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RESEARCH ARTICLE

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Silent screams: Listening to and making meaning from the voices of abused children

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Abstract

Background: Sexual violence against children is a major clinical, public health and human rights concern globally. Specifically, child sexual violence (CSV) is one of the world's leading causes of trauma in children. In extreme cases, victims of CSV grow up with a plethora of maladaptive behaviours, which may be salient in the course of growth but later present in adulthood as severe cases of comorbid psychopathologies. It is expected therefore that CSV cases be treated with urgency and policies/laws against perpetrators be translated into visible outcomes. However, many CSV cases go unreported; and where there are attempts at reporting, the manner and approach of handling these cases is discouraging and futile. In this study, we explored the lived experiences of CSV survivors in Nigeria who tried reporting and opening up their experiences.

Method: Using the hermeneutic phenomenological approach, responses from 11 girls aged 15 to 17 years at the time of the study and 8 to 16 years at onset of abuse were obtained. Data were gathered through interviews, and the victims' experiences were aggregated using content analysis.

Results: The major findings were summarized under the following themes: (a) silent screams, (b) trauma and the search for a therapeutic ear, (c) stigma and (d) withdrawal: our last resort. Respondents reported crying out and begging perpetrators to stop the act. They also reported experiencing trauma and related physical/mental health issues after the act. As they sought whom to disclose to, they reported feeling stigmatized and eventually having to withdraw and recoil.

Conclusions: Implications of the study cut across medical practice, social work, therapeutics and policy formation/implementation for the prevention of CSV and attending to CSV victims in hospitals, homes and schools. The importance of empathic therapeutic processes was discussed. The need for a multisectoral and multi-stakeholder approach in tackling CSV was also highlighted.

KEYWORDS
child sexual violence, physicians, stigma, therapeutic listening, trauma

1 | INTRODUCTION

Violence against children is a pervasive and common phenomenon occurring worldwide across boundaries of economic status, social class, race, geography, religion and culture, no matter the situation or context (Iorfa et al., 2022). Violence against children has become one of the most significant threats to the mental health, well-being and future of youths and incurs huge costs for both individuals and societies (Eze, 2013; Pinheiro, 2006; Raman et al., 2018). It is a significant social problem and a public health, human right and a social justice concern affecting the lives of millions of children (Hillis et al., 2016; Latzman et al., 2017; Zimmerman & Mercy, 2010). Violence against children comes in different forms including child sexual violence (CSV), emotional and psychological violence (World Health Organization [WHO], 2018) and other forms of physical abuse.

Globally the prevalence of violence against children ranges from 5% to 36% (Russell et al., 2020). In Nigeria, 44.8% of children reported been hit repeatedly with an object, often resulting in injures such as bruises and black eyes, and 16.8% reported experiencing emotional abuse within the home (Chinawa et al., 2013). Although the true burden of specific CSV in Nigeria is under-represented, it is estimated to vary between 5% and 38% across different parts of the country (David et al., 2018; Ige & Fawole, 2011; Manyike et al., 2015). Available data indicate that the rate of sexual victimization for females was about five times the rate for males (Miller et al., 2018; Oluwatosin et al., 2019). Olusanya et al. (1986) reported that children of elementary schools (aged 6–12 years) and adolescent girls (13–19 years) were the major victims of CSV, with 48.2% of reported cases over a 3-year period occurring in children below 13 years old. Ogunyemi (2000) also reported some baseline findings from a community-based project on the incidence of CSV in two Nigerian urban centres. About 38% and 28% of female and male respondents, respectively, reported being initiated to sex before the age of 18 years. These findings, among other things, point to the troubling dimensions CSV may be assuming in Nigeria.

Reports on the prevalence as well as the pattern and nature of sexual abuse among children is a very vital issue that is often underreported in paediatrics practice and other childcare forums (conferences, symposiums, seminars, etc.) in Nigeria. However, the relevance of discussions of this form cannot be downplayed especially with its wide impacts on physical and mental health.

