Recommendations for Care and Support of Female Rape Victims

Empfehlungen zur Betreuung und Versorgung von weiblichen mutmaßlich Stuprum-Betroffenen

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ABSTRACT

Introduction According to prevalence studies, at least 5% of all women in the Federal Republic of Germany experience rape during their lifetime. While the effects vary according to the individual, rape has serious consequences for the somatic, psychological, and psychosocial health of the victim. The medical care that is provided to presumed rape victims is of special importance, as this care can have a positive influence on the patient's ability to process their experience and engage in healing following such a traumatic event. Furthermore, doctors are the professionals whose help is most often sought in this context. Primary care following rape consists of three aspects: the forensic medical examination, medical care, and psychological care. In this position paper, each of these aspects are discussed in detail. Recommendations for follow-up care are also provided.

Methods In a multi-tiered process, a selective literature review was performed and a consensus among representative experts from different areas of specialization was formulated.

Goals The goal of this paper is to contribute to the further improvement and standardization of the medical care provided to women who are presumed rape victims.

ZUSAMMENFASSUNG

Einleitung In der Bundesrepublik Deutschland erleben laut Prävalenzstudien mindestens 5% aller Frauen in ihrem Leben eine Vergewaltigung. Eine Vergewaltigung hat, individuell unterschiedlich ausgeprägt, gravierende Folgen für die somatische, psychische und psychosoziale Gesundheit Betroffener. Der ärztlichen Versorgung mutmaßlich Stuprum-Betroffener kommt eine besondere Wichtigkeit zu, da diese einerseits den Verarbeitungs- und Heilungsprozess nach einem solchen einschneidenden Ereignis positiv beeinflussen kann und andererseits Ärztinnen und Ärzte in diesem Zusammenhang die am häufigsten konsultierten professionellen Helferinnen bzw. Helfer sind. Die Erstversorgung nach Stuprum setzt sich aus

3 Anteilen zusammen: der medizinisch-forensischen Untersuchung sowie der medizinischen und psychischen Versorgung. Auf die einzelnen Anteile wird detailliert in der Stellungnahme eingegangen. Ebenfalls werden Empfehlungen zur Nachbetreuung getroffen.

Methoden Es erfolgte eine selektive Literaturrecherche sowie die Erarbeitung eines Konsensus unter repräsentativen Expertinnen und Experten aus verschiedenen Fachbereichen in einem mehrstufigen Verfahren.

Ziele Ziel der Stellungnahme ist es, einen Beitrag zur weiteren Verbesserung und Standardisierung der ärztlichen Versorgung mutmaßlich Stuprum-betroffener Frauen zu leisten.

Introduction

Rape (stuprum in Latin) is a medical emergency. According to the Istanbul Convention, rape is defined as "… non-consensual vaginal, anal or oral penetration of a sexual nature of the body of another person with any bodily part or object …" [2].

In the Federal Republic of Germany, at least 5 % of all women presumably experience rape during their lifetime [1]. While the effects vary between individuals, this has serious consequences for the

- physical health (immediate effects: acute injury, infection with sexually transmitted diseases [STDs], pregnancy; long-term effects: psychosomatic illnesses such as chronic pain of the lower abdomen [3 – 5], dysmenorrhea, menstrual disorders, dyspareunia, sexual dysfunction [6, 7], cervical dysplasia and carcinoma [8], and alcohol, tobacco, and drug abuse [1, 9, 10]) and the
- psychosocial health (e.g., depression, post-traumatic stress disorder [1, 11], relationship problems, social isolation [1, 6, 9, 11])

of the affected women.

The World Health Organization (WHO) has emphasized the critical role of primary medical care following sexual violence in offering a form of early intervention and enabling the victims to cope with their experience [9, 12]. Primary care that is clinically competent, empathetic, and non-judgmental is experienced by the victims as a great support and has a notably positive influence on their further journey of processing and healing [13, 14].

Methods

A selective literature search was performed. Utilizing the PubMed, CINHAL, MEDLINE, Livivo, APA PsycArticles and APA PsycInfo databases, as well as Google Scholar, the search focused on publications that appeared up until July 2021 using specific search terms (rape, sexual assault, sexual violence, rape AND primary care, post assault care, forensic examination, trauma-informed care). Using the same criteria, the aforementioned databases were searched for publications using the German search terms for rape, sexual violence, sexual violence AND primary care, care. In a second step, the participating authors, who represent different areas of specialization, worked together to develop a formal consensus.

