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Olga Fernández-García, María Dolores Gil-Llario and Rafael Ballester-Arnal

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Sexual Victimization of Adolescents in Residential Care: Self-Reported and Other-Reported Prevalence

Q1 Q2 Q3 Olga Fernández-García [a], María Dolores Gil-Llario [a], and Rafael Ballester-Arnal [b]

[a]Department of Developmental and Educational Psychology, Faculty of Psychology, University of Valencia; [b]Department of Basic and Clinical Psychology and Psychobiology, Faculty of Health Sciences, Jaume I University

ABSTRACT

Adolescents in the child welfare system have been exposed to multiple forms of victimization, most notably sexual victimization, many times underreported and misreported. The main aim of this study was to explore the lifetime prevalence of sexual victimization among adolescents in residential care in Eastern Spain, contrasting self-reported information compared to the information reported by the professionals. Sexual abuse/assault characteristics and effects of gender and age were analyzed. Additionally, the association between sexual revictimization and the relationship with the aggressor as well as the age of the first episode of sexual abuse/assault was analyzed. The sample comprised 346 adolescents (34.1% females, 65.9% males) aged between 11 and 19 years old. The prevalence of sexual victimization reported by adolescents was 35.3%, more than double compared to the information reported by professionals (16.9%). Females experienced significantly more sexual victimization than males (OR = 0.23, 95% CI [0.14, 0.37]). The age of the victim at the first episode of sexual abuse/assault and the relationship with the aggressor were explanatory variables of revictimization. Research such as this is crucial to ascertain that these adolescents have very different needs that will influence the design of affective-sexual education initiatives, which are essential to ensure healthy sexual development.

Introduction

Children and adolescents in the child welfare system are considered a particular vulnerable group (Euser et al., 2014; Indias et al., 2019). This is the case for boys and girls who are in residential care, either because it is the most appropriate measure in view of their particular circumstances or because it is pending consideration of whether their home context improves or whether there is a foster care family that adequately meets their needs (Dirección General de Infancia y Adolescencia [DGIA], 2017). Most of them, prior to being cared for in residential care, have suffered multiple direct and/or indirect forms of victimization that may have contributed to forging their exit from their home (Browne, 2009; Collin-Vézina et al., 2011). These negative experiences can disrupt the child's healthy biopsychosocial development from a very early age (American Academy of Pediatrics, 2012).

Sexual victimization, any sexual behavior under coercion, manipulation or use of violence, has been shown to be one of the most frequent problems among adolescents and young adults in residential care. Indias et al. (2019) recruited adolescents from 24 residential care facilities in two Spanish regions and they reported that 41.1% of their sample had been victims of some form of sexual victimization in their lifetime, with higher prevalence than other regions in north-Eastern Spain (29.5%; Segura et al., 2015), but lower than in other European studies (62%; Allroggen et al., 2017 in Germany) and similar to other developed countries (38.3%; Wekerle et al., 2017 in Canada). In any case, these data are alarming when compared to results from studies that have recruited adolescents from the general community, which report much lower prevalence (8.7%, Pereda et al., 2014 in Spain; 10%, Sani et al., 2021 in Portugal; 15.1%, Méndez-López & Pereda, 2019 in Mexico). These data not only highlight the harsh childhoods that children and adolescents living in residential care facilities have, but it may also hint at the greater likelihood that they will experience negative outcomes in multiple areas of their lives (Fergusson et al., 2013; Wekerle et al., 2017) compared to adolescents living in their family homes.

When the prevalence of sexual victimization, in particular of vulnerable groups is analyzed, the source of the information must be taken into account. Thus, it has been found that when data are self-reported by adolescents in residential care facilities, a much higher prevalence is disclosed than when the information comes from government reports (Euser et al., 2013; Gilbert et al., 2009). This could be due to the fact that, in most cases, government records only include officially reported cases and, as a result, the actual frequency of sexual violence is likely to be underestimated (Allroggen et al., 2017; Euser et al., 2013), especially considering that although many children and adolescents disclose their sexual victimization experiences to others, they don't make official reports (Herrera, 2006). Lower prevalence is also reported when the information is provided by residential professionals (Deutsches Jugendinstitut, 2011), although they do not only rely on officially reported cases. It should be noted that retrospectively self-reported information, while certainly reporting

CONTACT María Dolores Gil-Llario dolores.gil@uv.es Departamento de Psicología Evolutiva y de la Educación, Facultad de Psicología, Universitat de València, Av. Blasco Ibáñez, 21, València 46010, Spain

data that are more in line with reality, also includes considerable false negative rates (between 40 and 50%; Hardt & Rutter, 2004; Scott et al., 2010) and presents some limitations (such as it requires the victim to recall the traumatic event and recognize it as an experience of sexual victimization; Paine & Hansen, 2002). Therefore, the combination of information reported by two or more sources is the most adequate method to capture a more complete spectrum of sexual victimization cases (Negriff et al., 2017; Smith et al., 2008).

