Victimization and Polyvictimization Among Spanish Adolescent Outpatients

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This article aimed to analyze lifetime and past-year victimization and polyvictimization experiences in adolescent outpatients from a southern European country. The sample included 143 adolescents (3/.6% boys, 64.4% girls), aged 12 to 17 (M = 14.28, SD = 1.4/). Experiences of victimization were assessed using the Juvenile Victimization Questionnaire (JVQ; Finkelhor, Hamby, Ormrod, G Turner, 200/). Results showed that 33.3% of those interviewed had experienced at least one type of victimization during their lifetime, and 84.6% reported past-year victimization. Gender and age differences were found. Based on community criteria, the proportion of polyvictims in the sample was 32.2% for lifetime victimization and 20.1% for past-year victimization. When assessing children in the context of outpatient mental

health services, it is essential that clinicians explore any history of exposure to violence, as this information is crucial in determining the young person's therapeutic needs.

KEYWORDS adolescents, clinical, outpatients, polyvictimization, victimization

The victimization of children and adolescents and, as has been observed more recently, their experiences of polyvictimization are a common problem that affects large numbers of young people worldwide. Polyvictimization has been conceptualized as victimization experiences in different episodes throughout one's childhood (Finkelhor, Ormrod, & Turner, 2007). Unfortunately, the study of polyvictimization has been largely neglected until recently. Epide- miological data on this phenomenon have been gathered in the United States (Finkelhor, Ormrod, Turner, & Hamby, 2005b), Canada (Cyr et al., 2013), Finland (Ellonen & Salmi, 2011), the United Kingdom (Radford, Corral, Brad- ley, & Fisher, 2013), and Spain (Pereda, Guilera, & Abad, 2014), among others. These studies, which have sought to follow a common approach in terms of the methods, definitions, and instruments used to allow cross-cultural comparison, have indicated that the rate of victimization in the general population ranges between 57% and 71% for the past year and between 67% and 84% when children and adolescents have been asked about their lifetime experiences.

Research has also shown a relationship between victimization and

mental health problems, especially when a child has been the victim of violence on multiple occasions (Finkelhor, 2007). Studies comparing these polyvictimized children with single-time victims and nonvictims have shown that the experi- ence of polyvictimization is associated with both internalizing symptoms (e.g., low self-esteem, self-blame, fear, anxiety, posttraumatic stress, depression) and externalizing symptoms (e.g., delinquency, aggressive and violent beha- vior, substance abuse), as well as with psychosocial problems in general (Chan, Brownridge, Yan, Fong, & Tiwari, 2011; Ellonen & Salmi, 2011; Ford, Elhai, Connor, & Frueh, 2010; Radford et al., 2013; Soler, Paretilla, Kirchner, & Forns, 2012). However, relatively few studies have focused specifically on children and adolescents exhibiting both internalizing and externalizing symp- toms, problems that could in themselves lead them to become polyvictims (Finkelhor, Ormrod, Turner, & Holt, 2009). Thus far, findings have suggested that these children are at greater risk of becoming victims of violence (Cuevas, Finkelhor, Ormrod, & Turner, 2008) and that their psychological problems might make them more vulnerable to further victimization (Cuevas, Finkelhor, Clifford, Ormrod, & Turner, 2010). This highlights the importance of out- patient assessment of the experiences of victimization among these groups of young people so as to have a more realistic view of their prognosis and to offer them appropriate treatment (Ford, Wasser, & Connor, 2011).

One of the first studies to be conducted with this focus was that of Fehon, Grilo, and Lipschitz (2001), who analyzed the self-reported

prevalence of lifetime victimization in a sample of psychiatrically hospitalized adolescents from the United States. They found that 52% of the sample reported witnes- sing one or more episodes of serious violence within their community, and 53% had observed family violence. Furthermore, 61% of these patients had been the direct victims of physical abuse and 39% had been victims of sexual abuse. The authors drew attention to the interrelationship between the differ- ent types of victimization considered and the high overall prevalence of this experience. To further this research, Ford, Connor, and Hawke (2009) focused on complex trauma or multiple traumatic experiences rather than just inter- personal victimization. The authors examined the medical records of children in a residential treatment center in the United States and found that 47% had been physically abused and 33% had been sexually abused at some point in their lives. They also identified other situations of risk linked to parental factors, such as violent behaviors or substance abuse (ranged between 42% and 71%), and to multiple out-of-home placements (45% had more than two placements).

Considerably less research has been conducted regarding the experience of victimization among youth receiving outpatient psychiatric treatment, and all investigations thus far have been conducted in the United States. The first study to do so was that of Threlkeld and Thyer (1992), who reviewed the charts of 117 adolescent outpatients to examine the prevalence of physical and sexual abuse. They found

that 28% had documented or strongly sus- pected histories of sexual abuse and 30% were cases of physical abuse. More recent chart review studies, such as that by Ford, Wasser, et al. (2011), found that 11% of adolescent outpatients had been victims of physical abuse, 11% had suffered sexual abuse, and 34% had been exposed to violence or other trauma during their lifetimes. Polyvictims accounted for 8% of this sample, and of these, 75% had experienced between five and seven of the different kinds of trauma considered, making them a high-risk group for psychiatric impair- ment. These results were also similar to those obtained by the same group with a smaller sample (Ford, Gagnon, Connor, & Pearson, 2011).

The literature just reviewed shows that victimization is common among clinical samples of children and adolescents. However, all of these studies have focused on specific forms of violence, generally those associated with the family context, and, as such, they have not examined the many other forms of victimization that children might suffer. Furthermore, all of these studies were conducted in the States and focused on lifetime experiences. This is relevant for two reasons. First, rates of victimization among children and adolescents might vary from one country to another, and second, there is a need for research that also examines past-year experiences of victimization in clinical samples, thus enabling a more comprehensive comparison with community populations.

