,6,8,10] the research community has begun recognizing and studying police officers' active involvement in the decision-making process [8]. Hence, how the police perceive a reported rape at the initial interview of the victim, is likely to inform the extent and type of supplementary investigation collected. Insufficiencies of steps taken initially may lead to evidence being overlooked, and cases wrongly dismissed [11]. The National Criminal Investigation Service in Norway (Kripos) reported in 2015 that 40% of police investigations of rape had been of poor quality and effectiveness [12]. Indications of low quality included insufficiencies in crime scene investigations and lack of securing a DNA profile from the alleged perpetrator. Research has confirmed that the forensic evidence collection is an important factor in the decision-making process of the prosecution of perpetrators [13]. An indication of suboptimal police investigation was shown in a previously published finding from the sexual assault center (SAC) at St. Olavs Hospital, Trondheim, Norway: Even though 55% of women reporting rape to the police had been medically examined at the SAC, including the collection of

* Corresponding author. St. Olavs University Hospital, Dept. of Neuropsychiatry, Trondheim University Hospital, P.B. 3250 Torgarden, Trondheim, N-7006, Norway.
E-mail address: bjarte.vik@ntnu.no (B.F. Vik).

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evidence kits, we found that the police submitted only 29% of the kits collected to further forensic analyses [14]. Other studies have disclosed similar results, but there is limited literature explaining why so many kits are never submitted to a crime laboratory in rape cases [15–18]. Some explanations have been related to resource constraints, like staffing cuts in the police or insufficient capacity in crime labs [15].

What informs police decisions as to which investigational steps is poorly understood [8]. The decision-making process will depend on varying legislation and organization of the criminal justice systems of different countries [3]. Also within each country there are differences in the approach to sexual crimes between different police districts [4,15,19]. According to a study from the US much of the decision-making in the police is hidden from public scrutiny due to large amounts of discretion in the everyday routines of police officers. The destiny of a reported rape case is therefore often coincidental and dependent on how the police officer who takes notes chooses to interpret and document the reported incident [8]. Cases in which the police struggle at finding enough evidence may be dismissed without further investigation. As an example, a study from England and Wales described that police officers did not advance cases for prosecution when they believed that there were no realistic chances of securing convictions [20].

What influences the perceived process, may be based on stereotypes about what constitutes a "real rape" [7,21]. Such stereotypes may be termed "rape myths" and are used to describe factors which can bias the investigation of rape. Such myths may in particular be triggered by the characteristics of victims [22]. One study assessing official police records in rape cases found police notes which suggested that reported incidents were not "a real rape" because the victim was either a regular drug user, a sex worker, had reported rape before, was "mental", or promiscuous [23]. The report concluded, in line with other studies, that the existence of such myths in the police environment may systematically predict case progression negatively [3,5,7,23,24]. An Australian criminological report from 2017 described several types of common misconceptions related to characteristics of the victim [25]: "People with disabilities are rarely victims of rape, and if subjected to rape they are not capable of relaying details about the incident"; "People with mental health problems often fabricate reports of rape"; "Intoxicated victims consent to sex but regret it afterwards and allege rape". In a study from the UK, victims with mental health problems or learning disabilities, were found to be less likely to have their rape progressed through the criminal justice system [4]. Also, they found that victims who had previously reported one or more episodes of rape to the police tended to have their cases dismissed [4]. Several of the studies mentioned above claim that certain characteristics of rape victims may induce bias according to the "real rape" stereotype and hence lead to suboptimal police investigations.

In a previous study from the Trondheim sexual assault center (SAC) we found that a large proportion of victims did have characteristics which could potentially bias the investigations [26]. The observed characteristics included victims with intellectual and/or physical disabilities; as well as those reporting to have a history of mental health problems; substance abuse; and former sexual assault. The combined groups were classified as having one or more vulnerability factors. The aim of this study was to describe police investigations and assess differences between cases of rape in which the victims were characterized as being vulnerable compared with victims who did not have such characteristics.

2. Material and methods

2.1. Design, settings and sample

This is a retrospective, descriptive study, based on merged data from police files and medical records in rape cases. During the observation period of this study (2003–2010) the Sør-Trøndelag Police District (STPD) in Norway covered a population of approximately 280 000 in the county of Sør-Trøndelag.[1] Trondheim, the largest city in the region, was included, with 160 000 inhabitants at the time [27]. The only medical sexual assault center (SAC) in the district is located at St. Olavs hospital in Trondheim, and the service of this SAC, which provided the medical data for the study, is described in detail elsewhere [28]. All cases of rape and attempted rape against women ≥16 years of age reported to the STPD from July 1, 2003 to December 31, 2010 were registered. Cases were identified based on the former Norwegian penal code, §192, applicable until September 2015. According to this law a rape was defined as in the following abbreviated version: penetration of penis/finger/foreign object in vagina/anus, penis in mouth, masturbation, and coercion by means of violence, threats, or during impaired consciousness [29]. The following specific crime denominations were included, as described by the same former penal code, §192: Sections 1 and 2 (rape), section 3 (aggravated rape) and section 4 (grossly negligent rape). Most of the cases included in our study were reported under sections 1 and 2 (rape). Cases of attempted rape were also included but covered by another paragraph in the same penal code (§49). A total of 475 cases were reported to police during the period. Cases were excluded according to Fig. 1. Patients who did not visit the SAC ($n = 161$), male victims ($n = 18$), victims < 16 years of age ($n = 49$), unidentified victims ($n = 3$) and duplicate registrations ($n = 21$) were excluded, leaving 223 cases eligible for study group 1 (Fig. 1). For analyses which were relevant only in cases with identified suspect, we excluded all cases with unidentified suspect (n = 47), leaving 176 cases eligible for the comparisons (study group 2) (Fig. 1).

2.1.1. Variables from police records and police investigational score (IS)

Data were collected from the police files regarding characteristics of suspects and victims, the reported incident, time from rape to police report, police investigations and legal outcome. In cases with more than one suspect information regarding the assumed most important suspect was recorded. Biological material from crime scene and suspects was collected by the police and found in police files. Information was collected about whether suspects and victims had formerly been registered as suspects/victims of crimes, and regarding time from police-reporting to legal decision-making. Police files provided data on to what extent different investigational procedures had been performed. We selected ten investigation variables for a police "investigational score" (IS), each of the ten variables counting a value of one score point (Table 2). We defined "high-quality investigation" for those with IS ≥ 7 of the 10 investigation variables. According to the Norwegian system, the police decide, in each case, whether a forensic medical record from the SAC is to be requested for further investigations, and we recorded whether the police had requested such medical forensic report from the SAC as one of our investigational factors. We also recorded whether the victim had contacted police before or after the SAC.

[1] In a police reform conducted by the Norwegian government in 2016 the number of police districts in Norway was reduced from 27 to 12. Sør-Trøndelag Police District was merged with Nord-Trøndelag Police District into Trøndelag Police District. The two counties Sør-Trøndelag and Nord-Trøndelag were formally merged in 2018 into Trøndelag county.

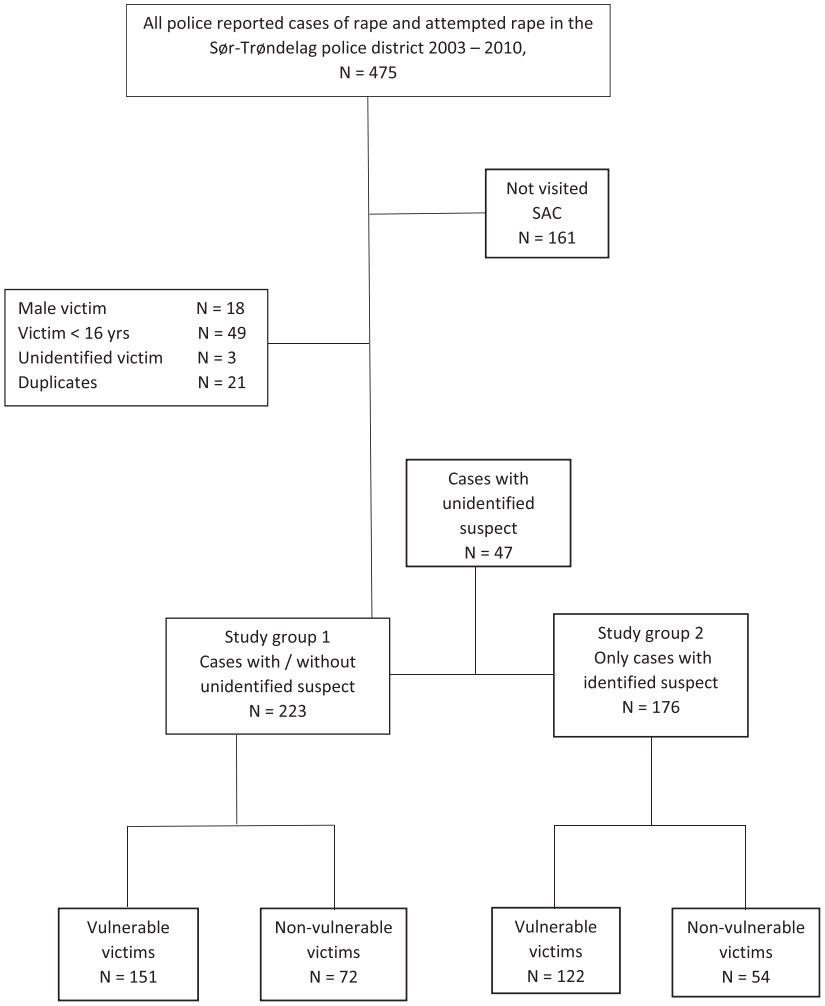

Fig. 1. Flow chart for all included and excluded police recorded cases of rape and attempted rape in the Sør-Trøndelag police district during the period 2003–2010, and with corresponding records from the Trondheim SAC. Study group 1 includes all cases with/without unidentified suspect. Study group 2 includes only cases with identified suspect. The chart shows numbers of vulnerable and non-vulnerable victims in the two study groups.

2.1.2. Variables from SAC records

Documentation on medical examinations, forensic and toxicological analyses were retrieved from SAC records. Victim alcohol intake in relation to the assault was classified by three categories; "no intake", "intake of <5 units of alcohol" and "intake of ≥5 units of alcohol/heavily intoxicated". Time from assault to medical exam at the SAC was dichotomized to "< 24 h" or "≥ 24 h", and results of toxicological samples from victims were noted as "no toxicological agents" or "≥ 1 toxicological agent". Information was collected on whether the victim was suspicious of having been deliberately drugged prior to the assault. A victim was considered vulnerable if at least one of the following features was present: Intellectual and/or physical disabilities; history of present/former mental health problems; history of present/former alcohol/substance abuse; and former sexual assault. Information on whether victims had vulnerability or not was retrieved mainly from SAC records. For details, see Refs. [14,26,30,31].

2.1.3. Data collection and merging

Data from police- and medical records were registered through two different web-based data collection systems developed and administered by the Unit of Applied Clinical Research at the Norwegian University of Science and Technology. In cases where SAC information was available and information in the police files was missing, victims' medical records were the source of information. In case of discrepancy between the two data sources, information from the police files was used. Thereafter data were merged into one complete dataset.

2.2. Study approval

The study was approved by the Regional Committee for Medical and Health Research Ethics, the Norwegian Director General of Public Prosecutions and the Advisory Board on Secrecy and Research. The merging of data was also approved by the Norwegian

Data Inspectorate.

2.3. Statistical analyses

For study group 1 (n = 223), we explored differences in victim- and assault characteristics (Table 1), and time between police report and legal decision between vulnerable and non-vulnerable victims, by using Pearson's chi-square and Fisher's Exact Tests (FET) as appropriate for the categorical variables. For the continuous variables we used Student's T-test and Mann Whitney *U* test. Since four of our ten investigation variables were relevant only in cases where suspects were identified (n = 176, Study group 2), the 47 cases with unidentified suspect were excluded when exploring differences in police investigation. We used similar statistical methodology for Study group 2 as for Study group 1 when comparing vulnerable and non-vulnerable victims with regard to each of the ten police investigation variables (Table 2), for the IS, and for investigation quality (dichotomously separated into high- and low-quality with an IS $\geq$ 7) (Table 3). For comparing high and low-quality of police investigation, we used logistic regression analyses, calculating crude (cOR) and adjusted odds ratios (aORs) with corresponding 95% confidence intervals (CIs). We also examined the scores and quality of police investigations in cases with each of the vulnerability factors separately, and for those with more than one vulnerability factor. We had three statistical models: 1) adjusting for victim age (three-categorical) only; 2) adjusting for victim age, victim alcohol intake (three-categorical) and whether suspect was registered as a former suspect or not in the police files;

Table 1
Victim – and assault characteristics among 223 victims of sexual assault and by vulnerability. Merged data from the Trondheim SAC and Sør-Trøndelag Police District.

Variable	Total N = 223 n (%)	Yes N = 151 n (%)	No N = 72 n (%)	*p*-value
Victim age				
Mean, median, SD, range	24.1, 20.9, 16-51	24.9, 21.3, ±8.5, 16-51	22.2, 19.9, ±7.2, 16-46	0.02[a], 0.004[b]
Victim origin, n=223				
Western	210 (94)	141 (93)	69 (96)	
Non-Western	11 (5)	9 (6)	2 (3)	0.5[c]
Missing	2 (1)	1 (1)	1 (1)	
Victim's occupation, n=223				
Employed/student	159 (71)	95 (63)	64 (89)	
Unemployed	56 (25)	50 (33)	6 (8)	< 0.001[d]
Missing	8 (4)	6 (4)	2 (3)	
Victim-suspect relationship, n=223				
Partner	16 (7)	13 (9)	3 (4)	
Friend/family	82 (37)	58 (38)	24 (33)	
Casual contact	87 (39)	55 (36)	32 (44)	
Stranger	36 (16)	24 (16)	12 (17)	0.5[e]
Missing	2 (1)	1 (1)	1 (1)	
Victim a former victim of a crime, n=217				
No	79 (36)	41 (28)	38 (54)	
Yes	138 (64)	106 (72)	32 (46)	< 0.001[d]
Victim a former suspect of a crime, n=217				
No	131 (60)	76 (52)	55 (79)	
Yes	86 (40)	71 (48)	15 (21)	< 0.001[d]
Victim alcohol intake, n=216				
No intake	35 (16)	30 (21)	5 (7)	
<5 units	48 (22)	35 (24)	13 (18)	
≥5 units	133 (62)	80 (55)	53 (75)	0.009[f]
Victim suspicious of being drugged, n=214				
No	190 (89)	128 (87)	62 (94)	
Yes	24 (11)	20 (14)	4 (6)	0.15[d]
Physical violence, n=223				
None/verbal	28 (13)	20 (13)	8 (11)	
Light/moderate	139 (62)	93 (62)	46 (64)	
Severe	22 (10)	16 (11)	6 (7)	0.8[f]
Missing	34 (15)	22 (15)	12 (17)	
Penetration, n=223				
No penetration	30 (14)	18 (12)	12 (17)	
Penetration by penis or foreign object	164 (74)	114 (76)	50 (69)	0.39[d]
Missing	29 (13)	19 (13)	10 (14)	
Place of assault, n=223				
Private	149 (67)	106 (70)	43 (60)	
Public	73 (33)	44 (29)	29 (40)	0.1[d]
Missing	1 (0)	1 (1)	0 (0)	
Time from assault to medical exam at the SAC, n=222				
<24 h	162 (73)	114 (76)	48 (67)	
≥24 h	60 (27)	36 (24)	24 (33)	0.15[d]
Tox. results victim, n=115				
No tox. agents	34 (30)	16 (21)	18 (47)	
≥1 tox. agent	81 (70)	61 (79)	20 (53)	0.005[d]

[a] *t*-test.
[b] Mann Whitney *U* test (test for differences in median).
[c] Fischer's Exact Test, df = 1.
[d] Chi square, df = 1.
[e] Fischer's Exact Test, df = 3.
[f] Chi square, df = 2.

Table 2
Ten variables for police investigation in 176 police reported cases of rape, by vulnerability (excluding 47 cases with unidentified suspect). Merged data from the Trondheim SAC and Sør-Trøndelag Police District.

Variable	Total N = 176 n (%)	Yes N = 122 n (%)	No N = 54 n (%)	*p*-value
Suspect interrogated, n = 171				
No	16 (9)	13 (11)	3 (6)	
Yes	155 (91)	106 (89)	49 (94)	0.4[a]
Victim interrogated, n=176				
No	5 (3)	4 (3)	1 (2)	
Yes	171 (97)	118 (97)	53 (98)	1.0[a]
Interrogation of other witnesses than victim and suspect, n=174				
No	42 (24)	33 (28)	9 (17)	
Yes	132 (76)	87 (73)	45 (83)	0.1[b]
Suspect arrested, n=160				
No	101 (63)	73 (66)	28 (56)	
Yes	59 (37)	37 (34)	22 (44)	0.2[b]
Police investigation of crime scene, n=176				
No	73 (42)	53 (43)	20 (37)	
Yes	103 (59)	69 (57)	34 (63)	0.5[b]
Police requested forensic medical record from SAC, n=176				
No/missing	93 (53)	62 (51)	31 (57)	
Yes	83 (47)	60 (49)	23 (43)	1.0[b]
Analysis of swabs and/or clothes collected from victim, n=158				
No/missing	93 (59)	64 (58)	29 (60)	
Yes	65 (41)	46 (42)	19 (40)	0.8[b]
Collection of swabs and/or clothes from suspect, n=176				
No/missing	99 (56)	73 (60)	26 (48)	
Yes	77 (44)	49 (40)	28 (52)	0.3[a]
Collection of biological material from crime scene, n=176				
No/missing	90 (79)	99 (81)	40 (74)	
Yes	37 (21)	23 (19)	14 (26)	2.0[b]
Suspect DNA profile taken, n=161				
No	74 (46)	55 (44)	19 (37)	
Yes	87 (54)	55 (50)	32 (63)	0.2[b]

[1] T-test.
[2] Mann Whitney *U* test (test for differences in median).
[a] Fischer's Exact Test (FET), df = 1.
[b] Chi square, df = 1.

and 3) adjusting for victim age, victim/suspect relationship (four categories), and reported penetration or not (by penis or object). Statistical significance was assumed when $p < 0.05$. Missing data were calculated but excluded when statistical tests were performed. Data analyses were performed using IBM SPSS Statistics for Windows, version 25.0.

3. Results

3.1. Victim- and assault characteristics (Table 1)

Among the 223 victims, 151 (68%) had at least one of the four vulnerability factors present: (Fig. 1, study group 1): 22 (10%) had intellectual and/or physical disability; 117 (53%) had a mental health problem; 29 (13%) had present or former alcohol or drug abuse; and 98 (44%) reported one or more prior incidents of sexual assault. Reporting more than one vulnerability factor occurred among 87 victims (39%). Table 1 presents victim- and assault characteristics by vulnerability among the 223 victims (Fig. 1). The mean age of victims was 24.9 (SD 8.5) years among the vulnerable and 22.2 (SD 7.2) years among the non-vulnerable ($p = 0.02$). The unemployment rate was higher among vulnerable victims than among the non-vulnerable (33% versus 8%, $X^2 = 16.5$, df = 1, $p = < 0.001$). The victim was more frequently registered as a former victim of a crime in the police files, when the victim was vulnerable compared with the non-vulnerable cases (72% vs. 46%, $X^2 = 14.3$, df = 1, $p < 0.001$). Additionally, a vulnerable victim was more often registered as a former suspect of a crime than a non-vulnerable victim (48% vs. 21%, $X^2 = 14.3$, df = 1, $p < 0.001$). Among the 223 cases, 59 (27%) attended the SAC before police reporting, while 15 (7%) police-reported before attending the SAC. In 149 cases (67%) SAC- and police-reporting were on the same day (no difference between the groups of vulnerable and non-vulnerable). For further descriptions of victim- and assault characteristics, see Table 1.

3.2. Investigational actions performed (Table 2) and police investigation score (IS)

Table 2 shows the police investigations performed among the 176 cases with only identified suspects by vulnerability (Study group 2). The suspects were interrogated by the police in 106 (89%) cases with vulnerable victims and in 49 (94%) cases where victims were non-vulnerable ($p = 0.4$, FET). All but five of the 176 victims were interrogated; here, four of those not interrogated were vulnerable. In cases where the victim was vulnerable the police interrogated other witnesses than victim and suspect borderline less often than in cases where the victim was non-vulnerable (73% vs. 83%, $X^2 = 2.4$, df = 1, $p = 0.1$). The suspect was arrested in 34% of the cases where victims were vulnerable and in 44% of cases involving non-vulnerable victims ($X^2 = 1.6$, df = 1, $p = 0.2$). Police investigation of crime scene was conducted in 59% of the cases, irrespective of victim vulnerability. The police requested a forensic medical record from the SAC in 47% of the cases, and there were no differences between the two groups of victims. Biological samples collected from victims at the SAC (swabs and/or clothes) were sent for further analyses at the Institute of Forensic Medicine in Oslo, Norway, in 41% of the cases, regardless of which group of victims involved. Collection of swabs and/or clothes from suspect was

Table 3
Vulnerability by police investigation quality in 176 cases of rape with identified suspect, crude and adjusted odds ratios for "low-quality investigation" are shown. Merged data from the Trondheim SAC and Sør-Trøndelag Police District.

Variable	Total, N = 176 n (%)	Police investigation score < 7, "low-quality investigation" N = 107 (61%)	Police investigation score ≥ 7, "high-quality investigation" N = 69 (39%)	Crude OR	OR Adjusted for Victim Age[a]	OR Adjusted for victim age, victim alcohol intake and suspect a former suspect[b]	OR Adjusted for victim age, victim/suspect relationship and penetration[c]
At least 1 vulnerability, N = 176							
Yes	122 (69)	79 (74)	43 (62)	1.7 (0.9–3.3)	1.8 (0.9–3.5)	2.0 (1.0–4.0)	2.1 (1.0–4.4)
No	54 (31)	28 (26)	26 (38)	Reference	Reference	Reference	Reference
Disability, N = 173							
Yes	20 (12)	12 (11)	8 (12)	1.0 (0.4–2.5)	1.0 (0.4–2.5)	1.0 (0.4–2.9)	0.9 (0.3–2.5)
No	153 (88)	93 (89)	60 (88)	Reference	Reference	Reference	Reference
Mental health problems, N = 163							
Yes	93 (57)	59 (60)	34 (53)	1.3 (0.7–2.4)	1.4 (0.7–2.6)	1.2 (0.6–2.4)	1.8 (0.9–3.6)
No	70 (43)	40 (40)	30 (47)	Reference	Reference	Reference	Reference
Alcohol/drug abuse, N = 174							
Yes	24 (14)	14 (13)	10 (15)	0.9 (0.4–2.1)	1.0 (0.4–2.5)	0.8 (0.3–2.2)	1.4 (0.5–4.0)
No	150 (86)	92 (87)	58 (85)	Reference	Reference	Reference	Reference
Former sexual assault, N = 162							
Yes	83 (51)	54 (55)	29 (45)	1.5 (0.8–2.8)	1.5 (0.8–2.9)	1.3 (0.7–2.7)	1.5 (0.7–3.0)
No	79 (49)	44 (45)	35 (55)	Reference	Reference	Reference	Reference
Number of vuln.factors, N = 176							
0	54 (31)	28 (26)	26 (38)	Reference	Reference	Reference	Reference
1	47 (27)	32 (30)	15 (22)	2.0 (0.9–4.5)	2.0 (0.9–4.6)	2.5 (1.0–5.9)	2.4 (0.9–6.0)
>1	75 (43)	47 (44)	28 (41)	1.6 (0.8–3.2)	1.6 (0.8–3.5)	1.6 (0.7–3.6)	1.9 (0.9–4.4)

[a] Adjusted for age, 3-categorial (16–17 yrs, 18–24 yrs, ≥ 25 yrs).
[b] Adjusted for age, 3-categorical (16–17 yrs, 18–24 yrs, ≥25 yrs), victim alcohol intake (3-categorical), and suspect a former suspect (dichotome).
[c] Adjusted for age, 3-categorical (16–17 yrs, 18–24 yrs, ≥25 yrs), victim/suspect relationship (4-categorical: partner, friend/family, casual < 24 h, stranger) and penetration (dichotome).

performed in 40% of cases with vulnerable victims and in 52% of cases with non-vulnerable victims (p = 0.3, FET). Biological material was collected from the crime scene less often in cases with vulnerable victims than in cases with non-vulnerable victims (19% vs. 26%, $X^2 = 3.4$, df = 1, p = 0.2). A DNA profile of the suspect was secured less often in cases where victims were vulnerable than in cases with non-vulnerable victims (50% vs. 63%, $X^2 = 2.3$, df = 1, p = 0.2, respectively). When computing the investigation score points (IS) for each case we found a mean and median IS of 5.3 (SD 2.3) and 5.0, resp. in cases with vulnerable victims vs. 5.9 (SD 2.4) and 6.0, resp. in cases with non-vulnerable victims, the difference was borderline significant (p = 0.13 and p = 0.16, resp.).