The studies about the most prevalent type of sexual victimization among adolescents are inconclusive. Many studies report that the most common sexual abuse/assault is the one committed by peers among young people (Allroggen et al., 2017; Euser et al., 2013; Indias et al., 2019). However, others (e.g., Segura et al., 2015) have reported sexual abuse/assault by a known adult as the most frequent. These inconsistencies have also been found in studies with adolescents in community samples (Méndez-López & Pereda, 2019; Pereda et al., 2014). In addition, there have been limited studies interested in examining the profile of the perpetrator as a means to better understand the variables that may be influencing the high rate of sexual victimization among adolescents in residential care facilities. More than 70% of the cases the aggressor is male and is approximately the same age as the victim (Allroggen et al., 2017; Euser et al., 2013). These characteristics of the perpetrator are the same for those studies with adolescents from a community sample (UBS Optimus Foundation, 2012).

Both, research with adolescents in residential care facilities and research including community-sampled youth, report female participants having higher rates of reporting sexual victimization experiences than male participants (Allroggen et al., 2017; Euser et al., 2013; Indias et al., 2019; MacMillan et al., 2013; Méndez-López & Pereda, 2019; Pereda et al., 2014). Some studies attribute these gender differences to the internalization of social gender norms and male stereotypes by boys, which leads them to suffer greater stigmatization when they are victims and to feel guilty for not having been able to stop the aggressor (Esnard & Dumas, 2013; Wekerle et al., 2017). In relation to the age of the participants at the time of assessment, although research has rarely concluded the existence of significant differences between the different age groups (Euser et al., 2013; Segura et al., 2015), older adolescents do seem to report a slightly higher percentage of lifetime sexual victimization compared to younger adolescents in residential care (Indias et al., 2019; Segura et al., 2015). These results are also similar among young people in community samples (Finkelhor et al., 2014; Méndez-López & Pereda, 2019; Pereda et al., 2014). The most commonly found justification is that older adolescents have had a longer period of time to experience these victimizations (Finkelhor, Ormrod et al., 2009) and their advanced metacognitive development allows them to more easily retrieve past memories and repeat these experiences (Ensink et al., 2016; Finkelhor, Ormrod et al., 2009).

There is a lack of studies focusing on age and frequency of victimization among children and adolescents living in residential care. However, among the few published studies, it has been found that victims are frequently victimized in more than one context and this makes them more likely to suffer multiple episodes of sexual abuse/assault (Finkelhor, Omrod et al., 2005; Turner et al., 2016). The multiple negative consequences of experiencing sexual victimization have been studied to a greater extent. Thus, the most common internalizing problems include depression, anxiety and post-traumatic stress disorder, and the most frequent externalizing problems include disruptive behavior at home and with peers and substance abuse (Finkelhor, Turner et al., 2009; Kendall-Tackett, 2009). This information is crucial to provide tailored and efficacious interventions among children and adolescents living in residential care to ensure adequate biopsychosocial development. In this way, government agencies will also be able to develop useful and effective action plans, which are as scarce as they are necessary at this time.

Finally, historically, the Eastern Spain, given its wealth and advantageous location, is overpopulated compared to other parts of Spain (the fifth most populated region in part of Spain; National Institute of Statistics, 2021). This part of Spain has had a significant growth of suburban areas (e.g., highest rural population growth of all Spanish regions in 2019, 34,000 people in a year; Regional Observatory of Valencia, 2019) where people have poorly paid jobs contributing to a greater number of dysfunctional families and, to that extent, to higher levels of neglect in the care of children, sometimes leading to child abuse (Mora Castro et al., 2018). This, together with the growing number of cases of sexual victimization of children and adolescents in residential care that are coming to light, makes the study of this controversial issue in this region of Spain especially relevant not only for academics and experts, but also for the general population and the government, which is becoming concerned about the characteristics of the adolescents in its care and aims to prevent this type of event from continuing to occur. In this regard, in recent years, a significant investment of resources has been made in the implementation of measures aimed at improving the care received by children and adolescents in the child welfare system. For all these reasons, we cannot rely on published data from regions with similar sociodemographic characteristics since this context has had and continues to have its own characteristics.

Objective of This Study

The first aim of our study was to assess the lifetime prevalence of sexual victimization of adolescents in residential care in Eastern Spain, and to describe the main characteristics of the different types of sexual victimization. To strengthen our evidence, we have obtained and contrasted information provided by both professionals and adolescents themselves. Having both sources of information will allow us to assess the degree of agreement between professionals and adolescents about the prevalence of sexual victimization. The second objective was to identify special vulnerable groups among adolescents in residential care facilities, analyzing differences in the prevalence of sexual victimization as a function of gender and age of the adolescent at the time he/she/they has been assessed, since

previous research has reported that both are important variables to explore in this group. The third and final aim was to examine whether the type of relationship with the aggressor and the age of the first episode of sexual abuse/assault could be variables related to the sexual revictimization of adolescents (greater number of episodes of sexual abuse/assault and/or more types of sexual victimization).

Method

Participants

The sample comprised 346 adolescents recruited from the child welfare system in Eastern Spain. All of them were teenagers who were in residential care because they had been deprived of their main rights and were in a situation of risk or lack of protection that endangered their physical and/or emotional well-being. In addition, although priority was given to the selection of centres located in urban areas with a medium population density, the representativeness of the population in rural areas was taken into account given their differential characteristics. Thus, in the final sample, around 16.19% of the participants were from cities with a population density >500,000, around 60.69% were from cities with a population density between 10,000 and 500,000, and around 23.12% were from cities with <10,000 inhabitants (considered rural areas).