THIS STUDY

In light of the preceding, the aim of this study was to determine the preva- lence of a broad range of victimization experiences in Spanish adolescent outpatients using the Juvenile Victimization Questionnaire (JVQ), an instru- ment that has already been employed in community samples in several different countries (Finkelhor, Hamby, Ormrod, & Turner, 2005). Although some recent studies have partially examined this question in similar samples from the same cultural context (Álvarez-Líster, Pereda, Abad, Guilera, & GReVIA, 2014; Pereda, Abad, & Guilera, 2013, 2014), to date, there have been no published data on both lifetime and preceding year victimization among these young people. In the process of gathering such data, we also sought to identify the subgroup of polyvictims who would be at high risk of psychiatric impairment, a subgroup that professionals need to be aware of to address their particular treatment needs. We hypothesized that victimization and polyvictimization would be common problems in the study sample, with a prevalence higher than that found in community samples in our country (Pereda, Guilera, & Abad, 2014) and similar to the rates reported for clinical samples in other countries (Ford, Wasser, et al., 2011). The study attempted to add to existing data (Fehon et al., 2001; Ford et al., 2009; Ford, Wasser, et al., 2011) regarding the prevalence of victimization and polyvictimization in children by analyzing a sample

of Spanish adolescent outpatients from both a lifetime and past-year victimization perspective, thereby extending the literature to a southern European country and to a group of young people that has not been widely studied.

METHODS

Participants

The sample was made up of 149 adolescents (35.6% boys, 64.4% girls), ranging in age from 12 to 17 years old (M = 14.28, SD = 1.45), who were undergoing psychological assessment in a total of 14 child and adolescent mental health centers in the Barcelona area (the sample represented approxi- mately 41% of all public centers in that geographical area). Regarding the demographic characteristics of children seen at the participating clinics, the age distribution of 12- to 17-year-old outpatients was comparable to the study sample (M = 14.31), but the distribution by sex differed, with males being underrepresented (35.6% male vs. 60.7% female) according to data provided by the Observatori del Sistema de Salut de Catalunya from the Health System Agency of Catalonia (personal communication, March 6, 2015).

The majority of participants (79.9%) were of Spanish origin, with the remainder coming from either South America (16.1%) or other European countries (2.7%). Application of an adapted version of the Hollingshead Index (Hollingshead, 1975) indicated that the

socioeconomic status (SES) of the adolescents ' families was as follows: low or medium low, 47.6%; medium, 19.5%; and medium high or high, 18.1%. SES information could not be obtained for 14.8% of the sample. Characteristics of the study participants are presented in Table 1.

Using criteria from the *Diagnostic and Statistical Manual of Mental Disorders* (4th ed. [*DSM–IV*]; American Psychiatric Association, 2000),we classified the adolescents according to the reasons for referral or the

TABKE 1 Sample Characteristics

Variable	Male		Female		Total	
	n	%	*n*	%	*n*	%
Age						
12–14	36	67.9	51	53.1	87	58.4
15–17	17	32.1	45	46.9	62	41.6
Marital status of parents						
Single or never lived together	1	1.9	1	1.0	2	1.3
Married or living together	19	35.8	32	33.3	51	34.2
Separated or divorced	14	26.4	20	20.8	34	22.8
Widow/widower	2	3.8	3	3.1	5	3.4
Not recorded	17	32.1	40	41.7	57	38.3
Child's country of origin						
Spain	45	84.9	74	77.1	119	79.9
Other	8	15.1	20	20.8	28	18.8
Don't know/refused	0	0.0	2	2.1	2	1.3
Socioeconomic status						
Low	8	15.1	21	21.9	29	19.5
Medium low	15	28.3	27	28.1	42	28.2
Medium	14	26.4	15	15.6	29	19.5
Medium high	6	11.3	13	13.5	19	12.8
High	4	7.5	4	4.2	8	5.4
Don't know/refused	6	11.3	16	16.7	22	14.8

diagnostic impression subsequently made by the center. The most common diagnoses were adjustment disorders (21.5%), anxiety disorders (19.5%), and attention-deficit and disruptive behavior disorders (17.4%), followed to a lesser extent by mood disorders (7.4%) and eating disorders (6.0%). Patients were excluded from the study if they were unable to complete the interview due to low cognitive status or the severity of their psychiatric symptoms.

Procedure

The study procedure was approved by the Bioethics Committee of the Uni- versity of Barcelona (IRB00003099), as well as by the respective ethics com- mittees of the participating centers, where required. We

contacted a sample of child and adolescent mental health centers from across the province of Barcelona, 70% of which agreed to participate. Children and youth from each center who were undergoing psychological assessment were asked to participate in the study. Professionals from these centers informed the ado- lescents' parents or legal guardians about the nature of the study and obtained their written informed consent, as well as that of the child, prior to inclusion.

The research interview was conducted in the health care setting during the process of diagnostic assessment being undergone by each adolescent. The two instruments used (see later) were administered by either a research assistant or a professional from the center in question; in both cases, the

interviewer had received training in the bases of developmental victimology and in collecting data on violence against children (United Nations Children's Fund, 2012). Following the interview, the results were written up in a report that was filed with each adolescent's chart. In accordance with the guidelines set out in Article 13.1 of Spain's 1996 Protection of Minors Act, any cases in which the child appeared to be at risk of abuse or neglect were communi- cated to the center manager. Data were collected between December 2009 and May 2012.

Instruments

SOCIODEMOGRAPHIC DATA SHEET

This questionnaire was created ad hoc to gather self-reported sociodemo- graphic data about the young person (age, sex, place of birth, and school grade) and his or her family environment (educational level and current occupations of parents, parents' country of origin, type of family unit). It also included a section to be completed by the interviewer based on the adolescent's case notes (e.g., clinical diagnosis, previous treatment).

JUVENILE VICTIMIZATION

The experiences of victimization were recorded by means of the JVQ

(Finkelhor, Hamby, et al., 2005). This study used the semistructured interview version for children between 8 and 17 years old. The Spanish version of this instrument has been approved by the questionnaire's principal author and covers 36 specific situations of victimization distrib- uted across six categories or modules: (a) conventional crime (nine items; e.g., personal theft, robbery, vandalism); (b) caregiver victimization (four items; e.g., physical abuse by caregiver, psychological abuse, neglect); (c) peer and sibling victimization (six items; e.g., physical intimidation, assault, verbal harassment); (d) sexual victimization (six items; e.g., sex- ual abuse, sexual assault, forced sex); (e) witnessing and indirect victimi- zation (nine items; e.g., witness to domestic violence or community violence); and (f) electronic victimization (two items; i.e., online sexual solicitations, harassment).