3.3. High- and low quality of police investigation (Table 3)

Table 3 describes the proportions of low-quality- and high-quality police investigations between cases with vulnerable and non-vulnerable victims. Among cases involving vulnerable victims we found that a low-quality police investigation had been performed in 65% vs. in 52% of the cases involving non-vulnerable victims (p = 0.1) (Table 3). The aOR for a low-quality police investigation was 2.1 in cases with vulnerable victims, compared with cases with non-vulnerable victims, when adjusted for victim age, victim/suspect relationship and penetration (aOR = 2.1, 95% CI [1.0–4.4]). Table 3 also illustrates the proportions of low- and high-quality police investigations regarding each vulnerability subgroup. When comparing cases with victims with mental health problems to cases with victims without such problems, the aOR for having a low-quality police investigation was 1.8 (95% CI [0.9–3.6]), when adjusted for victim age, victim/suspect relationship and penetration. For those with one vulnerability factor only and for those with more than one vulnerability factor the aOR for low quality investigation var 2.4 and 1.9 resp. compared to those with no vulnerability (aOR = 2.4, 95% CI [0.9–5.9]) and (aOR = 1.9, 95% CI [0.9–4.4]).

3.4. Investigational results

For all the 223 cases including those with unidentified suspect, *rape* was reported in 95% of the cases and *attempted rape* in 5%, and there were no differences between the groups of vulnerable and non-vulnerable victims with regards to that variable (p = 0.8, FET). The mean time from police reporting until legal decision-making was 9 months (278 days) in the vulnerability group and 8 months (246 days) in the non-vulnerability group (p = 0.29). Investigations led to prosecution in 10% of the cases, regardless of victim vulnerability (p = 0.8, FET) (study group 1). Among the 176 suspects who were identified, 75% admitted sexual contact, and this phenomenon was less common if the victim was vulnerable than if she was non-vulnerable (69% vs. 88%, $X^2 = 5.8$, df = 1, p = 0.03). Only two suspects admitted rape and five admitted culpability (study group 2).

4. Discussion

Based on merged records from the STPD and the Trondheim SAC, we found that 68% had at least one of the four vulnerability factors present. We found a borderline significant tendency that the police less often interrogated other witnesses than victim and suspect, less often arrested the suspect, less often collected biological material from the crime scene and a suspect DNA profile in cases with vulnerable victims compared to with non-vulnerable victims. According to our definition of "high investigational

quality" (score $\geq$ 7 of the 10 investigational actions performed) we found that as many as 65% of cases involving vulnerable victims got a low-quality police investigation, vs. 52% of the cases involving non-vulnerable victims. The adjusted odds ratio for having a police investigation of low quality was more than doubled in cases with vulnerable victims compared with cases involving non-vulnerable victims. To our knowledge no previous studies have conducted a comprehensive comparison of police investigation in rape cases based on such differences in victim vulnerability.

What is considered optimal investigation in each individual case is difficult to assess, as police investigations are tailored to each case. Still, it seems that an average IS of only 5.5 out of 10 investigation actions, regardless of victim vulnerability being present or not, indicates a potential for improvement. In line with our findings, a new report by Amnesty International, concludes that police investigations of rape cases in Norway are not optimal [2].

Despite the differences described in police investigations between cases with vulnerable and non-vulnerable victims, we found no differences in the prosecution rates between the two groups of victims we compared. Case closure was decided by the police in 90% of the cases irrespective of victim vulnerability. In line with this, there are many studies showing that the majority of cases are closed early in the legal process [3,5,6,10]. However, we did not explore whether cases with vulnerable victims were closed in the initial phases or later on in the investigational process.

Our analyses showed that the police submitted only 41% of the available forensic evidence kits for further analyses, regardless of victim vulnerability being present or not. This finding confirms and highlights the topic of untested sexual assault kits as still being present at our police district during the observation time of our study. In a new study from Michigan which questioned why sexual assault kits so often were not submitted for testing, one explanation was found to be the presence of victim-blaming beliefs and rape myths among police officers. A suggested remedy to the problem was training police on the utility of forensic evidence and best practices in sexual assault investigations [15]. Some researchers claim that the perpetrator seldom denies sexual contact when swabs have been collected from the victim [32,33]. Hence, untested kits result in loss of possible valuable medico-legal evidence. Even more disturbing, however, regardless of vulnerability, we found that the police requested a medico-legal report from the SAC in less than half of the police reported cases. Among victims who visit a SAC there can be body injuries which are routinely documented by trained SAC personnel. In addition, the emotional status of victims visiting the SAC and other information reported from the rape incident are often well documented in SAC records. According to a Danish study, in half of the rape cases, the forensic clinical examination and medical report was important for the prosecuting authorities in the decision-making process [13]. Hence, deciding to collect only 47% of the medical reports, could mean loss of important evidence.

We found that suspects admitted sexual contact in 75% of the cases, and that they did so significantly less often in the cases with vulnerable victims than in cases with non-vulnerable victims. By admitting sexual contact, the suspect implies that nothing criminal has occurred, only acts of consensual sex. The finding that less suspects admitted sexual contact in cases with vulnerable victims than in cases involving non-vulnerable victims could be interpreted as suspects' strategies and anticipations of whom the police are most likely to believe. Suspects may expect denial of any sexual contact as a more credible and respected scenario when it comes to victims with vulnerabilities than victims without. Nevertheless, almost none of the suspects admitted rape or culpability, regardless of victim vulnerability or not.

Among all the 223 women who reported rape to the police we found that a high proportion of them already had been registered in the police files as either a former victim and/or a former suspect of a crime. It was significantly more often so for the vulnerable victims than for the non-vulnerable. This indicates that there may be a link between involvement in criminal activity, either as a victim, as a suspect or both, and being a rape victim. In line with our findings, a report from the police district in the Norwegian capital Oslo (OPD) concluded that a population of women who have reported rape to the police are far more victimized but also more victimizing than the general population [34]. The OPD report mentioned individual differences in types of former criminal activity involvement within the sample of victims reporting rape to the police, but did not describe differences in police investigation depending on pattern of vulnerability among victims [34]. We did not find any significant risk for low-quality police investigation among those with prior or current drug abuse, or those with prior sexual assault compared to those without these vulnerability factors. However, others have shown an association between re-reporting of rape and early dismissal from police investigation [4]. When we explored the investigation regarding cases with victims with mental health problems we found a borderline significant aOR of 1.8 for low-quality police investigation compared to cases with victims without recorded mental health problems. This finding could be interpreted as a consequence of possible rape myths among investigating police officers towards victims with this specific vulnerability.

The data of this study are almost a decade old and hence they do not necessarily reflect more updated versions of how the police investigate rape in cases where victims have increased vulnerability. One example of progress was when the Norwegian government in 2015 changed the legislation regarding interrogations in cases where children and other especially vulnerable victims (adults with intellectual disability) were subjected to serious crimes. The purpose was to secure that interrogations were facilitated and adapted to the needs of these groups of victims, and thereby to strengthen their legal rights [35]. Theoretically, similar adaptions could have been implemented regarding interrogations and handling of other vulnerable groups of rape victims as well, for example those with mental health problems and/or alcohol or substance abuse. In January 2019, The Director General of Public Prosecutions in Norway announced a new review of the quality of police investigations in rape cases in 2020, based on recent disclosures of sub-optimal police work [36]. In other words, there is still a potential for improvements and a political wish to improve.

Some argue that the influence of rape myths on rape investigations may not be as pronounced as previously assumed [37]. They explain this through an increased public awareness of rape myths and the implementation of multidisciplinary rape response teams throughout the US and in many European countries [38,39]. In accordance with this, a UK study has shown increased likelihood of case progression in police districts which adhered tightly to a so-called "victim focused approach". This approach emphasizes on believing victims from when they report and supporting them to remain in the criminal justice system. The idea is also to actively involve multidisciplinary links along with the ongoing police investigation, such as Sexual Assault Referral Centers (SARCs), Independent Sexual Violence Advisors (ISVAs), specialist sexual violence services, and health sector [4].

Furthermore, it is natural to think of non-vulnerable victims as having a stronger ability than the vulnerable to stand up for their rights and advocate for themselves. Hence this may contribute to higher quality of investigations among the more resourceful victims. Another UK study describes a category of young vulnerable women involved in gang culture and how they are used to being exposed to threats and intimidations [40]. When these women

choose to report a rape to the police, they may have challenges already in terms of reduced victim credibility. Some may not have the courage or communicational skills to give honest answers during police interrogations. The risk of withdrawing the complaint is also high in such cases.

This study has several limitations. The data were collected retrospectively which means that information has not been systematically collected in a research context using standardized case report forms. Our data regarding police investigations were limited as we were not given access to original logs or notes in the police files, only to official records. We only had access to files from one out of the 27 police districts in Norway, limiting the national generalizability of our findings and possible identification of victims being a former victim/suspect in another district. The reliability of the data in a study like this is dependent on the accuracy by which both police officers and medical staff have recorded in each case.

When designing this study, all victims who had not visited the SAC were excluded (n = 161). This was done mainly for two reasons: Firstly, a sufficient and proper registration of vulnerability in victims was found only in SAC records. Secondly, in order to evaluate the quality of police investigations, we needed information regarding to what extent the police had utilized medical information in the process. A previous study from the same SAC showed, however, that one third of the police-reported rapes had occurred in rural areas, whereas the remaining had taken place in or near the city of Trondheim [14]. Among the former, 42% had attended the SAC vs. 61% among the latter. This implies that our exclusion of those who had not visited the SAC reduced the representability of cases from rural communities, compared to cases from the urban area. The low SAC attendance of victims of rapes perpetrated outside the urban area, may partly be explained by geographical reasons; distance may feel disconcerting. The geographical differences in forensic examination raises the question of whether health services and consequently also police investigations in rape cases are less adequate in rural areas than in the city.

Many of our findings are not statistically significant, and some variables have rather small sample size, which can lead to problems in determining significant associations. Further, when analyzing our findings of less thorough police investigations in cases involving vulnerable victims than in cases involving non-vulnerable victims, we point to rape myths among police officers as a possible explanation. This could, by some readers, be evaluated as a simplified and speculative interpretation. The report by the OPD mentioned above refers to specific victim-related challenges which often make rape case investigations extremely difficult. Typically, victims often lack the will or courage to cooperate, either by withdrawing their complaints or choosing not to show up for interrogations. Such challenges are sometimes seen even in cases where the police have decided to prosecute. These examples do not necessarily support the theory that rape cases have a low priority or that case closures result from rape myths in a preconceived police environment [34]. In order to obtain more accurate knowledge of how police officers think regarding different groups of rape victims, more qualitative studies based on interviews should be conducted on this topic in the future.

Our study also has strengths: Having access to sensitive police data for research purposes is uncommon in Norway and makes our findings an important source of information about how the police process cases of sexual violence in a Norwegian sample. Few prior studies have described such in-depth comparisons of police investigations of sexual assault cases depending on levels of vulnerability in victims. It is a unique strength of the study that we have merged information from police records and the SAC, both by enriching the variety of data available, and as information about how results from the forensic medical exams are being used in police investigations of rape crimes. The large number of variables and a long observation period of more than seven years also strengthen the study.

5. Conclusions

Previous literature has suggested that myths and misconceptions about sexual offending among law enforcement personnel can predict case progression negatively. Our results do not prove that rape myths existed among police officers at the STPD during the observation period of this study. Our findings do, however, show a trend indicating that vulnerable victims may have been less prioritized compared to non-vulnerable victims with regards to police investigations of rape. More studies are needed in the future regarding how the police respond to rape complaints in general, and on to what degree police investigations are influenced by different characteristics of victims.

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Declaration of competing interest

None.

CRediT authorship contribution statement

Bjarte Frode Vik: Writing - original draft. **Kirsten Rasmussen:** Writing - original draft. **Berit Schei:** Writing - original draft. **Cecilie Therese Hagemann:** Writing - original draft.

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Paper III

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Three groups of suspects in police reported rape cases: First-time suspects, recidivists and unidentified suspects. A comparative study

Bjarte Frode Vik[a,b,*], Kirsten Rasmussen[c,d], Berit Schei[e,f], Cecilie Therese Hagemann[a,f]

[a] Norwegian University of Science and Technology (NTNU), Department of Clinical and Molecular Medicine, P.B. 8905, N-7491, Trondheim, Norway
[b] St. Olavs Hospital, Department of Neuropsychiatry, P.B. 3250 Sluppen, N-7006, Trondheim, Norway
[c] Norwegian University of Science and Technology (NTNU), Department of Psychology, 7491, Trondheim, Norway
[d] St. Olavs Hospital, Forensic Research Unit, Brøset, P.B. 1803 Lade, 7440, Trondheim, Norway
[e] Department of Public Health and Nursing, Norwegian University of Science and Technology, P.B. 8905, N-7491 Trondheim, Norway
[f] Department of Obstetrics and Gynecology St. Olavs Hospital, P.B. 3250 Sluppen, N-7006, Trondheim, Norway

A B S T R A C T

Background: Previous studies show that reported suspects in adult rape cases often have a criminal record, and that many are rape recidivists. Annual numbers of police reported rapes have dramatically increased but the proportion of rapes being prosecuted and numbers of convictions are low. To increase knowledge about the suspects in cases of police reported rapes; whether they have committed the crime before or not may inform preventive measures.
Aims: To compare suspect, victim, and assault related characteristics among different groups of police-reported rape suspects (first-time suspects, recidivist suspects and unidentified suspects).
Methods: Retrospective, descriptive study of suspects in cases of rape or attempted rape reported by women ≥16 years of age in the Sør-Trøndelag police district, Norway, from 2003 to 2010.
Results: Among the 356 suspects included, 207 (58%) were first-time suspects, 75 (21%) were recidivists and 74 (21%) were unidentified. Being a first-time suspect was significantly associated with victim being <18 years, recidivist suspect was significantly associated with victim being a partner, both suspect- and victim unemployment, and suspect reporting intake of other drugs than alcohol. When suspects were unidentified, victims were more likely to have consumed alcohol prior to assault, and reporting the suspect being of non-Western origin. Also, the reporting of a public venue was more frequent when unidentified suspect.
Conclusions: The study shows different patterns in groups of suspects as to victim and assault characteristics. Detection and description of such differences can provide valuable information for future prevention programs, police investigation methods and health care guidelines.

1. Introduction

There has been a steady increase in police-reported rapes in Norway, from 400 per year in the 1990s to almost 1600 per year in 2016.[1,2] Despite increasing rates of police-reported rapes, the percentage of cases proceeding to prosecution is low and even decreasing in Norway, in line with findings from other countries.[3,4]

During the last 30 years a major focus of research and policy implications has been on the sexual recidivists and the prevention of sexual recidivism.[5,6] This is a result of the perception that sexual offending is a life-course persistent inclination, and it has led politicians to seek predominantly punitive solutions to a problem as complex as sexual violence. New research underlines the importance of understanding the origin and the development of sexual offending over time and the factors responsible for it, to better understand and prevent sexual recidivism in the future.[7] It has also been emphasized that the attention regarding research on prevention of sexual assault and offender treatment should be drawn towards youths who commit sexual crimes, as all data point to the origin of sexual offending in the early adolescent years.[8] Traditional theories regarding sexual assault postulate that sexual offenders specialize in types of victims and/or offences and are categorized in certain typologies.[5,9,10] Research has shown that rapists often have many previous convictions for a violent crime, and that they resemble violent offenders or criminals in general. In contrast, those convicted for sexual crimes against children tend to engage in sexual offending exclusively.[5,11] There are few characteristics, traits or patterns of human behavior which can be used to generalize hallmarks in a population of sexual assailants.[12] On the other hand, according to a report from the Oslo Police District (OPD), the population of sexual offenders are different from others in several ways.[13] They are both more victimized and victimizing, they have more mental health problems and have far more often a criminal record in the police files than the general male population. Two thirds of the persons reported to the OPD for rape in the year 2010 had formerly registered criminal activity in police files. In the period 2000–2010 the OPD registered an increase in sexual assaults committed by men of non-European descent. The

* Corresponding author. St. Olavs University Hospital, Dept. of Neuropsychiatry, Trondheim University Hospital, P.B. 3250 Sluppen, Trondheim, N-7006, Norway.
E-mail address: bjarte.vik@ntnu.no (B.F. Vik).

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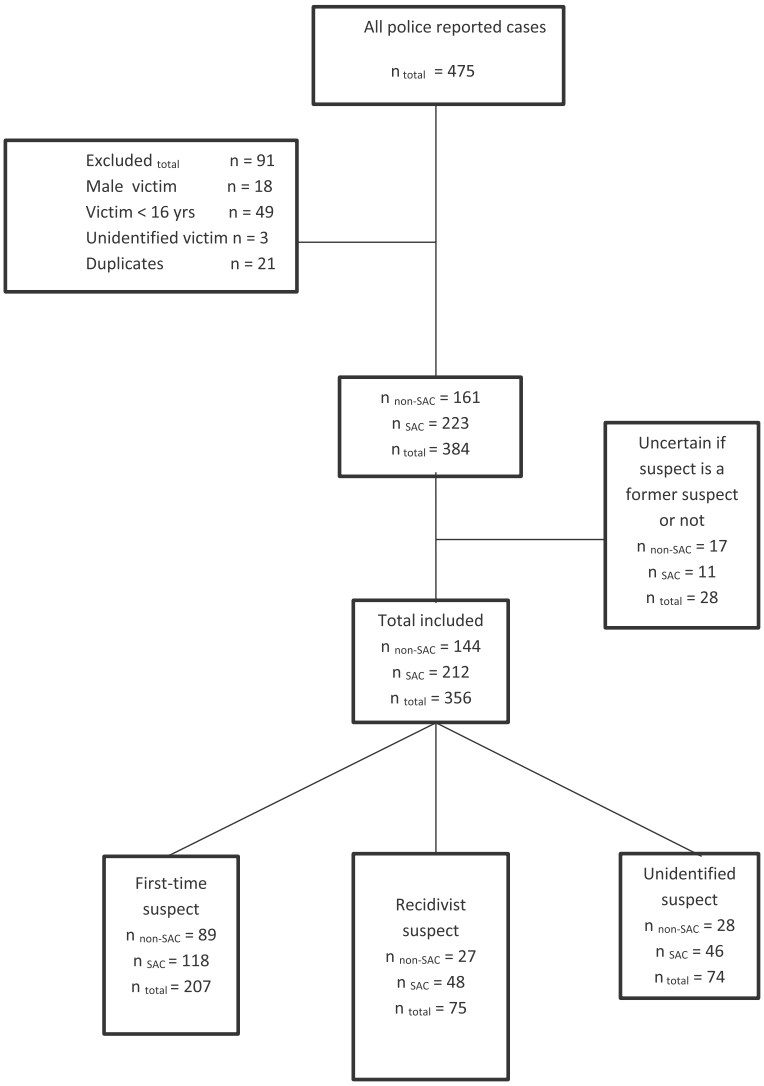

Fig. 1. Flow chart for included and excluded police-reported cases of rape and attempted rape in Sør- Trøndelag police district during the period 2003–2010. Police data are merged with data from the Trondheim SAC in corresponding cases of sexual assault.

authors emphasized that victims' threshold for reporting to the police was probably lower when the assailant's origin was non-European.[13]

Little is known about how the police prioritize in investigations of sexual assault cases. There is some evidence showing that preconceived attitudes in society towards sexual assault victims influence on how the police handle sex offences.[3] Theories on rape myths were introduced in the 1970s to explain false beliefs about how and why women are sexually assaulted.[14] Research has documented that law enforcement personnel endorse rape myths.[15–17] Recent research has shown that rape myths are documented in official rape case records and suggests that this may influence investigative responses and perhaps predict case progression in a negative way.[18] Preconceived attitudes are also described as existing towards sexual assault suspects. A British study showed that suspects who had a criminal record, especially as sex offenders, and those of non-white skin color, had an increased risk of getting convicted.[19] "The credible criminal" was the term used to describe these offenders and the findings were later supported by a Danish study.[3] However, research in this area is limited. The first aim of this study was to describe and to compare the following three groups of suspects of rape or attempted rape in the Sør-Trøndelag Police District (STPD): 1) Suspects who were police-reported for the first time (referred to as first-time suspects). 2) Suspects who had one or more former episodes registered in the STPD files as a suspect of rape or other violent crime (referred to as recidivists), and 3) Unidentified suspects. The descriptions and comparisons of the suspect groups were based on victim-, assailant and assault characteristics, in police reported rapes and attempted rapes. A second aim was to describe differences in police investigations and prosecution rates of rape cases depending on the group of suspect/assailant involved.

2. Material and methods

2.1. Study design and settings

We conducted a retrospective descriptive study of police-reported rapes and attempted rapes of female victims ≥16 years of age in the Sør-Trøndelag Police District (STPD) in Norway between July 1, 2003 and December 31, 2010. The population of the area is approximately 280 000, including the city of Trondheim with about 160 000 inhabitants.[20] The only medical sexual assault center (SAC) in the district is located at St. Olavs Hospital in Trondheim. Data from police files were merged with corresponding medical information from the SAC when available. The SAC's service is described in detail elsewhere.[21] The Institute of Forensic Medicine, Oslo University, carries out all forensic analyses of collected biological samples from sexual assault victims in Norway. The results from these analyses are kept in police files, and are usually unavailable for the SAC personnel.[22]

2.2. Participants

All police-reported cases of rape and attempted rape of women ≥16 years of age, were identified. Cases were selected based on the former Norwegian Penal Code.[23] According to this law, Chapter 19, section 192, rape was defined as in the following abbreviated version: Penetration of penis/finger/foreign object in vagina/anus, penis in mouth, masturbation, and coercion by means of violence, threats, or during impaired consciousness.[23,24] Four paragraphs under section 192 covered various distinctions of rape: Among the 320 suspects of rape included in this study, 306 were registered according to section 192, paragraphs 1 and 2 (rape), 9 suspects according to paragraph 3 (aggravated rape) and 5 suspects according to paragraph 4 (grossly negligent rape). Attempted rape, which was registered in 36 suspects in the study, is also punishable, but is covered by another paragraph in the Penal Code.

A total of 475 cases were police-reported during the period. Cases were excluded according to Fig. 1. Male victims (n = 18), those < 16 years of age (n = 49), unidentified victims (n = 3) and duplicate registrations (n = 21) were excluded. Additionally, some cases were excluded because of missing information regarding whether suspects were previously registered as suspects in police files or not (n = 28), leaving 356 cases eligible for the study. Among the 356 cases, we had corresponding medical information from the SAC in 212 cases (Tables 1 and 3 and Fig. 1).

2.3. Data collection and variables

Characteristics of suspects and victims were retrieved from police files, but in cases where SAC information was available and information in the police files was missing, victims' medical records were the source of information. We collected data on the following variables: Suspects' and victims' sociodemographics like age, origin (classified as Western if stated as Western Europe, North America or Oceania (Australia or New-Zealand), else classified as Non-Western), occupational status, and education. Age of unidentified suspects was based on victims' self-reporting. Furthermore, suspect-victim relationship was categorized into partner (current or previous partner/husband/boyfriend), family member or friend, casual contact (suspect known < 24 h) or stranger (suspect not previously known). Type of sexual acts involved anal, vaginal or oral penetration, or recorded as "no recollection/missing". Use of physical violence was graded as severe (presence of weapon/attempted strangulation/fracture or internal injuries), light/moderate (holding/punch/kick) or none/verbal threats. Location of assault/venue was categorized into private (woman's, assailant's or other person's residence) and public (any public indoor or outdoor location or a vehicle). Victim alcohol intake in relation to the assault was classified by three categories; "no intake", "intake of <5 units of alcohol" and "intake of ≥5 units of alcohol/heavily intoxicated". Suspect alcohol intake was dichotimized to "yes" or "no". In cases with more than one assailant, information regarding the presumably most active one was used. In cases with unidentified suspect, information given by the victim or other witnesses was used.