Of them, 34.1% (n = 118) were female adolescents, while 65.9% (n = 228) were male adolescents. All participants in the study were between 11 and 19 years of age (M = 15.73; SD = 1.76). Almost half of the sample (48.5%, *n* = 167) were between 14 and 16 years old, followed by 39.2% (*n* = 135) between 17 and 19 years old and only 12.2% (*n* = 42) who were between 11 and 13 years old. Although the majority of adolescents (57.9%) were born in Spain, 29.7% in Morocco and the remaining nationalities were underrepresented (Eastern European: 4.7%; West African: 3.3%; South/Central American: 2.7%; Pakistani: 1.2%; and Portuguese: 0.6%). The majority were between 7th and 10th grade, (49.7%, *n* = 172), followed by those doing associate degree[1] (29.1%, n = 101); 7.3% (*n* = 25) were between 1st and 6th grade, 0.6% (*n* = 2) in 11th or 12th grade and 1.8% (*n* = 6) in unregulated courses. The rest worked (2.1%, *n* = 7) or did none of the above (9.4%, n = 33). Regarding health problems, while only 11% (*n* = 37) reported physical health problems, the percentage of adolescents with mental health problems amounted to 29.9% (*n* = 100).

The inclusion criteria established for the selection of the sample were: (1) being 11 years of age or older and, and (2) living in a residential care facility at the time of the interview. Finkelhor, Omrod et al. (2005) suggested that youth can respond to surveys on child maltreatment with reliable information after age 10.

[1]An associate degree is the first level of non-vocational degree you can pursue following a high school diploma. Typically designed to be completed in two years or less, associate degree programs include introductory courses through which students can start to learn about a particular field or academic discipline.

Measures

Child and Adolescent Protection System Form (CAPSys; Fernández-García et al., in press)

This instrument consists of 67 items, 58 closed-ended responses (dichotomous and multiple-choice), and 9 open-ended responses, grouped into six dimensions: *General information* (9 items), *School/work situation* (9 items), *Protection system history* (9 items), *Family visitation history* (9 items), *Biological family information* (24 items), and *Experiences of sexual abuse/maltreatment* (7 items). For this study, information related to the dimensions "*General information*" (basic information about the adolescent in terms of gender, date of birth, nationality, physical or mental health problems, etc.), "*School/work situation*" (information about the participant's occupation) and "*Experiences of sexual abuse/maltreatment*" (information available to the residential care facilities professionals about the participant's possible experiences of sexual abuse) was used. It is an instrument designed to be completed by a professional from the residential care facility who knows the child well and has access to his/her/their record. The internal consistency of the CAPSys dimensions, measured as Cronbach´s alphas (r), was r = 0.61, r = 0.74 and r = 0.78, respectively.

The Juvenile Victimization Questionnaire (JVQ; Finkelhor, Hamby et al., 2005)

The JVQ evaluates, in a self-reported format, 36 different types of victimization against children and youth grouped into six modules: conventional crime (nine items), caregiver victimization (four items), victimization by peers and siblings (six items), sexual victimization (six items), witnessing and indirect victimization (nine items), and electronic victimization (two items). For each item the presence or absence of this victimization experience was scored as 1 or 0, respectively. In the current study, only the sexual victimization module was used, which inquired about 4 specific lifetime experiences of this type of victimization (sexual abuse/assault by a known adult, sexual abuse/assault by an unknown adult, sexual abuse/assault by a peer, and flashing/sexual exposure). Evidence of the validity of the Spanish adaptation of the JVQ has shown adequate psychometric properties (Pereda et al., 2016). The reliability for the sexual victimization module was r = 0.62 in our study.

Procedure

First, permission was obtained from the Directorate General for Childhood and Adolescence (DGCA) of the Valencian Region, the administrative agency responsible for implementing steps to protect minors and who has guardianship over them. Subsequently, the coordinators and directors of the residential care facilities were contacted to explain the project and to request authorization from them to enter the centers. Once this first contact had been established, the center's staff explained the proposal to the youth of the residential care facility and appointments were arranged with the minors who wished to participate on a voluntary basis. No financial assistance or compensation was offered to participants.

Three professionals from the research team with extensive experience in the evaluation and treatment of minors were trained in the application of this battery of instruments, with the aim of avoiding or reducing as much as possible the interviewer bias in the evaluation of the participants and ensuring the maximum reliability and validity of the data collected. The application of the standardized instruments was carried out in person, individually and in a comfortable environment of maximum privacy. Only the participant and one of the evaluators were present while the assessment was being completed. Adolescents had the option to complete the instruments as a semi-structured interview with the professional or autonomously, depending on the participant's comfort as well as their level of comprehension, reading, and writing skills. All participants were informed of the confidentiality of their responses before beginning to complete the battery as well as their right to leave the study at any time. CAPSys had to be completed by a professional from the center (director, psychologist, educator, etc.) who knew the adolescent well, and who had been previously instructed to ensure full understanding of the items on the form. A single professional was in charge of reporting information on the adolescent. The professional extracted the information mainly from the participant's child welfare system report, which includes all of the adolescent's data since entering in the child welfare system. Likewise, in specific questions, the professional was expected to convey their general knowledge about the adolescent's behavior in the center or respond with the information that the boy or girl had transmitted directly to him or her on the subject. The expert (the senior author) was always available to resolve any doubts.

