

## **A Case Report of Post-Traumatic Stress Disorder in an Adolescent Secondary To Sexual Violence**

**AUTHORS:** Egbe Enobakhare<sup>1\*</sup>, Tijani Oseni<sup>2</sup>, Victor Ohenhen<sup>3</sup>, Bawo Onesirosan James<sup>4</sup>

**Addresses:** <sup>1</sup>(Department of Family Medicine, Central Hospital, Benin City, Edo State, Nigeria.)

<sup>2</sup>(Department of Family Medicine, Irrua Specialist Teaching Hospital, Irrua, Edo State, Nigeria)

<sup>3</sup>(Department of Obstetrics and Gynaecology, Central Hospital, Benin City, Edo State, Nigeria)

<sup>4</sup>(Department of Clinical Services, Federal Neuropsychiatric Hospital, Benin City, Edo State, Nigeria)

**\*Corresponding author:** Egbe Enobakhare

**Email:** [egberella@gmail.com](mailto:egberella@gmail.com)

**Tel:** +234 803 468 7502

---

Date of Submission: 20-03-2021

Date of Acceptance: 04-04-2021

---

### **I. Introduction**

According to the World Health Organisation Consultation on Child Abuse Prevention, child sexual abuse (CSA) is the involvement of a child in sexual activity that he or she does not fully comprehend, is unable to give informed consent to, or for which the child is not developmentally prepared and cannot give consent, or that violates the laws or social taboos of society [1]. Certain factors make CSA highly unique and chief of these is that physical force is rarely used but that the perpetrator tries to manipulate the child's trust [1]. Also, it is universally accepted that children are more sexually abused by people that they know or trust such as; family members, neighbours, authority figures than they are abused by strangers [1,2]. A perpetrator will groom the child over time and frequently the sexual abuse occurs as repeated episodes over several weeks or years in locations that are familiar to the child [1].

While most data come from adults who report about their past experiences, the true incidence rates of CSA cannot be established because they are under or not reported at the time it occurred [3]. Under-reporting may be a reason for a low prevalence of CSA reported in south-eastern Nigeria [4].

Factors that increase the risk of victimization in children are; female sex, unaccompanied children, poverty, handicapped children and children in conflict zones [1]. Also, a child from a single-parent home, in foster care or adopted or a stepchild, socially isolated or whose parent(s) are mentally ill or dependent on drugs or alcohol is at a higher risk of victimization [1,5]. The consequences of sexual violence may be visible or not visible and may manifest physically, psychologically, socially and financially, creating long-lasting ripple effects not just on the victim but the family and society at large. Research in women has documented that sexual

violence contributes significantly to depression, alcohol/drug use and dependence, panic disorder, post-traumatic stress disorder (PTSD) and suicide attempts [6]. Unlike sexual violence in adults where they typically will be seen in emergency care, children present to the hospital through other means or circumstances [1]. Such circumstances include situations where an allegation has been made whether to the police or a caregiver and when behavioural changes or physical indicators have been found on the child [1].

Therapy should be wholistic and individualized to ameliorate the physical and emotional pain that follows trauma like sexual violence [7]. Chivers-Wilson quoted Matsakis that successful recovery is subjective and measured by whether the client increases involvement in the present, acquires skills and attitudes to regain control of his or her life, forgive him or herself for guilt, shame and other negative cognitions, and gain stress reduction skills for overall better functioning [7].

This case report highlights PTSD in a minor as a mental health consequence of CSA complicated by delays in seeking appropriate medical care at the time of the assault.

## **II. Case Report**

Miss C.C., a 13-year-old J.S.3 student accompanied by her parents presented to the General Practice Clinic with complaints of crawling body sensation, heaviness of the head, palpitation and recurrent inability to sleep of four weeks duration. Her symptoms were preceded 6 weeks before presentation by non-consensual intercourse with two armed robbers that invaded their home at night. The event was her sexual debut and there was no repeat episode thereafter. The robbers did not use a condom and she bled mildly in the process. Robbers ejaculated into her vulva. She had no medical care after the incidence as parents encouraged her to bath and using the lime fruit she was given by her mother, she washed the vulva. Her mother believed that lime fruit could prevent any infection and prevent pregnancy that could arise.