Table 1
Suspect, victim, assault and investigative characteristics and by former suspects of sexual assault or other violent crime, 2003–2010.

Variable	Total N = 356 n(%)	First-time suspects N = 207 n (%)	Recidivists N = 75 n (%)	Unidentified suspects N = 74 n (%)	p-value
Suspect characteristics					
Origin					
Western	235 (66)	150 (73)	57 (76)	28 (38)	0.004[a]
Non-western	98 (28)	55 (27)	17 (23)	26 (35)	
Missing	23 (7)	2 (1)	1 (1)	20 (27)	
Victim characteristics					
Age					
16–17 years	72 (20)	53 (26)	8 (11)	11 (15)	0.02[b]
18–24 years	160 (45)	80 (39)	42 (56)	38 (52)	
≥25 years	123 (35)	73 (35)	25 (33)	25 (34)	
Missing	1 (0)	1 (1)	0 (0)	0 (0)	
Occupation					
Employed/ student	219 (62)	132 (64)	41 (55)	46 (62)	0.1[a]
Unemployed	64 (18)	33 (16)	20 (27)	11 (15)	
Missing	73 (21)	42 (20)	14 (19)	17 (23)	
Victim alcohol intake					
No intake	103 (29)	65 (31)	25 (33)	13 (18)	0.007[b]
<5 units	67 (19)	36 (17)	8 (11)	23 (31)	
>5 units	157 (44)	89 (43)	38 (51)	30 (41)	
Missing	29 (8)	17 (8)	4 (5)	8 (11)	
Assault characteristics					
Victim-suspect relationship					
Partner	57 (16)	38 (18)	19 (25)	0 (0)	< 0.001[c]
Friend/family	134 (38)	97 (47)	29 (39)	8 (11)	
Casual contact	107 (30)	66 (32)	19 (25)	22 (30)	
Stranger	55 (15)	6 (3)	8 (11)	41 (55)	
Missing	3 (1)	0 (0)	0 (0)	3 (4)	
Penetration					
No penetration	70 (20)	31 (15)	17 (23)	22 (30)	0.006[a]
Penetration by penis or foreign object	249 (70)	155 (75)	55 (73)	39 (53)	
Missing	37 (10)	21 (10)	3 (4)	13 (18)	
Physical violence					
None/verbal	45 (13)	32 (16)	10 (13)	3 (4)	0.01[b]
Light/moderate	221 (62)	124 (60)	50 (67)	47 (64)	
Severe	44 (12)	17 (8)	12 (16)	15 (20)	
Missing	46 (13)	34 (16)	3 (4)	9 (12)	
Place of assault					
Private	235 (66)	157 (76)	56 (75)	22 (30)	< 0.001[a]
Public	113 (32)	46 (22)	19 (25)	48 (65)	
Missing	8 (2)	4 (2)	0 (0)	4 (5)	
More than 1 suspect					
1 suspect	316 (89)	185 (89)	70 (93)	61 (82)	0.24[a]
More than 1 suspect	38 (11)	22 (11)	5 (7)	11 (15)	
Missing	2 (1)	0 (0)	0 (0)	2 (3)	
Investigational data					
Other witnesses interrogated					
No	101 (28)	53 (26)	19 (25)	29 (39)	0.08[a]
Yes	251 (71)	150 (73)	56 (75)	45 (61)	
Missing	4 (1)	4 (2)	0 (0)	0 (0)	
Police investigation of crime scene					
No	204 (57)	120 (58)	39 (52)	45 (61)	0.5[a]
Yes	151 (42)	87 (42)	36 (48)	28 (38)	
Missing	1 (0)	0 (0)	0 (0)	1 (1)	

[a] Chi square, df = 2.
[b] Chi square, df = 4.
[c] Chi square, df = 6.

Table 2
Suspect and investigative characteristics, by identified former suspect of sexual assault or other violent crime, 2003–2010.

	Total N = 282 n (%)	First-time suspects N = 207 n (%)	Recidivists N = 75 n (%)	*p*-value
Suspect characteristics				
Age				
≤24 years	107 (38)	78 (38)	29 (39)	0.1[a]
25–34 years	91 (32)	66 (32)	25 (33)	
≥35 years	84 (30)	63 (30)	21 (28)	
Occupation				
Employed/ student	181 (64)	136 (66)	45 (60)	0.004[b]
Unemployed	42 (15)	21 (10)	21 (28)	
missing	59 (21)	50 (24)	9 (12)	
Education				
<13 years	88 (31)	62 (30)	26 (35)	1.0[b]
University/ college	27 (10)	19 (9)	8 (11)	
Missing	167 (59)	126 (61)	41 (55)	
Self-reported alcohol intake				
No	81 (29)	53 (26)	28 (37)	0.09[b]
Yes	164 (58)	124 (60)	40 (53)	
Missing	37 (13)	30 (15)	7 (9)	
Self-reported intake of other drugs than alcohol				
No	189 (67)	147 (71)	42 (56)	0.015[b]
Yes	24 (9)	13 (6)	11 (15)	
Missing	69 (25)	47 (23)	22 (29)	
Investigational and legal data				
Suspect interrogated				
No	25 (9)	23 (11)	2 (3)	0.03[b]
Yes	248 (88)	176 (85)	72 (96)	
Missing	9 (3)	8 (4)	1 (1)	
Suspect admits sexual contact				
No	76 (27)	60 (29)	16 (21)	0.09[b]
Yes	166 (59)	113 (54)	53 (71)	
Missing	40 (14)	34 (16)	6 (8)	
Suspect DNA-profile taken				
No	150 (53)	111 (54)	39 (52)	0.27[b]
yes	105 (37)	71 (34)	34 (45)	
missing	27 (10)	25 (12)	2 (3)	
Suspect arrested				
No	188 (67)	137 (66)	51 (68)	1.0[b]
Yes	78 (28)	57 (28)	21 (28)	
Missing	16 (6)	13 (6)	3 (4)	
Prosecution				
Yes	32 (11)	19 (9)	13 (17)	0.06[c]
Dismissal	239 (85)	179 (86)	60 (80)	
Missing	11 (4)	9 (4)	2 (3)	

[a] Chi square, *df* = 2.
[b] Chi square, *df* = 1.
[c] Exact unconditional test.

For victims who had been at the SAC, medical records provided data regarding extragenital and anogenital injuries (the latter included tears, abrasions and bruises (ecchymoses/petecchiae), and reported redness or swelling was excluded),[25] collection of biological trace evidence and results of victims' toxicological analyses.

Police files provided data on investigational issues like interrogations performed and results from these, collection of medical information, including forensic and suspects' toxicological analyses, results from these, and legal outcome. Data from police- and medical records were merged and registered through a web-based data collection system developed and administered by the Unit of Applied Clinical Research at the Norwegian University of Science and Technology. In case of discrepancy between the two data sources information from the police files were preferred.

The study was approved by the Regional Committee for Medical and Health Research Ethics, the Norwegian Director General of Public Prosecutions and the Advisory Board on Secrecy and Research. The merging of data was also approved by the Norwegian Data Inspectorate.

Table 3
SAC medico-legal information, by former suspects of sexual assault or other violent crime. Data only from the Trondheim SAC 2003–2010.

Variable	Total N = 212 n (%)	First-time suspects N = 118 n (%)	Recidivists N = 48 n (%)	Unidentified suspects N = 46 n (%)	*p*-value
Victim medico-legal findings					
Bodily injury (extragenital)					
No	71 (34)	35 (30)	21 (44)	15 (33)	0.2[a]
Yes	126 (59)	73 (62)	24 (50)	29 (63)	
Mising	15 (7)	10 (9)	3 (6)	2 (4)	
Anogenital injury					
No	140 (66)	80 (68)	34 (71)	26 (57)	0.5[a]
Yes	53 (25)	28 (24)	11 (23)	14 (30)	
Missing	19 (9)	10 (9)	3 (6)	6 (13)	
Tox. samples from victim					
No	107 (51)	50 (42)	31 (65)	26 (57)	0.02[a]
Yes	105 (50)	68 (58)	17 (35)	20 (44)	
Tox. results victim					
No tox. agents	31 (15)	22 (19)	7 (15)	2 (4)	0.08[a]
≥1 tox. agent	74 (35)	46 (39)	10 (21)	18 (39)	
Time from assault to med. exam					
<24 h	154 (73)	83 (70)	33 (69)	38 (83)	0.2[a]
≥24 h	57 (27)	34 (29)	15 (31)	8 (17)	
Missing	1 (1)	1 (1)	0 (0)	0 (0)	
Investigational and legal data					
Police requested forensic medical record from SAC					
No	39 (18)	20 (17)	11 (23)	8 (17)	0.9[a]
Yes	103 (49)	57 (48)	24 (50)	22 (48)	
Missing	70 (33)	41 (35)	13 (27)	16 (35)	
Analysis of swabs and/or clothes collected from victim					
No/missing	115 (54)	70 (59)	31 (65)	14 (30)	0.001[a]
Yes	97 (46)	48 (41)	17 (35)	32 (70)	

[a] Chi square, *df* = 2.

2.4. Statistical analysis

We compared suspect-, victim- and assault characteristics, as well as police investigations between the three groups of suspects described above. For the comparisons, Pearson's chi-square and Exact unconditional tests were used as appropriate for the categorical variables, and ANOVA and student's *t*-test for the continuous variables (age). Statistical significance was assumed when $p < 0.05$. Missing data were calculated but excluded when statistical tests were performed. Data analyses were performed using IBM SPSS Statistics for Windows, version 22.0.

3. Results

3.1. Suspect characteristics (Tables 1 and 2)

Among the 356 cases included in the study, 207 were first-time suspects (58%), 75 were recidivists (21%) and 74 were unidentified (21%). The mean age of identified suspects (first-time suspects and recidivists) was 30.4 years (SD = 10.9), ranging from 16 to 84 years. The mean age of unidentified suspects, based on victims' self-reporting, was 29.5 years, ranging from 18 to 58 years. (SD = 8.2).

Among unidentified suspects 35% were reported as non-Western, whereas the corresponding percentages were 27% and 23% among first-time suspects and recidivists ($X^2 = 11.3$, df = 2, p = 0.004) (Table 1).

Among the identified suspects shown in Table 2 the unemployment rate among first-time suspects was 10%, versus 28% among recidivists ($X^2 = 11.1$, df = 1, p = 0.004). One third of the identified suspects had less than 13 years of education, regardless of suspects being first-time suspects or recidivists. However, information was often missing regarding suspect education in the police records. Suspect alcohol consumption prior to the assault was reported by 60% of the first-time

suspects and 53% of the recidivists ($X^2 = 2.8$, df = 1, p = 0.09). Use of other drugs than alcohol in relation to the assault was reported by 6% of the first-time suspects and 15% of the recidivists ($X^2 = 6.4$, df = 1, p = 0.015) (Table 2).

3.2. Victim characteristics (Table 1)

Table 1 also shows victim characteristics by suspect category. Mean age of the victims was 25.3 years (SD = 9.6), ranging from 16 to 72 years. There was an association between first-time suspects and victims in the youngest age category (16–17 years), whereas victims assaulted by recidivists were somewhat older ($X^2 = 12.0$, df = 4, p = 0.02). The victim was of non-Western origin in only 3% of the cases. Most of the victims were employed and/or students (62%). Victim unemployment was more prevalent in cases with a recidivist suspect than in cases with a first-time suspect (27% versus 16%) ($X^2 = 4.6$, df = 2, p = 0.1). In 63% of the cases the victims had consumed alcohol prior to the assault. Victim alcohol consumption was associated with unidentified suspect ($X^2 = 5.4$, df = 4, p = 0.07). Although the percentages of victims who reported having consumed alcohol prior to the assault were about the same in the two groups of identified suspects (first-time suspects and recidivist suspects), there was an association between victim being highly intoxicated by alcohol (consumed > 5 units) and recidivist suspect.

3.3. Assault characteristics (Table 1)

The different assault characteristics by suspect category are shown in Table 1. The victim knew the suspect in almost two thirds of the cases with identified suspect, regardless of whether the suspect was a first-time or a recidivist suspect. Being a first-time suspect was associated with cases where the victim was a casual contact (known < 24 h) while recidivist suspect was associated with partner rape. There was also a higher occurrence of stranger rapes among the group of recidivist suspects than among first-time suspects ($X^2 = 138$, df = 6, p < 0.001). Among the 74 unidentified suspects, 22 were classified as casual contact while 41 were strangers.

Among the identified suspects 210 (75%) were accused of a penetrative assault, whereas penetration was reported in only 39 (53%) of the unidentified suspects, ($X^2 = 10.2$, df = 2, p = 0.006). The victims of recidivists more often reported to be exposed to physical violence than victims of first-time suspects (83% versus 68%) ($X^2 = 12.6$, df = 4, p = 0.01). Unidentified suspect was associated with a public venue, while three of four assaults committed by identified suspects occurred in a private place ($X^2 = 52$, df = 2, p < 0.001).

3.4. Victim injury and laboratory findings (SAC information, Table 3)

SAC information by suspect category is shown in Table 3. Among those victims who had been examined at the SAC, extragenital injury was registered in 59%, while anogenital injury was disclosed in 25% of the victims. There was no significant association between injury and suspect category. Half of the victims who attended the SAC had a toxicological blood sample collected; in 58% of victims of first-time suspects, in 35% of victims of recidivists and in 44% of victims of unidentified suspect ($X^2 = 7.6$, df = 2, p = 0.02). Samples disclosed ≥1 toxicological agent in 39% of victims of first-time suspects, in 21% of victims of recidivists and in 39% of victims of unidentified suspects ($X^2 = 5.0$, df = 2, p = 0.08). Around 70% of the victims at the SAC were examined within 24 h after the assault when the suspect was identified, this in contrast to when the suspect was unidentified where 83% of the victims came within 24 h ($X^2 = 2.8$, df = 2, p = 0.24).

3.5. Investigational and legal data (Tables 1–3)

The police requested a forensic medical record from the SAC in half of the cases in which victims had been medically examined, and there were no differences between the groups of suspects regarding that variable (Table 3). Analysis of swabs and/or clothes collected from victims was conducted in 46% of the cases; in 70% of cases with unidentified suspect, whereas only in 41% and 35% of first-time suspect cases and recidivist cases, respectively (X2 = 13.8, df = 2, p = 0.001) (Table 3).

Nearly all victims were interrogated by the police, but in cases where suspect was identified, the police interrogated other witnesses than the victim more often than in cases where suspect was unidentified (75% vs. 61%) ($X^2 = 5.1$, df = 2, p = 0.08) (Table 1). Interrogations of suspects were conducted in a significantly higher proportion of recidivists than among first-time suspects (96 vs. 85%, $X^2 = 5.1$, df = 1, p = 0.03) (Table 2). Among recidivists, 71% admitted sexual contact with the victim, whereas 54% of the first-time suspects admitted sexual contact ($X^2 = 3.0$, df = 1, p = 0.09) (Table 2). Only 2% of the suspects admitted rape or culpability and there were no differences in the groups of suspects regarding these two variables.

A DNA profile of the suspect was secured during investigations in somewhat more of the recidivist cases than in the first-time suspect cases ($X^2 = 1.2$, df = 1, p = 0.27) (Table 2). In 42% of the cases the police investigated the venue (Table 1).

During investigations, 28% of the identified suspects were arrested regardless of group of suspects involved (Table 2). Prosecution happened in 32 cases and was associated with recidivist suspects, of which 17% of the cases were prosecuted in court, whereas only 9% of the first-time suspect cases were prosecuted (Exact unconditional test, p = 0.06) (Table 2). A medical doctor from the SAC was summoned as an expert witness in only five of the 32 cases.

4. Discussion

In this study of police reported rape suspects, 207 of 356 were first-time suspects (58%), 75 were recidivists (21%) of prior sexual or violent crime, and 74 were unidentified suspects (21%). We found that the mean age of identified suspects was 30.4 years. The mean age of unidentified suspects, which was based on self-reporting from victims, was 29.5 years. This corresponds with findings reported by the OPD, that the mean age of offenders has been approximately 30 years throughout the decade 2000–2010.[13] The mean age of victims was 25.3 years. In a Danish study which also included merged data from police files and a SAC, victim mean age was 26 years.[4]

We found that first-time suspects reported higher alcohol intake prior to the assault compared to recidivists. Their corresponding victims were also often <18 years and an acquaintance. Being a first-time suspect was associated with victims reporting less physical violence than in cases of recidivists and unidentified suspects. These findings disclose a pattern of assault characteristics that are often seen in what the Norwegian police categorizes as *party-related rapes*. According to the OPD this category of rapes typically occurs when young people participate in parties or social events as part of the weekend night life, where alcohol, and often large amounts of it, is involved.[13] Our finding of association between first-time suspect and high alcohol intake in suspect is consistent with the OPD report, which describes that the group of offenders involved in *party-related rapes*, often has no prior criminal record.[13] In Norway, episodic heavy drinking is common and to a certain degree accepted in social settings, regardless of gender. Out of this we might consider that a possible consequence of this "Nordic pattern of drinking" could be the effect of disclaiming from responsibility of what happens under the influence of alcohol. Attitudes like these may contribute to trivializing the seriousness of sexual assaults happening in such settings, and maybe even partly explain why the police seem to put less investigational effort in first-time suspect cases compared with recidivist cases. Our findings of lower prosecution rates in this group compared to the recidivists is supported by a criminologist, describing that suspects who have a criminal record tend to get a

higher priority in criminal investigations than those who do not.[26] Hypothetically an explanation could be that police officers may experience more stress or discomfort when initiating full investigations of suspects who do not have a criminal record, compared with investigating men who are already registered as criminals. As mentioned earlier, there is research describing preconceived attitudes in society towards both victims and assailants of sexual offences, which can contribute to explaining how law enforcement prioritize when investigating sex crimes.[3,19] Literature is, however, sparse on this topic and more research is needed.

We found that recidivist suspect was associated with suspect and victim unemployment, lower suspect education, and suspect reporting intake of other drugs than alcohol. Our findings indicate that both recidivists and their victims seem to represent relatively vulnerable populations in the society. Compared to first-time suspects, the recidivists more often were accused of partner rape and the use of physical violence. Many studies describe stranger rapes as the more violent category when compared to rapes committed by known assailants, but one study from a Swedish SAC showed that women assaulted by their intimate partners were even more exposed to physical violence than women assaulted by strangers and acquaintances.[27] One interesting finding in our study was that while 25% of the recidivist suspects were categorized as partners, 11% were reported as strangers, both categories far more common than among the first-time suspects. This is supported by a research group from Finland which showed that a considerable proportion of men who commit attack rapes are, or have been, in a steady intimate relationship for a long time.[28] Based on this a researcher has questioned whether it is likely that some cases of partner- and stranger rapes might have been committed by the same perpetrator.[10] Based on our findings, we can even ask whether it is possible that some men who are in intimate relationships, occasionally attack not only their partner/spouse, but also other random women. Previous research has shown that crossover-offending is common among sex offenders, meaning that many admit to multiple victims and offences atypical of traditional criminal classification. This verifies that the theories of sex offender typologies are complex and have limitations.[5]

Our results show that the police have been somewhat more thorough in their investigational work regarding recidivist suspects than in cases of first-time suspects. Interrogations of suspects were more often done, a DNA-profile was more often secured, and the venue was more often investigated in the recidivist cases. Almost none of the suspects, regardless of group, admitted rape, but recidivist suspects more often admitted sexual contact with the victim, and recidivist cases also more often ended with prosecution. In most societies a small group of people commit a large proportion of the crimes, the so-called “acquaintances of the police”.[26] A Norwegian researcher has analyzed how law enforcement systematically follows and goes after citizens who habitually violate the law. She describes and justifies the police's close follow-up and sheds light on how priorities are made in crime investigations in general. In accordance with our findings, she explains why police investigations seem to be of higher quality in the cases of recidivist rape suspects compared with the two other groups of suspects. This phenomenon could also justify the higher prosecution rate in recidivist rape cases in our study. It is important to communicate this finding to the public for the purpose of helping victims of possible recidivist sexual assailants realize that police reporting has a relatively larger potential of bringing their assailants to court. More research is needed to confirm our findings regarding various degrees of police investigational efforts in separate groups of sexual assailants. As expected, most of the suspects registered as unidentified were either a stranger to the victim or a casual contact (known < 24 h). Cases with unidentified suspect was associated with non-Western suspect, high victim alcohol consumption prior to assault, a public venue. This category of rapes draws a picture of relatively dramatic and frightening assaults. Previous research has concluded that sexual assault against young women who are too intoxicated to resist, due to heavy episodic drinking, is a prevalent problem in Norway.[29] Although most victims in the total sample reported alcohol intake prior to the assault (63%), there was a significant association between unidentified suspect and victim alcohol consumption (71%). It seems that unidentified assailants are exploiting women who are incapacitated by alcohol. A study from the U.S. about unidentified sexual assailants supports our findings, describing that exploitation of the victim's intoxication is a commonly used means of coercion.[30] The association between unidentified suspect and the use of physical violence was extracted not only from victim interrogations, but also supported from SAC medical data, disclosing high percentages of both extragenital and anogenital injury.

Victims of unidentified suspects also tended to seek help at the SAC relatively shortly after the incidence, which may be explained through the physically and psychologically traumatizing nature of these assaults. It can also partly be explained through a British study showing that the threshold for seeking help and police-reporting a rape is lower when the suspect is a stranger to the victim.[31] Analysis of swabs and/or clothes collected from the victim was done significantly more often in cases where suspect was unidentified than in cases of identified suspects, which also presumably has to do with the higher percentage of these victims being medically examined within 24 h after the rape incident. Despite these analyses we ended up with a rather large group of unidentified suspects. However, the collected and stored DNA from unidentified males could be valuable evidence in future investigations. The unidentified suspects were also more often suspected of *attempt of rape* rather than *rape*, and penetration was less often reported, which is consistent with previous research concluding that stranger rapists seldom manage to complete the rape with penetration and ejaculation.[12]

We found an association between unidentified suspect and non-Western suspect. The OPD has showed an increasing occurrence of suspects of non-Norwegian/non-European origin in the period 2000–2010.[13] Correspondingly, men of non-European origin committed most of the so-called attack rapes, in which the assailant was unidentified. The numbers were, however, too small to constitute statistically significant results on that matter.[13] There is little research on how or why a foreign descent or a background from a different culture is connected to rape, and explanations to this could to our knowledge only be based on speculation.[12] We can, however, assume that persons who originate from foreign countries may have a more difficult social situation in Norway than ethnic Norwegians. Rapes reported to the police probably only account for 10% of the total amount of sexual coercions happening in the society.[32] The OPD claims that dark-skinned Norwegians could wrongly be classified by the victim of attack rape as non-Western, and Non-Western men are more likely to be police-reported than rapists of Norwegian/Western origin.[12,13] The OPD report underlines that the emphasis on rapists of non-Norwegian/non-European origin results from a strong focus on this topic in the media in recent years.[13] It is important that future research aims at looking behind the surface of the immigrant over-representation of sexual offenders, in search for nuanced and diverse explanations, which can contribute to diminish rather than increase stereotypical misconceptions.

4.1. Limitations

A limitation of the study is that data were collected retrospectively and partly by self-reporting. It is likely that some information about for example threats or physical violence has been lost as amnesia due to intoxication and/or psychological stress is common among rape victims. Unfortunately, for some of the variables from both data sources, there is a considerable amount of missing information. The information regarding police investigations are limited in this study, us not being allowed to look into police logs or notes, only to the official police records (BL). Especially disappointing was that education and employment data of identified suspects were not available in the records.

This could have given us a better picture of the suspects.

Our data represent only one of the 27 police districts in Norway, which limits the national generalizability of the findings. There is no reason to believe that the suspect pool in rape and attempted rape looks very different in the 27 police districts. For some of the variables, however, for example the representation of suspects with a non-Western origin, differences could be expected between urban and rural populations. In our study only 21% were recidivists, this in contrast to what has been found in a Danish study which reported up to two thirds.[3] This could partly be explained by us only being allowed to collect criminal register data from the STPD, and did not have access to the national register of accused offending. Estimates of recidivism rates is complicated partly due to the problem of under-reporting, and the U.S. Department of Justice concluded in 2015 that there is universal agreement in the scientific community that the observed recidivism rates of sex offenders are underestimates of actual reoffending.[5] This indicates that the percentage of recidivists among the reported suspects in our study may also be too low. It is reasonable to believe that many cases of first-time assailants are not reported to the police.