For this cross-sectional study, 60 residential care facilities in Eastern Spain were contacted, of which 47 were finally recruited. These homes and residences offer comprehensive and educational care to children and adolescents in care and/or guardianship who are deprived of a suitable family environment. The study complied with the ethical principles of the 1964 Declaration of Helsinki and was approved by the Experimental Research Ethics Committee of the University of Valencia (Spain).

Data Analysis

Descriptive analyses were conducted, including means and SDs for numerical variables, and percentages for categorical variables. For the JVQ sexual victimization module and each specific submodule we computed prevalence rates for lifetime, including odds ratios (OR), to compare across age, and beta coefficient (β) was used to compare gender groups. Variables related to sexual revictimization were explored by using logistic regressions and reporting ORs. OR was considered statistically significant when its 95% confidence interval (CI) did not include the value 1, and the β when its 95% CI did not include the value 0. Finally, to explore the variables related to sexual revictimization, the AC statistic for categorical variables and Pearson correlations for numerical variables were calculated to analyze the degree of agreement between the responses of both informants. The AC statistic, degree of agreement, can be interpreted as 0.25, 0.5, and 0.75 for small, median, and large level of concurrence, respectively (Gwet, 2002). SPSS v.24 was used for all data analysis and Excel to calculate degree of agreement.

Results

Self-Reported Sexual Victimization

In our sample, 35.3% of the adolescents (58.8% of female adolescents and 24.4% of male adolescents, *OR* = 0.23, 95% *CI* [0.14, 0.37]) reported at least one experience of sexual victimization during their lives. Sexual abuse/assault by a peer was the most common form of sexual victimization reported (21%). Differences between male and female participants were statistically significant for all types of sexual victimization reported, with boys reporting less sexual victimization than girls (Table 1). There were no statistically significant differences on any of the types of sexual victimization explored by age groups (Table 1). However, the percentage prevalence of sexual victimizations overall and for the sexual abuse/assault by a known adult was higher among older adolescents (17–19 years old) (37.9% and 16.7%, respectively), while adolescents between 14–16 years old reported a higher percentage of sexual abuse/assault by an unknown adult (8.8%). The percentage of sexual abuse/assault by a peer and flashing/sexual exposure was higher among younger adolescents (26.8% and 24.4%, respectively). Table 1 presents prevalence of different types of sexual victimization and differences between age and gender groups.

Considering the different types of sexual victimization (Table 2), sexual abuse/assault by a known adult was the one in which victims experienced more episodes (M (SD) = 7.92 (9.65)), and they were younger when this occurred (M (SD) = 10.18 (3.72)). Regardless of the type of victimization, the percentage of male offenders was higher, although the age of the perpetrator changed slightly depending on the type of sexual

Table 1. Prevalence of different types of sexual victimization in Spanish residential care adolescents reported by themselves, and differences between age and gender groups.

		Age group (%)				Gender (%)		
	Victimized *n* (%)	11–13	14–16	17–19	β (CI)[a]	M	F	OR (CI)[a]
Sexual victimization	122 (35.3)	34.1	35.6	37.9	0.007 (−0.02, 0.04)	24.4	58.8	**0.23** (0.14, 0.37)
S1. Sexual abuse/assault by a known adult	53 (15.9)	10	16.3	16.7	0.005 (−0.02, 0.03)	8.3	29.9	**0.21** (0.11, 0.39)
S2. Sexual abuse/assault by an unknown adult	25 (7.5)	4.9	8.8	6.1	−0.002 (−0.02, 0.01)	5.1	11.9	**0.39** (0.17, 0.90)
S3. Sexual abuse/assault by a peer	70 (21)	26.8	21.3	18.3	−0.02 (−0.04, 0.008)	15.3	31.4	**0.39** (0.23, 0.68)
S4. Flashing/sexual exposure	52 (15.5)	24.4	15.6	12.9	−0.02 (−0.4, 0.008)	9.7	26.3	**0.3** (0.16, 0.55)

Conditional percentage of the dependent variable knowing the category of the independent variable information.
[a]The 95% confidence interval does not include the null value (OR = 1; β = 0).

Table 2. Characteristics of each type of sexual victimization as self-reported by adolescents in residential care.