When conducting each interview using the JVQ, two time frames were considered: (a) victimization experienced during the lifetime of the adoles- cent, and (b) victimization experienced during the past year. In the event that an item was endorsed by the adolescent as forming part of his or her victimization experience, the interviewer then explored the most recent occurrence of this event in greater depth, asking, among other things, about the sex and age of the perpetrator, the number of times that the event had occurred, and whether or not the adolescent had been injured. The JVQ has

shown good psychometric properties (see Finkelhor, Hamby, et al., 2005), and it has been applied to youth from the general population of several European countries, including the United Kingdom (Radford et al., 2013), Finland (Ellonen & Salmi, 2011), and Spain (Pereda, Guilera, & Abad, 2014).

Data Analysis

We calculated the prevalence of victimization experiences for males and females, age groups 12 to 14 and 15 to 17 years, and for the whole sample, taking into account the JVQ modules, submodules, and items. In all cases, calculations were done according to two time frames: lifetime and past year. Percentage rates of victimization were compared between groups (i.e., boys vs. girls, and 12–14 vs. 15–17 years) by calculating the odds ratio (OR) and its corresponding confidence interval (95% CI). Values lower than 1 indicated a higher prevalence of victimization among boys and in the 12 to 14 age group, whereas values above 1 signified a higher prevalence among girls and in the 15 to 17 age group. This measure of association was considered significant when the CI did not include the value 1, which in this case would indicate differences between boys and girls or between the two age groups.

The Mann–Whitney U test, with a significance level of .05, was used to compare the number of victimizations,

both lifetime and in the past year, across the two age groups. To study the phenomenon of polyvictimization, we identified a group of polyvictims using various criteria reported in the scientific literature. Specifically, the group of polyvictims was defined by applying the criteria of: (a) Finkelhor, Ormrod, and Turner (2009), who for both lifetime and past year took the 10% of children reporting the greatest number of victimizations; (b) Pereda, Guilera, & Abad (2014), who, within the upper 10% in a community sample, defined polyvictims as those experiencing at least eight victimizations during their lifetime or six during the past year; and (c) Finkelhor, Ormrod, Turner, and Hamby (2005a), who defined a *victim group* (between one and three types of victimization), a *low polyvictim group* (four to six types of victimization), and a *high polyvictim group* (seven or more types of victimization).

RESULTS

It was discovered that during their lifetime, 99.3% of the adolescents had experienced at least one type of victimization (100% of males and 99% of females), and 84.6% of them reported a past-year event (86.8% of males and 83.3% of females; OR = 0.76, 95% CI [0.29, 1.99]). Tables 2 and 3 show the prevalence of victimization (lifetime and past year, respectively) by JVQ

TABKE 2 Lifetime Victimization: Juvenile Victimization Questionnaire Modules, Submodules, and Items

	Victimized		Gender (%)			Age (%)		
Victimization	*n*	%	*M*	*F*	OR[a,b] [95% CI]	12–14	15–17	OR[a,b] [95% CI]
C. Conventional crimes	122	81.9	84.9	80.2	0.72 [0.29, 1.78]	80.5	83.9	1.26 [0.54, 2.98]
Property victimization	99	66.4	71.7	63.5	0.69 [0.33, 1.43]	70.1	61.3	0.68 [0.34, 1.34]
C1. Robbery	33	22.1	35.8	14.6	0.31 [0.14, 0.69]*	20.7	24.2	1.21 [0.55, 2.63]
C2. Personal theft	62	41.6	43.4	40.6	0.91 [0.46, 1.79]	39.1	45.2	1.26 [0.65, 2.44]
C3. Vandalism	42	28.2	28.3	28.1	0.99 [0.47, 2.10]	36.8	16.1	0.35 [0.16, 0.79]*
Crimes against persons	102	68.5	73.6	65.6	0.69 [0.33, 1.44]	64.4	74.2	1.59 [0.78, 3.26]
C4. Assault with weapon	19	12.8	13.2	12.5	0.94 [0.35, 2.55]	14.9	9.7	0.61 [0.22, 1.70]
C5. Assault without weapon	60	40.3	49.1	35.4	0.57 [0.29, 1.13]	35.6	46.8	1.59 [0.82, 3.09]
C6. Attempted assault	44	29.5	35.8	26.0	0.64 [0.31, 1.32]	28.7	30.6	1.12 [0.55, 2.29]
C7. Threatened assault	54	36.2	41.5	33.3	0.71 [0.35, 1.41]	39.1	32.3	0.74 [0.37, 1.47]
C8. Kidnapping	7	4.7	1.9	6.3	3.51 [0.41, 29.93]	3.4	6.5	1.97 [0.42, 9.11]
C9. Bias attack	12	8.1	5.7	9.4	1.72 [0.45, 6.67]	9.2	6.5	0.68 [0.20, 2.37]
M. Caregiver victimization	78	52.3	47.2	55.2	1.38 [0.70, 2.71]	44.8	62.9	2.09 [1.07, 4.06]*
M1. Physical abuse	37	24.8	20.8	27.1	1.42 [0.64, 3.16]	24.1	25.8	1.09 [0.52, 2.32]
M2. Psychological/emotional abuse	61	40.9	34.0	44.8	1.58 [1.58, 3.17]	34.5	50.0	1.90 [0.98, 3.70]
M3. Neglect	8	5.4	3.8	6.3	1.70 [0.33, 8.74]	4.6	6.5	1.43 [0.34, 5.96]
M4. Custodial interference/family abduction	14	9.4	11.3	8.3	0.71 [0.23, 2.17]	11.5	6.5	0.53 [0.16, 1.78]
P. Peer and sibling victimization	93	62.4	64.2	61.5	0.89 [0.44, 1.79]	59.8	66.1	1.31 [0.67, 2.59]
P1. Gang or group assault	13	8.7	15.1	5.2	0.31 [0.10, 0.99]*	9.2	8.1	0.87 [0.27, 2.79]
P2. Peer or sibling assault	44	29.5	37.7	25.0	0.55 [0.27, 1.13]	25.3	35.5	1.63 [0.80, 3.31]
P3. Nonsexual genital assault	9	6.0	15.1	1.0	0.06 [0.01, 0.49]*	3.4	9.7	3.00 [0.72, 12.49]
P4. Physical intimidation	24	16.1	9.4	19.8	2.37 [0.83, 6.76]	12.6	21.0	1.83 [0.76, 4.42]
P5. Verbal/relational aggression	57	38.3	30.2	42.7	1.72 [0.85, 3.52]	36.8	40.3	1.16 [0.60, 2.27]
P6. Dating violence	5	3.4	3.8	3.1	0.82 [0.13, 5.08]	1.1	6.5	5.93 [0.65, 54.42]
S. Sexual victimization	24	16.1	5.7	21.9	4.67 [1.32, 16.48]*	8.0	27.4	4.32 [1.67, 11.98]*
With physical contact	17	11.4	3.8	15.6	4.72 [1.04, 21.51]*	5.7	19.4	3.94 [1.31, 11.84]*
S1. Sexual abuse/assault by known adult	13	8.7	3.8	11.5	3.30 [0.70, 15.49]	4.6	14.5	3.52 [1.03, 12.02]*
S2. Sexual abuse/assault by unknown adult	2	1.3	1.9	1.0	0.55 [0.34, 8.93]	1.1	1.6	1.41 [0.09, 22.98]