The analyses regarding police investigations are limited in this study, and some of our statements may be interpreted as discredit towards law enforcement and their investigational approach in cases of sexual assault. We are aware that judicial and investigational processes are extremely complex and demanding in this field, and that priorities made by the police are often a question of finances.

Finally, like most research regarding rape, this study lacks suspect information from all the cases that are never reported. Unreported adult male rapists constitute a large population and we have no knowledge on how they differ from assailants who are reported. Strengths of the study are the large number of variables, the long observation period of 7½ years and a relatively large sample. The merging of data from police files and corresponding SAC records is unique by enriching the variety of data available, especially regarding victim sociodemographic data, injuries and biological trace evidence. It also provides important insight in the impact of forensic evidence collected at a SAC, on the investigation of sexual assault cases.

4.2. Conclusions

Comparing separate groups of sexual assault suspects based on assault characteristics, has disclosed some obvious patterns of differences between the groups, which can provide valuable information for future prevention programs, police investigation strategies, health care guidelines and for new research projects. The recidivist suspects appear to represent a generally more vulnerable group than the first-time suspects, in our detection of a high unemployment rate and a possible drug abuse problem. The police seem to be more thorough in their investigations of recidivist suspects than in the other two groups of suspects, and recidivist suspect cases more often end with prosecution. This seems unfair, considering that the others may be just as guilty. The low reporting rates of sexual assault imply that most assaults go unrecorded. It is important to report sexual assault to the police and to health care. When more of these crimes are publicly reported, more cases will possibly be taken to court if investigated thoroughly. This will send a clear message to victims that reporting leads to more prosecution and conviction. It will also send a message to potential assailants, that rape is taken seriously, and that the risk of getting caught is increasing.

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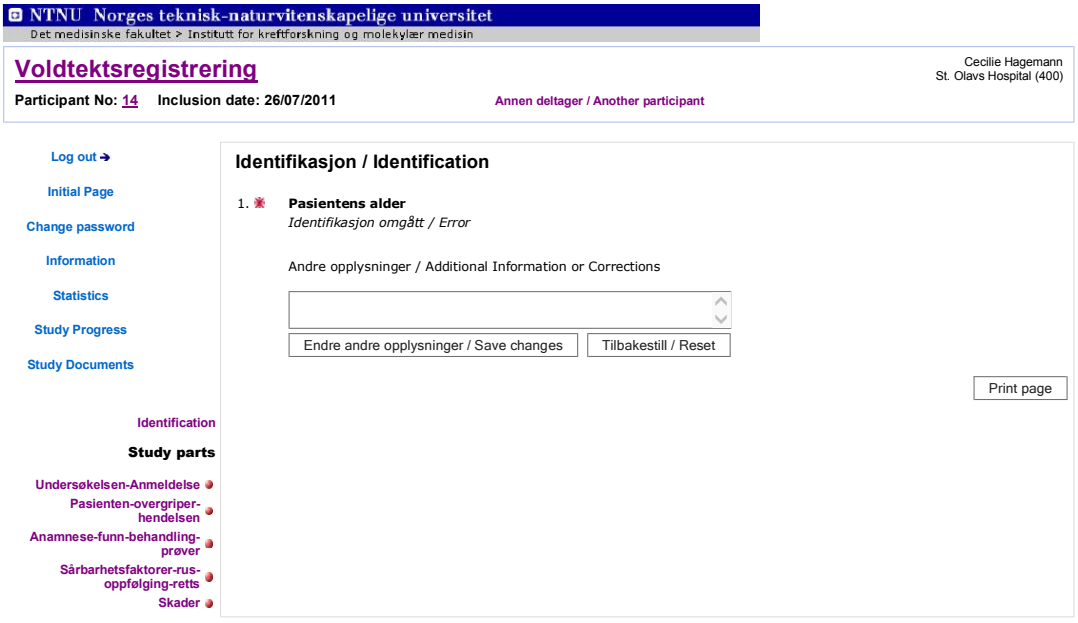
Appendix 1



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Det medisinske fakultet > Institutt for kreftforskning og molekylær medisin

Voldtektsregistrering

Cecilie Hagemann
St. Olavs Hospital (400)

Participant No: 14 **Inclusion date:** 26/07/2011 Annen deltager / Another participant

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Study Progress
Study Documents
Vis svarhistorikk / View log
Identification
Study parts
Undersøkelsen-Anmeldelse
Pasienten-overgriper-hendelsen
Anamnese-funn-behandling-prøver
Sårbarhetsfaktorer-rus-oppfølging-retts
Skader

Undersøkelsen-Anmeldelse

Om undersøkelsen – henvisning

1. * Dato for førstegangsundersøkelse(dd/mm/åååå)

2. * Tid på dagen for undersøkelsen Vanlig arbeidstid?
- ○ Nei
- ○ Ja
- ○ Uopplyst

3. * Tid som er gått etter hendelsen
- ○ Under 24 timer
- ○ Under en uke
- ○ Under en måned
- ○ Under ½ år
- ○ Under 1 år
- ○ Over 1 år
- ○ Under 72 timer
- ○ Uopplyst

4. Antall timer fra avlutning av overgrep til undersøkelsen, dersom under 72 timer

5. * Hvem var til stede ved undersøkelsen?
- ○ Bare lege(r)
- ○ Bare sykepleier
- ○ Begge
- ○ Uopplyst

6. Hvor var pas. henvist fra?
- ☐ Tok kontakt direkte
- ☐ Politi
- ☐ Lege
- ☐ Sosialkontor
- ☐ Krisesenterr
- ☐ Helsesøster
- ☐ Annet
- ☐ Uopplyst

7. Hvis henvist fra annet, hva?

8. I følge med hvem?
- ☐ Ingen ledsager
- ☐ Venn/venninne
- ☐ Foreldre
- ☐ Partner
- ☐ Helsearbeider
- ☐ Søsken
- ☐ Annet
- ☐ Uopplyst

9. Hvis annet, spesifiser

Anmeldelse og rettslig utfall

10. * Har pas. anmeldt saken (evt. opplysn. om senere anmeldelse)?
- ○ Anmeldt før u.s.
- ○ Anmeldt etter u.s. *
- ○ Anmeldt senere **
- ○ Ikke anmeldt
- ○ Annet
- ○ Uopplyst

*Rett etter us. **Senere enn i den akutte situasjonen

Save

11. Hvis annet, spesifiser

12. * Sakens gang
- ☐ Ikke anmeldt

- [ ] Saken henlagt, ukjent mistenkt
- [ ] Saken henlagt av andre årsaker (bevisets stilling)
- [ ] Etterforskn.pågår
- [ ] Tiltalt, gj.mann frifunnet
- [ ] Tiltalt, gj.mann dømt (ang. mndr. under)
- [ ] Voldsofferersatning idømt
- [ ] Annet
- [ ] Uopplyst

13. Hvis tiltalte dømt, antall mnd.

14. Hvis annet, spesifiser

15. * Hvor er forholdet anmeldt?

- [ ] Ikke anmeldt
- [ ] Trondheim politikammer
- [ ] Sør-Trøndelag politidistrikt
- [ ] Nord-Trøndelag politidistrikt
- [ ] Annet i Norge
- [ ] Annet land i Norden
- [ ] Utenfor Norden
- [ ] Uopplyst

16. Politiets anmeldelsesnummer

17. Dato anmeldt

18. * Dato for ankomst (dd:mm:åååå)

19. * Klokkeslett for ankomst (tt:mm)

20. * Klokkeslett for førstegangsundersøkelse (tt:mm)

Save

Andre opplysninger / Additional Information or Corrections

Lagre svar / Save and view log | Tilbakestill skjema / Reset

Vis svarhistorikk / View log | Print page

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Skader

Pasienten-overgriper-hendelsen

Opplysninger om kvinnen/mannen (pasienten)

1. * Fødselsår

2. * Kjønn
   - ○ Mann
   - ○ Kvinne
   - ○ Uopplyst

3. * Bostedsadresse
   - ○ Trondheim by
   - ○ Sør-Trøndelag utenom byen
   - ○ Utenfor fylket
   - ○ Utenfor landet
   - ○ Uopplyst

4. * Er pas. i arbeid utenfor hjemmet?
   - ○ Nei
   - ○ Ja
   - ○ Uopplyst

5. Hvis nei
   - ☐ Husmor
   - ☐ Skoleelev
   - ☐ Student
   - ☐ Stønad
   - ☐ Arbeidsledig
   - ☐ Annet, spesifiser under
   - ☐ Uopplyst

6. Annet, spesifiser

7. Hvis ja, type arbeid

8. * Hvilken utdannelse har pas.
   - ○ Mindre enn 9 år
   - ○ 9 – 12 år
   - ○ Høyskole
   - ○ Universitet
   - ○ Uopplyst

9. * Sivilstand nå
   - ○ ikke flyttet hjemmefra
   - ○ Aleneboende
   - ○ Samboende
   - ○ Gift
   - ○ Separert
   - ○ Skilt
   - ○ Annet
   - ○ Uopplyst

10. Hvis annet, angi

Save

11. * Sivilstand tidligere
   - ○ Samboende
   - ○ Gift
   - ○ Separert
   - ○ Annet
   - ○ Uopplyst

12. * Antall barn

13. * Antall svangerskap

14. * Etnisitet
   - ○ Norsk

- ○ Annet
- ○ Ikke norsk, vestlig
- ○ Ikke norsk, ikke vestlig
- ○ Uopplyst

15. Annet, spesifiser:

Overgriper(e)

16. Hvis flere overgripere, antall:

Opplysninger føres på overgriper I & II & III etter hvem som er viktigst

17. * Kjønn overgriper I
- ○ Mann
- ○ Kvinne
- ○ Uopplyst

18. Kjønn overgriper II
- ○ Uopplyst
- ○ Mann
- ○ Kvinne

19. Kjønn overgriper III
- ○ Uopplyst
- ○ Mann
- ○ Kvinne

20. * Alder overgriper I

(ca., antall år)

Save

21. Alder overgriper II

22. Alder overgriper III

23. * Etnisitet overgriper I
- ○ Norsk
- ○ Annet
- ○ Ikke norsk, vestlig
- ○ Ikke norsk, ikke vestlig
- ○ Uopplyst

24. Annen etnisitet, spesifiser

25. Etnisitet overgriper II
- ○ Norsk
- ○ Annet
- ○ Ikke norsk, vestlig
- ○ Ikke norsk, ikke vestlig
- ○ Uopplyst

26. Annen etnisitet, spesifiser

27. Etnisitet overgriper III
- ○ Norsk
- ○ Annet
- ○ Ikke norsk, vestlig
- ○ Ikke norsk, ikke vestlig
- ○ Uopplyst

28. Annen etnisitet, spesifiser

29. Relasjon til pas. familie/partner overgriper I
- ○ Far/stefar
- ○ Mor/stemor
- ○ Søsken*
- ○ Bestefar/-mor
- ○ Onkel/tante/søskenbarn
- ○ Annen slekt**
- ○ Ektemann/samboer
- ○ Tidligere ektemann
- ○ Kjæreste
- ○ Uoppl. familie/partner

* Bror, stebror, søster, stesøster, ** Sønn, datter

30. Relasjon til pas. familie/partner overgriper II

- ○ Kjæreste
- ○ Far/stefar
- ○ Mor/stemor
- ○ Søsken
- ○ Bestefar/-mor
- ○ Onkel/tante/søskenbarn
- ○ Annen slekt
- ○ Ektemann/samboer
- ○ Tidligere ektemann
- ○ Uoppl. familie/partner

Save

31. Relasjon til pas. familie/partner overgriper III

- ○ Kjæreste
- ○ Far/stefar
- ○ Mor/stemor
- ○ Søsken
- ○ Bestefar/-mor
- ○ Onkel/tante/søskenbarn
- ○ Annen slekt
- ○ Ektemann/samboer
- ○ Tidligere ektemann
- ○ Uoppl. familie/partner

32. Relasjon UTENOM familie/partner overgriper I

- ○ Venn/bekjent*
- ○ Ukjent fra før/tilfeldig**
- ○ Fremmede***
- ○ Autoritetsperson, spesifiser under****
- ○ Internett-kontakt
- ○ Annet, spesifiser under
- ○ Uopplyst

* Arbeidskamerat, skole/studie-kamerat, ** Møtt innenfor de siste 24 timer, *** Aldri sett før, **** Lærer, sjef, behandler, pleier, offentlig person (politi mm), taxisjåfør mm

33. Relasjon UTENOM familie/partner overgriper II

- ○ Venn/bekjent
- ○ Ukjent fra før/tilfeldig
- ○ Fremmede
- ○ Autoritetsperson, spesifiser under
- ○ Internett-kontakt
- ○ Annet, spesifiser under
- ○ Uopplyst

34. Relasjon UTENOM familie/partner overgriper III

- ○ Venn/bekjent
- ○ Ukjent fra før/tilfeldig
- ○ Fremmede
- ○ Autoritetsperson, spesifiser under
- ○ Internett-kontakt
- ○ Annet, spesifiser under
- ○ Uopplyst

35. Spesifiser autoritetsperson eller annet for alle overgriperne

Max 255 characters. [ ] remaining.

36. * Tid for overgrepet

- ○ Kl 7-20
- ○ Kl 20-24
- ○ Kl 0-7
- ○ Uopplyst

37. Tid på døgnet for overgrepet, start-tidspkt. Dato (dd.mm.åååå)

38. Tid på døgnet for overgrepet, start-tidspkt. Klokkeslett (tt:mm)

39. Tid på døgnet for overgrepet, stopp-tidspkt. Dato (dd.mm.åååå)

40. Tid på døgnet for overgrepet, stopp-tidspkt. Klokkeslett (tt:mm)

Save

41. Varighet av overgrepet (Ca antall minutter)

Hendelsen

42. Hvor skjedde det?
- ○ Hjemme hos pasienten
- ○ Hjemme hos overgriper
- ○ Annet privat sted
- ○ Offentlig lokale, Spesifiser
- ○ Utendørs, Spesifiser
- ○ Transportmiddel, Spesifiser
- ○ Pasienten husker ikke
- ○ Uopplyst

43. Spesifiser åsted

Max 255 characters. remaining.

44. Hvor alvorlig var den fysiske volden?
- ☐ Ingen
- ☐ Trussel om vold
- ☐ Trussel om hevn, spesifiser
- ☐ Mildere*
- ☐ Halsgrep
- ☐ Moderat**
- ☐ Grovere vold
- ☐ Bruk av våpen
- ☐ Pasienten husker ikke
- ☐ Pasienten hindret i å komme seg unna
- ☐ Tvungen abduksjon av beina
- ☐ Annet, Spesifiser
- ☐ Uopplyst

* Holdt fast, ** Slag, spark

45. Spesifiser hevn og/eller annet:

46. Seksuell handling (Rangeres etter den alvorligste.)
- ☐ Ingen
- ☐ Usikker/uopplyst
- ☐ Beføling kropp*
- ☐ Beføling kjønnsorgan**
- ☐ Forsøk inntrengning***
- ☐ Vaginal inntrengning****
- ☐ Anal inntrengning****
- ☐ Oral inntrengning****
- ☐ Tvunget til å suge/onanere overgriper
- ☐ Fremmedlegeme
- ☐ Annet
- ☐ Pasienten husker ikke

* Inkl. bryst, ** Inkl. finger i skjeden, ***Vaginalt, analt, oralt, **** Av penis, femmedlegeme, ikke fingre

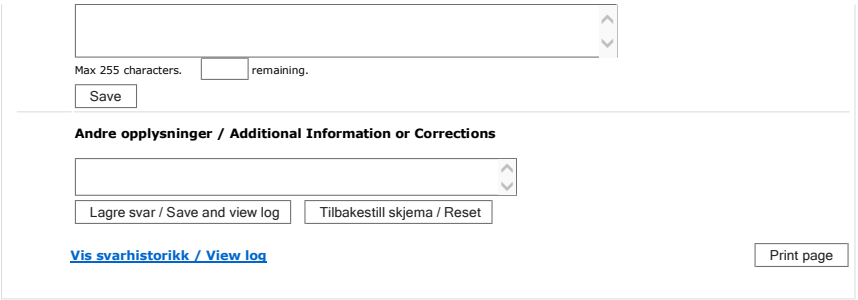
47. Spesifiser evt annet og/eller fremmedlegeme

Max 255 characters. remaining.

48. Sædavgang
- ☐ Nei
- ☐ Usikkert
- ☐ Vaginalt
- ☐ Oralt
- ☐ Analt
- ☐ Annet sted på kroppen
- ☐ På klær/sengetøy
- ☐ Andre steder
- ☐ Uopplyst

49. Kondom benyttet?
- ○ Nei
- ○ Ja
- ○ Pasienten vet det ikke
- ○ Annet
- ○ Uopplyst

50. Annet:



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Skader

Anamnese-funn-behandling-prøver

Seksuell anamnese / graviditet

1. * Graviditet i forb med overgrep
   - ☐ Aldri vært gravid
   - ☐ Gravid før, ikke nå
   - ☐ Gravid ved overgrepet, hvis ja, noter antall uker under
   - ☐ Gravid som følge av SO
   - ☐ Gravi-test neg (0-prøve)
   - ☐ Gravitest pos (0-prøve)
   - ☐ Ikke tatt gravitest (0-prøve)
   - ☐ Uopplyst
2. Antall uker
3. Hvis gravid som følge av overgrep
   - ☐ Svangerskapsavbrudd
   - ☐ Fostervannsprøve
   - ☐ Fødsel
   - ☐ Annet
   - ☐ Uopplyst
4. Hvis annet, angi her:
5. Seksuell debut/virgo
   - ○ Debut ved aktuelle SO
   - ○ Debutert før aktuelle hendelse, angi evt alder under
   - ○ Nei
   - ○ Annet
   - ○ Uopplyst
6. Angi evt alder v debut
7. * Siste frivillige samleie
   - ○ Debut ved aktuelle SO
   - ○ For < 72 timer siden
   - ○ 3-7 døgn siden
   - ○ 7-14 døgn siden
   - ○ > 14 døgn siden
   - ○ Uopplyst
8. Tidl fysiske /seksuelle overgrep (SO)
   - ☐ Aldri
   - ☐ SO i barndommen*
   - ☐ SO v/partner
   - ☐ Annet, angi under
   - ☐ Fys. overgrep barndom
   - ☐ Fysiske overgrep, annet
   - ☐ Fys. overgr. partner
   - ☐ SO ukjent overgr.
   - ☐ SO (ikke partner)
   - ☐ Uopplyst
   - ☐ SO 12-16 år
   - ☐ SO > 16 år
   - ☐ SO annet

   * Barndommen vil si < 12 år
9. Angi evt annet SO/ fysiske overgrep
10. * Prevensjon, nå
    - ☐ Ingen
    - ☐ Kondom
    - ☐ P-piller/p-plaster/ring
    - ☐ Spiral
    - ☐ P-sprøyte/ p-stav
    - ☐ Sterilisert/ hysterectomert

☐ Annet
☐ Uopplyst

Save

11. Angi evt. annet

Funn ved undersøkelsen
(Se ellers tilleggsvariabler til slutt (Var 60 - 65) ang rus-påvirkning, og mer detaljer om kroppslige (Var 78 – 81) og anogenitale (Var 68 – 77) skadefunn. Hvis anogenitale skadefunn, fyll ut tabellen på side 20)

12. ✱ Psykiske reaksjoner ved undersøkelsestidspunktet (alvorligste)

○ Ingen ved undersøkelsen
○ Moderate psykiske reaksjoner*
○ Alvorlige psykiske reaksjoner**
○ Vanskelig å vurdere
○ Annet, angi under
○ Uopplyst

* Gråt, innesluttethet, lett angst, sinne eller verbal aggresjon, ** Alvorlig angstm tilbaketrukkenhet, bevissthetsinnsnevring, desorientering, fortvilelse/håpløshet, hyperaktivitet, ubehersket eller overdreven sorgreaksjon

13. Angi evt annet

14. ✱ Fysiske skader på kroppen utenom genitalia

☐ Ingen
☐ Lette, blåflekker, skrubbsår etc
☐ Moderate: sår, kutt* etc.
☐ Alvorlige: brudd, mistanke om indre skader
☐ Merker etter halsgrep
☐ Skjæresår
☐ Uopplyst
☐ Kroppslig us ikke gjort

* Her menes ikke skjæresår

15. Fysiske skader på kroppen utenom genitalia (alvorligste skader)

○ Ingen skade
○ Mild skade: Rødhet, hevelse, blåmerker, overflatisk hudavskrap, overflatiske rifter, sugemerker (uansett lokalisasjon)
○ Moderate skade: Hevelse eller blålig misfarging i hoderegionen (inkl. "blåveis" rundt øyet og hevelse over nesen) som man kan forvente gir betydelig hodepine i etterkant), stikkmerker, bitemerker, lacerasjoner som krever suturering eller plastring.
○ Alvorlig skade: brudd, mistanke om indre skader, merker etter halsgrep, knivrisp (selv om det ikke trengs å sys)
○ Uopplyst
○ Kroppslig us ikke gjort

16. Beskriv fysiske skader med ord

Max 255 characters. remaining.

17. Fysiske skader forts:

Max 255 characters. remaining.

18. Gynekologiske funn

☐ Ingen forandringer
☐ Lokal rødme, hevelse
☐ Rifter, overflatesår
☐ Større skade
☐ Annen skade
☐ Annen sykdom
☐ Uopplyst

19. Beskriv gynekologiske funn med ord

Max 255 characters. remaining.

20. Gynekologiske funn forts.

Max 255 characters. remaining.