	Sexual victimization	S1. Sexual abuse/assault by a known adult	S2. Sexual abuse/assault by an unknown adult	S3. Sexual abuse/ assault by a peer	S4. Flashing/ sexual exposure
Average n° of times [M (SD)]	8.86 (11.49)	7.92 (9.65)	3.08 (5.79)	4.23 (5.79)	6.24 (8.27)
Average age of the adolescent [M (SD)][a]	11.39 (3.89)	10.18 (3.72)	11.83 (4.17)	12.81 (3.15)	12.04 (3.18)
Sex of perpetrator (%)					
Male	72.1	79.2	88	68.6	69.2
Female	25.4	18.9	12	30	26.9
Both	2.5	1.9	-	1.4	3.8
Average age of perpetrator [M (SD)][a]	26.62 (14.54)	36.26 (13.12)	31.46 (12.54)	14.7 (2.68)	22.31 (12.55)
Introduced any object (%)	39.1	40.4	28	32.9	25
Reported (%)	28.1	42.3	32	14.3	11.5
Talked about what happened (%)	26.9	44.2	28	12.9	9.6

[a]The age of the adolescent and the perpetrator refer to when the victimized experience occurred

victimization reported. Introduction of objects during the sexual abuse/assault was more frequent when the perpetrator was a known adult (40.4%). The victim usually reported to the police or the court or talked about what happened more often when the perpetrator was a known adult (42.3% and 44.2%, respectively). Sexual abuse/assault by a known adult was usually perpetrated by a family member (38.5%), while sexual abuse/assault by a peer was usually perpetrated by a classmate or a roommate (37.1%; Figure 1).

Almost half (45.08%) of the victims had suffered more than one form of sexual victimization (28.69% suffered two forms; 13.93% three forms; and 2.46% four forms of sexual victimization). All types of sexual victimization were shown to be predictive of increased sexual victimization in general (S1, *OR* = 8.39, 95% *CI* [5.1, 13.79]; S2, *OR* = 6.51, 95% *CI* [3.75, 11.3]; S3, *OR* = 7.43, 95% *CI* [4.76, 11.58]; S4, *OR* = 11.07, 95% *CI* [6.26, 19.59]). Having suffered more than one type of sexual victimization also showed significant positive correlations with the number of times the individual was victimized (r = 0.38, p < .001). Having suffered sexual abuse/assault by a family member was significantly positively associated with greater exposure to other types of abuse (r = 0.24, p = .01) and to happen more often (r = 0.29, p = .002) than other types of abuse. First time victimization age also exhibited significant positive correlations with greater revictimization (n° of types of sexual victimization, r = 0.38, p < .001; n° of times, r = – 0.39, p < .001)).

Other-Reported Sexual Victimization

Professionals reported that 16.9% of the participants were suspected of having suffered sexual victimization, and 51% of those cases were confirmed. There were statistically significant gender differences in the prevalence of sexual victimization reported by professionals (*OR* = 0.25, 95% *CI*

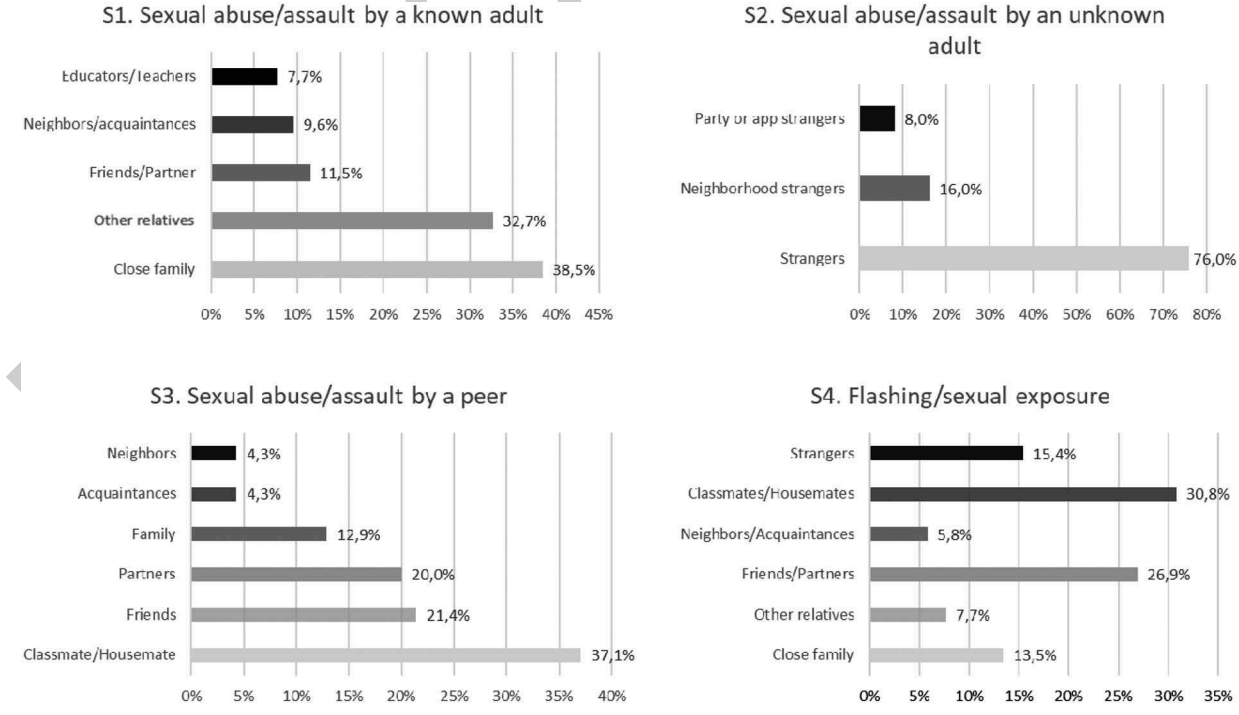

Figure 1. Perpetrator-victim linkage ("Who is the perpetrator") based on type of sexual victimization as self-reported by adolescents in residential care. Note: "*Stranger*" was understood as someone you have never seen and with whom you have never established contact of any kind prior to the sexual victimization even; "*Friend*" as a person with whom you have close ties of mutual affection that lead you to feel trust and real sincerity towards him or her; and "*Acquaintance*" as a person whom you know either because you have certain information about him or her or because you recognize his or her face identifying that it is not the first time you see him or her, but with whom you do not have a strong bond of affection that brings you trust and security.