Childhood and adolescent sexual violence has significant psychological and health consequences on the survivor and the society including sexual health outcomes, mental health problems, reproductive health problem, damage at the basic levels of nervous, endocrine and immune systems, and impairment of brain architecture and immune status (Hillis et al., 2016; Sean et al., 2008; WHO, 2018). Beyond the unnecessary hurt and pain it causes, CSV undermines children's sense of self-worth, hinders their development and furnishes them with a sense of guilt, blame and shame (United Nations Children's Fund, 2017; WHO, 2018). As if these are not bad enough, in Nigeria, the voices of survivors of child sexual abuse are stifled either by family members or by the stigma associated with sexual violence.

Key messages

- CSV is on the rise in sub-Saharan Africa and the rest parts of the world.
- In most cases, CSV goes unreported, and there is need for proper documentation.
- Some reported cases of sexual violence in Nigeria are mishandled, and this leads the victims to withdraw and receive no therapeutic intervention.
- There is need for a multisectoral, multistakeholder approach to tackling the issue of sexual violence and putting in place measure to aid effective therapy for victims.

This situation is like adding insult to injury as it leaves survivors in mental chains while the perpetrators walk free. The failure to listen to children has resulted in a failure to respond to their needs (Pinheiro, 2006). Based on the above, this paper aimed to explore the lived experiences of survivals of CSV in Gboko, Nigeria, with the hope that from sharing their stories, they may find succour and seek further professional help.

2 | METHOD

2.1 | Study area

This study was conducted in Gboko Local Government Area of Benue State. Gboko is located at the central zone of Nigeria at latitude 7°18′ N and longitude 8°58′ E (Amagu et al., 2019). It has a land mass of about 2264 km^2 with a population of about 360 128 people The climate is tropical, subhumid with a daily temperature of about 28°C and average annual rainfall of 1000 mm. The ethnic groups residing in this area are the Tivs, Idomas, Igedes, Etulos, Jukun-Awanu, Igalas, Hausas, Igbos and Yorubas. The predominant profession in the area is formal education and farming (Iorfa et al., 2022).

2.2 | Study design

The experiences of child survivors of sexual violence were explored using hermeneutic phenomenology. Hermeneutic phenomenology describes the lived experiences of several individuals who have or are experiencing a common phenomenon (Creswell et al., 2007). This design assumes that a direct and subjective account of lived experiences is knowable and therefore deals with a detailed description of the lived experiences of respondents (Brooks et al., 2015) and that the experiences and behaviours of the people experiencing the phenomenon are inseparable from the phenomenon itself (Moustakas, 1994). Because there is little known and very scarce scientific literature available about lived experiences of CSV survivors and its relation to opening up and getting a listening ear, a

phenomenological study is the most natural fit for further exploration and study (Iorfa et al., 2022).

2.3 | Procedure

Before the data collection process began, the first author conducted an interactive discussion with the trained interviewers. They were asked to spend considerable time bracketing out their experiences related with CSV. This process is referred to as an epoche (Creswell et al., 2007) and is based on the idea that if the interviewers are able to investigate their own experiences of the phenomenon in question, they will be better equipped to push those feelings and thoughts out when interviewing and interpreting data (Iorfa et al., 2022; Moustakas, 1994). The first author also participated in the epoche along the interviewers. This is useful because it allows the researcher and/or interviewer maximal objectivity in experiencing the data, having fresh perspectives into the phenomenon and learning about the experiences of the participants (Iorfa et al., 2022).