General Recommendations for Primary Care

Primary care following rape consists of a gynecological examination and a forensic medical examination, as well as psychosocial care.

The victim does not have to report the matter to the police in order to receive treatment.

The treating physician is not under any obligation to report the offence – neither on behalf of their institution nor in their capacity as a private individual.

The medical and psychosocial aspects of primary care should always be offered or recommended to the victims, regardless of whether they have reported the incident to the police or have opted for a confidential forensic examination [Vertrauliche Spurensicherung, VSS].

General principles and recommendations

- A space with a calm atmosphere should be available for use as the setting for primary care [14 – 16].
- Waiting times should be kept as short as possible.
- The treating physician and the involved nursing staff should be trained in primary care following rape and patient consultation in the context of trauma-informed care [9, 12, 17]. Professional training courses in this field should be undertaken regularly [9, 12].
- From a forensic point of view, it is preferable for the examination to be conducted by a certified medical specialist. If this isn't possible, the (forensic medical) examination should be performed by trained gynecological staff.
- Where possible, the examination should be conducted by two doctors, in line with the dual control principle.
- If there is a language barrier, a professional interpreter should be called in to assist with taking the patient's history, conducting the examination and providing advice to the patient. If the communication is limited due to language issues, it is always advisable, especially with regard to a potential police enquiry, to document which language was used for communication and how well the language was understood.
- If the victim has a preference regarding male or female care staff, this preference should be accommodated where possible [9, 18 – 21].
- The examination should always take place in the presence of an additional female support person [21].
- If there is an acute medical emergency (e.g., severe injury, panic attacks, dissociation, intoxication), the treatment of this condition takes priority [22, 23].

Dealing with the victim

- The victim should be asked if they would like an accompanying support person to be present during the consultation. The accompanying support person should be informed that they may be called as a witness in the case of a trial [19, 22].
- Police officers or judicial police staff should not be present during the physical and/or gynecological examination.
- All steps undertaken during the examination should be clearly explained to the victim, for the purpose of ensuring that there is informed consent [9, 14, 16, 21].
- The victim should be informed of their option to report the matter to the police. This should be explained once only, without placing any pressure on the victim.
- The victim should be informed that the examination is voluntary, and that she may interrupt or end the examination at any time. Any (partial) refusal, interruption or early termination of the examination should be documented. The medical examination and collection of evidence can worsen the patient's feeling of shame and loss of control. The patient must not be put under any pressure to be examined or undergo treatment and must be given as much control as possible over the examination process.
- The doctor should listen actively (give validation, confirm the patient's narrative, keep an eye on the patient's stress level, exert a calming influence, keep things focused on the "here and now", utilize resources, and place emphasis on the healing process) and convey a sense of calm and safety. The doctor should avoid making any criticisms [9, 13, 14, 24], in particular because negative social reactions can, for example, promote PTSD [17, 24 – 28].
- The doctor should treat the victim objectively and with empathy, and convey the message that she is taken seriously, her trauma is acknowledged, and she is not to blame for what has happened to her [17, 22, 24, 29]. The victim should feel safe and able to trust the medical staff taking care of her [30].

Information on forms of care (police report, confidential forensic examination, medical care only)

If the woman so wishes, the care provided may consist solely of medical and psychosocial care (see "Recommendations for the forensic examination"). Nevertheless, it is still necessary to keep medical documentation, even if the patient has not opted to have a forensic examination. These records may still serve as a relevant source of information if later required, subject to the doctor being released from the obligation to maintain medical confidentiality. However, the doctor should explain carefully to the victim how all of the forensic evidence, in the form of photos and DNA, may be useful in any potential subsequent trial.

Confidential forensic examination

If the victim does not wish to make a police report, the option of having a confidential forensic examination [Vertrauliche Spurensicherung, VSS] should be explained and offered to her. The confidential forensic examination may take place regardless of whether any report is made to the police. This means the victim may be provided with forensic evidence and medical documentation of her injuries which is admissible in court, without having to immediately report the incident to the police.

This gives victims the opportunity to recover physically as well as mentally, get some support, and think through the option of making a police report.

The preserved material can then be made available for assessment if the matter is reported to the police at a later time, depending on how long the forensic evidence is stored for. The victim should be informed on the duration of material storage and should sign to confirm this. The storage period varies in each case depending on the responsible health care institution [31 – 33].

Regardless of whether forensic evidence was collected and regardless of the storage period for any collected evidence, at present a rape may be reported up to 20 years after the event. If the victim was under 30 years of age at the time of the crime, the period of limitation begins when the victim turns 30.