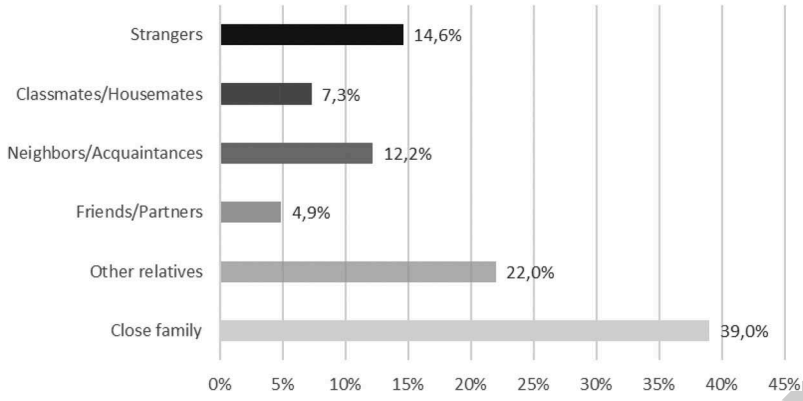

Figure 2. Perpetrator-victim linkage in the experiences of sexual victimization ("Who is the perpetrator") as reported by residential care professionals. Note: "*Stranger*" was understood as someone you have never seen and with whom you have never established contact of any kind prior to the sexual victimization even; "*Friend*" as a person with whom you have close ties of mutual affection that lead you to feel trust and real sincerity towards him or her; and "*Acquaintance*" as a person whom you know either because you have certain information about him or her or because you recognize his or her face identifying that it is not the first time you see him or her, but with whom you do not have a strong bond of affection that brings you trust and security.

[0.14, 0.45]), with male adolescents having the lowest percentages (male, 10%; female, 30.9% of the total of the sample). However, no statistically significant differences were found according to age (β = −0.007, 95% CI [−0.03, 0.16]; 11–13 years old, 20.5%; 14–16 years old, 18.2%; 17–19 years old, 14.8%). Professionals reported the perpetrators being mostly male adolescents (93.2%) known to the victim (91.5%) (mainly close family members, 39%; Figure 2). More than half of professionals (51.6%) reported emotional disorders as the sequelae of adolescents who had suffered sexual abuse and professionals declared that 75.6% of these adolescents had received therapeutic support. Table 3 present the information about the prevalence of sexual victimization and its characteristics reported by professionals.

Comparative Self-Reported Vs Other-Reported Information

The degree of agreement between adolescents and professionals about the information reported was 0.39 (see Table 4). Regarding prevalence, 74 adolescents reported having suffered sexual victimization without awareness among the professionals. However, professionals reported that 17 adolescents had suffered some type of sexual victimization while the adolescents denied it.

Table 3. Prevalence and characteristics of sexual victimization experiences in adolescents in the Spanish residential care as reported by professionals.

	M (SD)/%
Suspected sexual victimization	16.9
Confirmation of sexual victimization[a]	51
Average n° of times	7.04 (7.98)
Relationship with the perpetrator	
Known	91.5
Unknown	8.5
Sex of perpetrator	
Male	93.2
Female	6.8
Short- and long-term consequences	
Emotional disorders	51.6
Sexual disorders	12.9
Social interaction problems	12.9
Self-injurious behaviors	9.7
Urination and bowel and bladder control problems	6.5
None	6.5
Therapeutic support	75.6

[a]Percentage of confirmed cases out of the total number of suspected cases.

Table 4. Degree of agreement between information reported by adolescents and professionals regarding the prevalence of sexual victimization experiences and their characteristics.

	Degree of agreement
Prevalence of sexual victimization	0.39
Number of times	0.29[a]
Relationship with the perpetrator (Known/Unknown)	0.90
Who is the perpetrator (close family, other relatives, etc.)	0.70
Sex of perpetrator	0.93

[a]Degree of agreement of the variable *number of times* (quantitative variable) was calculated by performing a Pearson correlation.

Discussion

Using information reported by adolescents and professionals in residential care facilities, this study has shown the extent of lifetime sexual victimization of adolescents in residential care in Eastern Spain. Collecting information from two different sources in this group of adolescents in Spain was a methodological innovation itself, since in the current scientific literature there is no evidence of prevalence of lifetime sexual victimization among this high-risk group reported by different informants having been collected in the same study.