She developed worrying thoughts with the predominant content being that her future had been put in jeopardy because she may get pregnant for unknown men or get infected with human immunodeficiency Virus (HIV). She was preoccupied with concerns that she would be unable to get married as a single mother with a child. She was concerned that she had lost her virginity. She reported constant crawling body sensations two weeks after the assault that progressively worsened. She believed that insects were crawling around her body but any attempt to wipe them off revealed no insect and this was worse when idle. She also had the feeling that her head was too heavy for her neck especially when in school during lectures and she progressively lost concentration in many aspects. About the same time, she developed palpitations and poor sleep. She went to bed at 10 pm but repeatedly woke up at about the time that she was raped. She experienced frequent nightmares of being attacked by men who forcibly demanded sex and would wake up screaming. She felt un-refreshed on awakening. She avoided going to bed alone especially after the lights were switched off and avoided the room as frequently as she could.

She noticed that she had flashbacks of the event which made her cry out evoking fear and anxiety similar to the feelings she had the night she was raped. She began to have distressing recollections of the event with her having repeated vivid images of being tied up and raped. She was worried her classmates could get to know and thereafter withdrew from them. Her parents said she had increasingly lost her self-confidence. She stayed longer while bathing, scrubbed her body intensely claiming she was dirty. Male voices sounding assertive, even from TV frightened her, especially in the evenings. She was also described as increasingly withdrawn and anhedonic.

She attained menarche at 11 years and menstruated for 4 to 5 days in a regular cycle of 27 to 30 days. Her last menstrual period was 6 days before the event. She was not aware of contraceptives and had not used any. There was no weight loss, no change in appetite or bowel habits. She did not have low energy levels. She was unhappy but had no weepy spells and no suicidal ideation. There was no history of auditory or visual hallucinations. She had no neck swelling and no heat or cold intolerance. She had never used alcohol, tobacco or psychoactive substance in any form.

She tested negative twice for HIV which she initiated on her own in a private facility in the last three weeks but still had fears she was infected and would die unmarried. She feared she had no future that she was unsafe and had the idea she was running mad from excessive worry. She wanted treatment to prevent her from worrying and be able to concentrate at school.

She was the youngest of 6 children in a monogamous setting. Her mother was a 56-year-old accountant with the State Ministry of Budget and father was a 58-year-old self-employed estate surveyor. They lived in a 6 bedroom duplex with water closet system for toilet facilities in the outskirts of the City. They were Christians of the Catholic faith and she was a member of the group called Legion of Mary. The family net monthly income was a minimum of 750, 000 naira (approximately 1,700 dollars) and had health insurance coverage for the family.

Her premorbid personality was described as normally withdrawn and quiet with few friends. She had a cordial relationship with her siblings, parents and at school with teachers and classmates. She was usually

among the top five in class following exams and hoped to become a lawyer. She was in J.S.3. She had never broken any school rule. She had never been managed for any psychiatric illness and never had a similar illness in the past.

At examination, vital signs and calculated body mass index (BMI) were normal. Her mental state examination revealed an appropriately dressed, calm and cooperative adolescent. She exhibited an anxious mood related to recounting the rape which generated a crying out reaction with an obvious grief grimace. Her speech was coherent and spontaneous with relevant themes. Her thought processes were free-flowing with connected themes; content was a preoccupation with death as an unmarried girl from HIV/acquired Immunodeficiency syndrome (AIDS), having a fatherless child and feeling unsafe at home. There was no flight or paucity of ideas. She was well oriented in time, place and person. Her long- and short-term memories were intact. There were no delusions or hallucinations. She had good judgement, intelligence and good insight about her problem.

Other systemic examination findings were normal. A diagnosis of Post-traumatic stress disorder in an adolescent secondary to sexual violence was made with a differential of mixed anxiety-depression.