(*Continued*)

TABKE 2 (Continued)

Victimization	Victimized		Gender (%)			Age (%)		
	n	%	*M*	*F*	OR[a,b] [95% CI]	12–14	15–17	OR[a,b] [95% CI]
S3. Sexual abuse/assault by peer/sibling	3	2.0	0.0	3.1	—	1.1	3.2	2.87 [0.25, 32.34]
S4. Forced sex (including attempts)	6	4.0	0.0	6.3	—	0.0	9.7	—
Without physical contact	15	10.1	1.9	14.6	8.88 [1.13, 69.54]*	4.6	17.7	4.48 [1.35, 14.81]*
S5. Flashing/sexual exposure	8	5.4	0.0	8.3	—	2.3	9.7	4.55 [0.89, 23.37]
S6. Verbal sexual harassment	8	5.4	1.9	7.3	4.14 [0.50, 34.57]	3.4	8.1	2.50 [0.57, 10.88]
W. Witnessing and indirect victimization	122	81.9	77.4	84.4	1.58 [0.68, 3.69]	75.9	90.3	2.97 [1.12, 7.87]*
Family violence	35	23.5	22.6	24.0	1.08 [0.49, 2.39]	24.1	22.6	0.92 [0.42, 1.98]
W1. Witness to domestic violence	26	17.4	15.1	18.8	1.30 [0.52, 3.23]	18.4	16.1	0.85 [0.36, 2.03]
W2. Witness to parent assault to sibling	16	10.7	11.3	10.4	0.91 [0.31, 2.67]	11.5	9.7	0.83 [0.28, 2.40]
Community violence	118	79.2	75.5	81.3	1.41 [0.63, 3.16]	71.3	90.3	3.76 [1.44, 9.84]*
W3. Witness to assault with weapon	56	37.6	39.6	36.5	0.89 [0.45, 1.77]	36.8	38.7	1.07 [0.54, 2.09]
W4. Witness to assault without weapon	88	59.1	58.5	59.4	1.04 [0.53, 2.05]	48.3	74.2	3.01 [1.48, 6.12]*
W5. Burglary of family household	20	13.4	15.1	12.5	0.79 [0.30, 2.07]	12.6	14.5	1.20 [0.46, 3.09]
W6. Murder of family member or friend	9	6.0	9.4	4.2	0.42 [0.11, 1.63]	6.9	4.8	0.69 [0.17, 2.86]
W7. Witness to murder	2	1.3	1.9	1.0	0.54 [0.03, 8.76]	1.1	1.6	1.43 [0.09, 23.37]
W8. Exposure to random shootings, terrorism or riots	16	10.7	9.4	11.5	1.22 [0.40, 3.71]	10.3	11.3	1.12 [0.39, 3.20]
W9. Exposure to war or ethnic conflict	2	1.3	0.0	2.1	—	0.0	3.2	—
INT. Electronic victimization	39	26.2	11.3	34.4	4.10 [1.59, 10.59]*	23.0	30.6	1.48 [0.71, 3.09]
INT1. Harassment	27	18.1	11.3	21.9	2.19 [0.83, 5.83]	13.8	24.2	2.00 [0.86, 4.63]
INT2. Unwanted sexual solicitations	18	12.1	0.0	18.8	—	9.2	16.1	1.90 [0.70, 5.13]

Note. M = male; F = female; OR = odds ratio; 95% CI = 95% confidence interval.

[a]When prevalence was lower than 1%, OR was not computed. [b]OR computed excluding missing values (no more than 2.0% of missing values per item).

*Statistically significant at $p < .05$.

module, submodule, and items for boys and girls separately, with the ORs and their corresponding 95% CIs for comparison purposes.

Caregiver Victimization

Over half of the sample (52.3%) reported victimization by a caregiver at some point during their lifetime, while around a third (34.2%) said they had suffered such an experience in the past year. Experiences of this kind were more likely to be reported by the older age group (15 to 17 years), where the prevalence was 62.9% for the lifetime measure (*OR* = 2.09, 95% CI [1.07–4.06]). Addition- ally, psychological/emotional abuse was the most common form of maltreat- ment in both the lifetime (40.9%) and past-year categories (26.2%), the next most common being physical abuse (24.8% and 16.1%, respectively).

Conventional Crime

Overall, 81.9% of the adolescents reported being the victim of some kind of conventional crime during their lifetime, and 63.1% had experienced such an event in the past year. During their lifetime, approximately two thirds of the sample had been the victim of property crime (66.4%), with a similar propor- tion reporting crime against the person (68.5%). When considering the past year, these rates fell to 38.9% and 50.3%, respectively. The most common kinds of conventional crime, with a prevalence of around 40%, were experi- ences such as personal theft, threats, or assault without a weapon.

In terms of gender differences, boys suffered more robbery than did

girls, both during their lifetime (35.8% of males and 14.6% of females, OR = 0.31, 95% CI [0.14, 0.69]) and over the past year (20.8% of males and 7.3% of females, OR = 0.30, 95% CI [0.11, 0.84]). Age differences were also observed for the past year, with the younger age group experiencing more assaults with a weapon (14.9%, OR = 0.09, 95% CI [0.01, 0.73]) and more threatened assaults (34.5%, OR = 0.37, 95% CI [0.16, 0.82]).

