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Male sexual assaults in the Paris, France area: An observational study over 8 years

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ABSTRACT

Background: Male sexual assaults were long ignored, possibly because of the myth acceptance that a man can only be the perpetrator of sexual assaults. It is increasingly admitted that all males can be victims of rape. We described the characteristics of a series of male adolescent and adult victims of sexual assault who had a forensic medical examination.
Methods: We conducted an observational study over 8 years.
Results: We included 98 male patients aged 15 years and older (range 15–66, median 25) at the time of a reported sexual assault. Assailants were known by the victim in 59 cases (60%). Forty-four patients (45%) had physical or mental vulnerability. Anal penetration was reported in 49 cases (50%). Genital examination showed abnormalities compatible with traumatic injuries in 23 cases (24%). Psychological symptoms were found in 81 victims (83%), including shame (39, 40%) and anxiety (38, 39%). Of 98 victims, sperm could be detected in 6 cases (6%) (anal, 4; oral, 1; skin, 1). Male victims were more frequently disabled or vulnerable than female victims examined in the same centre (45% vs. 13%, $p < 0.001$). At the one-month follow-up consultation, psychological symptoms, including sleep disorders and fear, were observed in most patients and the proportions of physical and psychological complaints were similar among male and female victims.
Conclusion: Male victims of sexual assault experienced high level of psychological trauma and felt more ashamed than women, which suggests that sexual assaults should be considered as severe among men as among women.

1. Introduction

Sexual violence, a human-rights abuse, is a worldwide phenomenon of unknown magnitude because of underreporting [1]. For a long time, male sexual assaults were ignored because of the myth acceptance that a man cannot be sexually assaulted, but can only be the perpetrator of sexual assaults. Most series of published cases of sexual assaults affecting adolescents and adults included a large majority of female cases, commonly over 95% [2,3]. Men are supposed to be strong, sexually dominant, heterosexual, and they assault women with force. Men could not report a sexual assault because it would ask them about their own sexuality and they might blame themselves for what happened and felt responsible [4–6]. However, male sexual assaults have been widespread reported in three situations during the last decades: rape during war conflicts since the early 1990s, rape in prison or in institution and rape among gay men since the 1980s. In the 1990's, the International Criminal Tribunal for the Former Yugoslavia reported that during the conflict, men were forced to rape other men, forced to perform fellatio and other sexual acts on guards and each other, suffered castrations and other sexual mutilations [7]. Some studies reported sexual violence as a weapon of war against boys and men, documented in dozens of conflicts that occurred in countries such as Croatia, Greece, Uganda, Democratic Republic of Congo and Chile [8–10], and more recently during the Israeli–Palestinian conflict [11]. There is a shortage of research on adult male victims of sexual assault, reviewed until 2009 in [12]. It has been increasingly suggested in the last two decades that all males can be victims of rape [12–15]. Most studies were limited to the description of either somatic or psychological disorders following the assaults. In this study, we described the characteristics of a series of male adolescent and adult victims of sexual assault who had a forensic medical examination. We compared victims assaulted by known or by unknown assailants. We also compared vulnerable victims with

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other victims and male victims with a sample of female victims of sexual assault living in the same geographical area and consecutively examined in our Department [3].

2. Methods

2.1. Study design

We conducted an observational and retrospective study. We consecutively included all eligible male individuals aged 15 years and older at the time of a reported sexual assault who were referred to the Department of Forensic Medicine (Bondy, France), over 8 years and 10 months. The words used for the description of the assault included sexual assault, rape and sexual touching. The Department, which belongs to a general hospital, is the referral centre for all sexual assaults survivors of the Seine-Saint-Denis area, which accounts for approximately 1.5 million inhabitants. Victims were examined either at the request of the police, or of other physicians such as accident and emergency doctors, or directly at their own request. Victims were excluded from our sample if they refused to undergo clinical examination, or if they had insufficient knowledge of French or English for a medical interview. Examinations were performed by trained forensic physicians after patients had reported the assault to the police or when they planned to do shortly after the medical examination until March 1, 2014. After this date, all victims were received, whether or not they reported the assault to the police. Twelve forensic physicians were involved in data collection. An ethics approval of the project (No. 10-005) was given by the institutional review board (00006477) of Paris North Hospitals.