Save

Behandling

21. Forordninger ved undersøkelsen

☐ Ingen

- ☐ Nødprevensjon
- ☐ Antibiotika mot PID*
- ☐ Beroligende
- ☐ Sovemedisin
- ☐ Smertestillende
- ☐ Xylokain salve
- ☐ Kvalmestillende
- ☐ Har allerede tatt nødprev.
- ☐ Tetanusvaksine
- ☐ Hepatitt B- vaksine
- ☐ HIV postexpo. profyl.
- ☐ Annet, spesifiser under
- ☐ Uopplyst

* Pelvic inflammatory disease, som regel Azitromax gitt

22. Angi evt. annet

23. Sykmelding
- ○ Ingen, ikke i arbeid
- ○ Ingen, trenger ikke
- ○ Ja, angi uker under
- ○ Uopplyst

24. Angi evt antall uker

25. Henvist til videre oppfølging
- ☐ Gyn pol
- ☐ Fastlege
- ☐ Sosialkontor
- ☐ Barneklinikken
- ☐ Psykolog/psykiater
- ☐ BUP
- ☐ PP-tjeneste
- ☐ Ikke henvist
- ☐ Studenthelsetjenesten
- ☐ Annet overgrepsmottak
- ☐ Innlagt somatisk sykehus (i forlengelse av 1. kontakt)
- ☐ Innlagt psykiatrisk sykehus (i forlengelse av 1. kontakt)
- ☐ Annet, spesifiser under
- ☐ Uopplyst

26. Angi evt. annet

Kliniske prøver tatt / prøvesvar

27. Bakteriologi Klamydia (prøve tatt)
- ☐ Skjede
- ☐ Livmorhalskanal
- ☐ Endetarmsåpning
- ☐ Munn
- ☐ Urin/urethra
- ☐ Annet
- ☐ Uopplyst

28. Annet, spesifiser

29. Bakteriologi Gc (prøve tatt)
- ☐ Skjede
- ☐ Livmorhalskanal
- ☐ Endetarmsåpning
- ☐ Munn
- ☐ Annet
- ☐ Uopplyst

30. Annet, spesifiser

Save

31. Annen bakteriologisk prøve tatt
- ☐ Ingen annen prøve tatt
- ☐ Vanlig baktus fra livmorhals/skjede
- ☐ Urin dyrkning
- ☐ Annet
- ☐ Uopplyst

32. Annet, spesifiser

33. Sædcelleprøve (børste*) (prøve tatt)
- ☐ Ikke tatt
- ☐ Skjede
- ☐ Livmorhalskanal
- ☐ Annet
- ☐ Uopplyst

* Børsteprøve brukt vanligvis fra 2008, før dette bruk av "rødt strå"

34. Annet, spesifiser

35. Toksikologi (prøve tatt)
- ☐ Ikke tatt
- ☐ Blod
- ☐ Urin
- ☐ Annet
- ☐ Uopplyst

36. Annet, spesifiser

37. Gravitest (prøve tatt)
- ☐ Ikke tatt
- ☐ Blod
- ☐ Urin
- ☐ Annet
- ☐ Uopplyst

38. Annet, spesifiser

39. Serologi (blodprøve) (prøve tatt)
- ☐ Ikke tatt
- ☐ Hiv
- ☐ Hepatitt B
- ☐ Hepatitt C
- ☐ Syfilis
- ☐ Herpes simplex
- ☐ Annet
- ☐ Uopplyst

40. Annet, spesifiser:

Save

41. * Mikroskopi mhp sæd (prøvesvar)
- ☐ Ingen sædceller påvist
- ☐ Ikke aktuelt
- ☐ Sædceller påvist
- ☐ Prøve tatt fra cervix
- ☐ Prøve tatt fra skjede
- ☐ Uopplyst

42. Positivt svar PCR/Dyrkning (0-prøve)
- ☐ Ikke tatt
- ☐ Ingen infeksjon
- ☐ Gardnerella
- ☐ Herpes simplex
- ☐ Anogenitale vorter
- ☐ Klam. fra livmorhalskanal/skjede
- ☐ Klam. urin
- ☐ Klam. anus
- ☐ Klam. munn
- ☐ Gc-prøve fra livmorhalskanal/skjede
- ☐ Gc urethra
- ☐ Gc anus
- ☐ Gc munn
- ☐ Urindyrking (urinveisinfeksjon)
- ☐ Candida
- ☐ Trichonomas
- ☐ Annet, spesifiser under
- ☐ Uopplyst

43. Spesifiser annet

44. Positivt svar PCR/Dyrkning (senere prøve)

- ☐ Ikke tatt
- ☐ Ingen infeksjon
- ☐ Gardnerella
- ☐ Herpes simplex
- ☐ Anogenitale vorter
- ☐ Klam. livmorhalskanal/ skjede
- ☐ Klam. urin
- ☐ Klam. anus
- ☐ Klam. munn
- ☐ Gc livmorhalskanal/ skjede
- ☐ Gc urethra
- ☐ Gc anus
- ☐ Gc munn
- ☐ Urindyrking (urinveisinfeksjon)
- ☐ Candida
- ☐ Trichonomas
- ☐ Annet, spesifiser under
- ☐ Uopplyst

Kryss ved positivt svar

45. Spesifiser annet

46. Positive prøvesvar (0-prøve)

- ☐ 0-prøve ikke tatt
- ☐ Ingen positive prøvesvar
- ☐ Hepatitt B
- ☐ Hepatitt C
- ☐ HIV
- ☐ Herpes simplex antist
- ☐ Syfilis
- ☐ Annet, spesifiser
- ☐ Uopplyst

47. Spesifiser annet

48. Positive prøvesvar (senere prøve)

- ☐ Ingen senere prøve tatt
- ☐ Ingen positive prøvesvar
- ☐ Hepatitt B
- ☐ hepatitt Bs antistoff lavt titer (<100 IU/l)
- ☐ Hepatitt Bs antistoff høyt titer (immun) (>100 IU/l)
- ☐ Hepatitt C
- ☐ HIV
- ☐ Syfilis
- ☐ Herpes simplex antist
- ☐ Annet, spesifiser
- ☐ Uopplyst

49. Spesifiser annet

Sporprøver

50. Sporprøver tatt

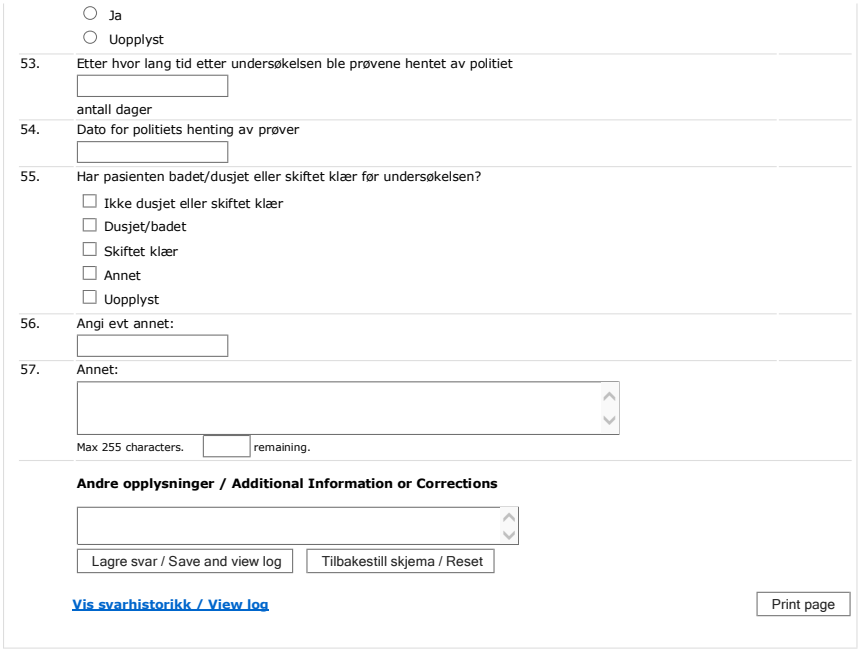
- ☐ Ingen sporprøver tatt
- ☐ Prøve tatt fra ytre kjønnsorgan
- ☐ Prøve tatt fra ytre skjede
- ☐ Prøve tatt fra indre skjede
- ☐ Prøve tatt fra livmorhalskanalen
- ☐ Prøve tatt fra ytre endetarm
- ☐ Prøve tatt fra indre endetarm
- ☐ Prøve tatt fra munn
- ☐ Prøve tatt fra neglekanter
- ☐ Klær tatt i beslag på mottaket
- ☐ Annet, spesifiser under
- ☐ Uopplyst

Save

51. Spesifiser annet

52. Sporprøver hentet av politiet

- ○ Nei



○ Ja
○ Uopplyst

53. Etter hvor lang tid etter undersøkelsen ble prøvene hentet av politiet

antall dager

54. Dato for politiets henting av prøver

55. Har pasienten badet/dusjet eller skiftet klær før undersøkelsen?

☐ Ikke dusjet eller skiftet klær
☐ Dusjet/badet
☐ Skiftet klær
☐ Annet
☐ Uopplyst

56. Angi evt annet:

57. Annet:

Max 255 characters. remaining.

Andre opplysninger / Additional Information or Corrections

Lagre svar / Save and view log | Tilbakestill skjema / Reset

Vis svarhistorikk / View log | Print page

If System Error, Print Screen and send image to Berit.Bjelkasen@ntnu.no | Last updated: 03.06.2014

NTNU Norges teknisk-naturvitenskapelige universitet
Det medisinske fakultet > Institutt for kreftforskning og molekylær medisin

Voldtektsregistrering

Cecilie Hagemann
St. Olavs Hospital (400)

Participant No: 14 **Inclusion date:** 26/07/2011 Annen deltager / Another participant

Log out
Initial Page
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Statistics
Study Progress
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Vis svarhistorikk / View log
Identification
Study parts
Undersøkelsen-Anmeldelse
Pasienten-overgriper-hendelsen
Anamnese-funn-behandling-prøver
Sårbarhetsfaktorer-rus-oppfølging-retts
Skader

Sårbarhetsfaktorer-rus-oppfølging-retts

Sårbarhetsfaktorer

1. Tidligere psykiatrisk anamnese
   - ☐ Nei
   - ☐ Ja, uspes.
   - ☐ Tidligere innlagt psyk
   - ☐ Tidligere psyk. beh.
   - ☐ Tidligere rusmisbruker*
   - ☐ Uopplyst

   * Tidligere, dvs tørrlagt
2. Handikapp / funksjonshemmet
   - ☐ Nei
   - ☐ Psykisk, uspes
   - ☐ Fysisk, uspes
   - ☐ Rusmisbruker*
   - ☐ Sikkert mentalt tilbakestående
   - ☐ Andre fysiske (sanser, bevegelse)

   * Nåværende, hvilke(t) rusmiddel
3. Angi rusmiddel

Alkohol/rus-inntak ved overgrepet

4. Alkohol (forurettede) Selvrapportert inntak (frivillig)
   - ☐ Intet alkoholinntak
   - ☐ Mindre inntak (< 5 alkoholenheter*)
   - ☐ Større inntak (5 alkoholenheter eller mer/evt. synlig beruset).
   - ☐ Større inntak med amnesiperiode ("Black outs" eller dyp søvn)
   - ☐ Uaktuelt – gammel sak eller residiverende overgrep
   - ☐ Uopplyst

   * 1 alkoholenhet = 33 cl øl, 1 glass vin eller 1 drink
5. Tid på døgnet for alkoholinntak, start-tidspkt. Dato (dd.mm.åååå)
6. Tid på døgnet for alkoholinntak, start-tidspkt. Klokkeslett (tt:mm)
7. Tid på døgnet for alkoholinntak, stopp-tidspkt. Dato (dd.mm.åååå)
8. Tid på døgnet for alkoholinntak, stopp-tidspkt. Klokkeslett (tt:mm)
9. Påført rus
   - ○ Nei, ingen mistanke om dette
   - ○ Ja, mener å være påført rusmiddel/legemiddel
   - ○ Uopplyst
10. Mistanke om spes stoff? mengde?

    Save
11. Tid på døgnet for mistenkt inntak påført rusmiddel. Dato (dd.mm.åååå)
12. Tid på døgnet for mistenkt inntak påført rusmiddel. Klokkeslett (tt:mm)
13. Annet rusmiddel/legemiddel (forurettede)*
    - ○ Nei
    - ○ Ja
    - ○ Uopplyst

    * Selvrapportert inntak (frivillig)
14. Hvilke(t) stoff(er) 1, mengde:
15. Stoff/ medikament1: Tid på døgnet for inntak stoff/medik, start-tidspkt. Dato (dd.mm.åååå)
16. Stoff/ medikament1: Tid på døgnet for inntak stoff/medik, start-tidspkt. Klokkeslett (tt:mm)
17. Stoff/ medikament1: Tid på døgnet for inntak stoff/medik, stopp-tidspkt. Dato (dd.mm.åååå)

18. Stoff/ medikament1: Tid på døgnet for inntak stoff/medik, stopp-tidspkt. Klokkeslett (tt:mm)

19. Hvilke(t) stoff(er) 2, mengde:

20. Stoff/ medikament2: Tid på døgnet for inntak stoff/medik, start-tidspkt. Dato (dd.mm.åååå)

Save

21. Stoff/ medikament2: Tid på døgnet for inntak stoff/medik, start-tidspkt. Klokkeslett (tt:mm)

22. Stoff/ medikament2: Tid på døgnet for inntak stoff/medik, stopp-tidspkt. Dato (dd.mm.åååå)

23. Stoff/ medikament2: Tid på døgnet for inntak stoff/medik, stopp-tidspkt. Klokkeslett (tt:mm)

24. Hvilke(t) stoff(er) 3, mengde:

25. Stoff/ medikament3: Tid på døgnet for inntak stoff/medik, start-tidspkt. Dato (dd.mm.åååå)

26. Stoff/ medikament3: Tid på døgnet for inntak stoff/medik, start-tidspkt. Klokkeslett (tt:mm)

27. Stoff/ medikament3: Tid på døgnet for inntak stoff/medik, stopp-tidspkt. Dato (dd.mm.åååå)

28. Stoff/ medikament3: Tid på døgnet for inntak stoff/medik, stopp-tidspkt. Klokkeslett (tt:mm)

29. Evt. flere opplysninger om stoff/medikament inntak

Max 255 characters. remaining.

30. * Alkohol (overgriper)

- Nei
- Ja
- Uopplyst

Save

31. Annet rusmiddel/legemiddel (overgriper)

- Nei
- Ja, kjent misbruker
- Ja, ruset ved overgrepet
- Uopplyst

Oppfølging ved lege ved voldtektsmottaket / gyn pol

32. * Oppfølgning intervall til første kontroll

- Møter ikke
- < 3 uker
- 3 uker - 3 måneder
- > 3 måneder
- Ingen kontroll avtalt
- Uopplyst

33. Kontroll hos lege ved voldtektsmottaket etterpå. Antall ganger

- 0
- 1
- 2 eller flere

Oppfølging ved psykiatrisk sykepleier/rådgiver/psykolog BUK

34. * Ved ankomst: Informert om oppfølgingstilbud:

- Nei
- Ja
- Uopplyst

35. * Hvis ja, ønsket kontakt/oppfølging

- ☐ Nei
- ☐ Ja
- ☐ Hadde annen oppfølging
- ☐ Uopplyst

36. Kontakt med rådgiver:

- Nei
- Ja, rådgiver ringte
- Ja, pasienten tok selv kontakt
- Ja, pårørende tok kontakt
- Annet, spes. under
- Uopplyst

37. Antall dager etter akutthenvendelsen

38. Hvis annet, spesifiser

39. Antall telefonkonsultasjoner med rådgiver

40. Antall samtaler med rådgiver

Save

41. Pårørende , antall telefonkonsultasjoner m rådgiver

42. Pårørende, antall samtaler m rådgiver

43. Hvilke pårørende?

- ☐ Mor
- ☐ Far
- ☐ Partner
- ☐ Annen familie, hvilke
- ☐ Andre, hvilke
- ☐ Uopplyst

44. Angi annen familie og andre

45. Hvordan sluttet kontakten?

- ☐ Etter gjensidig avtale
- ☐ Pasienten ønsket å slutte
- ☐ Pasienten uteble
- ☐ Rådgiver besluttet å slutte
- ☐ Annen hjelpeinstans overtok
- ☐ Annet
- ☐ Uopplyst

46. Angi annet

Rettsvesen

47. Rådgiver / psykiatrisk sykepleier og kontakt med rettsvesen

- ☐ Ingen kontakt m/politi/ rettsvesen
- ☐ Kontakt med bistandsadvokat
- ☐ Kontakt med aktor
- ☐ Kontakt med forsvarer
- ☐ Skrevet erklæring til aktorat
- ☐ Skrevet erklæring til bistandsadvokat
- ☐ Rådgiver innkalt som vitne
- ☐ Uopplyst

48. Psykiatrisk sykepleiers post- traumatisk stress score

- ☐ Ingen problemer
- ☐ Søvnproblemer
- ☐ Drømmer eller mareritt om det som er hendt
- ☐ Depresjon, nedtrykt sinnstilstand
- ☐ Skvettenhet ved plutselige lyder eller brå bevegelser
- ☐ Tendenser til å isolere seg fra andre
- ☐ Irritasjon, blir lett ergelig
- ☐ Følelser som svinger lett opp og ned
- ☐ Dårlig samvittighet, selvbebreidelser, skyldfølelse
- ☐ Frykt for situasjoner som minner om det som er hendt
- ☐ Anspenthet i kroppen
- ☐ Nedsatt evne til å huske
- ☐ Dårlig konsentrasjonsevne
- ☐ Annet
- ☐ Uopplyst

49. Scoringsverdi (0-12)

50. Etter hvor lang tid etter overgrepet ble post-traumatisk stress scoret (symptomer oppgitt)

antall dager

Save

51. Dato for posttraumatisk stress score

52. * Legeerklæring sendt til politi:*

- ○ Nei

- ○ Ja, men ikke innkalt som vitne
- ○ Ja, og lege innkalt som vitne
- ○ Ja, andre innkalt som vitne
- ○ Uopplyst

* Rettsmedisinsk journal etter egen mal for voldtektssaker

53. Etter hvor lang tid ble legeerklæring innsendt til politiet (mnd)

54. Signeringsdato for erklæring til politiet

55. Tilbakemelding fra Den Rettsmedisinske Kommisjon

- ○ Nei
- ○ Ja, og ingen kommentar
- ○ Ja, og mindre kommentarer, ikke nødvendig med tilleggserklæring
- ○ Ja, og nødvendig med tilleggserklæring
- ○ Annet
- ○ Uopplyst

56. Tilbakemelding fra Den rettsmedisinske kommisjon datert

Alkohol/rus-detaljer

57. * Rusprøve tatt

- ☐ Ingen rus-prøver tatt
- ☐ Ja, rus-urinscreening
- ☐ Ja, blodprøve
- ☐ Ja, kun blod-alkohol tatt
- ☐ Ikke aktuelt
- ☐ Uopplyst

Dato og tid for prøvetaking rusprøver

58. Urin dato: (dd.mm.åååå)

59. Urin klokkeslett: (tt:mm)

60. Blod dato: (dd.mm.åååå)

Save

61. Blod klokkeslett: (tt:mm)

62. Ca tid fra starttidspunkt for hendelsen til prøvetaking urin, timer

63. Ca tid fra starttidspunkt for hendelsen til prøvetaking blod, timer

64. Rusprøver sendt hvor?

- ☐ Farmak.avd., St Olav*
- ☐ Folkehelseinst., Oslo
- ☐ Klinisk kjemisk avdeling, St Olavs
- ☐ Annet
- ☐ Uopplyst

Akkreditert for rettsmed –bruk fra 2007

65. Symptomer angitt av pasienten

- ☐ Ingen
- ☐ Blackout
- ☐ Trøtt, sedert, sløv
- ☐ Oppstemt, euforisk, ukritisk
- ☐ Annet
- ☐ Uopplyst

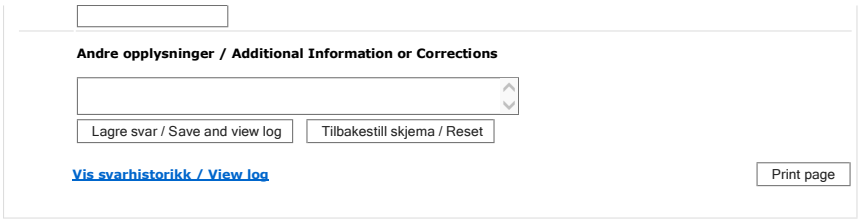
66. Annet, spesifiser

67. Kliniske tegn på ruspåvirkning

- ☐ Ingen tegn
- ☐ Unormalt trøtt, sedert, sløv
- ☐ Oppstemt, euforisk, ukritisk
- ☐ Små pupiller*
- ☐ Utvidede pupiller**
- ☐ Uttalt alkoholpåvirkning
- ☐ Lett alkoholpåvirkning
- ☐ Annet
- ☐ Uopplyst

* Opioider kan gi små pupiller, ** Kan være stressbetinget

68. Annet, spesifiser



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Det medisinske fakultet > Institutt for kreftforskning og molekylær medisin

Voldtektsregistrering

Cecilie Hagemann
St. Olavs Hospital (400)

Participant No: 14 **Inclusion date:** 26/07/2011 Annen deltager / Another participant

Log out
Initial Page
Change password
Information
Statistics
Study Progress
Study Documents
Vis svarhistorikk / View log
Identification
Study parts
Undersøkelsen-Anmeldelse
Pasienten-overgriper-hendelsen
Anamnese-funn-behandling-prøver
Sårbarhetsfaktorer-rus-oppfølging-retts
Skader

Skader

Anogenitale skader påvist

1. Markert på skisse
   - ○ Ja
   - ○ Nei
   - ○ Uopplyst
2. Foto/video
   - ○ Ja
   - ○ Nei
   - ○ Uopplyst
3. Kolposkopi
   - ○ Ja
   - ○ Nei
   - ○ Uopplyst
4. * GU utført
   - ○ Ja, akutt
   - ○ Nei, ikke indikasjon
   - ○ Nei, pas ønsket det ikke
   - ○ Ja, men ikke akutt
   - ○ Annet
   - ○ Uopplyst
5. Annet, spesifiser
6. * Anoskopi utført
   - ○ Ja, akutt
   - ○ Nei, ikke indikasjon
   - ○ Nei, pas ønsket det ikke
   - ○ Ja, men ikke akutt
   - ○ Annet
   - ○ Uopplyst
7. Annet, spesifiser
8. Hvis skade er påvist, angi lokalisasjon:
   - ☐ Labia majora
   - ☐ Labia minora
   - ☐ Periurethralt
   - ☐ Perineum
   - ☐ Bakre kommissur
   - ☐ Fossa navicularis
   - ☐ Hymen
   - ☐ Vaginalvegg
   - ☐ Portio
   - ☐ Anus
   - ☐ Rectum
   - ☐ Annet
   - ☐ Uopplyst
9. Annet, spesifiser
10. Type anogenital-skade:
    - ☐ Ingen skade
    - ☐ Rifter, lacerasj, fissur
    - ☐ Hud/slimhinne-avskrap
    - ☐ Blåflekk, ekkymose
    - ☐ Petekkier
    - ☐ Rødhet
    - ☐ Hevelse
    - ☐ Ømhet/smerte*
    - ☐ Annet
    - ☐ Uopplyst

* Ingen synlig skade, men palpasjonsømhet

Save

11. Annet, spesifiser

12. Om hymenskade

- [ ] Normal hymenalrest, uten tegn til ferske skader
- [ ] Fersk gjennomgående rift/kløft i hymen
- [ ] Rødblå misfarging/ ekkymose
- [ ] Slimhinneavskrap
- [ ] Hymen uten dype kløfter baktil
- [ ] Petekkier
- [ ] Rødhet
- [ ] Hevelse
- [ ] Ømhet
- [ ] Annet
- [ ] Uopplyst

13. Annet, spesifiser

14. Om anale skader

- [ ] Ingen fersk skade påvist
- [ ] Fersk rift / fissur
- [ ] Ekkymose
- [ ] Slimhinneavskrap
- [ ] Venøs stase
- [ ] Perianalt arrvev*
- [ ] Hemorhoider
- [ ] Marisker
- [ ] Petekkier
- [ ] Rødhet
- [ ] Hevelse
- [ ] Ømhet
- [ ] Uopplyst
- [ ] Annet

* DD: Mb Crohn, ulykker, tidligere med. prosedyrer

15. Annet, spesifiser

16. Om rectale skader

- [ ] Ingen fersk skade påvist
- [ ] Ekkymose
- [ ] Slimhinneavskrap
- [ ] Venøs stase
- [ ] Interne rifter (ved anoskopi)
- [ ] Hemorhoider
- [ ] Petekkier
- [ ] Rødhet
- [ ] Hevelse
- [ ] Ømhet
- [ ] Annet
- [ ] Uopplyst

17. Annet, spesifiser

18. Type anogenital skade Fossa navicularis

- [ ] Normal, ingen skade
- [ ] Rift / laserasjon/ fissur
- [ ] Hud/slimhinne-avskrap
- [ ] Blåflekk (ekky-mose)
- [ ] Petekkier
- [ ] Rødhet
- [ ] Hevelse
- [ ] Ømhet
- [ ] Annet
- [ ] Uopplyst

19. Annet, spesifiser

20. Type anogenital skade Bakre kommisur

- [ ] Normal, ingen skade
- [ ] Rift / laserasjon/ fissur
- [ ] Hud/slimhinne-avskrap

- ☐ Blåflekk (ekky-mose)
- ☐ Petekkier
- ☐ Rødhet
- ☐ Hevelse
- ☐ Ømhet
- ☐ Annet
- ☐ Uopplyst

Save

21. Annet, spesifiser

22. Type anogenital skade Perineum
- ☐ Normal, ingen skade
- ☐ Rift / laserasjon/ fissur
- ☐ Hud/slimhinne-avskrap
- ☐ Blåflekk (ekky-mose)
- ☐ Petekkier
- ☐ Rødhet
- ☐ Hevelse
- ☐ Ømhet
- ☐ Annet
- ☐ Uopplyst

23. Annet, spesifiser

24. Type anogenital skade Peri-urethralt
- ☐ Normal, ingen skade
- ☐ Rift / laserasjon/ fissur
- ☐ Hud/slimhinne-avskrap
- ☐ Blåflekk (ekky-mose)
- ☐ Petekkier
- ☐ Rødhet
- ☐ Hevelse
- ☐ Ømhet
- ☐ Annet
- ☐ Uopplyst

25. Annet, spesifiser

26. Type anogenital skade Labia minora
- ☐ Normal, ingen skade
- ☐ Rift / laserasjon/ fissur
- ☐ Hud/slimhinne-avskrap
- ☐ Blåflekk (ekky-mose)
- ☐ Petekkier
- ☐ Rødhet
- ☐ Hevelse
- ☐ Ømhet
- ☐ Annet
- ☐ Uopplyst

27. Annet, spesifiser

28. Type anogenital skade Labia majora
- ☐ Normal, ingen skade
- ☐ Rift / laserasjon/ fissur
- ☐ Hud/slimhinne-avskrap
- ☐ Blåflekk (ekky-mose)
- ☐ Petekkier
- ☐ Rødhet
- ☐ Hevelse
- ☐ Ømhet
- ☐ Annet
- ☐ Uoppyst

29. Annet, spesifiser

30. Type anogenital skade Vaginalvegg
- ☐ Normal, ingen skade
- ☐ Rift / laserasjon/ fissur
- ☐ Hud/slimhinne-avskrap
- ☐ Blåflekk (ekky-mose)

- ☐ Petekkier
- ☐ Rødhet
- ☐ Hevelse
- ☐ Ømhet
- ☐ Annet
- ☐ Uopplyst

Save

31. Annet, spesifiser

32. Type anogenital skade Portio

- ☐ Normal, ingen skade
- ☐ Rift / laserasjon/ fissur
- ☐ Hud/slimhinne-avskrap
- ☐ Blåflekk (ekky-mose)
- ☐ Petekkier
- ☐ Rødhet
- ☐ Hevelse
- ☐ Ømhet
- ☐ Annet
- ☐ Uopplyst

33. Annet, spesifiser

Antall skader pr lokalisasjon

34. Hymen

35. Fossa navicularis

36. Bakre kommisur

37. Perineum

38. Periurethralt

39. Labia minora

40. Labia majora

Save

41. Vaginalvegg

42. Portio

43. Anus

44. Rectum

45. Total antall skader genitalt

46. Total antall skader perianalt

47. Total antall skader anogenitalt

48. Utfyllende kommentar

Max 255 characters. remaining.