Peer and Sibling Victimization

Victimization by peers or siblings was reported by 62.4% of the adolescents for lifetime events and by 37.6% for the past year. The most frequent kinds of experiences involved verbal harassment or relational aggression (38.3% life- time, 14.1% past year) and physical assault (29.5% lifetime, 18.1% past year). The lowest prevalence in this module corresponded to dating violence (3.4% lifetime, 2% past year), which was reported by similar proportions of boys and girls. Further, although there were no differences between the two age groups, boys were significantly more likely than girls to experience gang and group assault (15.1% of males and 5.2% of females, OR = 0.31, 95% CI

TABKE 3 Past Year Victimization Juvenile Victimization Questionnaire Modules, Submodules, and Items

	Victimized		Gender (%)			Age (%)		
Victimization	*n*	%	M	F	OR[a,b] [95% CI]	12–14	15–17	OR[a,b] [95% CI]
C. Conventional crimes	94	63.1	69.8	59.4	0.63 [0.31, 1.29]	66.7	58.1	0.69 [0.35, 1.36]
Property victimization	58	38.9	37.7	39.6	1.08 [0.54, 2.16]	42.5	33.9	0.69 [0.35, 1.36]
C1. Robbery	18	12.1	20.8	7.3	0.30 [0.11, 0.84]*	12.6	11.3	0.87 [0.32, 2.38]
C2. Personal theft	32	21.5	20.8	21.9	1.08 [0.48, 2.47]	24.1	17.7	0.67 [0.30, 1.51]
C3. Vandalism	22	14.8	9.4	17.7	2.08 [0.72, 6.00]	18.4	9.7	0.50 [0.18, 1.37]
Crimes against persons	75	50.3	60.4	44.8	0.53 [0.27, 1.05]	55.2	43.5	0.63 [0.33, 1.21]
C4. Assault with weapon	14	9.4	11.3	8.3	0.71 [0.23, 2.17]	14.9	1.6	0.09 [0.01, 0.73]*
C5. Assault without weapon	37	24.8	34.0	19.8	0.48 [0.23, 1.02]	26.4	22.6	0.81 [0.38, 1.74]
C6. Attempted assault	25	16.8	24.5	12.5	0.45 [0.19, 1.06]	18.4	14.5	0.77 [0.32, 1.87]
C7. Threatened assault	40	26.8	35.8	21.9	0.50 [0.24, 1.05]	34.5	16.1	0.37 [0.16, 0.82]*
C8. Kidnapping	1	0.7	0.0	1.0	—	1.1	0.0	—
C9. Bias attack	6	4.0	3.8	4.2	1.11 [0.20, 6.26]	4.6	3.2	0.69 [0.12, 3.9]
M. Caregiver victimization	51	34.2	30.2	36.5	1.33 [0.65, 2.72]	34.5	33.9	0.97 [0.49, 1.94]
M1. Physical abuse	24	16.1	13.2	17.7	1.41 [0.55, 3.67]	18.4	12.9	0.66 [0.26, 1.65]
M2. Psychological/emotional abuse	39	26.2	22.6	28.1	1.36 [0.62, 2.97]	25.3	27.4	1.14 [0.55, 2.39]
M3. Neglect	2	1.3	1.9	1.0	0.55 [0.03, 8.93]	1.1	1.6	1.41 [0.09, 22.98]
M4. Custodial interference/family abduction	5	3.4	3.8	3.1	0.82 [0.13, 5.08]	4.6	1.6	0.34 [0.04, 3.12]
P. Peer and sibling victimization	56	37.6	43.4	34.4	0.68 [0.34, 1.36]	41.4	32.3	0.68 [0.34, 1.34]
P1. Gang or group assault	10	6.7	11.3	4.2	0.34 [0.09, 1.27]	8.0	4.8	0.58 [0.14, 2.34]
P2. Peer or sibling assault	27	18.1	22.6	15.6	0.63 [0.27, 1.48]	17.2	19.4	1.15 [0.50, 2.67]
P3. Nonsexual genital assault	3	2.0	5.7	0.0	—	3.4	0.0	—
P4. Physical intimidation	11	7.4	3.8	9.4	2.64 [0.55, 12.69]	9.2	4.8	0.50 [0.13, 1.97]
P5. Verbal/relational aggression	21	14.1	11.3	15.6	1.47 [0.53, 4.05]	17.2	9.7	0.52 [0.19, 1.44]
P6. Dating violence	3	2.0	1.9	2.1	1.11 [0.10, 12.50]	1.1	3.2	2.87 [0.25, 32.34]
S. Sexual victimization	11	7.4	1.9	10.4	6.05 [0.75, 48.61]	4.6	11.3	2.64 [0.74, 9.45]
With physical contact	6	4.0	0.0	6.3	—	2.3	6.5	2.93 [0.52, 16.53]
S1. Sexual abuse/assault by known adult	2	1.3	0.0	2.1	—	1.1	1.6	1.41 [0.09, 22.98]
S2. Sexual abuse/assault by unknown adult	0	0.0	0.0	0.0	—	0.0	0.0	—
S3. Sexual abuse/assault by peer/sibling	2	1.3	0.0	2.1	—	1.1	1.6	1.41 [0.09, 22.98]
S4. Forced sex (including attempts)	3	2.0	0.0	3.1	—	0.0	4.8	—