Participants for this study were part of a larger study in which participants were randomly selected by trained research assistants during a CSV awareness campaign and asked if they were willing to participate in the study. Those who accepted were told about the nature and purpose of the study, assured of confidentiality and told they were free to withdraw from the study at any point they felt like, without any consequences. Consent to undertake the study was given by school authorities, whereas informed assent to participate was obtained from the participants. A total of 53 adolescents were recruited. However, the researchers decided on a criterion of female adolescents who were between the ages of 15 and 17, who had experienced at least one sexual abuse or molestation involving violence that ranged from kissing, fondling with genitals or actual vaginal intercourse and who could communicate in English. Nineteen persons gave oral assent and were engaged in the study; however, for the present paper, only those who indicated that they had reported (at least once) the abuse they experienced, were included. Thus, only responses from 11 CSV survivors were included in the present study. In order to create a sense of safety and privacy, participants were allowed to choose a section of the school where they felt most comfortable to undertake the interview. They were asked questions about their demographic status and socio-economic status of their parents. Among other things, participants were asked to reflect on their experiences when they tried to recount their sexual victimization encounter to significant others before the interview session commenced. A semi-structured interview guide was designed to tap into respondents' experiences. Interviewers were given the freedom to expand on issues of interest and ask follow-up questions, probing further into an issue when necessary. Although the interview guide was used for each participant, the interview flowed naturally into a conversational style much more than a question and answer session, and participants were allowed to expand on issues as much as they wanted to. Interviewers were asked to (if necessary) probe areas that may stimulate new ideas and bring up old memories. Interview sessions lasted from 6 to 13 min for each participant. Participants were thanked for their participation and given free counselling sessions.

2.4 | Ethics statement

The study was approved by the University of Uyo, Department of Psychology Ethical Review Board, and was performed in accordance with the ethical standards as laid down in the 1964 Declaration of Helsinki and its later amendments.

2.5 | Participants

Eleven female adolescents participating in a CSV awareness lecture participated in the study. They were students of different secondary schools in Gboko, Benue State Nigeria. Their age ranged from 15 to 17 years at the time of the study and 8 to 16 years at onset of abuse. All participants agreed being victims of sexual abuse at least once in their lives and having reported this abuse to significant others at least once. More details on participants' characteristics are presented in Table 1.

2.6 | Data analysis

Transcribed recordings of the interview sessions were analysed through content analysis after being carefully read and reread by the first author. Actual names of participants were replaced with pseudonyms closely related to their actual names and which reflect their religion. In the initial content analysis, transcripts were read and reread by the first author following the methods described by Charmaz and Mitchell (1996) looking out for emerging patterns and synthesizing themes within each case, across cases and comparing them. Transcripts that had reoccurring and identified themes were reanalysed by the researchers. Exclamations and verbatim quotes were also lifted from the transcripts when they supported and helped evidence the experiences. The commonalities and differences observed in the emerging themes within and between cases were further subjected to repeated analysis by the authors to see if and in which way the findings were consistent or hindered conclusions. Where perspectives differed, the audio tapes and transcripts were reviewed and consensus reached by the authors. The identified themes were discussed in relation to prior knowledge on CSV and CSV survivors.

3 | FINDINGS AND DISCUSSION

CSV survivors were open and free in discussing their experiences (related to opening up issues of abuse to significant others) with the interviewers. Experiences of the adolescents echoed a broad spectrum of negative experiences during the time of abuse and in their attempts to open up. It was observed that about 53% of perpetrators

TABLE 1 Participants' demographics and nature and characteristics of abuse

Participant	Age (x)	Abusive behaviours experienced	Relationship with abuser	Number of times	Opened up to
Aningir (P1)	15 (13)	Vaginal intercourse/fondling with private parts	Brother	3	Father
Joy (P2)	16 (12)	Vaginal intercourse	Cousin	Cannot recall	Elder sister
Nambien (P3)	16 (10)	Fondling with breasts/genitals/sexual kissing	Cousin	5	Mother
Rebecca (P4)	16 (15)	Sexual kissing and fondling with private parts	Male friend	2	Mother
Chioma (P5)	17 (14)	Vaginal intercourse	Neighbour	6	Mother
Deborah (P6)	16 (8)	Vaginal intercourse/oral sex/fondling with private parts	Uncle/female friend	Cannot recall	Mother/father
Dingdan (P7)	17 (16)	Vaginal intercourse	Male friend	3	Elder sister
Peace (P8)	15 (12)	Fondling with private parts	Female friend	1	Teacher (female)
Aishatu (P9)	16 (13)	Vaginal intercourse	Cousin	4	Uncle
Jennifer (P10)	16 (14)	Fondling with breasts/genitals/sexual kissing	Neighbour	3	Matron
Ramat (P11)	16 (11)	Fondling with breasts/genitals	Female friend	Cannot recall	Mother

