SEXUAL ABUSE OF BOYS UP TO 17 YEARS OF AGE – PROBLEMS OF THE FORENSIC EXAMINATION

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ABSTRACT

Sexually abused children rarely report their experiences. In reality, many of them are unable to expose the abuse or deny it until adulthood. Goal: the present study has the goal of summarising the most commonly encountered difficulties during the forensic medical evaluation of existent or nonexistent sexual violence over male persons. Materials: the medical records from 37 cases of male persons that had reported that they were the victims of sexual abuse in the Stara Zagora District within a ten-year period were processed.

Methods: The described cases were processed through the documental method and statistically in Excel. The patients were divided into 3 age groups: up to 6 years old, 7–11 years old, 11–17 years old. Results: In 68.96% of the cases, the perpetrator was 1 familiar person, in 24.14% two familiar persons and in 6.90% - relatives. More than half of the victims reported experiencing violence until the third day (62.06%). In 7 of the boys (24.14%) traumatic damage to the anal area could be observed, in six of the examined boys (20.69%) there was traumatic damage on the head, body and limbs. In 55.17% of the cases the abuse was committed through a threat, in 20.69% the boys reported systemic violence, 20.69% were coerced through physical violence and threat, and in 3.45% through physical violence.

INTRODUCTION

Sexual abuse of children is a global problem to social health. Sexually abused children often do not report it. Some children deny the experienced sexual violence despite the presence of convincing evidence (DeVoe, E. R., Faller, K. C., 1999; Orbach, Y., Lamb, M. 1999). In reality, many of them are unable to expose the abuse they have experienced or continue to deny until adulthood (Berliner, Conte, 1995; Lamb, Edgar-Smith, 1994, Goodman-Brown, T. B., et all. 2003), due to fear of revenge or of negative consequences for the family, feelings of shame and self-blame, loyalty to the perpetrator, post-traumatic stress disorder, etc. (Arata, C. M., 1998; Koverola, C., Foy, D.,1993; Sauzier, 1989; Summit, 1983). The lack of reliable confirming medical evidence or witness reports obstructs the solving of sexual abuse cases, since psychological profiles are not reliable evidence for its confirmation or rejection (London K., et all. 2008). In research literature there are more data about sexual abuse of girls and women than of boys and men. This gave us a reason to initiate the current study.

GOAL:

The present study aims to summarise the most commonly encountered difficulties in the forensic medical evaluation of existent or nonexistent sexual violence over male persons.

MATERIAL:

The medical record documents of 37 cases of male persons that had reported that they were victims of sexual violence in the Stara Zagora District within a ten-year period (2003-2012) were processed.

METHODS:

The described cases were processed through the documental method and statistically in Excel. The patients were divided into 3 age groups: up to 6 years old, 7–11 years old, 11–17 years old.

RESULTS:

A total of 37 cases were processed, in which a man or a boy had declared that they were sexually abused. Twenty-nine of the cases involved children up to 17 years of age. Their age distribution is shown in Table 1. The mot affected group is the one from 7 to 11 years of age (51.36%).

Table 1 – Age distribution of the male persons that reported being victims of sexual violence

Age	Number	%
Up to 6 years of age	8	21.62%
From 7 to 11 years of age	19	51.36%
From 12 to 17 years of age	2	5.40%
Over 18 years of age	8	21.62%

Table 2 – Distribution of the male persons up to 17 years of age – victims of sexual abuse, in relation to the perpetrator

Perpetrator	Number	%
1 familiar person	20	68.96%
2 familiar persons	7	24.14%
Relatives - cousins	2	6.90%

In our study we found out that all assailants and perpetrators of sexual abuse over boys were familiar persons. In 68.96% of the cases it was one familiar person, in 24.14% it was two familiar persons, and in 6.90% it was relatives (cousins).

Table 3 shows the results regarding the distribution of the boys who declared that they had been sexually abused, in accordance to the period from the incident to the performance of the forensic-medical certification. More than half of the victims reported their experiences on the third day (62.06%).

Table 3 – Distribution of the male persons up to 17 years of age examined in relation to experienced sexual abuse, in accordance to the time of performing the examination

Days to examination	Number	%
The same day	9	31.03%
Up to 72 hours	9	31.03%
From 4 to 7 days	1	3.45%
From 8 to 14 days	7	24.14%
More than 14 days	3	10.35%

In seven (24.14%) of the certified boys we established traumatic damage in the anal area, in six of the examined boys (20.69%) there was traumatic damage on the head, body and limbs, with 3 of these cases (10.35%) being combined – with the presence of traumatic damage in the perianal area and other areas of the body. Traumas in the anal area were most often rhagades, scrapings and flushing.

In 55.17% of the cases, the assault was committed through a threat, in 20.69% the boys reported systemic violence, the same number were coerced through beating and threat, and in 3.45% through beating.

In one of the 16-year-old boys there were condylomas in the anal area. His examination was conducted 3 months after the incriminating date.

In one of the cases we established flushing of the anal and perianal mucosa on the 10th day after the experienced violence.