Without physical contact	7	4.7	1.9	6.3	3.47 [0.41, 29.59]	3.4	6.5	1.93 [0.42, 8.95]
S5. Flashing/sexual exposure	0	0.0	0.0	0.0	—	0.0	0.0	—
S6. Verbal sexual harassment	7	4.7	1.9	6.3	3.51 [0.41, 29.93]	3.4	6.5	1.97 [0.42, 9.11]
W. Witnessing and indirect victimization	83	55.7	50.9	58.3	1.35 [0.69, 2.65]	51.7	61.3	1.48 [0.76, 2.86]
Family violence	13	8.7	5.7	10.4	1.94 [0.51, 7.38]	10.3	6.5	0.60 [0.18, 2.04]
W1. Witness to domestic violence	8	5.4	3.8	6.3	1.70 [0.33, 8.74]	8.0	1.6	0.19 [0.02, 1.56]
W2. Witness to parent assault to sibling	8	5.4	3.8	6.3	1.70 [0.33, 3.74]	5.7	4.8	0.83 [0.19, 3.63]
Community violence	75	50.3	47.2	52.1	1.22 [0.62, 2.38]	44.8	58.1	1.70 [0.88, 3.29]
W3. Witness to assault with weapon	29	19.5	18.9	19.8	1.08 [0.46, 2.52]	21.8	16.1	0.69 [0.29, 1.58]
W4. Witness to assault without weapon	57	38.3	32.1	41.7	1.47 [0.73, 2.98]	33.3	45.2	1.62 [0.83, 3.17]
W5. Burglary of family household	3	2.0	1.9	2.1	1.09 [0.10, 12.26]	1.1	3.2	2.91 [0.26, 32.89]
W6. Murder of family member or friend	2	1.3	3.8	0.0	—	1.1	1.6	1.41 [0.09, 22.98]
W7. Witness to murder	0	0.0	0.0	0.0	—	0.0	0.0	—
W8. Exposure to random shootings, terrorism or riots	6	4.0	7.5	2.1	0.26 [0.05, 1.44]	4.6	3.2	0.70 [0.13, 3.97]
W9. Exposure to war or ethnic conflict	0	0.0	0.0	0.0	—	0.0	0.0	—
INT. Electronic victimization	25	16.8	7.5	21.9	3.43 [1.11, 10.60]*	17.2	16.1	0.92 [0.38, 2.22]
INT1. Harassment	16	10.7	7.5	12.5	1.75 [0.54, 5.73]	10.3	11.3	1.10 [0.39, 3.14]
INT2. Unwanted sexual solicitations	9	6.0	0.0	9.4	—	6.9	4.8	0.69 [0.17, 2.86]

Note. M = male; F = female; OR = odds ratio; 95% CI = 95% confidence interval.

[a]When prevalence was lower than 1%, OR was not computed. [b]OR computed excluding missing values (no more than 2.0% of missing values per item).

*Statistically significant at $p < .05$.

[0.10, 0.99]) and nonsexual genital assault (15.1% of males and 1.0% of

females, OR = 0.06, 95% CI [0.01, 0.49]) during their lives.

Sexual Victimization

Some kind of sexual victimization had been experienced by 16.1% of the adolescents during their lifetimes and by 7.4% in the past year. Prevalence rates were similar for sexual victimization with and without physical contact (around 10% for lifetime and around 4% for past year). Both age and gender differences were observed for lifetime sexual victimization in gen- eral, with the highest rates corresponding to girls and older adolescents (21.9%, OR = 4.67, 95% CI [1.32, 16.48], and 27.4%, OR = 4.32, 95% CI [1.67,

11.98], respectively); the same pattern was found for lifetime rates of sexual victimization with and without physical contact. Lifetime sexual victimiza- tion involving physical contact was reported by 15.6% of girls and by 19.4% of adolescents aged 15 to 17 years. Sexual assault by a known adult was also more common among the older age group (14.5%, OR = 3.52, 95% CI [1.03, 12.02]).

Witnessing and Indirect Victimization

Experiences of this kind were reported by 81.9% of the youth interviewed when considering lifetime victimization and by approximately half of the sample (55.7%) for the past year. Exposure to community violence had similar prevalence rates, and for the lifetime

measure it was more common in the 15 to 17 age group (90.3%, OR = 3.76, 95% CI [1.44, 9.84]). For both time frames, the most frequent experience reported was witnessing assault without a weapon, and over the lifetime, this was more common in the older age group (74.2%, OR = 3.01, 95% CI [1.48, 6.12]). Exposure to family violence was reported by 23.5% of the adolescents for lifetime and by 8.7% for the past year. Within this category, lifetime episodes of violence between parents (or between a parent and his or her partner) were more common than was sibling assault (17.4% and 10.7%, respectively).

Electronic Victimization

Electronic victimization had been experienced by approximately 26.2% of the youth during their lifetime and by 16.8% in the past year. For both time frames, the prevalence was higher among girls (34.4%, OR = 4.10, 95% CI [1.59, 10.59]; and 21.9%, OR = 3.43, 95% CI [1.11, 10.60], respectively). Within
this category of victimization, boys did not report online sexual solicitations, only harassment.

Polyvictimization

Among youth who reported some kind of victimization, the mean number of different types experienced during lifetime for the sample as a whole was approximately 6, with a range of 1 to 18 (Table 4); there were no significant differences between gender (U = 2,459.500, p = .82) or the two age groups (U = 2,201.500, p = .07). For past-year victimization, the corresponding mean number was approximately 4, with a range of 1 to 13; once again, there were no differences according to gender (U = 1,813.000, p = .89) or age group (U = 1,616.500, p = .12). Because lifetime victimization has been identified as a cumulative phenomenon, polyvictimization was defined and analyzed by age.

It was determined that if the group of polyvictims was identified as the top 10% of the distribution, a criterion used in some previous studies (Finkel- hor et al., 2009), lifetime polyvictims would be those reporting 12 or more types of victimization in the 12 to 14 age group and 13 or more incidents in the 15 to 17 age group (Table 4); for the past year, the corresponding number of victimizations was found to be nine for the younger group and seven for the older adolescents. If, however, the cutoff for the top 10% was instead defined according to data from a community sample recruited in the same geographical region (Pereda, Guilera, & Abad, 2014), 32.2% of these

TABKE 4 Victimization Types and Score Thresholds According to Age Group

	Lifetime			Past year		
	12–14 (n = 87)	15–17 (n = 62)	Total (n = 149)	12–14 (n = 87)	15–17 (n = 62)	Total (n = 149)
No victimization (%)	1.1	0.0	0.7	14.9	16.1	15.4
1–3 victimizations (%)	N/A	N/A	N/A	39.1	51.6	44.3
4–6 victimizations (%)	N/A	N/A	N/A	27.6	24.2	26.2
7 victimizations + (%)	N/A	N/A	N/A	18.4	8.1	14.1
Number of victims	86	62	148	74	52	126
Mean number of victimizations among victims (*SD*)	5.79 (3.90)	6.89 (4.07)	6.25 (4.0)	4.23 (2.78)	3.44 (2.35)	3.90 (2.63)
Children above mean (%)	41.4	45.2	38.9	34.5	32.3	40.3
Number of victimizations in the upper tenth percentile	12+	13+	13+	9+	7+	8+
Children in upper tenth percentile (%)	9.2	8.1	8.1	8.1	8.1	9.4
Number of victimizations in the upper tenth percentile based on a community sample[a]	7+	9+	8+	6+	6+	6+
Children in the upper tenth percentile based on a community sample[a] (%)	34.5	30.6	32.2	24.1	14.5	20.1

Note. N/A = not applicable. Categories are based on the criteria of Finkelhor et al. (2005a) for past-year victimization.

