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Sexual Violence against Minors: A Study of 35 Cases

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Abstract **Original Research Article**

Sexual violence refers to any contact or interaction (visual, verbal, or psychological) where an adult uses a child or adolescent for sexual stimulation, either for their own satisfaction or that of a third party. It represents a fairly common, urgent, and challenging situation to diagnose, while avoiding any underestimation or overestimation. Hence, the relevance of our study, which aims to describe and analyze the psychological and social aspects of sexual abuse in minors under the age of 18 who were seen at the pediatric psychiatry department of Arrazi Hospital in Salé. The identified risk factors were as follows: an average age of 10 years, male gender, and a conflicted family dynamic. The only factor associated with the occurrence of post-traumatic stress disorder (PTSD) after sexual assault was having a stay-at-home mother. Furthermore, it was observed that the higher the age of the first sexual assault, the greater the risk of developing depressive disorders. Victims from families marked by domestic violence had a 25.5 times higher risk of developing this disorder after a sexual assault. Compared to victims with parents in a couple, those who were divorced had a higher number of comorbid PTSD diagnoses, while widowhood was associated with a decrease in the number of comorbid diagnoses. Lastly, it was found that justice intervention in response to sexual assault was associated with a higher number of comorbid psychiatric disorders with PTSD. To ensure the care of children who are victims of abuse and family violence, it is essential to involve professionals from various disciplines. A comprehensive and multidisciplinary evaluation must be conducted, taking into account medical, psychological, psychiatric, and social aspects. Thus, this information provides valuable foundations for developing strategies for the prevention and early detection of child abuse.

Keywords: Sexual violence, aggression, children, risk factors, psychological characteristics.

INTRODUCTION

Sexual violence is a violation of children's rights to life, survival, development, and protection. The World Health Organization (WHO) defines it as "any sexual act, attempt to obtain a sexual act, comment or advance of a sexual nature, or acts directed against a person's sexuality using coercion, committed by any person regardless of their relationship with the victim, in any setting, including but not limited to the home and workplace" [5].

Child sexual abuse refers to any form of contact or interaction between a child and an adult, an older adolescent, or a person with greater knowledge, where the child is used as an object of sexual gratification for the perpetrator's needs [6].

Child abuse is a serious public health problem due to its destructive consequences for both the individual and the community. It is a relatively common issue, requiring urgent diagnosis and challenging to identify while avoiding underestimation or overestimation [1]. Unfortunately, some children are subjected to violence by adults, far from experiencing an environment of love and protection. Among these forms of violence, sexual abuse is observed, including exhibitionism, pornographic images or comments, caresses, kissing, fondling, requests for masturbation, attempted rape, or rape [2].

Regarding the understanding and management of this phenomenon, Africa lags behind, even though it is not a new or rare issue on the continent. Few studies address this problem in African literature. This gap can be attributed to the taboo surrounding sexual assaults

within African society, where silence is generally preferred [2].

I. Study Objectives:

- Evaluate the psychological and social dimensions of sexual abuse in minors under 18 years of age.
- Highlight the specific characteristics of these sexual abuses based on psychosocial contexts.
- Describe the immediate psychological and social repercussions.

II. METHODOLOGY

1. Study Design:

This is a retrospective descriptive and analytical study, based on a hetero-questionnaire, with information collected from patient records.

2. Study Sample:

Out of 40 identified records, 5 were deemed unusable, leaving 35 patients as part of our study.

3. Location and Recruitment Period:

The data were collected from patient records seen in consultation between January 2021 and January 2023.

4. Inclusion Criteria:

- Patients aged under 18 years.
- Patients whose sexual assault was either the reason for consultation or part of their medical history.

5. Exclusion Criteria:

- Patients aged over 18 years.
- Patients whose sexual assault was neither the reason for consultation nor part of their medical history.
- Patients with autism spectrum disorder and/or intellectual developmental disorder.

6. Evaluation Tools:

The questionnaire used in this study consisted of 95 questions, distributed as follows:

- Sociodemographic data (age, gender, parental marital status, their professions, family dynamics, schooling, etc.)
- Psychiatric and addictive histories of each patient and their families.
- Questions concerning sexual assault (disclosure mode, type of assault, circumstances of occurrence, location, frequency, reactions of those around them, etc.)