Note: x = age at the time the abuse occurred; P1 = participant 1, etc.; sexual kissing = kissing that is beyond a mere peck and considered sexually arousing by the recipient.

of CSV were close family relations with whom CSV survivors had initial regard, respect and trust. CSV survivors reported to have never expected or thought violation would come from these close family relations. A respondent expressed distaste for the perpetrator who was an uncle but seemed to rationalize the act when it occurred with a cousin or friend of the same age bracket. As expected, CSV victims expressed dissatisfaction with societal conditions and strategies put in place to curb CSV. Majority of CSV survivors were either not living with their parents or had experienced the abuse at times when they stayed with relatives or significant others other than their biological parents. CSV survivors who had related the experience to parents reported a mixture of positive and negative emotions. Those whose parents had blamed them for the experiences reported feeling largely responsible for the act and rationalizing with the fact that had they been less attractive, they would not have been abused. Survivors whose parents had confronted the abusers and taken time to comfort and console them externalized the blame to the abusers and seemed to be better adjusted than their former counterparts. The themes discovered in the interviews are discussed in the proceeding sections.

3.1 | Silent screams

Survivors repeatedly highlighted that they did not in any form encourage the continuance of the act. Those who did not report crying said they begged and pleaded it stopped. Joy (P2) said: '… when my Uncle first held me and started caressing my breasts and kissing me, I screamed out, but he put his hand on my mouth. I still did not stop, I screamed silently inside of me … until his phone rang and I had the chance to get out of his grip'. Jennifer (P10) recounted: '… my neighbor was strong and I think 7 years older than me … but I screamed and shouted stop until he let go of me … I was ready to kill him if I had a knife'. Aishatu (P9) recounted: '… I always begged him, but he was way older and would threaten me. Sometimes he would use tape to hold my lips so I wouldn't shout … at one point, after the rape, I wrote in my diary, "even with my lips closed, the walls hear my heart screaming out loud", I always wrote my heart out'. Many more accounts resound disapproval by victims. Contrary to opinions which posit that victims are to blame, it was observed that perpetrators insisted and would not yield the pleading of their victims. They screamed out all the same, however silent it may have been.

3.2 | Trauma and the search for a therapeutic ear

Psychophysical trauma can have profound effects on development and well-being throughout the life course in children. Because traumatic events in childhood occur at key psychosocial and biological stages of development, their impact may continue into adulthood (Bussey & Wise, 2007). People who experience a childhood trauma are at risk for a variety of negative health outcomes (Zoellner & Maercker, 2006); however, there may be opportunities for recovery and growth after traumatic experiences depending on the severity of the trauma and in cases of CSV, on the manner in which the traumatic event was handled. CSV survivors in this study have provided insights into the kind of listening they would want and which would better elicit responses regarding their horrible experiences as well as relieve their experience of trauma. Participants recounted that they felt very traumatized when the abuse happened and they sought someone to talk to about the incidence. For instance, Chioma (P5) recounted: '… I kept feeling his body on me …. when I closed my eyes and, in my dreams, … I wanted to tell my aunty but each time she wasn't in the mood'. Ramat (P11) said, '{laughs} I think it is funny … I felt it around my breasts sometimes as if something is walking around there, the way his hands were moving around my breasts'.