The diagnosis and course of illness were explained to her and her parents. They were informed the stressor was the rape that occurred from the armed robbers and the condition was treatable with drugs and cognitive therapy. She was counselled against the suppression of thoughts and memories connected to the event as it could maintain her symptoms. In particular, she was encouraged to remember the trauma as often as possible and her parents were counselled to patiently give listening ears to her whenever she shared the memory as the ensuing symptoms overtime will subside. Her parents were counselled against stigmatizing her and advised to always seek medical help in cases of health issues early. She had a pregnancy test done which was negative. She was advised to see the psychiatrist for psychological support and placed on oral fluoxetine 20mg daily, lorazepam 1mg mornings and 2mg at nights. On follow-up, after two weeks her sleep had improved with fewer nightmares and the episodes of recollections had reduced significantly. She was counselled on positive living. Apart from preoccupation with death as an unmarried girl and still feeling unsafe, other aspects of mental state examination were not impaired. She was to continue oral fluoxetine 20mg daily, lorazepam 1mg at night.

On her next appointment, she had seen the psychiatrist who provided interactive counselling. The family had contracted security services to alert them of any eventualities. She was confident she could become a good lawyer in future and had learned being raped was a common occurrence not peculiar to her. She no longer had feelings of being unsafe. She was adherent to medications and had improved significantly with better sleep and no nightmare. Her recollections had ceased and related better with siblings and parents. She had attended one of her group activities in church since the last visit and related well with other members. She was to continue fluoxetine 20mg daily. She returned in six weeks and parents were happy with her improvement. She had a pre-test counselling, retroviral screening done which was non-reactive and had post-test counselling. She was happy to be HIV negative and would ensure to stay negative. She had resumed her group activities fully and related well with members. She was concentrating well on her studies. There were no preoccupations, no insomnia and no somatic symptoms. She was adherent to medications and had no distressing side effect. Her mental state and cognitive function were not impaired. She was to be maintained on fluoxetine 10mg daily and given a 3-month appointment but advised to present to the out-patient department if she had any health issue before the appointment date.

### **III. Discussion**

A child is anyone who has not reached the age of 18 [8,9]. Child sexual abuse (CSA) is a multidimensional construct that is defined as sexual incidents before age 18 (the age of legal consent), which involved: involuntary or coerced sexual experiences of a male or female (regardless of the age of the perpetrator) [10,11]. For an act to be defined as CSA, four concepts must be present; It must involve a child; the act must be sexual; true consent must be absent, and the act must constitute abuse [12]. True consent requires full, free, voluntary, and unforced participation [12].

CSA is a serious public health concern with major lifelong negative consequences for the victim [13,14,15]. It is a social menace growing at an alarming speed in sub-Saharan Africa [13]. Approximately one in three girls has experienced sexual abuse by age 24 [16]. In Nigeria one in four girls have experienced sexual abuse by age 18 [9]. Young adolescents are at greatest risk of CSA [14]. Studies also revealed that in South Africa one woman is raped in every 17 seconds and this did not include the number of child rape victims [17]. In Agbor, Delta State, South-South Nigeria, 1,128 cases of rape were recorded between January and July in 2008 [18]. Also, in Benin City, Edo State, South-South Nigeria, the prevalence of rape as seen in a Specialist Hospital was stated to be 2.3% [5]. This is an alarming figure that is yet to be addressed by the government.

Survivors of CSA experience various forms of stigma and stigmatization behaviour in response to disclosure [19]. Thus most survivors don't disclose. This could explain why the index patient did not disclose the abuse to anybody, neither did she report to the law enforcement agency nor did she present to the hospital

for treatment until she developed PTSD. She feared stigmatization from her colleagues in school and the larger society, and also feared she may not be able to find a suitable husband in future should she disclose her experience. Stigmatization could be in form of self-blame, shame, internalization, anticipatory stigma and negative social reaction upon disclosure [19].