Kroppslige (ekstragenitale) skader

49. Skader markert på kroppsskisse

- ○ Ja
- ○ Nei
- ○ Uopplyst

50. Foto/video foreligger

- ○ Ja
- ○ Nei
- ○ Uopplyst

Save

51. * Kroppslig undersøkelse utført

- ○ Ja, akutt
- ○ Nei, ikke indikasjon
- ○ Nei, pas ønsket det ikke
- ○ Ja, men ikke akutt
- ○ Annet
- ○ Uopplyst

52. Hvis skade er påvist, angi lokalisasjon:

- ☐ Hode/ansikt
- ☐ Hals/svelg
- ☐ Lepper/munnslimhinne/tenner
- ☐ Skuldre
- ☐ Bryst/rygg
- ☐ Buk
- ☐ Lille bekken (uterus/ blære/ urinrør)
- ☐ Hofter
- ☐ Armer/hender
- ☐ Ben/føtter
- ☐ Typisk "defence injury"
- ☐ Merker innside lår
- ☐ Annet
- ☐ Uopplyst

53. Annet, spesifiser

54. Hvis skade er påvist, type skade:

- ☐ Rifter, lacerasj, fissur
- ☐ Hudavskrap
- ☐ Blåflekk /ekkymose
- ☐ Petekkier
- ☐ Rødhet
- ☐ Hevelse
- ☐ Ømhet/smerte*
- ☐ Brudd
- ☐ Tannskade
- ☐ Forstuvning
- ☐ Indre organ-skade**
- ☐ Hjernerystelse
- ☐ Annen hodeskade
- ☐ Petekkier etter kvelning
- ☐ Bitt-merke
- ☐ Sugemerke
- ☐ Skarpvoldsskade, risp/stikk/skjære/huggsår
- ☐ Skuddsår
- ☐ Arr etter selvskading
- ☐ Merker etter fingre/grep
- ☐ Annet
- ☐ Uopplyst

* Ingen synlige skader, men palpasjonsømhet, ** F.eks i buken

55. Spesielt om halsgrep

- ☐ Intet halsgrep
- ☐ Ingen følger
- ☐ Heshet
- ☐ Svelgebesvær
- ☐ Pustebesvær
- ☐ Svartning for øynene
- ☐ Besvimelse, bevisstløshet
- ☐ Ufrivillig urin/fæces avgang
- ☐ Annet
- ☐ Uopplyst

56. "Injury extent score" Se under Study documents for definisjon

- ○ 0
- ○ 1
- ○ 2
- ○ 3

Antall skader kroppslig pr lokalisasjon

57. Hode/ansikt

58. Hals/svelg

59. Lepper/munnslimhinne/tenner

60. Bryst/rygg

Save

61. Buk

62. Lille bekken/(uterus/ blære/ urinrør)

63. Armer/hender

64. Ben/føtter

65. Typisk "defence injury"

66. Merker innside lår

67. Merker etter fingre/grep

68. Antall Annet

69. Totalt antall kroppslige skader

70. Totalt antall skader (kroppslige og anogenitale)

Save

Undersøkers erfaring

71. Undersøkers erfaring?

- ○ Første sak
- ○ 2-5 saker
- ○ Håndtert > 5 saker
- ○ Håndtert > 30 saker
- ○ Overlege ved voldtektsmottak
- ○ Uopplyst

Kontaktårsak

72. Aktuelle kontaktårsak

- ☐ Voldtekt/forsøk < 14d
- ☐ Voldtekt/forsøk > 14d
- ☐ Incest
- ☐ Vold i nære relasjoner
- ☐ Falsk anmeldelse
- ☐ Annet
- ☐ Uopplyst

73. Annet:

Max 255 characters. remaining.

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Appendix 2

NTNU Norges teknisk-naturvitenskapelige universitet
Det medisinske fakultet > Institutt for kreftforskning og molekylær medisin

Politiregistrering voldtekt

Cecilie Hagemann
St. Olavs Hospital (400)

Participant No: 2001001 **Inclusion date:** 06/06/2011 Annen deltager / Another participant

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Rettstoksikologi
Variabler fra Overgrepsenhetens registre
Hendelsen
Sykehistorie og funn

Identifikasjon / Identification

1. **Politiets anmeldelsesnummer**
2 cechag (06/06/2011)

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NTNU Norges teknisk-naturvitenskapelige universitet
Det medisinske fakultet > Institutt for kreftforskning og molekylær medisin

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Rettslige data

1. * Anmeldelsestidspunkt Dato (dd.mm.åååå)

2. * Hvem anmelder?
- ○ Politipatrulje
- ○ Fornærmede selv
- ○ Familie
- ○ Annen relasjon
- ○ Helsetjenesten
- ○ Annen offentlig tjeneste
- ○ Annet
- ○ Uopplyst

3. Hvis annet, hvem?

4. * Fornærmede ønsker ikke å anmelde?
- ○ Nei, vil ikke anmelde
- ○ Ja, vil anmelde
- ○ Uopplyst
- ○ Annet

5. Hvis annet, hva

6. * Anmeldelsessted (Politienhet)
- ○ Sentrum politistasjon
- ○ Heimdal politistasjon
- ○ Klæbu lensmannskontor
- ○ Melhus lensmannskontor
- ○ Malvik lensmannskontor
- ○ Skaun lensmannskontor
- ○ Orkdal og Agdenes lensmannskontor
- ○ Meldal lensmannskontor
- ○ Hemne og Snillfjord lensmannskontor
- ○ Hitra lensmannskontor
- ○ Frøya lensmannskontor
- ○ Røros lensmannskontor
- ○ Holtålen lensmannskontor
- ○ Midtre Gauldal lensmannskontor
- ○ Rennebu lensmannskontor
- ○ Oppdal lensmannskontor
- ○ Rissa lensmannskontor
- ○ Ørland og Bjugn lensmannskontor
- ○ Åfjord lensmannskontor
- ○ Selbu og Tydal lensmannskontor
- ○ Annet
- ○ Uopplyst

7. Hvis annet, hva

8. * Etterforskende politienhet
- ○ Sentrum politistasjon
- ○ Heimdal politistasjon
- ○ Klæbu lensmannskontor
- ○ Melhus lensmannskontor
- ○ Malvik lensmannskontor
- ○ Skaun lensmannskontor
- ○ Orkdal og Agdenes lensmannskontor
- ○ Meldal lensmannskontor
- ○ Hemne og Snillfjord lensmannskontor
- ○ Hitra lensmannskontor
- ○ Frøya lensmannskontor
- ○ Røros lensmannskontor

- ○ Holtålen lensmannskontor
- ○ Midtre Gauldal lensmannskontor
- ○ Rennebu lensmannskontor
- ○ Oppdal lensmannskontor
- ○ Rissa lensmannskontor
- ○ Ørland og Bjugn lensmannskontor
- ○ Åfjord lensmannskontor
- ○ Selbu og Tydal lensmannskontor
- ○ Annet
- ○ Uopplyst

9. Hvis annet, hva

10. Dato for påtalemessig avgjørelse (dd.mm.åååå)

Save

11. Dato for rettskraftig avgjørelse (første endelige dom): (dd.mm.åååå)

12. Rettskraftig avgjørelse:

- ☐ Ikke straffbart forhold (10/50)
- ☐ Henlagt p.g.a. foreldelse (15/67)
- ☐ Påtale trukket
- ☐ Henlagt, manglende opplysninger om gjerningsperson (14)
- ☐ Henlagt pga mangel på bevis/ bevisets stilling (17/58)
- ☐ Henlagt, gjerningsperson ikke strafferettslig ansvarlig (65)
- ☐ Forelegg (40)
- ☐ Tiltale/domstolsbehandling (42)
- ☐ Annet
- ☐ Henlagt pga ressursmangel (25/78)
- ☐ Henlagt, åpenbar grunnløs (26/104)
- ☐ Jevnbyrdighet i alder og utvikling (60)
- ☐ Konfliktråd (37/44)
- ☐ Siktelse (tilståelsesdom) (41)
- ☐ Påtaleunnlatelse (43)
- ☐ Ennå ikke rettskraftig avgjort
- ☐ Ukjent avgjørelse/ikke opplyst

13. Hvis annet, angi

14. Avgjørelseskode:

15. Initialt henlagt pga uidentifisert gjerningsperson:

- ○ Nei
- ○ Ja
- ○ Ikke opplyst

16. Dersom tiltale:

- ☐ Ubetinget fengsel
- ☐ Betinget fengsel
- ☐ Dels ubetinget, dels betinget fengsel
- ☐ Annen straff *
- ☐ Frifinnelse
- ☐ Erstatning
- ☐ Annet
- ☐ Ikke opplyst

* F.eks. Bot, inndragning, samfunnstjeneste, rettighetstap (besøksforbud, sikring, voldsalarm)

17. Dersom annen straff, erstatning eller annen tiltale, angi:

Max 255 characters. remaining.

18. Straffeutmåling:

Max 255 characters. remaining.

19. Hvilke(n) straffekode(r) er brukt (STRASAK-koder)?

- 1401: Voldtekt (§l92, 1. og 2.ledd)
- 1413: Forsøk på voldtekt (§192, jfr §49)
- 1420: Voldtekt (§192, 3.ledd) (grovere)
- 1423 Grov uaktsom voldtekt (§192, 4. ledd)
- Annet
- Ikke opplyst

20. Dersom annen straffekode, angi:

Save

21. Ble dommen anket?

- Nei
- Ja, av påtalemyndighetene
- Ja, av påtalte
- Ja, av begge parter
- Uopplyst
- Ikke aktuelt

22. Utfall av eventuell anke:

Max 255 characters. remaining.

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Det medisinske fakultet > Institutt for kreftforskning og molekylær medisin

Politiregistrering voldtekt

Cecilie Hagemann
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Participant No: 2001001 **Inclusion date:** 06/06/2011 Annen deltager / Another participant

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Overgripere/mistenkte

Dersom flere overgripere, føres opplysningene på I, II og III etter grad av deltakelse i overgrepet.

1. Antall overgripere

Opplysninger føres på overgriper I & II & III etter hvem som er viktigst

2. * Kjønn overgriper I
   - ○ Mann
   - ○ Kvinne
   - ○ Uopplyst

3. Kjønn overgriper II
   - ○ Uopplyst
   - ○ Mann
   - ○ Kvinne

4. Kjønn overgriper III
   - ○ Uopplyst
   - ○ Mann
   - ○ Kvinne

5. * Alder overgriper I

(ca., antall år)

6. Alder overgriper II

7. Alder overgriper III

8. * Etnisitet overgriper I
   - ○ Norsk
   - ○ Annet
   - ○ Ikke norsk, vestlig
   - ○ Ikke norsk, ikke vestlig
   - ○ Uopplyst

9. Annen etnisitet, spesifiser

10. Etnisitet overgriper II
    - ○ Norsk
    - ○ Annet
    - ○ Ikke norsk, vestlig
    - ○ Ikke norsk, ikke vestlig
    - ○ Uopplyst

Save

11. Annen etnisitet, spesifiser

12. Etnisitet overgriper III
    - ○ Norsk
    - ○ Annet
    - ○ Ikke norsk, vestlig
    - ○ Ikke norsk, ikke vestlig
    - ○ Uopplyst

13. Annen etnisitet, spesifiser

14. Bosted overgriper I
    - ○ Trondheim by
    - ○ Sør-Trøndelag utenom byen
    - ○ Utenfor fylket
    - ○ Utenfor landet
    - ○ Uopplyst
    - ○ Ikke aktuelt

15. Bosted overgriper II

- Trondheim by
- Sør-Trøndelag utenom byen
- Utenfor fylket
- Utenfor landet
- Uopplyst
- Ikke aktuelt

16. Bosted overgriper III
- Trondheim by
- Sør-Trøndelag utenom byen
- Utenfor fylket
- Utenfor landet
- Uopplyst
- Ikke aktuelt

17. * Er mistenkte I i arbeid utenfor hjemmet?
- Nei
- Ja
- Uopplyst
- Ikke aktuelt

18. * Er mistenkte II i arbeid utenfor hjemmet?
- Nei
- Ja
- Uopplyst
- Ikke aktuelt

19. * Er mistenkte III i arbeid utenfor hjemmet?
- Nei
- Ja
- Uopplyst
- Ikke aktuelt

20. Hvis nei mistenkt I
- Hjemmeværende
- Skoleelev
- Student
- På stønad
- Arbeidsledig
- Annet
- Ikke aktuelt

Save

21. Hvis annet mistenkt I, angi

22. Hvis nei mistenkt II
- Hjemmeværende
- Skoleelev
- Student
- På stønad
- Arbeidsledig
- Annet
- Ikke aktuelt

23. Hvis annet mistenkt II, angi

24. Hvis nei mistenkt III
- Hjemmeværende
- Skoleelev
- Student
- På stønad
- Arbeidsledig
- Annet
- Ikke aktuelt

25. Hvis annet mistenkt III, angi

26. Hvilken utdannelse har mistenkte I?
- Mindre enn 9 år
- 9-12 år
- Høyskole
- Universitet
- Uopplyst

- Ikke aktuelt

27. Hvilken utdannelse har mistenkte II?

- Mindre enn 9 år
- 9-12 år
- Høyskole
- Universitet
- Uopplyst
- Ikke aktuelt

28. Hvilken utdannelse har mistenkte III?

- Mindre enn 9 år
- 9-12 år
- Høyskole
- Universitet
- Uopplyst
- Ikke aktuelt

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Overgripere/mistenkte 2

1. Tidligere mistenkt for forbrytelse, mistenkt I?
   - ○ Nei
   - ○ Ja, for vold
   - ○ Ja, for seksualforbrytelse
   - ○ Ja, for narkotika
   - ○ Ja, for skadeverk
   - ○ Ja, for vinning
   - ○ Ja, for annen krim
   - ○ Uopplyst
   - ○ Ikke aktuelt
2. Hvis annen krim, mistenkt I, angi
   - [ ]
3. Tidligere mistenkt for forbrytelse, mistenkt II?
   - ○ Nei
   - ○ Ja, for vold
   - ○ Ja, for seksualforbrytelse
   - ○ Ja, for narkotika
   - ○ Ja, for skadeverk
   - ○ Ja, for vinning
   - ○ Ja, for annen krim
   - ○ Uopplyst
   - ○ Ikke aktuelt
4. Hvis annen krim, mistenkt II, angi
   - [ ]
5. Tidligere mistenkt for forbrytelse, mistenkt III?
   - ○ Nei
   - ○ Ja, for vold
   - ○ Ja, for seksualforbrytelse
   - ○ Ja, for narkotika
   - ○ Ja, for skadeverk
   - ○ Ja, for vinning
   - ○ Ja, for annen krim
   - ○ Uopplyst
   - ○ Ikke aktuelt
6. Hvis annen krim, mistenkt III, angi
   - [ ]
7. Tidligere dømt for forbrytelse, mistenkt I?
   - ○ Nei
   - ○ Ja, for vold
   - ○ Ja, for seksualforbrytelse
   - ○ Ja, for narkotika
   - ○ Ja, for skadeverk
   - ○ Ja, for vinning
   - ○ Ja, for annen krim
   - ○ Uopplyst
   - ○ Ikke aktuelt
8. Hvis dømt for annen krim, mistenkt I, angi
   - [ ]
9. Tidligere dømt for forbrytelse, mistenkt II?
   - ○ Nei
   - ○ Ja, for vold
   - ○ Ja, for seksualforbrytelse
   - ○ Ja, for narkotika
   - ○ Ja, for skadeverk
   - ○ Ja, for vinning
   - ○ Ja, for annen krim
   - ○ Uopplyst
   - ○ Ikke aktuelt

10. Hvis dømt for annen krim, mistenkt II, angi

Save

11. Tidligere dømt for forbrytelse, mistenkt III?

- Nei
- Ja, for vold
- Ja, for seksualforbrytelse
- Ja, for narkotika
- Ja, for skadeverk
- Ja, for vinning
- Ja, for annen krim
- Uopplyst
- Ikke aktuelt

12. Hvis dømt for annen krim, mistenkt III, angi

13. Inntatt alkohol før handlingen, mistenkt I?

- Nei
- Ja
- Uopplyst
- Ikke aktuelt

14. Inntatt alkohol før handlingen, mistenkt II?

- Nei
- Ja
- Uopplyst
- Ikke aktuelt

15. Inntatt alkohol før handlingen, mistenkt III?

- Nei
- Ja
- Uopplyst
- Ikke aktuelt

16. Andre rusmidler, mistenkt I?

- Nei
- Ja, hva
- Uopplyst
- Ikke aktuelt

17. Hvis ja, hva (mistenkt I)?

18. Andre rusmidler, mistenkt II?

- Nei
- Ja, hva
- Uopplyst
- Ikke aktuelt

19. Hvis ja, hva (mistenkt II)?

20. Andre rusmidler, mistenkt III?

- Nei
- Ja, hva
- Uopplyst
- Ikke aktuelt

Save

21. Hvis ja, hva (mistenkt III)?

22. * Har mistenkte vært til avhør (mistenkte I)?

- Nei
- Ja
- Uopplyst
- Ikke aktuelt

23. * Har mistenkte vært til avhør (mistenkte II)?

- Nei
- Ja
- Uopplyst
- Ikke aktuelt

24. * Har mistenkte vært til avhør (mistenkte III)?

- ○ Nei
- ○ Ja
- ○ Uopplyst
- ○ Ikke aktuelt

25. Tid for avhør av mistenkte (dato, dd.mm.åååå)

26. Er mistenkte I varetektsfengslet?

- ☐ Nei
- ☐ Ja
- ☐ Uopplyst
- ☐ Annet
- ☐ Ikke aktuelt

27. Hvis annet

28. Er mistenkte II varetektsfengslet?

- ☐ Nei
- ☐ Ja
- ☐ Uopplyst
- ☐ Annet
- ☐ Ikke aktuelt

29. Hvis annet

30. Er mistenkte III varetektsfengslet?

- ☐ Nei
- ☐ Ja
- ☐ Uopplyst
- ☐ Annet
- ☐ Ikke aktuelt

Save

31. Hvis annet

32. Er det oppgitt en psykiatrisk diagnose hos mistenkte før overgrepet? (Mistenkte I)

- ☐ Nei
- ☐ Ja, psykisk utviklingshemming
- ☐ Ja, psykose
- ☐ Ja, personlighetsforstyrrelse
- ☐ Alkohol/rusmisbruk
- ☐ "Rar", "snodig", "spesiell" *
- ☐ Annet
- ☐ Ikke aktuelt

* For eksempel snakker med seg selv, unngår øyekontakt med fornærmede

33. Annet, angi:

34. Er det oppgitt en psykiatrisk diagnose hos mistenkte før overgrepet? (Mistenkte II)

- ☐ Nei
- ☐ Ja, psykisk utviklingshemming
- ☐ Ja, psykose
- ☐ Ja, personlighetsforstyrrelse
- ☐ Alkohol/rusmisbruk
- ☐ "Rar", "snodig", "spesiell" *
- ☐ Annet
- ☐ Ikke aktuelt

* For eksempel snakker med seg selv, unngår øyekontakt med fornærmede

35. Annet, angi:

36. Er det oppgitt en psykiatrisk diagnose hos mistenkte før overgrepet? (Mistenkte III)

- ☐ Nei
- ☐ Ja, psykisk utviklingshemming
- ☐ Ja, psykose
- ☐ Ja, personlighetsforstyrrelse
- ☐ Alkohol/rusmisbruk
- ☐ "Rar", "snodig", "spesiell" *
- ☐ Annet
- ☐ Ikke aktuelt

* For eksempel snakker med seg selv, unngår øyekontakt med fornærmede

37. Annet, angi:

38. Er det oppgitt en rettspsykiatrisk konklusjon hos mistenkte I?

- ☐ Nei
- ☐ Ja, men psykiatrisk lidelse ikke funnet
- ☐ Psykotisk på handlingstiden
- ☐ Bevisstløs på handlingstiden
- ☐ Psykisk utviklingshemmet i høy grad
- ☐ Alvorlig psykisk lidelse (men ikke psykotisk)
- ☐ Sterk bevissthetsforstyrrelse
- ☐ Lettere psykisk utviklingshemmet
- ☐ Mangelfullt utviklede sjelsevner
- ☐ Varig svekkede sjelsevner
- ☐ Fare for gjentakelse av straffbare handlinger
- ☐ Ikke aktuelt

39. Er det oppgitt en rettspsykiatrisk konklusjon hos mistenkte II?

- ☐ Nei
- ☐ Ja, men psykiatrisk lidelse ikke funnet
- ☐ Psykotisk på handlingstiden
- ☐ Bevisstløs på handlingstiden
- ☐ Psykisk utviklingshemmet i høy grad
- ☐ Alvorlig psykisk lidelse (men ikke psykotisk)
- ☐ Sterk bevissthetsforstyrrelse
- ☐ Lettere psykisk utviklingshemmet
- ☐ Mangelfullt utviklede sjelsevner
- ☐ Varig svekkede sjelsevner
- ☐ Fare for gjentakelse av straffbare handlinger
- ☐ Ikke aktuelt

40. Er det oppgitt en rettspsykiatrisk konklusjon hos mistenkte III?

- ☐ Nei
- ☐ Ja, men psykiatrisk lidelse ikke funnet
- ☐ Psykotisk på handlingstiden
- ☐ Bevisstløs på handlingstiden
- ☐ Psykisk utviklingshemmet i høy grad
- ☐ Alvorlig psykisk lidelse (men ikke psykotisk)
- ☐ Sterk bevissthetsforstyrrelse
- ☐ Lettere psykisk utviklingshemmet
- ☐ Mangelfullt utviklede sjelsevner
- ☐ Varig svekkede sjelsevner
- ☐ Fare for gjentakelse av straffbare handlinger
- ☐ Ikke aktuelt

Save

41. Dato for rettspsykiatrisk konklusjon: (dd.mm.åååå)

42. Nekter mistenkte initialt seksuell kontakt med fornærmede (Mistenkte I)?

- ○ Nei
- ○ Ja
- ○ Uopplyst
- ○ Ikke aktuelt

43. Nekter mistenkte initialt seksuell kontakt med fornærmede (Mistenkte II)?

- ○ Nei
- ○ Ja
- ○ Uopplyst
- ○ Ikke aktuelt

44. Nekter mistenkte initialt seksuell kontakt med fornærmede (Mistenkte III)?

- ○ Nei
- ○ Ja
- ○ Uopplyst
- ○ Ikke aktuelt

45. Innrømmer mistenkte (evt. etter hvert) seksuell kontakt med fornærmede(Mistenkte I)?

- Nei
- Ja
- Uopplyst
- Ikke aktuelt

46. Innrømmer mistenkte (evt. etter hvert) seksuell kontakt med fornærmede(Mistenkte II)?
- Nei
- Ja
- Uopplyst
- Ikke aktuelt