Care following a police report

If a police report is made, the victim must be informed that she needs to release the treating physician from the obligation of medical confidentiality, so as to enable the physician to disclose the documented evidence and forensic evidence to the police and justice authorities [16].

For each request to disclose documents, the doctor must obtain a signed release from confidentiality from the patient in order to provide the information to the investigating authorities.

The German Society of Forensic Medicine recommends an interdisciplinary examination conducted by gynecological and forensic medical staff [21]. However, this procedure may not always be followed depending on the health care institution, the associated competencies, the available options in terms of facility and staff, and the victim's injury patterns. Nevertheless, the quality standards for relevant documentation of evidence and collection of forensic evidence must be met in every case [20, 21].

In the case of a forensic medical examination, we recommend the use of forensic evidence kits developed especially for this purpose [9, 20, 21, 34]. These contain templates for taking the patient's medical history, as well as materials for the forensic examination and instructions on how to perform the examination and collect the evidence correctly and systematically [21].

Medical history

- Taking the patient's medical history involves taking a general history, as well as the patient's gynecological history, and the history relating to the event.
- Both the medical history and the history relating to the progression of events should serve to guide the clinical and forensic examination, the collection of forensic evidence, the medical care (e.g., risk of having contracted an STI, risk of pregnancy), and any other support measures the victim may require [22, 35].
- To minimize the stress placed on the victim, questioning about details of the event should be limited to what is necessary in order to perform the examination, provide care, and collect forensic evidence [21].

- The following points should be included in the medical history:
  - The circumstances of the assault including the date, time and place, any use of weapons, violence, physical restraints or other objects, any further violence or threats, and a description of any violent force applied to the throat including associated defecation or urination, aura, swallowing difficulties, sore throat, hoarseness or sensation of a foreign body (globus sensation);
  - Details of whether the victim became unconscious/blacked out at any time or suffered any loss of memory, and suspicion of intoxication;
  - Details of oral, vaginal or anal contact or penetration, the presence or absence of ejaculation (explain this term if necessary), and the use of a condom by the perpetrator;
  - Any bleeding from the perpetrator or the victim; this may be relevant for assessing the risk of hepatitis or HIV infection;
  - Details of consensual sexual activity prior to or after the assault, including details about the place of contact (oral, genital, anal) and the use of condoms;
  - Information on whether the victim has wiped herself, showered, taken a bath, changed her clothes, eaten anything, used toothpaste or mouthwash, used an enema, or changed or removed a tampon, sanitary pad or barrier contraceptive device since the assault;
  - Documentation of the victim's current complaints/pains.

Recommendations for the Forensic Medical Examination

A forensic medical examination may be performed following a police report or in the context of a confidential forensic examination. The forensic medical examination includes a description of the victim's psychological state, a comprehensive physical examination, a gynecological examination, and the collection of forensic evidence.

In this process, the following should be noted:

- In order for a forensic medical examination to take place, the victim must provide a written declaration of consent [21].
- If the victim is not competent to give consent, e.g., in the case of intoxication, a forensic medical examination may only be performed once the victim has regained her capability to give consent; alternatively, consent may be given by a caregiver (e.g., in the case of psychiatric illnesses) or by court order (e.g., if the victim is in a coma).
- If the victim intends to undergo a forensic examination, she should be encouraged to do this as soon as possible after the assault [22].
- Where possible, medical care should be provided immediately following the forensic examination.
- If the victim intends to undergo a forensic examination, she should be told:
  - to avoid taking a bath, showering, or changing her clothes before the examination,
  - to keep any condoms that were used,
  - to avoid eating, drinking or smoking if the assault involved oral penetration,
  - to leave any tampons, etc. that are currently in place in the vagina (these should only be removed after swabs have been taken of the external genitals).

Forensic medical examinations are subject to the following requirements:

- The entire examination and collection of forensic evidence should take place according to an examination protocol/documentation form. (Forensic evidence kits contain the relevant protocols and corresponding documentation forms.)
- For the collection of forensic evidence, certain procedures must be abided by, and a complete chain of evidence without any gaps must be ensured (i.e., the forensic evidence collected must be delivered and stored in such a way as to be understandable at a later time) [14, 36].
- While collecting forensic evidence, it must be ensured that there is no contamination from the physician's own DNA or DNA from previous examinations. Accordingly, the table and chairs used in the examination should first be cleaned to ensure that they are free of DNA (i.e., cleaned with commercially available surface disinfectants containing alcohol).
- Evidence such as clothing, panty liners, tampons, condoms, etc. should be secured in paper bags. If no police report is made, these may be kept by the clinic or by the victim herself. In the latter case, the patient should be informed that the use of this material as evidence in a later trial may be contested due to the possibility of manipulation.
- A detailed examination of the entire body should be performed, taking care that the victim only has to partially remove her clothes at any one time. The general physical examination and collection of forensic evidence should be performed first; only after this should the doctor proceed to the anogenital examination.
- When it comes to the physical and anogenital examination, all of the injuries must be documented including details of the size, form, color and depth (where applicable, i.e., for stab wounds), as well as their precise location, and must also be documented photographically and annotated on a body chart [14, 20, 21]. The absence of injury (negative findings) or presence of very minor injuries (trivial injuries) must also be documented, as well as any refusal by the victim to have a particular body area examined.
- Photographical evidence of the injuries provides a useful supplement to the graphical documentation on the body chart and to the description of the findings. The photography should be conducted with sensitivity, and the victim's express consent must be obtained for photos to be taken as part of the examination. If photographic documentation is taken, this should be noted in the report. A portrait shot of the victim may be taken for future allocation of the file. The photos should comprise informative detail shots and shots with a size scale (overview and close-up shots with a size scale; shots should be taken perpendicular to the injuries) and a color scale, and these should be preserved and enclosed with the documentation [21]. Having photos taken of their anogenital area can be especially shame-

ful and embarrassing for the victim [21]; for this reason, no overview shots should be taken of the anogenital area. Informative detail shots should be taken; these should be preserved and enclosed with the documentation [21].
- Digital photos should not be deleted (even shots that are considered out of focus). This serves to safeguard the staff conducting the examination.
- Collection of physical evidence from the victim's body must, to the extent possible, be performed at the same time as the examination, so as to save the victim from undergoing the same step repeatedly [15].
- The extent of forensic evidence to be collected depends on the nature of the assault (e.g., type of penetration, degree of violence, and the time elapsed since the assault).
- A cheek swab should be taken from the victim for DNA analysis [21]. Alternatively, the victim can provide DNA in the form of a blood sample (EDTA tube).
- Depending on the information from the patient's medical history, the following swabs should be taken [20, 21]:
  - Vaginal penetration: external genitals, vulval vestibule, posterior vaginal wall and perineum/perianal area
  - Anal penetration: perineum/perianal area, rectum
  - Oral penetration: mouth (It is important to get good samples from the cheek pouches and mucobuccal folds.).
- Always ensure the sample tubes are correctly labelled.
- Moistened swabs should be used to take samples from any flecks of blood, saliva or sperm that may be present, as well as from injuries, and from under the victim's fingernails.
- Blood and urine tests are required as evidence of any consumption or administration of alcohol, drugs or medications [21]. Testing for consumption or administration of alcohol, drugs or medications should be selective, i.e., it should be performed if there is a basis for suspicion (amnesia relating to the incident, manifest symptoms, suspicion on the part of the victim, etc.) [35]. In this process, the following should be noted:
  - In cases of sexual assault with suspected impairment of the victim's consciousness through alcohol, drugs or medication, it is most often possible to prove the use of alcohol [37–41].
  - Various other substances may be used by the perpetrator, such as benzodiazepines, γ-Butyrolactone (is metabolized to gamma-Hydroxybutyrate [GHB]), or GHB itself, as well as ketamine, anticholinergic drugs, antihistamines, and muscle relaxants [39]. These substances may, in some circumstances, only persist for a short time after the assault, e.g., GHB persists for 6 to 8 hours in the blood and approx. 12 hours in urine [39]. For this reason, the samples (blood and urine) should be taken as soon as possible (preferably before the start of the actual forensic medical examination). If a longer time has elapsed since the assault, a hair analysis may be performed [42].

Recommendations for Medical Care

If a confidential medical examination without a forensic examination is desired, the option of having a confidential forensic examination and what this involves should be explained to the victim, nevertheless. If the patient explicitly rejects the option of a confidential forensic examination, her wish must be accepted unconditionally, and must be documented.

Even in the case of purely medical care, a documentation form should be used; this assures a systematic examination procedure and may also serve as "evidence" in any future criminal proceedings.

General recommendations

- Physical injuries should be adequately identified, documented and treated; specialists from other disciplines should be involved if and where necessary.
- The patient's tetanus vaccination status should be determined, and a vaccine/booster should be given, if indicated.
- Following violence applied to the throat (strangling/throttling), the patient should always be examined by an ENT specialist, with imaging if necessary (CT/MRI of the throat).
- The victim should be offered a (urine) pregnancy test.
- The victim should be offered emergency contraception (ulipristal acetate, levonorgestrel or, in exceptional cases, a copper IUD) [12].