Self-blame, shame and negative social reaction to survivors of CSA increase with abuse severity and may lead to a variety of adverse outcomes including low self-esteem, anxiety disorders, poor school performance, PTSD, maladaptive behaviour, depression, and suicide [8,9,15,19,20]. Miss C.C. was ashamed of what happened to her and blamed herself. Rather than disclose, she internalised the problem for fear of negative social reaction from her peers and the public leading to her developing PTSD.

Children who have been sexually abused also find it difficult to build relationships [8,20] CSA has a negative consequence on the sexual well-being of survivors [20]. They tend to engage in high-risk sexual behaviours such as multiple sex partners, prostitution, repeat sexual assault in adulthood later in life exposing them to the risk of HIV and other sexually transmitted infections (STIs). They are also more likely to engage in unprotected sex. Others develop an aversion to sex, making it difficult for them to enjoy marital life later in life. They have trust issues. They become suspicious each time a male adult come close to them.

The consequence of CSA is long term and varies from child to child. The occurrence of CSA is independent of family socioeconomic status [15]. The consequences, however, depends on the kind of support the child gets from family and others around [9]. Miss C.C. had a very supportive family who belonged to the high socioeconomic class and it was easy for her to recover from the PTSD once treatment was initiated.

However just as not all traumatic events will lead to PTSD, most persons that seek early and appropriate care may not develop PTSD. The parent of the index case recognised some consequences of sexual assault that includes sexually transmitted infections and pregnancy and gave non-medical help. One would expect that high educational attainment of the family and having well-paying jobs should automatically equate to early presentation following trauma at a health facility. Also, this family did not practise out-of-pocket payment for healthcare as a lot of persons do in Nigeria which delays healthcare-seeking behaviour. A study done in south-west Nigeria documented that the likelihood of seeking appropriate healthcare was higher among those, who completed tertiary level of education, with higher socioeconomic status and participated in health insurance scheme [21].

Risk factors for PTSD in adolescents are; poor family function, co-morbid psychological problem, perceived life threat, social withdrawal, low social support, black race, female gender, positive family or previous history of psychiatric disorder, prior victimization and pre-existing negative affectivity about self and environment [22,23]. Some of these including perceived life threat and social withdrawal were found in the index client. Behaviours that maintain PTSD as found in C.C. are avoidance of reminders and suppression of thoughts and memories related to trauma [23].

The best approach is preventing the occurrence of PTSD following a traumatic event, early intervention is essential and is usually multimodal; treatment of client using pharmacotherapy and non-pharmacotherapy and intervention for parents [24]. The index patient received both forms. In her cognitive behavioural therapy, she was taught techniques to overcome fears and worries by not suppressing memories and thoughts of the distressing event, and unlearning avoidance of reminders. She was encouraged to dispel the belief that all males were bad. Psychological aid was provided through encouraging her to talk about the event and parents received counselling on the need to provide support by listening and laying emphasis on establishing that she was safe. She improved significantly most probably because of her good social support, no personal or family history of psychiatric illness and early intervention. Other methods of non-pharmacotherapy that can be used though not applied in this case are desensitization involving graded exposure to anxiety stimulus and play techniques especially in younger children to help process traumatic memory.

Prevention of CSA would reduce the risk of mental health problems such as PTSD, secondary victimisation and intergenerational transmission of abuse [14]. Prevention approach currently focuses on identification, prosecution and punishment of perpetrators [14]. However preventive measures should be more comprehensive; targeting potential perpetrators and onset of CSA [14]. Such measures should include interventions that focus on educating children to protect themselves by recognising, resisting and reporting sexually abusive behaviours (the three Rs of CSA prevention) [14]. These measures could not apply in the index patient as she was abused by armed robbers, it, however, applies to the majority of CSA cases. The government, health care providers and non-governmental organisations should seize every available opportunity including mass media, consulting clinics, schools etc to educate potential victims on the need to promptly report CSA to a health facility for prompt evaluation and treatment as well as the law enforcement agency for investigation and punishment of perpetrators [25]. Government should also ensure full implementation of the Child Rights Acts (CRA) [25].