With regard to opening up, some participants reported having the following experiences; Ramat (P11) said, '… so I decided to tell my mother, but she didn't do anything. She said she (perpetrator) was

only playing with me'. Rebecca (P4) said, '… I didn't tell my mother the first time it happened, so when I told her about the second one and that it had happened before, she hit me and insulted me that I liked it, that was why I kept quiet the first time …'.

3.3 | Stigma

Stigmatization involves negative feelings and thoughts about the self as bad and blameworthy as a result of CSV (Finkelhor & Browne, 1985). Stigmatization is seen as shame and a self-blaming style of attribution (Feiring et al., 1996). Shame because there is often the desire to hide the abused self from exposure to the scrutiny and censure of others. Research has shown that shame is negatively correlated with disclosing (Cermak & Molidor, 1996; Correa & Nuñez, 2010; Fontes & Plummer, 2010). As observed, participants reported feeling stigmatized and consequently ashamed of themselves. Jennifer (P10) recounted: '… I know some girls who have experience rape and it is usually something not to talk about … I thought my own will be different but the moment the matron knew, she started behaving somehow towards me'. Aningir (P1) reported, 'when I decided to tell my father, he called me and my brother demon possessed and organized family prayers for us. Everyone in the house knew about it from there and I was ashamed of myself'. More severe CSV has been associated with higher levels of stigmatization (Feiring & Cleland, 2007; Kallstrom-Fuqua et al., 2004).

3.4 | Withdrawal: Our last resort

A great percentage of the participants mentioned that they had no option than to withdraw not only from those they tried to open up to but from the public in general. Chioma (P5) recounts: '… so I decided not to talk to anyone about it again …'; Ramat (P11), 'I will never tell anyone close to me again …'; and Deborah (P6), 'I keep to myself … after I spoke about it, it hasn't… he hasn't stopped coming but I will handle it myself now'. When a child is abused and adequate attention is not given, he/she take the available option, which is withdrawal. In this sense, the victim withdraws from significant others, social gatherings, etc. Bartlett et al. (2007) reported that adolescents who have experienced abuse might suffer from depression, anxiety or social withdrawal. In addition, adolescents who live in violent situations tend to run away to what they perceive to be safer environments. They engage in risky behaviours such as smoking, drinking alcohol, early sexual activity, using drugs, prostitution, homelessness, gang involvement and carrying guns (Runyan et al., 2005), which are all in a bid to escape from the reality of the abuse.

4 | CONCLUSIONS AND IMPLICATIONS

CSV is a common problem worldwide, and its health and psychosocial effects are felt by abused children, their families and their communities. CSV has been linked to changes in the victims' mental and behavioural development throughout their lives, putting them at risk of engaging in potentially dangerous behaviours in the future. Family physicians have an important role in identifying cases of CSV in their practices, reporting such cases to child welfare agencies, preventing further harm to identified children as well as to other children in the families and providing further ongoing support and education to families. More so, because sometimes these cases are brought to the hospitals, it is important for physicians to develop therapeutic skills that enable them to properly listen to the experiences of the CSV victims and effectively attend to their needs. This may mean that all frontline health, education and welfare professionals need to be made aware of and trained to respond proactively to violence against children. And there needs to be gender sensitization in all these cadres so that sexual violence against girls is prevented. For psychologists and social workers, it is important to pay deliberate attention to the individual victims of CSV and take their family history and background into consideration when clerking. This background information may be particularly important in understanding some dynamics that may underlie individual decisions to either disclose or hold back when abuses occur. The study has implications for parents and significant others as well as other relevant stakeholders. In situations of abuse, parents and other stakeholders may need to be less accusative and more accommodating of their children. Sexual victimization may be perpetrated by anyone, and it is therefore important that parents/stakeholders do not dismiss the testimonies of their children as false. The need for patience in listening to abused children cannot be overemphasized.

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CONFLICT OF INTEREST

The authors declare no conflict of interest.

DATA AVAILABILITY STATEMENT

The data used for this study are available with the corresponding author upon reasonable request.

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