

# A Case of Restricted Disclosure Due to Anticipatory Stigma and Shame In An 11year Old Survivor of Sexual Assault

Anyanwu Onyinye Uchenna<sup>1</sup>, Uro-Chukwu Henry Chukwuemeka<sup>2</sup>, Johnson A Obuna<sup>3</sup>

<sup>1</sup> Lecturer, Ebonyi State University, Abakaliki, Consultant Paediatrician, Alex Ekwueme Federal University Teaching Hospital, Consultant Paediatrician, National Obstetrics Fistula Centre, Abakaliki, Nigeria

<sup>2</sup> Associate Professor, National Obstetrics Fistula Centre, Abakaliki, Nigeria

<sup>3</sup> Professor, National Obstetrics Fistula Centre, Abakaliki, Nigeria

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## Abstract

Sexual violence, a common form of GBV, may often be hidden by survivors for reasons such as shame, and anticipatory stigma. Myths, can make certain acts of sexual violence appear more acceptable than others such as peno-vaginal penetration. The effect of non- or restricted disclosure is that clients may not receive complete care from the existing health systems. We report a case of restricted disclosure resulting from anticipatory stigma by a girl child who was sexually assaulted by a male neighbor.

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## Introduction

Coordinated services for survivors of GBV (Gender based violence) have been established. Despite this progress, shame and phobia of stigmatization born out of societal and cultural beliefs with regards to GBV still make victims withhold vital information during clinic visitations.<sup>1</sup> Sexual violence, the commonest form of GBV, has recorded an increased prevalence.<sup>2</sup> Children may not disclose violence for many interrelated and contextual reasons, such as shame and anticipatory stigma. Certain acts of sexual violence may appear more acceptable than others such as peno-vaginal penetration. The effect of restricted disclosure is that clients may not receive complete care from the existing health systems. We report a case of restricted disclosure resulting from anticipatory stigma by a child who was sexually assaulted by a neighbor.

## Case report

An 11 year old girl was brought to the GBV clinic in the company of her father and a community whistle blower (CWB). CWBs are persons trained by partners of the GBV-program in the state to recognize occurrences of GBV in communities. Client presented with forceful finger vaginal penetration 14 weeks earlier. The client lived in the same compound as the assailant in a "Face-Me-I-Face-You" building (a residential settlement where a group of one or two-room apartments have their entrances facing each other along a walkway which leads to the main entrance of the building). The assailant grabbed her on the walkway, pulled her into his room, tore her clothing and threatened to kill her with a knife. He thereafter penetrated her vagina with his little finger before letting her go. He repeated the same the next day and this time threatened to kill her and her father if she responded

## \*Corresponding Author

Prof. H.C. Uro-Chukwu  
Department of Training, Research & Mobilization,  
National Obstetric Fistula Centre,  
Abakaliki, P.M.B 063  
Abakaliki, Ebonyi State, Nigeria  
Email: hurochu@gmail.com

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to her father's call. Soon she was quiet and he penetrated her vagina again with his finger before locking her in his apartment and went going away for six hours. Prior to this, she had a negative coitarche history.

The assailant was an unmarried 30-years old man. He is a primary school teacher and started living in the compound recently. Before the incident, she had never spoken to him. The client was the first of six children in a monogamous family settling with four girls and two boys. Her father was a carpenter while her mother was a farmer. Both parents have had primary education. They all lived in a two-room apartment. She received no formal pubertal nor sex education. The client was currently in primary six (last primary class) and has a future ambition of being an accountant. Menarche was attained two days earlier. On examination, she was cheerful, with good communication skills. She was not pale, afebrile, and well hydrated. Vaginal examination revealed normal female external genitalia, no evidence of female genital mutilation, no obvious bruises. There was very little quantity of menstrual blood and no fragments of the hymen. The doctor was informed by the CWB that the client had forceful peno-vaginal penetration, which the client did not volunteer. She later admitted to peno-vaginal penetration, saying that she was ashamed and did not want to say that because she was afraid of stigmatization. A once cheerful client cried because she and her father had agreed not to reveal the full details of the event "so that her future as a woman will not be marred". Pregnancy test, retroviral screening, hepatitis panel and Venereal Disease Research Laboratory (VDRL) tests were done and all yielded negative results. She was subsequently counseled adequately and was scheduled for follow-up psychotherapy. The case was also taken up by the state GBV task force so that assailant could be prosecuted once apprehended.

## Discussion

Sexual violence, is regarded as a concealable stigmatized identity (CSI).<sup>1</sup> CSIs are those identities which can be hidden and for which a person can be devalued by the society if it is disclosed.<sup>1</sup> Disclosure is the process of making information known to another.<sup>3</sup> In this context disclosure is the process of making all relevant information about sexual violence of a child known to the doctor. The doctor in turn institutes care in response to information received from a patient such as relevant investigations and treatment. Any degree of misinformation or restricted disclosure may influence instituted management.<sup>4</sup> All forms of sexual violence have been reported to have negative health consequences.<sup>2</sup> However empirical evidence in Nigeria and most other countries, view peno-vaginal penetration sometimes as a taboo and survivors maybe stigmatized.<sup>5</sup> In a culture where virginity is measured by the presence or absence of a hymen, victims of sexual violence, often restrict disclosure of an act of sexual violence even from their doctor without

knowing that the absence of genital injury on hymen does not exclude intercourse with or without consent.<sup>6</sup> Survivors differ in how long they continue to disclose, and to whom they disclose, these are often influenced by the types of reactions received during disclosure.<sup>1</sup> Because of societal negative stereotypes and beliefs about rape, our index patient restricted disclosure and felt safer sharing that she had finger penetration rather than peno-vaginal penetration.<sup>7</sup>

Although hymenal examination does not reliably predict virginity status, its absence implies that there has been some penetration which could be recent or remote.<sup>8</sup> Berenson et al observed however in their case control study that genital examination of the abused child rarely differs from that of the non-abused child thus focus on the child's history as the primary evidence of abuse should be taken.<sup>9</sup> This emphasizes the importance of history and its reliability. It is therefore worthy of note that if a client decides to hold back information, as in the index client, serious consequences arise both legal and in terms of quality of care for such patients.<sup>4,10</sup>

A notable change in affect was observed in the client. She needed psychotherapy to overcome shame that overwhelmed her after complete disclosure. More work is needed on advocacy and education especially in rural communities where some of these clients come from to reduce stigma for victims of sexual assault. Clients need to know they can trust the system to protect them both from stigma and assailants.

## Conclusions

Anticipatory stigma may limit client's full disclosure of sexual assault. Patience and continual counseling would build trust and help clients receive complete care from health systems.

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