Though the primary care physician in this index case was quite knowledgeable and able to promptly detect symptoms, the rising trend of traumatic events cannot be overlooked. Hence, primary care Physicians

should regularly be provided continuous medical education to ensure that they can promptly recognize and provide appropriate treatment especially in such clients like C.C. who present with somatic complaints. What cannot be downplayed is the collaboration and integration of various modalities of treatment for this client that made management productive. This wholistic treatment can best be provided in a one-stop centre where professional services are rendered to all clients of sexual violence. State governments should arise to the occasion to provide a one-stop centre for victims of sexual violence.

#### **IV. Conclusion**

Morbidities can arise from CSA which can be quite debilitating to not only victims but also impact negatively on their families. Mental health consequences require prompt recognition and early multi-disciplinary treatment. Treatment should apply all-inclusive modalities focusing on the various impacts; psychological, physical and social to facilitate total recovery. Like in the case report they benefit from a long-term follow-up to put control back into their hands.

#### **List of abbreviations**

CSA: child sexual abuse, PTSD: post-traumatic stress disorder, HIV: human immunodeficiency virus, BMI: body mass index, AIDS: acquired immunodeficiency syndrome, STIs: sexually transmitted infections.

#### **Declarations**

#### **Ethics approval and consent to participate**

Approval for the case report was waived.

#### **Consent for publication**

A signed informed consent was obtained from the guardian of the index client.

#### **Availability of data and materials**

Data sharing is not applicable to this article as no datasets were neither generated nor analysed during the current study.

#### **Funding**

No funding was received by the authors for this work.

#### **References**

- [1]. World Health Organisation. Guidelines for medico-legal care for victims of sexual violence. Geneva. WHO. 2003 [cited 2020 July 07]. Available from; [http://www.who.int/violence\\_injury\\_prevention/publications](http://www.who.int/violence_injury_prevention/publications)
- [2]. Adeleke NA, Olowookere AS, Hassan MB, Komolafe JO, Asekun-Olarinmoye EO. Sexual assault against women at Oshogbo southwestern Nigeria. *Niger J Clin Pract* 2012; 15:190-3.
- [3]. World Health Organisation. Guidelines for medico-legal care for victims of sexual violence. Geneva. WHO. 2003 [cited 2020 August 21]. Available from; [http://www.who.int/violence\\_injury\\_prevention/publications](http://www.who.int/violence_injury_prevention/publications)
- [4]. Chinawa JM, Ibekwe RC, Ibekwe MU, Obi E, Mouneke VU, Obu DC, et al. Prevalence and pattern of sexual abuse among children attending Ebonyi State University Teaching Hospital, Abakiliki, Ebonyi State. *Niger J Paed.* 2013; 40(3): 227–31
- [5]. Enobakhare E, EromonP, OhenhenV, Odiko D. Prevalence and pattern of rape in children and young persons in a Specialist Hospital in Benin City, South-South, Nigeria. *Journal of Medical and Dental Sciences.* 2018; 17 (10): 69-76.
- [6]. World Health Organization/London School of hygiene and tropical medicine. Preventing intimate partner and sexual violence against women: taking action and generating evidence. Geneva, WHO, 2010.
- [7]. Chivers-Wilson KA. Sexual assault and posttraumatic stress disorder: a review of the biological, psychological and sociological factors and treatments. *Mcgill J Med.* 2006; 9(2): 111–118.
- [8]. Azi AS, Saluhu AI. The Effect of Child Abuse on the Academic Performance of School Children: Implication on the Nigerian Economy *Asia Pacific Journal of Education, Arts and Sciences.* 2016; 3(3).
- [9]. Okunlola OB, Gesinde AM, Nwabueze AC, Okojide A. Review of Child and Adolescent Sexual Abuse in Nigeria: Implications for 21st Century Counsellors. *CIJP*(2020); 5(1): 71-86.
- [10]. Pratiwi AA, Asyary A. The Impact of Child Sexual Abuse. *JUMP Health,* 2017;1(1): 13-17.
- [11]. McTavish JR, Sverdlichenko I, MacMillana HL, Wekerle C. Child sexual abuse, disclosure and PTSD: A systematic and critical review. *Child Abuse & Neglect* 2019; 92: 196–208.
- [12]. Mathews B, Collin-Ve'zina D. Child Sexual Abuse: Toward a Conceptual Model and Definition. *Trauma, Violence, & Abuse.* 2019; 20(2): 131-148.
- [13]. De Veauuse Brown NF, Annor FB, Swahn MH, Self-Brown SR. Sexual Violence Experience Among Nigerian Girls and Young Women: What Are the Roles of Early Sexual Debut, Multiple Sex Partnerships, and Traditional Gender Role Beliefs? *Journal of Interpersonal Violence* 2020; 1-21.
- [14]. Letourneau EJ, Schaeffer CM, Bradshaw CP, Feder KA. Preventing the Onset of Child Sexual Abuse by Targeting Young Adolescents With Universal Prevention Programming. *Child Maltreatment* 2017; 22(2): 100-111.
- [15]. Okeafor CU, Okeafor IN, Tobin-West CI. Relationship Between Sexual Abuse in Childhood and the Occurrence of Mental Illness in Adulthood: A Matched Case-Control Study in Nigeria. *Sexual Abuse* 2018; 30(4): 438–453.
- [16]. National Population Commission of Nigeria, UNICEF Nigeria, &and U.S. Centers for Disease Control and Prevention. *Violence against children in Nigeria: Findings from a national survey, 2014.* Abuja, Nigeria: UNICEF, 2016.
- [17]. Rape statistics- South Africa and worldwide 2011 [cited 2020 May.17]. Available online: [www.rape.co.za](http://www.rape.co.za)
- [18]. Rape in Nigeria: NGO records 1,128 rape cases in Delta in six months. Peace Women. 2009 [Cited 2020 Sep.17]. Available online: [www.newsrescue.com](http://www.newsrescue.com)
- [19]. Kennedy AC, Prock KA. I Still Feel Like I Am Not Normal'': A Review of the Role of Stigma and Stigmatization Among Female Survivors of Child Sexual Abuse, Sexual Assault, and Intimate Partner Violence. *Trauma, Violence, & Abuse.* 2018; 19(5) 512-527.