Sexually transmitted infections (STIs)

(You can find more on this in the AWMF Guideline "Sexuell übertragbare Infektionen [STI] – Beratung, Diagnostik und Therapie" [Sexually Transmitted Infections [STI] – Consultation, Diagnosis and Treatment], section 4.3.2., "Diagnostik von STI bei sexuellem Missbrauch" [Diagnosis of STIs in Cases of Sexual Abuse] [43].)

A baseline status (point zero status) should be determined for the following infections: Chlamydia trachomatis, Neisseria gonorrhoeae, and Trichomonas vaginalis based on a vaginal swab, as well as syphilis, HIV, and Hepatitis B and C based on serum testing. It is very important to explain the need for follow-up checks after 2, 6 and 12 weeks to the patient.

Administration of prophylactic antibiotics should be considered. At the patient's request, if there is a high risk of infection and/or if poor compliance with subsequent follow-up appointments is suspected, administration of a prophylactic one-off treatment for Chlamydia trachomatis, Neisseria gonorrhoeae, and, if applicable, Trichomonas vaginalis is recommended [43].

The patient's Hepatitis B vaccination status should be determined, and a vaccine/booster should be given, if indicated.

Post-exposure prophylaxis for HIV should be considered.

Recommendations for Psychological and Psychosocial Care

(See also the AWMF Guideline: "Diagnostik und Behandlung von akuten Folgen psychischer Traumatisierung" [Diagnosis and Treatment of Acute Sequelae of Psychological Trauma] [44].)

To ensure reliable ongoing psychosocial support for the victim, it is a good idea to collaborate with women's counselling services, forensic medicine examination centers, legal aid centers, financial support programs, outpatient and inpatient psychotherapy providers, women's shelters, etc.

In general, the following recommendations for providing psychological and psychosocial support for the victim are made:

- Build up a relationship with the victim and ask her about her needs and worries [9, 14, 24].
- Investigate any tendencies to self-harm or suicidal behavior [13, 30] and determine whether hospitalization is necessary in this context.
- Help the victim to access short-term relief: who from the victim's social setting is able to offer support, which counselling services can the victim turn to?
- Determine if there is any (acute) need for protection and investigate the options for victim protection, especially in the case of sexual violence within a relationship [16]. The victim should be discharged into a safe environment, ideally accompanied by a trusted person.
- Psychoeducation may be provided by informing the victim of possible psychological reactions that may occur, such as flashbacks, overwhelming emotions and phases of emotional numbness, dissociation, and increased agitation with sleeping disorders; this helps the victim to classify and understand these occurrences as reactions [14, 24]. During the first contact with the victim, it should suffice to cautiously address the issue and to advise the patient to attend follow-up appointments and seek help from specialist counselling services if further support is needed.
- Any risk factors that increase the likelihood of developing long-term psychological symptoms (e.g., the suspected perpetrator is the victim's current or former intimate partner, preexisting psychiatric conditions, previous rape or other traumatic experiences [11] such as psychological, physical or sexual violence during childhood or adulthood) should be identified [24]. Victims who have already experienced this kind of trauma before should receive a more thorough psychoeducation including an explanation of the risks and support options (see points listed below).
- Finding and using resources: the doctor should have a discussion with the patient about what support might be available in her social setting.
- If so desired, the doctor may refer the patient to psychosocial and/or psychotherapeutic support resources as deemed appropriate [9, 13 – 16]. The doctor should explain to the victim that she is entitled to these support services under the Crime Victims Compensation Act [Opferentschädigungsgesetz, OEG].
- The victim should be given information on specialized counselling services, women's shelters, OEG trauma outpatient services and other places she can go to for help – e.g., for legal advice [9, 13, 14, 45].
- Victims should be given this information in writing, as concentration and memory function are often impaired during the acute situation [14, 18, 34, 36].
- Prescription of benzodiazepines should be avoided if possible, as they do not prevent post-traumatic stress disorders; instead, they promote the chronification of such [44].

Recommendations for Follow-up Support

For ongoing care following the acute intervention, the victim should attend follow-up appointments at certain intervals (after 2, 6 and 12 weeks is recommended from the perspective of infectious diseases), or they should be directed to the appropriate points of contact (registered gynecologists, general practitioner, outpatient clinics for infectious diseases, health authorities) [13, 14, 30, 34, 36].