47. Innrømmer mistenkte (evt. etter hvert) seksuell kontakt med fornærmede(Mistenkte III)?
- Nei
- Ja
- Uopplyst
- Ikke aktuelt

48. Innrømmer mistenkte voldtekt/voldtektsforsøk/grov uaktsom voldtekt(Mistenkte I)?
- Nei
- Ja
- Uopplyst
- Ikke aktuelt
- Annet

49. Hvis annet, hva (Mistenkte I)

50. Innrømmer mistenkte voldtekt/voldtektsforsøk/grov uaktsom voldtekt(Mistenkte II)?
- Nei
- Ja
- Uopplyst
- Ikke aktuelt
- Annet

Save

51. Hvis annet, hva (Mistenkte II)

52. Innrømmer mistenkte voldtekt/voldtektsforsøk/grov uaktsom voldtekt(Mistenkte III)?
- Nei
- Ja
- Uopplyst
- Ikke aktuelt
- Annet

53. Hvis annet, hva (Mistenkte III)

54. Erkjenner mistenkte straffeskyld (Mistenkte I)?
- Nei
- Ja
- Uopplyst
- Ikke aktuelt

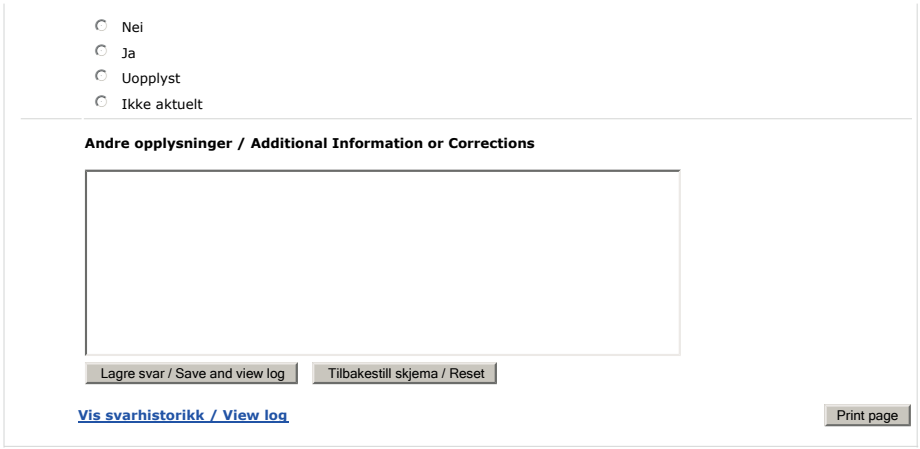
55. Erkjenner mistenkte straffeskyld (Mistenkte II)?
- Nei
- Ja
- Uopplyst
- Ikke aktuelt

56. Erkjenner mistenkte straffeskyld (Mistenkte III)?
- Nei
- Ja
- Uopplyst
- Ikke aktuelt

57. Ble det foretatt en registrering av mistenktes DNA-profil(Mistenkte I)?
- Nei
- Ja
- Uopplyst
- Ikke aktuelt

58. Ble det foretatt en registrering av mistenktes DNA-profil (Mistenkte II)?
- Nei
- Ja
- Uopplyst
- Ikke aktuelt

59. Ble det foretatt en registrering av mistenktes DNA-profil (Mistenkte III)?



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Det medisinske fakultet > Institutt for kreftforskning og molekylær medisin

Politiregistrering voldtekt

Cecilie Hagemann
St. Olavs Hospital (400)

Participant No: 2001001 **Inclusion date:** 06/06/2011 Annen deltager / Another participant

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Fornærmede / handlingen

1. Er fornærmede avhørt?
   - ○ Nei
   - ○ Ja
   - ○ Uopplyst
   - ○ Fornærmede ønsker ikke å bli avhørt
   - ○ Annet
2. Hvis annet, angi
3. Tid for avhør av fornærmede (dato, dd.mm.åååå)
4. Hvis ja, skjedde første avhør før eller etter medisinsk undersøkelse?
   - ○ Før
   - ○ Etter
   - ○ Medisinsk undersøkelse ikke utført
   - ○ Uopplyst
5. Er det oppgitt en psykiatrisk diagnose hos fornærmede før overgrepet?
   - ☐ Nei
   - ☐ Ja, psykisk utviklingshemming
   - ☐ Ja, psykose
   - ☐ Ja, personlighetsforstyrrelse
   - ☐ Alkohol/rusmisbruk
   - ☐ Annet
6. Hvis annet, angi hva
7. Er det oppgitt en psykiatrisk diagnose hos fornærmede etter overgrepet?
   - ☐ Nei
   - ☐ Ja, post traumatisk stress symptomer
   - ☐ Ja, psykose
   - ☐ Ja, suicidalitet
   - ☐ Alkohol/rusmisbruk
   - ☐ Angst og/eller depresjon
   - ☐ Annet
8. Hvis annet, angi hva
9. Første overgrep: (dd.mm.åååå)
10. Siste overgrep: (dd.mm.åååå)

Save

11. Hvis ett overgrep: Tid på døgnet for overgrepet, start-tidspkt. Dato (dd.mm.åååå)
12. Hvis ett overgrep: Tid på døgnet for overgrepet, start-tidspkt. Tidspunkt: (tt:mm)
13. Tid på døgnet for overgrepet, slutt-tidspkt. Dato (dd.mm.åååå)
14. Tid på døgnet for overgrepet, slutt-tidspkt. Klokkeslett: (tt:mm)
15. Frekvens
    - ○ Ett overgrep
    - ○ Gjentatte overgrep
    - ○ Annet
    - ○ Uopplyst

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Etterforskningen

1. Er det identifisert et åsted?
   - ○ Nei
   - ○ Ja
   - ○ Uopplyst
2. Har det vært noen politipatrulje på åstedet?
   - ○ Nei
   - ○ Ja
   - ○ Uopplyst
3. Har politiet foretatt åstedsundersøkelse?
   - ○ Nei
   - ○ Ja
   - ○ Uopplyst
4. Tid for åstedsundersøkelse, dato (dd.mm.åååå)
5. Tid for åstedsundersøkelse, klokkeslett (tt:mm)
6. Er det foretatt teknisk beslag*?
   - ☐ Nei
   - ☐ Ja, antall oppgis under
   - ☐ Film, video
   - ☐ PC
   - ☐ Beslag fra åsted
   - ☐ Våpen
   - ☐ Annet
   - ☐ Uopplyst

   * Se beslagsrapport. Herunder menes ikke rettsmedisinsk beslag.
7. Oppgi evt antall beslag
8. Hvis andre beslag, angi her
9. Er det foretatt sporsikring av biologisk materiale hos fornærmede?
   - ○ Nei
   - ○ Ja, hos Overgrepsenheten, St Olavs Hospital
   - ○ Ja, av andre
   - ○ Uopplyst
10. Hvis andre, angi

    Save
11. Tid for sporsikring fornærmede, dato (dd.mm.åååå)
12. Tid for sporsikring fornærmede, klokkeslett (tt:mm)
13. Er det foretatt sporsikring av biologisk materiale hos mistenkte I?
    - ○ Nei
    - ○ Ja, av politiet
    - ○ Ja, av andre
    - ○ Annet
    - ○ Uopplyst
    - ○ Ikke aktuelt
14. Hvis andre eller annet, angi
15. Tid for sporsikring mistenkt I, dato (dd.mm.åååå)
16. Tid for sporsikring mistenkt I, klokkeslett (tt:mm)
17. Er det foretatt sporsikring av biologisk materiale hos mistenkte II?

- Nei
- Ja, av politiet
- Ja, av andre
- Annet
- Uopplyst
- Ikke aktuelt

18. Hvis andre eller annet, angi

19. Tid for sporsikring mistenkt II, dato (dd.mm.åååå)

20. Tid for sporsikring mistenkt II, klokkeslett (tt:mm)

Save

21. Er det foretatt sporsikring av biologisk materiale hos mistenkte III?

- Nei
- Ja, av politiet
- Ja, av andre
- Annet
- Uopplyst
- Ikke aktuelt

22. Hvis andre eller annet, angi

23. Tid for sporsikring mistenkt III, dato (dd.mm.åååå)

24. Tid for sporsikring mistenkt III, klokkeslett (tt:mm)

25. Er det gjort beslag av fornærmedes klær?

- Nei
- Ja
- Uopplyst

26. Tid for beslag av fornærmedes klær, dato (dd.mm.åååå)

27. Tid for beslag av fornærmedes klær, klokkeslett (tt:mm)

28. Er det gjort beslag av mistenktes(I) klær?

- Nei
- Ja
- Uopplyst
- Ikke aktuelt

29. Tid for beslag av mistenktes(I) klær, dato (dd.mm.åååå)

30. Tid for beslag av mistenktes(I) klær, klokkeslett (tt:mm)

Save

31. Er det gjort beslag av mistenktes(II) klær?

- Nei
- Ja
- Uopplyst
- Ikke aktuelt

32. Tid for beslag av mistenktes(II) klær, dato (dd.mm.åååå)

33. Tid for beslag av mistenktes(II) klær, klokkeslett (tt:mm)

34. Er det gjort beslag av mistenktes(III) klær?

- Nei
- Ja
- Uopplyst
- Ikke aktuelt

35. Tid for beslag av mistenktes(III) klær, dato (dd.mm.åååå)

36. Tid for beslag av mistenktes(III) klær, klokkeslett (tt:mm)

37. Er det dokumentert fysiske skader hos fornærmede?

- Nei
- Ja, på Overgrepsenheten, St Olavs Hospital
- Ja, av politiet

- Ja, annet
- Uopplyst

38. Hvis annet, hva

39. Tid for dokumentasjon av skader, fornærmede, dato (dd.mm.åååå)

40. Tid for dokumentasjon av skader, fornærmede, klokkeslett (tt:mm)

Save

41. Er det dokumentert fysiske skader hos mistenkte I?

- Nei
- Ja, av politiet
- Ja, annet
- Uopplyst
- Ikke aktuelt

42. Hvis annet, hva

43. Tid for dokumentasjon av skader, mistenkt I, dato (dd.mm.åååå)

44. Tid for dokumentasjon av skader, mistenkt I, klokkeslett (tt:mm)

45. Er det dokumentert fysiske skader hos mistenkte II?

- Nei
- Ja, av politiet
- Ja, annet
- Uopplyst
- Ikke aktuelt

46. Hvis annet, hva

47. Tid for dokumentasjon av skader, mistenkt II, dato (dd.mm.åååå)

48. Tid for dokumentasjon av skader, mistenkt II, klokkeslett (tt:mm)

49. Er det dokumentert fysiske skader hos mistenkte III?

- Nei
- Ja, av politiet
- Ja, annet
- Uopplyst
- Ikke aktuelt

50. Hvis annet, hva

Save

51. Tid for dokumentasjon av skader, mistenkt III, dato (dd.mm.åååå)

52. Tid for dokumentasjon av skader, mistenkt III, klokkeslett (tt:mm)

53. Er det vitner avhørt (utenom medisinsk sakkyndig og fornærmede):

- Nei
- Ja, antall
- Vitner innkalt, men ikke møtt
- Annet
- Uopplyst

54. Angi eventuelt antall

55. Hvis annet, hva

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Politiregistrering voldtekt

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Medisinske undersøkelser av fornærmede

1. Er medisinsk undersøkelse foretatt?
   - ○ Nei
   - ○ Ja
   - ○ Uopplyst
2. Tid for medisinsk undersøkelse fornærmede, dato (dd.mm.åååå)
3. Tid for medisinsk undersøkelse fornærmede, klokkeslett (tt:mm)
4. Hvis ja, er erklæring blitt innhentet?
   - ○ Nei
   - ○ Ja
   - ○ Uopplyst
5. Mandat fra politiet datert (dd.mm.åååå)
6. Hvis ja, er erklæringen nevnt i eventuelle domspremisser?
   - ○ Nei
   - ○ Ja, se nedenfor
   - ○ Uopplyst
   - ○ Ikke aktuelt
7. Aktuell tekst om legeerklæringen i dommen

   Max 255 characters. remaining.
8. Er skisser/fotografi vedlagt saken?
   - ☐ Nei
   - ☐ Ja, av åsted
   - ☐ Ja, av skader på fornærmede
   - ☐ Ja, av klær
   - ☐ Ja, annet
   - ☐ Uopplyst
   - ☐ Ikke aktuelt
9. Hvis annet, hva
10. Hvor ble medisinsk undersøkelse utført?
    - ○ Ikke utført
    - ○ Overgrepsenheten, St Olavs Hospital
    - ○ Legevakt, fastlege
    - ○ Annet
    - ○ Uopplyst

    Save
11. Hvis annet, hva
12. Er medisinsk sakkyndig innkalt som vitne?
    - ☐ Nei
    - ☐ Ja, psykiater/psykolog
    - ☐ Ja, lege fra Overgrepsenheten, St Olavs Hospital
    - ☐ Ja, annen lege
    - ☐ Uopplyst
13. Hvis annen lege, angi
14. Er det foretatt rettsmedisinsk beslag?

- [ ] Nei
- [ ] Ja
- [ ] Sporprøver fra fornærmede
- [ ] Annet
- [ ] Uopplyst

15. Hvis ja, angi antall

16. Hvis andre beslag, angi

17. Har politiet selv undersøkt klær?
- ○ Nei
- ○ Ja
- ○ Uopplyst
- ○ Ikke aktuelt

18. Er det sendt prøver til Rettsmedisinsk Institutt?
- ○ Nei
- ○ Ja
- ○ Uopplyst
- ○ Ikke aktuelt

19. Dato for politiets innsending av prøver til Rettsmedisinsk institutt: (dd.mm.åååå) (Evt. dato mottatt RMI)

20. Antall prøver mottatt av Rettsmedisinsk Institutt:

Save

21. Antall prøver analysert av Rettsmedisinsk institutt:

22. Er sporsikringspakken analysert?
- ○ Nei
- ○ Ja, sporsikringspakken omtalt i analyserapporten
- ○ Ja, analyse av aktuelle prøver uten at sporsikringspakken er nevnt
- ○ Uopplyst
- ○ Ikke aktuelt

23. Analyserapporten fra Rettsmedisinsk institutt datert: (dd.mm.åååå)

24. Er det påvist spermier på fornærmedes kropp?
- ○ Nei
- ○ Ja, på genitalia
- ○ Ja, utenfor genitalia
- ○ Uopplyst
- ○ Ikke aktuelt

All relevant tekst angående prøver sendt til Rettsmedisinsk Institutt, eventuelle resultater og vektlegging av disse i saksavgjørelsen vedlegges som fritekst.

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Basert på lab-rapport fra Rettsmedisinsk

1. Vattpinner tatt til sporsikring fra fornærmede
   - ☐ Nei
   - ☐ Ja, fra anogenitalt område
   - ☐ Ja, fra kropp utenom genitalia
2. Antall vattpinner totalt
3. Sædvæske (sure fosfataser/PSA) påvist på vattpinnene tatt fra fornærmede?
   - ☐ Nei
   - ☐ Ja, fra anogenitalt område
   - ☐ Ja, fra kropp utenom genitalia
   - ☐ Ikke testet
   - ☐ Usikkert resultat
   - ☐ Annet
   - ☐ Uopplyst
4. Hvis annet, angi
5. Sædceller påvist på vattpinnene tatt fra fornærmede?
   - ☐ Nei
   - ☐ Ja, fra anogenitalt område
   - ☐ Ja, fra kropp utenom genitalia
   - ☐ Ikke testet
   - ☐ Usikkert resultat
   - ☐ Annet
   - ☐ Uopplyst
6. Sædvæske (sure fosfataser/PSA) påvist på klær fra fornærmede?
   - ☐ Nei
   - ☐ Ja, på truse
   - ☐ Ja, på andre klær
   - ☐ Ikke testet
   - ☐ Usikkert resultat
   - ☐ Annet
   - ☐ Uopplyst
7. Hvis annet, angi
8. Sædceller påvist klær fra fornærmede?
   - ☐ Nei
   - ☐ Ja, på truse
   - ☐ Ja, på andre klær
   - ☐ Ikke testet
   - ☐ Usikkert resultat
   - ☐ Annet
   - ☐ Uopplyst
9. Hvis annet, angi
10. Vattpinner tatt til sporsikring fra mistenkte/siktede (I)?
    - ☐ Nei
    - ☐ Ja, fra anogenitalt område
    - ☐ Ja, fra kropp utenom genitalia
    - ☐ Kun referanseprøve tatt
    - ☐ Ikke aktuelt

    Save
11. Antall vattpinner totalt (mistenkte I)
12. Vattpinner tatt til sporsikring fra mistenkte/siktede (II)?

- ☐ Nei
- ☐ Ja, fra anogenitalt område
- ☐ Ja, fra kropp utenom genitalia
- ☐ Kun referanseprøve tatt
- ☐ Ikke aktuelt

13. Antall vattpinner totalt (mistenkte II)

14. Vattpinner tatt til sporsikring fra mistenkte/siktede (III)?
- ☐ Nei
- ☐ Ja, fra anogenitalt område
- ☐ Ja, fra kropp utenom genitalia
- ☐ Kun referanseprøve tatt
- ☐ Ikke aktuelt

15. Antall vattpinner totalt, (mistenkte III)

16. DNA-typing foretatt?
- ☐ Nei
- ☐ Ja, av vattpinner tatt fra fornærmede, anogenitalt område
- ☐ Ja, av vattpinner tatt fra fornærmede, utenfor anogenitalt område
- ☐ Ja, av vattpinner tatt fra mistenkte, anogenitalt område
- ☐ Ja, av vattpinner tatt fra mistenkte, utenom anogenitalt område
- ☐ Ja, av truse tatt fra fornærmede
- ☐ Ja, av andre klær tatt fra fornærmede
- ☐ Ja, av klær tatt fra mistenkte
- ☐ Ja, av laken, sneip, kondom, blod eller annet fra åsted
- ☐ Ja, fostervannsprøve/ abortmateriale
- ☐ Annet
- ☐ Uopplyst

17. Hvis annet, angi

18. DNA-match funnet?
- ☐ Nei
- ☐ Ja, vattpinner tatt fra fornærmede matcher mistenkte
- ☐ Nei, vattpinner tatt fra fornærmede, annet mannlig DNA
- ☐ Ja, vattpinner tatt fra mistenkte, fornærmedes DNA
- ☐ Ja, fra truse tatt fra fornærmede, matcher mistenkte
- ☐ Nei, fra truse tatt fra fornærmede, annet mannlig DNA
- ☐ Ja, fra andre klær tatt fra fornærmede, matcher mistenkte
- ☐ Nei, fra andre klær tatt fra fornærmede, annet mannlig DNA
- ☐ Ja, av klær tatt fra mistenkte, matcher fornærmedes DNA
- ☐ Ja, av laken, sneip, blod eller annet fra åsted, matcher fornærmedes og mistenktes DNA
- ☐ Ja, fostervannsprøve/abortmateriale matcher mistenktes DNA
- ☐ Nei, fostervannsprøve/ abortmateriale mismatcher mistenktes DNA
- ☐ Annet
- ☐ Uopplyst
- ☐ Ikke aktuelt

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Politiregistrering voldtekt

Cecilie Hagemann
St. Olavs Hospital (400)

Participant No: 2001001 **Inclusion date:** 06/06/2011 Annen deltager / Another participant

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Rettstoksikologi

1. Er det tatt blod og/eller urinprøve av fornærmede?
   - ○ Nei
   - ○ Ja, hos Overgrepsenheten, St Olavs Hospital
   - ○ Ja, av andre
   - ○ Uopplyst
2. Tid for blod/urinprøve fornærmede, dato (dd.mm.åååå)
3. Tid for blod/urinprøve fornærmede, klokkeslett (tt:mm)
4. Rusprøver av fornærmede sendt hvor?
   - ○ Farmak.avd. St.Olavs Hospital
   - ○ Folkehelseinst. i Oslo
   - ○ Annet
   - ○ Uopplyst
   - ○ Ikke aktuelt
5. Hvis annet, angi
6. Hvis ja, hvilke stoffer ble eventuelt påvist hos fornærmede?
   - ☐ Ingen
   - ☐ Etanol
   - ☐ Benzodiazepiner
   - ☐ Annet
   - ☐ Uopplyst
   - ☐ Ikke aktuelt
7. Hvis annet, angi
8. Er det tatt blod og/eller urinprøve av mistenkte I?
   - ○ Nei
   - ○ Ja
   - ○ Uopplyst
   - ○ Ikke aktuelt
9. Hvis ja, hvem tok prøven?
10. Er det tatt blod og/eller urinprøve av mistenkte II?
    - ○ Nei
    - ○ Ja
    - ○ Uopplyst
    - ○ Ikke aktuelt

    Save
11. Hvis ja, hvem tok prøven?
12. Er det tatt blod og/eller urinprøve av mistenkte III?
    - ○ Nei
    - ○ Ja
    - ○ Uopplyst
    - ○ Ikke aktuelt
13. Hvis ja, hvem tok prøven?
14. Tid for blod/urinprøve mistenkte I dato (dd.mm.åååå)
15. Tid for blod/urinprøve mistenkte I klokkeslett (tt:mm)
16. Tid for blod/urinprøve mistenkte II dato (dd.mm.åååå)
17. Tid for blod/urinprøve mistenkte II klokkeslett (tt:mm)
18. Tid for blod/urinprøve mistenkte III dato (dd.mm.åååå)

19. Tid for blod/urinprøve mistenkte III klokkeslett (tt:mm)

20. Rusprøver av mistenkte I sendt hvor?
- ○ Farmak.avd. St.Olavs Hospital
- ○ Folkehelseinst. i Oslo
- ○ Annet
- ○ Uopplyst
- ○ Ikke aktuelt

Save

21. Hvis annet, angi

22. Rusprøver av mistenkte II sendt hvor?
- ○ Farmak.avd. St.Olavs Hospital
- ○ Folkehelseinst. i Oslo
- ○ Annet
- ○ Uopplyst
- ○ Ikke aktuelt

23. Hvis annet, angi

24. Rusprøver av mistenkte III sendt hvor?
- ○ Farmak.avd. St.Olavs Hospital
- ○ Folkehelseinst. i Oslo
- ○ Annet
- ○ Uopplyst
- ○ Ikke aktuelt

25. Hvis annet, angi

26. Hvis ja, hvilke stoffer ble eventuelt påvist hos mistenkte I?
- ☐ Ingen
- ☐ Etanol
- ☐ Benzodiazepiner
- ☐ Annet
- ☐ Uopplyst
- ☐ Ikke aktuelt

27. Hvis ja, hvilke stoffer ble eventuelt påvist hos mistenkte II?
- ☐ Ingen
- ☐ Etanol
- ☐ Benzodiazepiner
- ☐ Annet
- ☐ Uopplyst
- ☐ Ikke aktuelt

28. Hvis ja, hvilke stoffer ble eventuelt påvist hos mistenkte III?
- ☐ Ingen
- ☐ Etanol
- ☐ Benzodiazepiner
- ☐ Annet
- ☐ Uopplyst
- ☐ Ikke aktuelt

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Variabler fra Overgrepsenhetens registre

Opplysninger om fornærmede

1. Alder

2. Kjønn
   - Mann
   - Kvinne
   - Uopplyst

3. Bostedsadresse
   - Trondheim by
   - Sør-Trøndelag utenom byen
   - Utenfor fylket
   - Utenfor landet
   - Uopplyst

4. Er fornærmede i arbeid utenfor hjemmet?
   - Nei
   - Ja
   - Uopplyst

5. Hvis nei
   - Husmor
   - Skoleelev
   - Student
   - På stønad
   - Arbeidsledig
   - Annet
   - Uopplyst

6. Hvis annet, hva

7. Hvis ja, hvilken type arbeid?

8. Hvilken utdannelse har fornærmede?
   - Mindre enn 9 år
   - 9 - 12 år
   - Høyskole
   - Universitet
   - Uopplyst

9. Sivilstand nå
   - Ikke flyttet hjemmefra
   - Aleneboende
   - Samboende
   - Gift
   - Separert
   - Skilt
   - Uopplyst