---

*A Case Report of Post-Traumatic Stress Disorder in an Adolescent Secondary To Sexual Violence*

---

- [20]. Sanjeevi J, Houlihan D, Bergstrom KA, Langley MM, Judkins J. A Review of Child Sexual Abuse: Impact, Risk, and Resilience in the Context of Culture, *Journal of Child Sexual Abuse*, 2018; 27(6): 622-641.
- [21]. Latunji OO, Akinyemi OO. Factors influencing health-seeking behaviour among civil servants in Ibadan, Nigeria. *Ann Ib Postgrad Med*. 2018; 16(1): 52-60.
- [22]. Trickey D, Siddaway AP, Meiser-Stedman R, Serpell L, Field AP. A meta-analysis of risk factors for post-traumatic stress disorder in children and adolescents. *Clinical Psychology Review*. 2012; 32(2): 122-138.
- [23]. World Health Organization. WHO/WONCA joint report: Integrating mental health into primary care - a global perspective. Geneva; World Health Organization 2008. Available online: [http://www.who.int/mental\\_health/policy/services/mentalhealthintoprimrycare/en/](http://www.who.int/mental_health/policy/services/mentalhealthintoprimrycare/en/)
- [24]. Kaminer D, Seedat S, Stein DJ. Post-traumatic stress disorder in children. *World Psych J*. 2005; 4(2): 121-125.
- [25]. Oseni TIA, Lawani OE, Oyedeji AI. A Case of Sexual Abuse of a Minor. *African Journal of Reproductive Health* 2016; 20(1): 109-113.

XXXX, et. al. "A Case Report of Post-Traumatic Stress Disorder in an Adolescent Secondary To Sexual Violence." *IOSR Journal of Dental and Medical Sciences (IOSR-JDMS)*, 20(04), 2021, pp. 29-33.