Physical and psychological sequelae should be determined, and the victim should be referred, as appropriate, for further care.

The importance of follow-up checks should be explained [36], and the victim should be supported in attending these follow-up appointments [30].

The following issues should be addressed in these appointments:

- Testing for sexually transmitted infections (see AWMF Guideline "Sexuell übertragbare Infektionen [STI] – Beratung, Diagnostik und Therapie" [Sexually Transmitted Infections {STI} – Consultation, Diagnosis and Treatment] [43]).
- Completion of vaccinations (see AWMF Guideline "Sexuell übertragbare Infektionen [STI] – Beratung, Diagnostik und Therapie" [Sexually Transmitted Infections {STI} – Consultation, Diagnosis and Treatment] [43]) and treatment, where applicable.
- Conversation about and assessment of the victim's psychological state and, where appropriate, referral of the victim to a suitable specialized counselling service or an OEG outpatient clinic for trauma victims, or initiation of a trauma-focused psychotherapy. For this purpose, the utilization of questionnaires such as the PTSS-10, PCL-5 and PHQ is recommended.

Conclusion

The medical care that is provided to presumed rape victims is of special importance, as this care can have a positive influence on the patient's ability to process their experience and engage in healing following such a traumatic event. Furthermore, doctors are the professionals whose help is most often sought in this context [2].

The goal of this paper is to contribute to the further improvement and standardization of the medical care provided to women who are presumed rape victims.

Annex/Attachments/Useful Contacts

- Documentation forms
  - The Projekt Medizinische Soforthilfe [Immediate Medical Help Project] from Frankfurt am Main provides extensive background information, as well as extensive documentation forms and further assistance: https://www.soforthilfe-nach-vergewaltigung.de/medizinerinnen/
- iGOBSIS (intelligentes Gewaltopfer-Beweissicherungs- und -Informationssystem [intelligent information system for managing victims of violence and preserving evidence]) is a web-

based documentation system and information portal that provides support and further training modules for documentation of injuries, collection of forensic evidence, and referral of patients for psychosocial support: https://gobsis.de/

- Flyer for coping strategies: https://www.bbk.bund.de/SharedDocs/Downloads/BBK/DE/Publikationen/Broschueren_Flyer/Mit_belastenden_Ereignissen_umgehen_Flyer.pdf?__blob=publicationFile
- Assistance for people exposed to violence in their social milieu
  - *Women's counselling services and emergency helplines for women and girls exposed to violence.* https://www.frauen-gegen-gewalt.de/de/hilfe-vor-ort.html
  - *"Violence against women" helpline.* Women can call the free number 0 80 00 11 60 16 for advice and information from the staff of the "Violence against women" helpline; help is available in several languages and covers all forms of violence against women. www.hilfetelefon.de
  - *"Sexual abuse" helpline.* Women can call 08 00 2 25 55 30 free of charge from anywhere in Germany to reach the "sexual abuse" helpline on Mondays, Wednesdays and Fridays from 9 a.m. to 2 p.m. and on Tuesdays and Thursdays from 3 to 8 p.m. Calls are anonymous. The helpline's online counselling services are available for youths on www.save-me-online.de.
  - *Berta-Telefon.* This is a point of contact for victims of organized sexual and ritual violence. Persons can call 08 00 3 05 07 50 to reach pedagogy and psychology specialists working on behalf of the Independent Commissioner for Child Sexual Abuse Issues, under the professional oversight of N. I. N. A. e. V. https://nina-info.de/berta.html
  - *"Number against grief" ("Nummer gegen Kummer").* Pressure and conflicts within the family can lead to the exertion of violence against children and adolescents. Funding is being increased for the "Nummer gegen Kummer" helpline for children and adolescents, available under 116 111, and the parents' line under 08 00 1 11 05 50. Also, offerings of low-threshold help for children, adolescents and parents are being expanded within the online network.
  - *Pregnant women in emergency situations (Schwangere in Not).* The "Schwangere in Not" helpline, for pregnant women in emergency situations, operates 24/7 under the number 08 00 4 04 00 20. By calling this number, pregnant women in conflict situations will be connected immediately to someone who can help. https://schwanger-und-viele-fragen.de/de/
  - *Women's shelters throughout Germany.* https://www.frauenhauskoordinierung.de/hilfe-bei-gewalt/frauenhaussuche/; www.frauenhaus-suche.de

Conflict of Interest

The authors declare that they have no conflict of interest.

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