If we first analyze the self-reported prevalence rate, the adolescents in our study reported a high prevalence of sexual victimization (35.3%), similar to that reported by studies with similar sample characteristics (Indias et al., 2019; Segura et al., 2015; Wekerle et al., 2017). Youth immersed in the child welfare system have often witnessed, directly and/or indirectly, situations of abuse and/or neglect in their immediate environment and have not grown up with their basic physical and emotional needs met (Indias et al., 2019). This, among other things, not only increases the likelihood that they will become involved in toxic affective relationships given their problems in

establishing secure attachments, but also predisposes them to exhibit low sexual assertiveness and lack the necessary skills to refuse unwanted sexual relations (Hanson, 2016; Thompson et al., 2017). Euser et al. (2013) considered that a structural problem of residential care facilities could be behind this high prevalence. They argued that, in these settings live large groups of children with frequent behavioral problems, which could increase the risk of sexual abuse/assault by peers, the most frequent type of victimization. Several studies focused on this high-risk population group (Allroggen et al., 2017; Euser et al., 2013; Indias et al., 2019) as our study did (specifically abuse/assault perpetrated by classmates or housemates). However, this was not the type of sexual abuse/assault in which victims were exposed to the most episodes. Sexual abuse/assault committed by a known adult was one in which the victims had the experience on more occasions, had objects introduced into their body more frequently and occurred when the victim was younger. It is also the one that was most frequently reported to the police or officers of the court and, therefore, had to be recounted. This could be due to the fact that, in a majority of cases, this type of abuse/assault is committed by a close relative, so that the victim-offender contact is recurrent and makes it easier for the latter to find and justify times in which he/she stays alone with the victim (Aydin et al., 2015). Likewise, given that the family is the first socializing agent, it is also logical that this is the abuse/assault that occurs at an earlier age of the victim (Amador Moncada et al., 2018). Sexual abuse committed by a close relative seems to cause the greatest maladjustment in the victims, due in part to the trauma that occurs at such young ages when the person who should provide security and meet all the child's needs is the main source of discomfort (Swanson & Mallinckrodt, 2001).

In this study we took into account that, although the victims themselves are the most accurate and precise source of information (Paine & Hansen, 2002; Save the Children, 2004), they may report a significant percentage of false negatives (Scott et al., 2010). The feeling of shame and guilt involved in disclosing this type of experience (Feiring & Taska, 2005; Herrera, 2006), the hardship of having to relive the traumatic experience, and the immature cognitive and emotional development of the child at the time of the event (problems in becoming aware of the experience; London et al., 2005), could be behind the lack of self-disclosure of positive cases (Negriff et al., 2017). Therefore, collecting information on the prevalence of sexual victimization of this group through other informants like residential care professionals was crucial. In this regard, adolescents reported a prevalence rate of sexual victimization more than double that of professionals. This is a difference that Euser et al. (2013) attributed to the lack of bonding between the residential care facility caregiver and the child, leading to the latter's unwillingness to disclose these experiences to the professional. This reluctance is increased in those cases in which the adolescent has suffered sexual abuse/assault in the residence itself. The degree of agreement found between the information provided by the two sources was moderate to low; since 74 of the cases of sexual victimization reported by the adolescents were not known to the professionals and 17 of the cases reported by the professionals were not declared by the adolescents. Regarding cases reported by professionals but not reported by adolescents, London et al. (2005) attributed causality to the immature cognitive and emotional development of the child at the time of the event. Those cases of sexual abuse at an extremely young age detected and reported by health professionals, school professionals, etc. may be in the adolescents´ written records but the adolescent may have no memory of the event. Likewise, it should also be taken into account that there may be cases in which the adolescent, due to the harshness and discomfort involved in reaffirming that he/she suffered sexual abuse, has preferred to answer negatively when asked by the investigator (Classen et al., 2005). Regardless, these data on the degree of agreement justify combining information reported by more than one source is the most advisable method to collect data as close to reality as possible (Negriff et al., 2017; Shaffer et al., 2008), especially if we take into account that, in our study, professionals acknowledged that only half of the cases about which they had suspicions had been confirmed (legally).

As for the victim profile, there was a higher degree of agreement between the information provided by both groups of informants. They agreed that female adolescents experience a markedly higher number of episodes of sexual abuse/assault (regardless of the type of sexual victimization), while the age of the adolescents at the time of assessment was not shown to be influential. In relation to gender, some studies attribute these notable differences to male gender stereotypes that may be limiting disclosures of sexual abuse/assault in boys (Esnard & Dumas, 2013; Wekerle et al., 2017). Thus, they argue that it is not that there is such a marked difference between the rate of sexual victimization cases in men and women, but that men have a higher percentage of false negatives. Not finding the age effects among residential care adolescents reflects that younger adolescents have been exposed to the same degree of victimization that is expected for older youths (Indias et al., 2019).

Regarding information on the characteristics of the aggressor, the degree of agreement among informants was also high. They agreed that the perpetrator was usually a man known to the victim. This profile is consistent with that found in studies of similar populations (Allroggen et al., 2017; Euser et al., 2013). This may be attributed to people who are known and related having easier access to children, and to children not suspecting such people and trusting them more easily (Aydin et al., 2015). However, if we inquire into the victim-aggressor link, while adolescents revealed that most of the time they were schoolmates or housemates, professionals pointed out that they were close family. Also, these data should interpreted cautiously since the proportion of responses from professionals to these questions on the profile of the perpetrator was limited.