[a]Based on the criteria of Pereda, Guilera, & Abad (2014) for a community sample recruited in northeastern Spain.

adolescent outpatients would be classified as polyvictims for lifetime victimi- zation and 20.1% for past-year events, as compared with 8.1% and 9.4% when applying the first criterion.

Another way of classifying polyvictims using general population data would be to apply the criterion proposed by Finkelhor et al. (2005a), who defined three groups based on the number of past-year victimizations: the victim group (1–3 different types of victimization), the low polyvictim group (4–6 types), and the high polyvictim group (7 or more types). According to this criterion, using data derived from a community sample in the United States, 40.3% of our adolescent outpatients could be considered polyvictims, varying between 46.0% and 32.3% according to age group (Table 4).

In a further analysis of polyvictimization, we took into account the six modules into which the JVQ items are organized and compared polyvictims with other victims in terms of the number of different modules in which they had experienced some kind of victimization (Table 5). To perform this analysis, we used a broad definition of polyvictimization based on the cutoffs obtained in the Spanish community sample (see penultimate row in Table 4 [i.e., 7+ and 9+ for lifetime and 6+ for past year]). The majority of lifetime polyvictims (83.6%) experienced victimization in four or more modules, as did almost two thirds (63.3%) of past-year polyvictims. For the other victim group, the corresponding percentages were far smaller (23.3% and 9.4%, respectively).

DISCUSSION

This study, which took a comprehensive view of victimization and considered a wide range of victimizing experiences, revealed a high prevalence of

TABKE / Number of Victimization Modules According to Lifetime and Past-Year Victimization Status

	Lifetime		Past year	
Number of modules[a]	Polyvictims (n = 49) (%)	Victims (n = 99) (%)	Polyvictims (n = 30) (%)	Victims (n = 96) (%)
One module	0.0	17.2	0.0	31.3
Two modules	4.1	29.3	13.3	32.3
Three modules	12.2	30.3	23.3	27.1
Four modules	40.8	17.2	36.7	9.4
Five modules	26.5	6.1	23.3	0.0
Six modules	16.3	0.0	3.3	0.0

[a]Modules included are those from the Juvenile Victimization Questionnaire: Conventional Crime, Caregiver Victimization, Peer and Sibling Victimization, Sexual Victimization, Witnessing and Indirect Victimization, and Electronic Victimization.

victimization among Spanish adolescents attending outpatient mental health services. Almost all of the youth interviewed had experienced some kind of violence during their lifetimes, and 84.6% had faced such an experience in the past year. These percentages were much higher than those reported for community samples in the same country (83.0% of adolescents during their lifetimes and 68.6% in the past year; Pereda, Guilera, & Abad, 2014) and in other cultural contexts (Cuevas et al., 2008).

Conventional crime was one of the most common kinds of victimization in this sample, affecting 81.9% of the adolescents, both boys and girls, although boys and, especially, younger adolescents reported more violent forms of such events. This experience of violence among boys has also been reported in previous studies in the same cultural context (Pereda, Guilera, & Abad, 2014) and in community samples from other countries (Cyr et al., 2013; Finkelhor et al., 2009), highlighting that these young people are at risk of suffering serious repercussions due to violence. As for the greater prevalence of more violent experiences among our younger adolescents, one possible explanation for this is that these experiences produce more serious psycho- logical effects (Margolin & Gordis, 2000) and, therefore, they are overrepre- sented in clinical samples such as this. It is also possible, however, that the greater impulsivity shown by less mature younger children (Caspi, Roberts, & Shiner, 2005) might lead them

into social situations that produce more violent forms of victimization than is the case at older ages.

Another common form of victimization among these youth involved exposure to violence, the prevalence of which was the same as that for conventional crime and twice the percentage reported in a Spanish commu- nity sample (48.9%; Pereda, Guilera, & Abad, 2014). Exposure to community violence was especially frequent, particularly among older adolescents. Aside from their older age, this finding could be explained by the fact that they probably have greater freedom to roam the streets, including potentially dangerous areas, without parental control. This highlights how these young people are at high risk of developing psychological problems, as previously noted by meta-analytic studies (Fowler, Tompsett, Braciszewski, Jacques-Tiura, & Baltes, 2009). Our results further indicated that a high percentage of these adolescent outpatients had witnessed violence between their parents or between a parent and his or her partner, which, as other authors have noted, can have serious effects on a young person's social and emotional development (Evans, Davies, & DiLillo, 2008; Kitzmann, Gaylord, Holt, & Kenny, 2003). Much less research has examined the effects of being exposed to parent–sibling violence, which, in this sample, had also affected a signifi- cant proportion of adolescents at some point in their lives (Finkelhor, Ormrod, & Turner, 2008). The reported experiences of conventional

crime and the exposure to community and family violence suggest that certain aspects of family life and of the neighborhoods in which these adolescents live, aspects associated with high levels of violence and greater socioeconomic deprivation, increase the risk that these young people will develop psycho- logical problems. Consequently, these aspects need to be taken into account by both intervention programs and policymakers (Aisenberg & Herrenkohl, 2008).

A relationship between exposure to family violence and victimization by caregivers has been demonstrated previously (Hamby, Finkelhor, Turner, & Ormrod, 2010). In the sample of adolescent outpatients in this study, over half (52.3%) reported experiences of physical abuse, emotional abuse, neglect, or abduction by a caregiver, a figure that is much higher than the 25.3% found in the Spanish community sample (Pereda, Guilera, & Abad, 2014). Regarding physical abuse, 24.8% of those interviewed had suffered some kind of physi- cal assault by their main caregivers, a figure that is much lower than that obtained in a study of inpatients (47% in Ford et al., 2009) but higher than the percentage in another outpatient sample (11% in Ford, Gagnon, et al., 2011). It should be noted that we used a broad definition of physical abuse, covering severe and less severe cases, and this could explain the differences with respect to other outpatient samples. Although the cross-sectional design of our study has not allowed us to say whether victimization precedes or causes

psychological problems, it is clear that child maltreatment is associated with serious social and psychological effects (Gilbert et al., 2009).