7. Statistical Analysis:

Initially, we described our sample according to various socio-demographic characteristics, psychiatric histories, and family dynamics, followed by characteristics of the sexual assaults. Quantitative variables were expressed as median, and qualitative variables were expressed as frequency and percentage.

Subsequently, we conducted an analysis of factors associated with the diagnosis of PTSD and depressive disorders, as well as factors associated with the presence of comorbidities related to PTSD. For this purpose, we performed univariate analysis followed by multivariate analysis using logistic regression models (PTSD and depressive disorders) and a linear regression model (presence of comorbidities related to PTSD). In all statistical tests, the significance level was set at 0.05.

Statistical analysis was performed using the JAMOVI software.

III. RESULTS

1. Descriptive Statistics:

• Socio-demographic characteristics:

In our sample:

- Age groups were distributed as follows: between 3 and 6 years (8.6%), between 6 and 9 years (20%), between 9 and 12 years (25.7%), between 12 and 15 years (25.7%), and over 15 years (20%).
- Gender: There was a clear male predominance with a sex ratio of 1.5.
- School level before the assault: 51.7% of patients had a level considered as medium, while 24.1% had a good level, and 6.9% had a low level.
- Regarding the parental marital status, 62.9% were in a couple, 20% were divorced, 11.4% were separated, and 5.7% were widowed.
- In terms of socio-professional status, 12% of fathers were unemployed, and 62.1% of mothers were homemakers.
- As for family dynamics, it was distributed as follows: Harmonious and absence of conflict (22.9%), Presence of marital conflicts (22.9%), presence of domestic violence (20%), Blended family (11.4%), Extended family (11.4%), Large family (5.7%), and single-parent family (5.7%).

Personal and family psychiatric histories:

- Regarding psychiatric histories, 20% had personal psychiatric histories, and 43.3% had family histories of psychiatric disorders.

Characteristics of sexual assaults in our sample:

- Circumstances of occurrence: In 50% of cases, sexual assaults occurred in a context of physical violence. In other cases, they involved either threats (46.7%), manipulation (26.7%), or verbal violence (16.7%).

- Frequency: In 67.6% of cases, sexual assaults occurred repeatedly, while in 32.4% of cases, there was only one physical assault.
- Age at the time of the first assault: The median age at the time of the assault was 10 years [7, 14].
- Type of sexual violence: The different types of sexual violence were distributed as follows, in descending order of frequency:
    - Touching, caresses, kisses: 58.8%
    - Anal penetration: 55.9%
    - Sexual demands (masturbation, fellatio): 23.5%
    - Vaginal penetration: 17.6%
    - Exhibitionism, voyeurism: 14.7%
    - Attempted rape: 8.8%
    - Exposure to pornographic content: 2.9%
- Location of the assault: The location of the assault was known to the victim in 80% of cases.
- Relationship of the perpetrator with the victim: The perpetrator was known to the victim in 82.9% of cases.
- Gender of the perpetrator: The perpetrator was male in 97.1% of cases.
- Time elapsed after disclosure of the assault: Sexual assault was disclosed as follows:
    - Immediately after the assault: 31.3%
    - Within the month following the assault: 21.9%
    - Within the year following the assault: 25%
    - Within 10 years following the assault: 21.9%
- Reactions of those around the victim after the assault: The different reactions of the patient's surroundings after the assault were as follows:
    - Support for the patient: 60.6%
    - Intervention and involvement of the justice system: 78.8%
    - Stigmatization and blaming of the victim: 21.2%
    - Keeping the victim's secret and passivity: 6.1%
- Psychiatric disorder diagnosed after the assault: The different psychiatric disorders diagnosed in victims after the assault were, in descending order of frequency:
    - Post-traumatic stress disorder (PTSD): 77.1%
    - Depressive disorder: 54.3%
    - Secondary enuresis: 28.6%
    - Oppositional defiant disorder: 14.3%
    - Conduct disorder: 11.4%
    - Anxiety disorder: 11.4%
    - Encopresis: 11.4%
    - Psychotic disorder: 8.6%
    - Substance use disorder: 2.9%
- School decline after the assault: A decline in the victim's school performance was observed in 100% of cases following the sexual assault.