2.2. Measures and variables

All patients had similar general, genital and anal examinations. Genital and anal examinations were not performed, if the patient reported sexual touching without any sexual penetration. Genital examination included a visual examination of external genitalia. Anal examination included a visual examination of the anal sphincter and the anal margin. Anoscopy was performed at the examiner's discretion, in case of traumatic lesions on visual examination or if the victim expressed complaints such as pain or bleeding following the assault. No dyes were used. Lacerations, bruises, abrasions and scars were recorded. In case of significant traumatic lesions observed by anoscopy, patients were referred to a specialized proctologist. Relevant forensic and toxicology samples were collected. Trace samples were collected using swabs. In case of recent anal penetration (less than 48 h), swabbing were performed before and at the time of insertion of a single-use anoscope. Water was used as a lubricant. Swabs were also collected from the mouth and the surface of the body when indicated. Swabs were collected for spermatozoa, DNA and sexually transmitted infection (*Chlamydia trachomatis* and *Neisseria gonorrhoeae*) testing, as previously described [3,16]. The slides were prepared immediately by direct smearing of the swab, left to dry, and frozen. When the victim reported partial amnesia or when the police requested toxicology sampling, blood and urine were analysed for the presence and concentration of alcohol and illicit psychoactive substances, including cannabis, cocaine, opiates, and amphetamines, tested by gas chromatography-mass spectrometry. Patients were examined for the first time on the day of referral. The follow-up included a second examination scheduled 1 month later. The sample period ran from January 1, 2008 to October 31, 2016.

Assailant-victim relationship was categorized as follows: assailants known by the victim, i.e., intimate partners, family members or acquaintances (group 1) and unknown assailants, i.e., individuals previously unknown to the victim (group 2). Unknown individuals were defined as persons that the victim had never met or met for the first time within the 24 h preceding the assault. Data collected at the first examination included the following: descriptions of the patients, the assailants, the assaults, and the medical examination (Boxes 1–3 and Table 1). During the second medical examination, somatic and psychological symptoms were noted the same way they were noted during the first examination. Data collected at the follow-up examination included the evaluation of the victims' psychological status and the reaction of the victim's relatives when having learnt about the assault. All variables are categorical, except the ages and the times to examination.

Patients and assailants characterisations were based on patient report: did they have any medical problem, and if the answer was "yes", what kind of problem? Did they use any drug or psychoactive treatment? Which substances were involved? Have the patient been already assaulted before, when and by who? Since when did they know the assailant? Did the assailant use drugs or psychoactive treatment? Which ones?

Physical assault characterisation was based on patient report and recorded as binary (yes or no) answers. These included the following: Was the patient threatened? Was he confined? Was a weapon used? Was he drugged by the assailant or others? Was he punched? Slapped? Kicked? Did he have his hair pulled? Was he scratched or bitten? The characteristics of the sexual assault were also reported as binary (yes or no) answers to the following: Did he report oral penetration? Anal penetration? Digital penetration? Penile penetration? Was there sexual touching? Use of a condom? If the assailant was male, did he ejaculate?

In the first examination, data were collected about the symptoms reported by the victim (somatic and psychological symptoms), the time of examination, the presence of recent traumatic injuries, and the types of injuries. Victims were also asked whether they had a prior medical opinion. Somatic symptoms included reports of fatigue, pain, bleeding, pelvic symptoms and functional impairment. The presence of psychological symptoms was reported. If present, they were categorised as anxiety, fear, fear of the abuser, shame, sadness, disgust, sleep disorders, eating disorders, depressive symptoms, intrusive images or revivification, feeling of guilt, social withdrawal, anger, general tiredness, humiliation, rumination, self-mutilation, lassitude, unrest, confusion, hypervigilance, avoidance and suicidal ideation. Patients described their symptoms and the interviewer coded those symptoms as falling into the research categories. The different types of injuries reported were bruises, hematomas, wounds and bone fractures. Localisations of injuries were categorised as extragenital injuries and genital injuries (anus and penis). We recorded the victim's report of the first person whom he informed the assault. In the second medical examination, somatic and psychological complaints were noted the same exact way than during the first examination. Variables were also the same. The time between the two examinations was noted. All victims were examined by a forensic physician and by a specialised psychologist. A specialised opinion was required from a psychiatrist if needed, at the first examiner's discretion.

We performed three comparisons. First, victims of assault by someone they knew were compared with victims of assault by unknown individuals (Table 2). Second, we compared victims, whether or not they were vulnerable, i.e. mentally or physically disabled (Table 3). Third, victims were compared to a sample of 797 assaulted women examined in the same department from January 1, 2008 to March 1, 2011 and described elsewhere [3] (Table 4).