In terms of peer and sibling victimization, the prevalence of dating violence was again higher than that found in the Spanish community sample, with both boys and girls reporting the kind of violent couple relationships that have been shown to be detrimental to behavioral and mental health. Although the observed percentages (3.4% lifetime, 2.0% past year) were within the range reported for this kind of violence among youth in the United States (Hamby & Turner, 2013), they were twice as high as the figure for the general population in Spain (Pereda, Guilera, & Abad, 2014). Therefore, our results suggest that teenagers ' use of physical violence is a relevant issue for a significant minority of dating youths. It should also be noted that the experi- ence of other forms of violence among these young people plays a significant role not only in their perpetration of aggressive behaviors toward dating partners (Sears, Byers, & Price, 2007), but also in their experiences as a victim of this form of violence (Gagné, Lavoie, & Hébert, 2005). Although the results obtained could be considered to represent mild forms of physical dating violence, we should nonetheless be aware of the relationship identified in longitudinal studies between these experiences and future, more serious acts of partner violence (Foshee, Benefield, Ennett, Bauman, & Suchindra, 2004). Consequently, these behaviors should be the focus of

prevention and inter- vention to help avoid a cascade of adverse outcomes.

Within our sample, sexual victimization was quite prevalent, affecting 16.1% of the participants. The most serious forms of abuse involved physical contact and a known adult, with girls and older adolescents being the most likely victims. Once again, this figure was twice that observed in the general Spanish population (8.7%; Pereda, Guilera, & Abad, 2014), although it was much lower than the prevalence obtained in samples of adolescent inpatients (39.3% in Fehon et al., 2001; 33% in Ford et al., 2009) and similar to the rate found in a chart review study of adolescent outpatients (Ford, Gagnon, et al., 2011). It is essential to take these types of experiences into account when providing treatment for young people, especially because research has indi- cated that sexual victimization is the most serious form of maltreatment, independent of other forms of victimization experienced by the young person (Boxer & Terranova, 2008); it should be noted, however, that not all studies have found this differential effect (Cuevas et al., 2008).

To date, no study has analyzed the experience of electronic victimization among adolescent outpatients, and in this sense, the percentages obtained here will serve as a point of comparison for future research in this context. This kind of victimization was reported by 26.2% of our adolescents for lifetime experiences and by 16.8% for

the past year, and it was a significantly more common experience among girls. The high rate of electronic victimiza- tion suffered by girls in our study was consistent with the pattern observed in the Spanish community sample, although the overall percentages obtained in this study were twice as high as previously reported (12.6% for lifetime and 8.9% for past year; Pereda, Guilera, & Abad, 2014). Although a solid explana- tion for these higher results was not identified, it might be that these adoles- cents have less parental supervision (possibly related to the higher victimization by caregivers found in the sample). Another potential explana- tion is that these adolescents might present with higher impulsivity traits or a greater need for attention (perhaps related to their symptomatology). Both hypotheses could partially explain their higher electronic victimization when compared to more supervised and controlled adolescents.

The experience of more than one type of victimization was common in the group of adolescent outpatients in this study. Over lifetime, these youth had experienced a mean of six different types of victimization, two more than the number reported in recent studies involving community samples (Cyr et al., 2013; Pereda, Guilera, & Abad, 2014). Furthermore, the proportion of these young outpatients who would be classified as lifetime polyvictims was, at 32.2%, three times higher than the expected 10.0%. The majority of these polyvictims had suffered several different types of violence in terms of

the context in which the event occurred or the type of perpetrator, such that the most common profile involved experiences in four or more of the six modules assessed by the JVQ; these results were in line with those obtained in the Spanish community sample (Pereda, Guilera, & Abad, 2014). One would expect to encounter considerable distrust in young people who have been victimized on multiple occasions in different contexts, and clinicians, there- fore, need to be alert to their particular treatment needs. Indeed, among a population of young people seeking psychological help, it is important to identify those with a history of multiple victimizations, as it is likely that particular attention will need to be paid to their ability to develop bonds with significant others, an aspect that might make it difficult to establish a ther- apeutic alliance (Eltz, Shirk, & Sarlin, 1995).

Limitations

This study has a number of limitations. First, it was not possible to examine the experience of victimization in relation to the individual diagnosis or symptoms presented by these adolescents, and, therefore, we cannot say whether certain types of victimization are associated with specific kinds of psychological problems or different levels of distress. A further limitation is that the cross-sectional nature of the data prevents us from knowing whether victimization precedes or is a consequence of psychological distress, although previous research has suggested that psychological disorders are both the result of and a

possible risk factor for victimization (Cuevas et al., 2008). In this regard, the treatment offered to these young people should aim to address both aspects; that is, the reduction and control of symptoms and the preven- tion of further episodes of victimization (Cuevas et al., 2010).

The underrepresentation of male outpatients in the sample study should also be kept in mind; if the number of male outpatients was higher, general prevalence rates for sexual victimization and electronic victimization could be lower for the outpatient population and robberies or physical assaults by peers could be higher, following the patterns found in studies with commu- nity samples (Pereda, Guilera, & Abad, 2014). A final limitation is that the use of interviews in this study differs from the methods used in other studies to gather information, such as questionnaires (Pereda, Guilera, & Abad, 2014) or chart review (Ford, Gagnon, et al., 2011), and this limits the extent to which the different sets of results can be compared.

CONCLUSIONS

Although this cross-sectional study cannot establish causal relationships between victimization and psychopathology, it can be concluded that when exposure to violence and victimization appears early in the life of children, there can be serious psychological effects. In this regard, it is essential that clinicians explore any history of exposure to violence when assessing children who are referred to

mental health services (Cuevas et al., 2008; Fehon et al., 2001). Likewise, it is important to consider different types of victimization, including more recent but no less common forms such as electronic victimization, as this information is crucial for determin- ing the young person's therapeutic needs and for offering effective and individualized treatment programs. In other words, clinicians should be aware of the effects of polyvictimization and make efforts to identify poly- victimized children, keeping in mind that these children can have higher levels of psychological distress as well as a reduced resilience capacity; consequently, additional efforts might be needed to help them in a ther- apeutic context. Clinicians' experience and current knowledge about child victimization and polyvictimization can help minimize the negative effects of these situations on the patient.

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