2. Analytical Statistics

a. Factors associated with the diagnosis of post-traumatic stress disorder (PTSD):

In univariate and multivariate analysis, adjusting for the studied parameters (age, gender, school level before the assault, personal and family psychiatric histories, parental marital and socio-professional status, as well as different characteristics of sexual assaults), only the mother's occupation was associated with the diagnosis of PTSD. Indeed, victims whose mothers were homemakers had a 14.17 times higher risk of developing post-traumatic stress disorder after sexual assault (OR=14.17, 95% CI= [1.36-147.07], p=0.026).

b. Factors associated with the diagnosis of depressive disorder:

In univariate and multivariate analysis, taking into account the studied parameters such as age, gender, school level before the assault, personal and family psychiatric histories, parental marital and socio-professional status, as well as different characteristics of sexual assaults, two factors were identified as associated with the diagnosis of depressive disorder: age at the time of the first assault and a family dynamic marked by domestic violence (Table 2).

Indeed, the older the age at the time of the first sexual assault, the greater the risk of developing a depressive disorder (OR=1.36, 95% CI= [1.04-1.78], p=0.022). At the same time, victims with a family dynamic marked by domestic violence had 25.5 times higher risk of developing a depressive disorder after sexual assault (OR=25.55, 95% CI= [1.27-513.13], p=0.034).

Table: Factors associated with the presence of depressive disorder in victims of sexual assault: Logistic regression through univariate and multivariate analysis.

	Univariate analysis			**Multivariate analysis**		
	OR	IC 95%	*p*	OR	IC 95%	*p*
Age at the time of the assault.	1,34	[1,06 – 1,69]	0,011	1,36	[1,04 – 1,78]	0,022
Domestic violence	6,92	[0,73 – 65,26]	0,091	25,5	[1,27 – 513,13]	0,034

c. Factors associated with the presence of comorbid psychiatric disorders with PTSD:

During univariate and multivariate analyses, adjusting for the studied parameters such as age, gender, pre-assault school level, personal and family psychiatric history, marital and socio-professional status of parents, as well as different characteristics of sexual assaults, we identified two factors associated with the presence of comorbid psychiatric disorders with PTSD: the marital status of parents and the intervention of the justice system.

Indeed, compared to victims whose parents were married, being divorced was associated with a higher number of comorbid diagnoses (SE=0.99, 95% CI= [0.29-1.69], p=0.007), while widowhood was associated with a decrease in the number of comorbid diagnoses (SE=-1.18, 95% CI= [-2.3 - -0.007], p=0.007).

Additionally, the intervention of the justice system as a reaction of the victim's entourage after the sexual assault was associated with a higher number of comorbid psychiatric disorders with PTSD (SE=0.82, 95% CI= [0.18 – 1.46], p=0.014).

IV. DISCUSSION

According to the data from the DGSN (National Directorate of General Security) for the period from 2008 to 2012, the age group most vulnerable to sexual violence was the 15 to 18 age group, followed by the 12 to 15 age group, and then children under the age of 12. There was also a significant increase in cases of sexual violence for all age groups starting from the year 2010 [4]. In our study aiming to assess the profile of patients who were victims of sexual violence, we found that in our sample, the median age most affected by sexual assaults was 10 years, with a minimum age of 7 years and a maximum age of 14 years. These results are consistent with the general trend observed in national statistics regarding the age of victims of sexual violence.

In our sample, approximately 60% of the victims were male, which contradicts the literature showing that in several international studies, rates of sexual and physical violence are 1.5 to 3 times higher in girls [21, 22]. Similarly, a study conducted in Senegal revealed that the majority of sexual abuse victims were girls, accounting for 84.70% [29]. Moreover, in Morocco, a total of 8,129 cases of sexual violence involving female victims were recorded, representing 70% [4]. These results highlight a significant discrepancy between the rates of male victims in our sample and the trends generally observed in the literature and national data. It is essential to consider these divergences when analyzing and discussing the results of our study. Factors such as sampling methodology, cultural context, characteristics of the studied population, and local specificities can contribute to these observed differences.

Our study also revealed the presence of marital conflicts, with a percentage of 22.9% within the families of sexual assault victims, and 20% of parents being divorced. Indeed, the lack of communication between parents and their children, poor socioeconomic conditions, and family disorganization (divorce, single parents) have been identified as risk factors for child sexual abuse [15].

When examining the time elapsed after the disclosure of the assault in our study, we observed that in 25% of cases, it occurred within the year following the assault, and in 21.9% of cases, it occurred within the next 10 years. This trend could be explained by the fact that victims and their families are often hesitant to seek help from health institutions and judicial authorities due to shame or modesty, in order to preserve the family's honor [30].