Finally, there is recent research focusing on the detection of the main consequences derived from experiences of sexual victimization, an essential aspect to have knowledge about in order to develop interventions tailored to the needs of the victims. In our study, consistent with most research to date working with this population (Finkelhor, Turner et al., 2009; Kendall-Tackett, 2009), professionals reported emotional control problems in almost half of the sample, followed by sexual and social interaction problems.

Nevertheless, there is now specific concern about the multiple episodes and types of sexual victimization faced by victims of child sexual abuse/assault, especially for adolescents in residential care (Classen et al., 2005; Indias et al., 2019). The findings of our study also confirmed this tendency to experience more than one type of sexual victimization among victims of sexual abuse/assault. However, few studies have focused on the risk factors of the victimizing event itself that could explain this tendency to experience more than one type of sexual victimization and a greater number of episodes when the adolescent has suffered sexual abuse/assault in childhood. The results of our analyses have allowed us to verify that those victims who face a greater number of episodes are also involved in more types of sexual victimization (by a known or unknown adult, by a peer or by sexual exposure). In addition, the age of the victim at the time of the first episode of sexual abuse/assault and the type of relationship with the aggressor, especially when it is a close family member, is also positively associated with the previously mentioned variables (number of episodes of sexual abuse/assault and types of sexual victimization). Thus, this leads us to confirm that the earlier the negative experience occurs and the closer the relationship with the aggressor, there is a greater probability that the adolescent will suffer sexual revictimization (more episodes of sexual abuse/assault and/or diverse types of sexual victimization). The age at which initial sexual assaults occur may increase adolescent's vulnerability by exacerbating the psychological impact of a victimization experience, thereby increasing his or her chances of being revictimized (Casey & Nurius, 2005). In this sense, something similar occurs when sexual abuse/assault is caused by a family member, since the early attachment mismatch entails not only interaction problems but also problems of emotional regulation and self-esteem, which places the victim in a situation of greater vulnerability (Gawryszewski et al., 2012).

Strengths and Limitations

One of the most relevant contributions of this study are the prevalence figures of sexual victimization duly contrasted by several informants and the large sample size of this study, considering that is a sensitive issue among a population difficult to access to. Among other strengths of this research is also its methodological approach, compiling information from different informants and contrasting the information reported by the victims themselves and by the professionals who work with them on a daily basis in the same study. In addition, an innovation of this study was the complete analysis of the profile of the aggressor, which is unusual in these studies and may contribute to improving the early detection of cases.

The current study was not without limitations. It was not easy to obtain the collaboration and motivated participation of the residential care facilities' professionals, and they did not always get involved in the study. This is a limitation that should be taken into account when interpreting the results, since we had more missing data than desired in some of the questions answered by the professionals (up to 26.3%). It is also important to keep in mind the limitations of self-report instruments to assess sexual victimization (Acierno et al., 2003), due to the introspection capacity required to provide information on this issue (del Valle & Zamora, 2021), although from the age of 11 children are considered to have sufficient metacognition to provide a self-report (Finkelhor, Omrod et al., 2005). It should also be noted that, with respect to the information provided by the professional, there was only one professional/expert reporting information for each adolescent, so it was not possible to verify the veracity of the data provided by the professional. Lastly, it should be noted that, although all the measurement tools obtained a Cronbach's Alpha of 0.6 or above in the reliability analysis, some professionals consider this value to be acceptable but not good (Nunnally & Bernstein, 1994). Q6

Conclusions

Adolescents in residential care constitute a population with critical sexual victimization history, although this is not always registered in their records. In this group, in which experiences of sexual abuse/assault from a young age by caregiving figures are so common, our findings confirm that these experiences constitute a risk factor for subsequent sexual revictimization. However, this should not mean that other types of sexual victimization, such as those perpetrated by the peer group, should go unnoticed.

This study has allowed us to confirm that adolescents in residential care are a particularly vulnerable group who, due to the events that marked their childhood, have very different needs from those of other adolescents in the community. Thus, providing them with the necessary knowledge to demystify false information, the skills to allow them to enjoy consensual sexual exchanges and the attitudes that allow them to guide their psychosexual development in a positive way, are essential aspects if we want them to enjoy a healthy experience of sexuality. In this sense, research such as the one presented here is key when designing affective-sexual education initiatives that focus on the distinctive characteristics of this group and work to reverse the negative consequences derived from experiences of sexual victimization. The results of this research should also enable government agencies to develop useful and effective action plans, which are so scarce and needed right now. In addition, the results presented can be interpreted as a wake-up call to those geographic areas with similar sociodemographic and historical characteristics on the importance of continuing research on this issue.

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Disclosure Statement

No potential conflict of interest was reported by the author(s). Q7

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ORCID

Olga Fernández-García http://orcid.org/0000-0002-8476-4838
María Dolores Gil-Llario http://orcid.org/0000-0003-4985-1327
Rafael Ballester-Arnal http://orcid.org/0000-0003-4421-1144

Data Availability Statement

The data that support the findings of this study are available from the corresponding author upon reasonable request.

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