10. Sivilstand tidligere
    - Samboende
    - Gift
    - Separert
    - Annet
    - Uopplyst

    Save

11. Hvis annet, angi

12. Antall barn

13. Antall svangerskap

14. Etnisitet

- ○ Norsk
- ○ Annet
- ○ Ikke-norsk, vestlig
- ○ Ikke-norsk, ikke-vestlig

15. Hvis annet, angi

Overgriper(e)
Opplysninger føres på I & II & III etter hvem som er viktigst, hvis flere

16. Relasjon til fornærmedes familie, mistenkt I

- ☐ Far/stefar
- ☐ Mor/stemor
- ☐ Søsken *
- ☐ Bestefar/-mor
- ☐ Onkel/tante/søskenbarn
- ☐ Annen slekt **
- ☐ Ektemann/samboer
- ☐ Tidligere ektemann
- ☐ Kjæreste
- ☐ Uoppl. familie/partner

* Bror, stebror, søster, stesøster ** Sønn, datter

17. Relasjon til fornærmedes familie, mistenkt II

- ☐ Far/stefar
- ☐ Mor/stemor
- ☐ Søsken *
- ☐ Bestefar/-mor
- ☐ Onkel/tante/søskenbarn
- ☐ Annen slekt **
- ☐ Ektemann/samboer
- ☐ Tidligere ektemann
- ☐ Kjæreste
- ☐ Uoppl. familie/partner

* Bror, stebror, søster, stesøster ** Sønn, datter

18. Relasjon til fornærmedes familie, mistenkt III

- ☐ Far/stefar
- ☐ Mor/stemor
- ☐ Søsken *
- ☐ Bestefar/-mor
- ☐ Onkel/tante/søskenbarn
- ☐ Annen slekt **
- ☐ Ektemann/samboer
- ☐ Tidligere ektemann
- ☐ Kjæreste
- ☐ Uoppl. familie/partner

* Bror, stebror, søster, stesøster ** Sønn, datter

19. Relasjon UTENOM familie/par, mistenkte I

- ☐ Venn/bekjent *
- ☐ Ukjent fra før/tilfeldig **
- ☐ Fremmede ***
- ☐ Autoritetsperson ****
- ☐ Annet
- ☐ Internett-kontakt
- ☐ Kundeforhold *****
- ☐ Uopplyst

* Arbeidskamerat, skole/studie-kamerat ** Møtt innenfor de siste 24 timer *** Aldri sett før **** Lærer, sjef, behandler, pleier, offentlig tjenestemann (politi mm), taxisjåfør med mer. ***** Ved salg av seksuelle tjenester

20. Hvis autoritetsperson eller annet, angi

Save

21. Relasjon UTENOM familie/par, mistenkte II

- ☐ Venn/bekjent *
- ☐ Ukjent fra før/tilfeldig **
- ☐ Fremmede ***
- ☐ Autoritetsperson ****
- ☐ Annet

- [ ] Internett-kontakt
- [ ] Kundeforhold *****
- [ ] Uopplyst

* Arbeidskamerat, skole/studie-kamerat ** Møtt innenfor de siste 24 timer *** Aldri sett før **** Lærer, sjef, behandler, pleier, offentlig tjenestemann (politi mm), taxisjåfør med mer. ***** Ved salg av seksuelle tjenester

22. Hvis autoritetsperson eller annet, angi

23. Relasjon UTENOM familie/par, mistenkte III

- [ ] Venn/bekjent *
- [ ] Ukjent fra før/tilfeldig **
- [ ] Fremmede ***
- [ ] Autoritetsperson ****
- [ ] Annet
- [ ] Internett-kontakt
- [ ] Kundeforhold *****
- [ ] Uopplyst

* Arbeidskamerat, skole/studie-kamerat ** Møtt innenfor de siste 24 timer *** Aldri sett før **** Lærer, sjef, behandler, pleier, offentlig tjenestemann (politi mm), taxisjåfør med mer. ***** Ved salg av seksuelle tjenester

24. Hvis autoritetsperson eller annet, angi

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Hendelsen

1. Åsted for initial kontakt (møteplass)?
   - ☐ Hjemme hos fornærmede
   - ☐ Hjemme hos overgriper
   - ☐ Annet privat sted
   - ☐ Offentlig lokale
   - ☐ Utendørs
   - ☐ Transportmiddel
   - ☐ Uopplyst
   - ☐ Fornærmede husker ikke
2. Spesifiser evt.
3. Åsted for overgrepet?
   - ☐ Hjemme hos fornærmede
   - ☐ Hjemme hos overgriper
   - ☐ Annet privat sted
   - ☐ Offentlig lokale
   - ☐ Utendørs
   - ☐ Transportmiddel
   - ☐ Uopplyst
   - ☐ Fornærmede husker ikke
4. Spesifiser evt.
5. Beskriv den fysiske volden?
   - ☐ Ingen
   - ☐ Trussel om vold
   - ☐ Trussel om hevn
   - ☐ Mildere *
   - ☐ Drag i håret
   - ☐ Suging
   - ☐ Biting
   - ☐ Klyping med hender
   - ☐ Halsgrep/kvelning med rep etc.
   - ☐ Kneblet/holdt for munnen
   - ☐ Fastbinding
   - ☐ Moderat **
   - ☐ Klyping med verktøy, pisking etc.
   - ☐ Brenning(for eksempel m/sigarett)
   - ☐ Skjæring (for eksempel m/kniv)
   - ☐ Grovere vold
   - ☐ Bruk av våpen
   - ☐ Annet
   - ☐ Uopplyst
   - ☐ Fornærmede husker ikke
   - ☐ Fornærmede hindret i å komme seg unna ***
   - ☐ Tvungen abduksjon av beina

   * Holdt fast ** Slag, spark *** Holdt av andre, døra låst, bundet osv.
6. Hvis annet, oppgi

   Max 255 characters. remaining.
7. Annet, forts.

Max 255 characters. remaining.

8. Hva slags reaksjoner fra fornærmede?

- ☐ Ingen, fulgte instrukser/krav
- ☐ Verbal motstand *
- ☐ Fysisk motstand
- ☐ Handlingslammet
- ☐ Annet
- ☐ Uopplyst

* F.eks skriker, forhandler med overgriper

9. Hvis annet, oppgi

10. Seksuell handling

- ☐ Ingen
- ☐ Beføling kropp *
- ☐ Klemming
- ☐ Kyssing/slikking kropp
- ☐ Beføling kjønnsorgan **
- ☐ Forsøk inntrengning ***
- ☐ Vaginal inntrengning av penis
- ☐ Vaginal inntrengning av fingre
- ☐ Vaginal inntrengning av fremmedlegeme
- ☐ Slikking av offerets kjønnsorgan (cunnilingus)
- ☐ Anal inntrengning av penis
- ☐ Anal inntrengning av fingre
- ☐ Anal inntrengning av fremmedlegeme
- ☐ Slikking av offerets anus (anilingus)
- ☐ Oral inntrengning av penis (fellatio)
- ☐ Oral inntrengning av fingre
- ☐ Oral inntrengning av fremmedlegeme
- ☐ Tvunget til å suge overgriper
- ☐ Tvunget til å onanere overgriper
- ☐ Gnir penis mot fornærmede
- ☐ Samleieliknende bevegelser
- ☐ Annet
- ☐ Fornærmede husker ikke
- ☐ Usikker/Uopplyst

* Inkl. bryst ** Ikke inntrenging *** Vaginalt, analt, oralt

Save

11. Hvis fremmedlegeme, hva?

12. Hvis annet, angi

13. Sædavgang

- ☐ Nei
- ☐ Usikker
- ☐ Vaginalt
- ☐ Oralt
- ☐ Analt
- ☐ Annet sted på kroppen
- ☐ På klær/sengetøy
- ☐ Andre steder
- ☐ Uopplyst

14. Hvis annet, angi

15. Kondom benyttet?

- Nei
- Ja
- Fornærmede vet ikke
- Annet
- Uopplyst

Seksuell historie/ graviditet

16. Hvis gravid som følge av overgrep
- Svangerskapsavbrudd
- Fostervannsprøve
- Fødsel
- Annet
- Uopplyst

17. Hvis annet, oppgi

18. Seksuell debut/virgo?
- Debut ved aktuelle SO
- Debutert før aktuelle hendelse
- Nei
- Annet
- Uopplyst

19. Hvis annet, oppgi

20. Siste frivillige samleie
- Debut ved aktuelle SO
- For < 72 timer siden
- 3-7 døgn siden
- 7-14 døgn siden
- > 14 døgn siden
- Uopplyst

Save

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Sykehistorie og funn

1. Tidl fysiske /seksuelle overgrep (SO)
   - ☐ Aldri
   - ☐ SO i barndommen*
   - ☐ SO v/partner
   - ☐ Annet
   - ☐ Fys. overgr. barndom
   - ☐ Fys. overgr. annet
   - ☐ Fys. overgr. partner
   - ☐ SO ukjent overgr.
   - ☐ SO (ikke partner)
   - ☐ Uopplyst
   - ☐ SO 12-16 år
   - ☐ SO > 16 år
   - ☐ SO annet

   *Barndommen vil si < 12 år
2. Hvis annet, angi
3. Prevensjon, nå
   - ☐ Ingen
   - ☐ Kondom
   - ☐ P-piller/p-plaster/ring
   - ☐ Spiral
   - ☐ P-sprøyte/ p-stav
   - ☐ Sterilisert/ hysterektomert
   - ☐ Annet
   - ☐ Uopplyst
4. Hvis annet, angi
5. Psykiske reaksjoner ved undersøkelsestidspunktet (alvorligste)
   - ○ Ingen ved undersøkelsen
   - ○ Moderate psykiske reaksjoner *
   - ○ Alvorlige psykiske reaksjoner **
   - ○ Vanskelig å vurdere
   - ○ Annet
   - ○ Uopplyst

   * Gråt, innesluttethet, lett angst, sinne eller verbal aggresjon ** Alvorlig angst, tilbaketrukkenhet, bevissthetsinnsnevring, desorientering, fortvilelse/håpløshet, hyperaktivitet, ubehersket eller overdreven sorgreaksjon
6. Hvis annet, angi
7. ✱ Fysiske skader på kroppen utenom genitalia (alvorligste skader)
   - ☐ Ingen
   - ☐ Lette, blåflekker, skrubbsår
   - ☐ Moderate: sår, kutt *
   - ☐ Alvorlige: brudd, mistanke om indre skader
   - ☐ Merker etter halsgrep
   - ☐ Skjæresår
   - ☐ Uopplyst
   - ☐ Kroppslig us ikke gjort

   * Her menes ikke skjæresår
8. Beskriv fysiske skader nærmere:

Max 255 characters. remaining.

9. Gynekologiske funn

- ☐ Ingen forandringer
- ☐ Lokal rødme, hevelse
- ☐ Rifter, overflatesår
- ☐ Større skade
- ☐ Annen skade
- ☐ Annet, sykdom
- ☐ Gynekologisk undersøkelse ikke utført
- ☐ Uopplyst

10. Beskriv gynekologisk funn nærmere:

Max 255 characters. remaining.

Save

11. Tidligere psykiatrisk sykehistorie

- ☐ Nei
- ☐ Ja, uspes
- ☐ Tidligere innlagt psyk
- ☐ Tidligere psyk. beh.
- ☐ Tidligere alkohol/rusmisbruker *
- ☐ Ukjent

* Tidligere, dvs tørrlagt

12. Handikapp / funksjonshemmet

- ☐ Nei
- ☐ Psykisk, uspes
- ☐ Fysisk, uspes
- ☐ Alkohol/rusmisbruker *
- ☐ Psykisk utviklingshemmet
- ☐ Andre fysiske (sanser, motorikk)

* Nåværende, hvilke(t) rusmiddel

13. Angi evt. rusmiddel

Alkohol/rus

14. Alkohol (forurettede)

- ☐ Intet alkoholinntak
- ☐ Mindre inntak (< 5 alkoholenheter *)
- ☐ Større inntak (5 alkoholenheter eller mer/evt. synlig beruset).
- ☐ Større inntak med amnesiperiode (”Black outs” eller dyp søvn)
- ☐ Uaktuelt – gammel sak eller residiverende overgrep
- ☐ Ingen opplysninger

* 1 alkoholenhet = 33 cl øl, 1 glass vin eller 1 drink

15. Påført rus

- ○ Nei, ingen mistanke om dette
- ○ Ja, mener å være påført rusmiddel/legemiddel

16. Mistanke om spes. stoff? mengde?

Max 255 characters. remaining.

17. Annet rusmiddel/legemiddel (fornærmede) *

- Nei
- Ja
- Usikkert

*Selvrapportert inntak (frivillig)

18. Hvilke(t) stoff(er), mengde:

Max 255 characters. remaining.

Andre opplysninger / Additional Information or Corrections

Lagre svar / Save and view log | Tilbakestill skjema / Reset

Vis svarhistorikk / View log | Print page

If System Error, Print Screen and send image to Berit.Bjelkasen@ntnu.no | Last updated: 29.06.2011

Appendix 3

St. Olavs Hospital HF
Universitetssykehuset i Trondheim

HELSE MIDT-NORGE

Trondheim, januar 2011

Informasjon om forskningsprosjekt

Vi henvender oss til deg på grunn av at du er registrert som tidligere pasient ved St Olavs Hospital i perioden 2003 – 2010.

Vi vil med dette informere deg om at vi planlegger å foreta en studie ved St Olavs Hospital fra den samme tidsperioden. Studien vil ta utgangspunkt i skriftlige sykehusjournaler, prøvesvar, samt eventuelle ultralyd- og røntgenundersøkelser som måtte foreligge. Alle opplysningene og prøvene vil bli behandlet uten navn og fødselsnummer eller andre direkte gjenkjennende opplysninger. Det vil ikke være mulig å identifisere deg i resultatene av studien når disse publiseres.

Studien vil ikke medføre noen ekstra samtale, undersøkelse eller behandling for deg.

Studien er godkjent av den regionale komiteen for medisinsk og helsefaglig forskningsetikk.

Det er frivillig å delta i studien. Dersom du *ikke* ønsker at dine journalopplysninger skal brukes eller har spørsmål til studien, kan du kontakte prosjektleder **Cecilie Hagemann på telefon 72 57 38 25 eller 73 59 75 37**. Alternative telefonnummer er gynekologisk poliklinikk 72 57 47 19 eller 72 57 47 09.

Vennlig hilsen

Cecilie Hagemann
Prosjektleder og overlege ved Kvinneklinikken
St Olavs Hospital HF
7006 Trondheim

Appendix 4

Fra: post@helseforskning.etikkom.no
Sendt: 09.11.2010
Til: cecilie.hagemann@stolav.no;rek-4@medisin.ntnu.no
Emne: REK midt; Endelig godkjenning av prosjekt 2010/1941

Vedrørende prosjektsøknad "Skademønster og rusmiddelfunn blant ofre for seksuelle overgrep" (saksnummer 2010/1941).

Med hjemmel i lov om behandling av etikk og redelighet i forskning § 4 og helseforskningsloven (hfl.) § 10 har Regional komité for medisinsk og helsefaglig forskningsetikk Midt-Norge vurdert prosjektet i sitt møte 24. september 2010. Komiteen viser til prosjektprotokoll, målsetting og plan for gjennomføring, og finner at prosjektet har et forsvarlig opplegg som kan gjennomføres under henvisning til evt. merknader og vilkår for godkjenning, jf. hfl. § 5.

Merknader og vilkår:

-Komiteen godkjenner informasjonsskrivet under forutsetning av at skrivet revideres i henhold til skriftlig tilbakemelding fra REK Midt datert 05.11.10.

-Komiteen vil presisere at prosjektmedarbeiderne har taushetsplikt i henhold til hfl. § 7. Personopplysninger skal behandles konfidensielt, og undersøkelsesresultater inkludert evt. navnelister, oppbevares forskriftsmessig. Alle personopplysninger skal i den grad det er praktisk mulig oppbevares avidentifisert/kryptert, jf. hfl. § 32, og i minimum fem år etter prosjektslutt.

-Prosjektleder skal sende sluttmelding til den regionale komiteen for medisinsk og helsefaglig forskningsetikk når forskningsprosjektet avsluttes. I sluttmeldingen skal resultatene presenteres på en objektiv og etterrettelig måte, som sikrer at både positive og negative funn fremgår, jf. hfl. § 12.

Vedtak:

”Regional komité for medisinsk og helsefaglig forskningsetikk, Midt-Norge godkjenner at prosjektet gjennomføres med de vilkår som er gitt.”

Vedtaket kan påklages og klagefristen er tre uker fra mottagelsen av dette brev, jf. hfl. § 10 og fvl. §§ 28 og 29. Klageinstans er Den nasjonale forskningsetiske komité for medisin og helsefag (NEM), men en eventuell klage skal rettes til REK Midt-Norge. Avgjørelsen i NEM er endelig. Det følger av fvl. § 18 at en part har rett til å gjøre seg kjent med sakens dokumenter, med mindre annet følger av de unntak loven oppstiller i §§ 18 og 19.

Vennlig hilsen

Sven Erik Gisvold
leder, REK Midt

Hilde Eikemo
rådgiver, REK Midt

Appendix 5

REK
REGIONALE KOMITEER FOR MEDISINSK OG HELSEFAGLIG FORSKNINGSETIKK

Region:	Saksbehandler:	Telefon:	Vår dato:	Vår referanse:
REK midt	Linda Tømmerdal Roten	73597506	12.12.2016	2011/276/REK midt
			Deres dato:	**Deres referanse:**
			07.12.2016	

Vår referanse må oppgis ved alle henvendelser

Cecilie Therese Hagemann
NTNU

2011/276 092-04 Medisinske funn og rettslig utfall ved seksuelle overgrep mot voksne kvinner
Vi viser til søknad om søknader om prosjektendringer mottatt 05.12.2016 og 07.12.2016 for ovennevnte forskningsprosjekt. Søknadene om prosjektendringer er behandlet på fullmakt av REK midts sekretariat med hjemmel i helseforskningsloven § 11 og forskrift om behandling av etikk og redelighet i forskning § 10.

Det søkes her om:

1. Forlengelse av prosjektet til ny sluttdato 31.12.2020. Opprinnelig sluttdato for prosjektet var 31.12.2015.
2. Endring av prosjektgruppen ved at seniorforsker Jim Aage Nøttestad (som nylig døde) går ut av gruppen og ph.d.-kandidat Bjarte Frode Vik som er overlege i psykiatri ved St. Olavs Hospital inkluderes i gruppen.

Vurdering
REK midt har vurdert søknader om prosjektendringer. Komiteen har ingen forskningsetiske innvendinger mot endringene av prosjektet. Under forutsetning av at vilkårene nedenfor tas til følge, er hensynet til deltakernes velferd og integritet fremdeles godt ivaretatt.

Vilkår for godkjenning

1. Godkjenningen er gitt under forutsetning av at prosjektet gjennomføres slik det er beskrevet i søknaden, protokollen og prosjektendringene datert 05.12.2016 og 07.12.2016. Prosjektet må også gjennomføres i henhold til tidligere vedtak i saken og de bestemmelser som følger av helseforskningsloven (hfl.) med forskrifter.
2. Prosjektleder skal sende søknad om prosjektendring til REK midt dersom det skal gjøres vesentlige endringer i forhold til de opplysninger som er gitt i søknaden, jf. hfl. § 11.
3. Prosjektleder skal sende sluttmelding til REK midt på eget skjema senest 30.06.2021 (6 måneder etter prosjektslutt), jf. hfl. § 12. I sluttmeldingen skal resultatene presenteres på en objektiv og etterrettelig måte, som sikrer at både positive og negative funn fremgår, jf. helseforskningsloven § 12.
4. Forskningsprosjektets data skal oppbevares forsvarlig, se personopplysningsforskriften kapittel 2, og Helsedirektoratets veileder for «Personvern og informasjonssikkerhet i forskningsprosjekter innenfor helse- og omsorgssektoren». Av kontrollhensyn skal prosjektdata oppbevares i 5 år etter sluttmelding er sendt REK. Data skal derfor oppbevares til denne datoen, for deretter å slettes eller anonymiseres, jf. hfl. § 38.

Besøksadresse:
Det medisinske fakultet
Medisinsk teknisk forskningssenter 7489
Trondheim

Telefon: 73597511
E-post: rek-midt@medisin.ntnu.no
Web: http://helseforskning.etikkom.no/

Vedtak
Regional komité for medisinsk og helsefaglig forskningsetikk Midt-Norge godkjenner søknad om prosjektendring med de vilkår som er gitt.

Klageadgang
Du kan klage på komiteens vedtak, jf. forvaltningsloven § 28 flg. Klagen sendes til REK midt. Klagefristen er tre uker fra du mottar dette brevet. Dersom vedtaket opprettholdes av REK midt, sendes klagen videre til Den nasjonale forskningsetiske komité for medisin og helsefag for endelig vurdering.

Med vennlig hilsen

Hilde Eikemo
Sekretariatsleder, REK midt

Linda Tømmerdal Roten
Rådgiver

Kopi til: *post.kvinne@stolav.no; rek-lbk@medisin.ntnu.no; rek-midt@medisin.ntnu.no*

Appendix 6

RIKSADVOKATEN

NTNU
Det medisinske fakultet
Universitetslektor/overlege Cecilie Hagemann
7491 Trondheim

DERES REF.:	VÅR REF.:	DATO:
	2014/00471-016 AGR/ggr 639.2	07.12.2016

FRITAK FOR TAUSHETSPLIKT – PROSJEKTET MEDISINSKE FUNN OG RETTSLIG UTFALL VED SEKSUELLE OVERGREP MOT VOKSNE KVINNER

Det vises til brev av 5. desember 2015, hvor det ble opplyst at en av prosjektmedarbeiderne, Jim Aage Nøttestad, har avgått ved døden. Det er søkt om å erstatte ham med en ny prosjektmedarbeider, psykiater og overlege Bjarte Frode Vik ved St. Olavs Hospital.

Riksadvokaten har tidligere forelagt søknader om fritak for taushetsplikt fra de øvrige forskningsmedarbeiderne i prosjektet for Rådet for taushetsplikt og forskning. Rådet har samtykket til at det dispenseres fra taushetsplikten i samsvar med søknadene, under den forutsetning at innsamling, oppbevaring og bruk av opplysningene må foregå på en faglig forsvarlig måte, samt at alle personidentifiserende opplysninger anonymiseres ved eventuelle publikasjoner.

Riksadvokaten samtykker til fritak for taushetsplikt i tråd med søknaden og under denne forutsetningen.

Riksadvokaten har ikke funnet grunn til å forelegge søknaden for Rådet for taushetsplikt og forskning. Det vises til at Rådet tidligere har samtykket til at det dispenseres fra taushetsplikten under nevnte forutsetning, at søkeren representerer et sterkt fagmiljø samt formålet med prosjektet. Politiregisterloven § 33 gir riksadvokaten mulighet til å dispensere fra taushetsplikten slik at personer utenfor politiet og påtalemyndigheten kan bruke opplysninger fra straffesaker til bruk i forskningsøyemed. Vilkårene er at det "finnes rimelig og ikke medfører uforholdsmessig ulempe for andre interesser." Riksadvokaten finner det klart at søknaden bør innvilges. Vedtak kan derfor treffes uten å forelegge søknaden for Rådet, jf. forvaltningslovforskriften § 9 annet ledd.

Postadresse:
Postboks 8002 Dep
0030 Oslo

Kontoradresse:
Stortorvet 2
0155 Oslo

Telefon: +47 22 47 78 50
Telefaks: +47 22 33 31 12
E-post: postmottak@riksadvokaten.no

Vedlagt følger en taushetserklæring i to eksemplarer, og det bes om at Bjarte Frode Vik undertegner og returnerer det ene eksemplaret. Utskrift av lovreglene som det er vist til i taushetserklæringen følger også vedlagt.

Knut Erik Sæther
ass. riksadvokat

Anne Grøstad
førstestatsadvokat

Vedlegg

Gjenpart: Rådet for taushetsplikt og forskning (sak 2015/9, 2014/5 og brev av 9. august 2004)