DISCUSSION

In our study we established that 72.98% of the male persons that had reported sexual abuse were boys up to 11 years of age. Similar data were reported by Risin LI, Koss MP. (1987), Finkelhor D, et al. (1990), Doll LS, Joy D, Bartholow BN. et al. (1992). In their studies they determined that the average age of experiencing sexual abuse is 9.8 – 10 years, and 58% of the affected boys were younger than 11 years. Other authors – Faller KC. (1989), Moisan PA., et al. (1997), Sarwer DB, et al. (1997), Schulte JG, et al. (1995), Spencer MJ, Dunklee P. (1986) – reported that despite the different age of experiencing the abuse, it usually begins before puberty (63%).

From the presented data it is evident that the perpetrator is a familiar person, as in 68.96% of the cases it was one familiar person, in 24.14%: two familiar persons, and in 6.90% – relatives (cousins). In the studies of Miteva R. (2012) it was established that sexual abuse over male persons was most commonly performed by a familiar person, in 82.67%. In another study, Miteva R. (2012) reported that in boys and girls up to 18 years of age, the perpetrators of sexual abuse against the two sexes, women – 70.38% and men – 82.18%, in average 71.32%, was committed by a familiar person. Finkelhor D. (1984) reported that 3% to 4.8% of the surveyed men in the USA shared that they had had sexual contact with an older man in before puberty.

The conducting of a forensic medical study of boys that had reported being victims of sexual abuse should be careful, in order to avoid further emotional trauma to the examinee. Andenæs, A. (1995) advises that for little children the interview (anamnesis) be performed at the child's home where its daily life takes place. During the physical examination, all anatomical areas should be carefully examined for the presence of traumatic damage, and material evidence must be carefully collected. When necessary, laboratory and microbiological examinations can also be performed. Early reporting of the sexual abuse is of major significance. In our study we found out that 62.06% of the victims reported the abuse within the first three days. Sakelliadis Emm. I, et al. (2009) reported that it is less likely to find material (biological) evidence on the victim after the 72nd hour. Claytor et al. (1989), Spencer MJ, Dunklee P. (1986) reported that in 86% of the boys that went to an examination within 3 days after the incident, there was anal flushing, scraping and rhagades of the anus, as well as spermatozoa on the rectal tampons in 27% of the cases. In a survey conducted by Finkelhor D,. et al. (1990) it was revealed that 42% of the sexually abused children exposed the abuse within 1 year of the incident, 20% told about it later, and 38% had nor reported it until the time of the survey. Clayden GS. (1988) pointed out that the findings from the physical examination were minimal when it is performed after a long period of time.

We established that in 7 (24.14%) of the certified boys there was traumatic damage in the anal area, in six (20.69%) of the examinees there was traumatic damage on the head, torso or limbs, with 3 (10.35%) of these cases being combined – with traumas in the perianal area and other body parts. The traumatic damage in the anal area is most commonly rhagades, scrapings and flushing. Similar data was encountered in literature as well (Christian et al, 2000), who established that traumatic damage in the anal area could be observed in 24% of the children who had been sexually abused. Heppenstall-Heger A. et al., (2003), reported that in 52% of the cases the anal trauma from sexual violence was exhibited as suffusion, scrapings and wounds, specifying that only the rhagades would heal with a clear cicatrix, whereas the other traumas heal without a trace. Paul, D. M., 1990 emphasised that the scrapings, suffusions and flushing in the anal area are not found after the 4th day of the trauma, which could obstruct the proving of sexual abuse, unless it was reported on time.

According to Heger A. et al., (2002) only in 1% of the cases when the boys declared that they had suffered sexual violence with anal penetration, there had been traumatic damage confirming the incident.

D. Muram,1989 and McCann J., et al. (1989) believe that flushing or oedema in the genital area could be caused by touching and penetration, as well as a result of poor hygiene, rash, masturbation, etc. In our study, there was one case with flushing of the anal and perianal mucosa on the 10^{th} day after experiencing the sexual abuse, which was most likely due to the aforementioned reasons.

In their report, Hobbs CJ, Wynne JM. pointed out that not every dilatation of the anal orifice could be due to penetration. They indicated that in little children it could be caused by the filling of the lower third of the intestines with fecal masses. According to Gubler Ch. et al., (2005) rhagades in the anal area could be due to various diseases of the skin or the gastrointestinal tract.

In the reports of Muram D. 1989, Kerns DL, Ritter ML, 1992, Adams JA, et al. 1994, it is emphasised that no material evidence are found in many personal assaults, and the injured mucosa with scraping and suffusion in the anal-genital area recovers quickly. For their part, Finkel MA. (1989), McCann J, et al. (1992) and McCann J, Voris J. (1993) believe that in certain cases there is irrefutable evidence of anal-genital trauma, and yet the child denies such an incident took place.

One of the most important elements in identifying sexual abuse is the presence of ejaculate in the victim's anus, on their body, clothes or on other material evidence. It should be noted that the lack of evidence of ejaculation does not, in any way, invalidate a sexual abuse complaint (Sakelliadis Emm. I, et al. 2009).

CONCLUSION

The role of the forensic medical examination of great importance for the proper investigation of the cases of sexual violence over boys. It should be noted that the lack of traumatic damage in the anal-genital area or presence of spermatozoa does not rule out the possibility that the victim was sexually abused, as well as that not all traumatic damage in the same area must be caused by sexual violence. The timely conducting of an examination – up to the 72^{nd} hour – allows for a more objective evaluation of the inflicted damage and more reliable interpretation of the findings.

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