According to the findings of our study, in 82.9% of cases, the perpetrator was familiar to the victim. These results are consistent with many other studies revealing that perpetrators are often family members, teachers, neighbors, educators, and other individuals close to the child, which generally leads to a lack of suspicion on the child's part towards them [23].

Furthermore, other studies have indicated that when the abuse is committed by someone the child knows and who holds a certain authority over them, it generally leads to a more significant psychological impact [26].

Indeed, the results of our study corroborate with the observation of a significant increase in assaults starting from the year 2010, mainly in public spaces like the street, and to a lesser extent, at school and in the family home [4]. It is interesting to note that the majority of victims in our study knew the place where the assault occurred, which reinforces the trend observed in the literature concerning assaults taking place in familiar locations to the victims.

The consequences of all forms of abuse on the child leave psychological sequelae that can have a significant impact on their adult life. These damages can be profound and permanent, as they result from disruptions occurring during the crucial period of the child's neurobiological development [24]. Among these forms of abuse, sexual violence seems to be the main cause of psychological trauma in children [25]. Indeed, our study identified several psychiatric disorders diagnosed following sexual assaults, with post-traumatic stress disorder (PTSD) followed by depressive disorder being the most frequent. This situation highlights the importance of increased vigilance and thorough research by healthcare

professionals, particularly child psychiatrists, when caring for any patient in consultation. These precautions are essential to help child victims overcome psychological sequelae and begin a healing process.

The results of our study have also revealed a significant association between victims with stay-at-home mothers and an increased risk of developing post-traumatic stress disorder (PTSD) after sexual assault. This association can be attributed to several potential factors, such as the level of available social support, coping mechanisms (stress management strategies) employed, and specific family dynamics. Since stay-at-home mothers may have less free time and resources to actively support their children, victims may have limited access to appropriate psychological support, which could contribute to an increased risk of developing PTSD.

Moreover, the family dynamic associated with stay-at-home mothers could also play a role. Factors such as family tensions, dysfunctional relationships, or unresolved conflicts may be present in these families, which could increase the vulnerability of victims and predispose them to psychological disorders such as post-traumatic stress disorder (PTSD).

Similarly, in our sample, a significant link was found between an older age at the time of the first sexual assault and an increased risk of developing depressive disorder. This could be influenced by several factors:

1. Emotional impact: Sexual assaults at an older age can have a deeper emotional impact on the victim, as they are more aware of the consequences of the event. Experiencing victimization at an older age can lead to greater emotional distress and deeper trauma, increasing the risk of developing depressive disorder.
2. Duration of trauma: Sexual assault experienced at an older age can lead to prolonged trauma, as the victim is likely to carry the emotional burden for a longer period. This extended duration of exposure to trauma can contribute to the worsening of depressive symptoms.
3. Social stigma: Victims of sexual assault at an older age may face increased social stigma, which can lead to an increased sense of shame, guilt, and isolation. These factors can worsen depressive symptoms.
4. Social support: Victims of sexual assault at an older age may also be less likely to seek or receive adequate social support. A lack of support can worsen feelings of distress and isolation, thus increasing the risk of developing depressive disorder.

The significant association between victims from families marked by domestic violence and a 25.5 times higher risk of developing depressive disorder after sexual assault found in our study can be explained by several interrelated factors:

1. Cumulative trauma: Victims living in families marked by domestic violence may be exposed to repeated and cumulative trauma. The cumulative effect of these traumatic experiences can intensify psychological consequences, increasing the risk of developing depressive disorder after sexual assault.
2. Isolation and limited social support: In families where domestic violence is present, victims may feel isolated and have limited access to adequate social support. The lack of emotional support and the feeling of being trapped in an abusive family situation can worsen emotional distress, thus fostering the development of depressive disorder.
3. Feelings of shame and guilt: Victims living in households with domestic violence may experience feelings of shame and guilt related to their family situation. These negative emotions can be reinforced after sexual assault, contributing to an increased risk of developing depressive disorder.
4. Impact on self-esteem: Domestic violence can have devastating effects on the self-esteem of victims, and sexual assault can exacerbate these negative feelings. Low self-esteem is a known risk factor for the development of depression.
5. Effects on the resilience process: Domestic violence can compromise the coping ability and resilience process of victims, making it more challenging for them to manage the traumatic consequences of sexual assault and increasing the risk of depressive disorders.

Regarding the association between parental marital status and a higher number of comorbid psychiatric diagnoses with PTSD, several factors may explain this:

1. Family stress: Divorce can lead to an increased level of family stress for victims. Conflicts and disruptions associated with parental separation can worsen symptoms and contribute to the development of comorbid disorders such as anxiety or depression.
2. Resources and support: Victims whose parents are divorced may face additional challenges in accessing adequate resources and support. Financial, emotional, and social resources may be reduced after divorce, which can have a negative impact on the mental health of victims and increase the number of comorbid diagnoses.

3. Post-divorce family dynamics: Changes in family dynamics after divorce can also influence the number of comorbid diagnoses. Modifications in family relationships, changes in child custody, and emotional adjustments can create a less stable environment for victims, which can worsen symptoms and contribute to the development of comorbid psychiatric disorders.

Regarding widowhood, the association with a decrease in the number of comorbid psychiatric diagnoses may be linked to factors specific to this situation. For example, widowhood may be associated with increased family and social support, as well as a sense of solidarity within the extended family. These support factors can have a positive impact on the mental health of victims and contribute to a decrease in the number of comorbid diagnoses.

In the same vein, the Ontario Child Health Study (OCHS) as well as New York studies have shown that parental adversity was a predictive factor for child sexual abuse [31]; Finkelhor *et al*., (2005) suggested that the unavailability of a parental figure can expose a child to the risk of sexual abuse. These studies support this hypothesis [32].

The association between judicial intervention as a reaction from the surrounding environment following sexual assault and a greater number of comorbid psychiatric disorders with PTSD can be explained by several factors:

1. Traumatic legal procedure: Judicial intervention can lead to a traumatic legal process for victims of sexual assault. Investigations, interrogations, court hearings, and confrontations with the perpetrator can be extremely stressful and emotionally taxing experiences. This repeated exposure to the judicial system can worsen PTSD symptoms and increase the number of comorbid psychiatric disorders.
2. Emotional stress: The involvement of the judicial system can lead to significant emotional stress for victims as they must relive the sexual assault during legal proceedings. This additional stress can impact the mental health of victims and contribute to the development of comorbid psychiatric disorders.
3. Social isolation: Judicial intervention can also lead to social isolation for victims, as they may feel stigmatized, judged, or misunderstood by their surroundings. The lack of social support can exacerbate PTSD symptoms and increase the risk of developing other psychiatric disorders.
4. Victim-blaming effects: In some cases, victims may encounter victim-blaming attitudes, where they are held responsible for the sexual assault or criticized for their reaction to the judicial intervention. These attitudes can lead to increased psychological distress in victims and contribute to comorbid psychiatric disorders.

However, it is essential to note that these explanations are based on assumptions and require further in-depth analysis and additional studies to confirm these associations and better understand the underlying mechanisms.

V. LIMITATIONS

Our study had several limitations:

- A small sample size that may not fully represent the target population.
- Missing information in patient records that could have affected the quality and comprehensiveness of the collected data.
- The data collection methodology was also considered a potential limitation as it may introduce biases or errors in the results.
- The impact of time was considered, as the study's results may be influenced by social, economic, or political changes that occurred over time.

All these limitations should be considered when interpreting the results and considering avenues for future research.

VI. CONCLUSION

This data provides valuable foundations for developing approaches to the prevention and early detection of child abuse. Clinicians identifying cases of physical or sexual abuse in a child should also be aware of the possibility that siblings may have been exposed to similar situations. This awareness is crucial when evaluating other children living in the same household at the time of identification, with the overall goal of reducing the frequency of abuse.

The management of children who are victims of abuse and any form of violence within the family requires the involvement of professionals from different disciplines. A multidisciplinary assessment should be carried out, taking into account medical, psychological, psychiatric, and social aspects.

The prevention of sexual violence requires a reform of the current social protection policy to address the vulnerability and fragility factors that increase the risk of becoming a victim of sexual violence.

It is also necessary to strengthen the skills of professionals working with children, promote networking among stakeholders involved in care, develop life projects in consultation with the child by considering their voice, enhance coordination between organizations, and create a collective to advocate for

and strengthen the prevention and protection of children. Finally, it is essential to involve and enable the effective participation of children by supporting their initiatives and providing them with access to information.

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