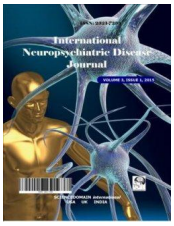

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Adolescents' Disclosure of Sexual Violence Victimization in Nigeria: Prevalence, Barriers and Mental Health Implications

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Author's contribution

The sole author designed, analyzed and interpreted and prepared the manuscript.

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ABSTRACT

Aim: Despite the adverse mental health consequences of sexual violence, the majority of cases are unreported by victims. Non-disclosure prevents access to appropriate therapeutic and legal interventions. The design of interventions to facilitate reporting of sexual abuse is hinged on the recognition of the barriers to reporting. The current study assessed the prevalence of disclosure and barriers to disclosure among adolescent victims of sexual violence in Lagos, Nigeria.
Study Design and Methodology: Using a cross-sectional study design, self-reported questionnaires designed to assess sexual violence, disclosure of victimization and barriers to disclosure were administered to 220 adolescents attending a public co-educational secondary school in Lagos, south-West Nigeria. The findings are discussed in the context of their mental health implications.
Results: The mean age of the participants was 15.8 (±1.2) years, and 58.2% were males. Only 9.2% of the victims of sexual violence ever reported to anyone. Frequently reported barriers to disclosure were stigma (78.9%), consideration of discussion about sex as taboo (73.7%), fear of parents/ authority figures (76.3%), mistrust of law enforcement agencies (71.1%) and fear of perpetrators (63.2%). Other reported barriers include ignorance that the act constituted sexual

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abuse (34.2%), self-blame/guilt (31.6%) and fear of not being believed (36.8%).
Conclusion: There is an unmet need for interventions to facilitate reporting of sexual violence by victimized adolescents. Such interventions must address stigma, debunk myth, promote sexual education and ensure appropriate response of legal and social institutions to victims in order to restore public confidence.

Keywords: Sexual violence victimization; sexual abuse; reporting; disclosure; barriers to reporting; mental health problems.

1. INTRODUCTION

Sexual violence or sexual abuse is a public health problem and human right concern that is increasingly attracting global attention [1]. It encompasses unwanted inappropriate sexual exposure usually involving genital touching, fondling oral, anal and vaginal intercourse or attempted intercourse. Globally, about 150 million girls and 73 million boys are sexually abused annually [1]. According to systematic reviews and meta-analysis, 1 in 13 males and 1 in 5 females experience sexual abuse or sexual violence victimization before the age of 18 years [2,3]. Sexual abuse has been reported among adolescents in Africa including Nigeria [4-6]. It is estimated that one in ten children are victims each year; by the age of 16, 1 out of 4 experience coerced sex, and at 18 years, more than 1 in 3 have been victimized [4]. However, the specific rates vary considerably across studies due to heterogeneity in the definition of what constitutes sexual abuse, attitudes to disclosure and other methodological differences.

Sexual abuse is associated with negative mental and physical health consequences including depression, suicidal behaviour, post-traumatic stress disorders (PTSD), anxiety disorders, substance use disorders, increased risk taking behaviour, unwanted pregnancy, transmission of sexually transmitted diseases and HIV-AIDS [7-21]. In spite of the dire physical and mental health implications, very few victimized individuals report cases of sexual abuse to appropriate authorities, or even make informal disclosures [22-25]. Non-reporting of sexual abuse may lead to re-victimization and prevent access to appropriate therapeutic and legal interventions thereby worsening outcomes [18-20,26].

Understanding the barriers to reporting of sexual abuse is essential in designing strategies to facilitate reporting by victimized adolescents. Previous studies, conducted predominantly in North America and Europe, identified a number of barriers to reporting including stigma, shame, self-blame, guilt, fear of perpetrator, fear of not being believed, uncertainty about whether their experience could be defined as abuse, ambivalent relationship with perpetrator, peer influences, concerns about criminal justice system, unsupportive responses to initial disclosure and anticipation of negative reactions to disclosures [27-33].

However, there is limited data on the barriers to disclosure of sexual abuse in Africa. In light of the evidence that culture influence barriers to reporting, the current study was designed to contribute to the body of knowledge on this subject in a previously under-researched cultural setting [34]. This study assessed the prevalence of disclosure and the self-reported barriers to disclosure among adolescents who had been victims of sexual abuse. The mental health implications of these findings are subsequently discussed.

2. METHODS

The study design was a cross-sectional descriptive study of a sample of students attending a public co-educational secondary (high) school in Lagos, Nigeria. Prior to the commencement of the study, ethical approval was obtained from the Lagos Educational Authority District Office. The students were duly educated about the nature and purpose of the study and their assent obtained before recruitment into the study. They were informed of their right to choose not to participate and to withdraw consent during the research. Informed Consent was also obtained from the parents or guardians of the students. The participants (n=220) were recruited from senior secondary school classes 4 to 6 (grade 10 to 12) by convenient sampling methods.

The current report is part of a larger study of violence and mental health problems among school children. However the current data set is limited to history of sexual violence victimization,

disclosure of victimization and barriers to disclosure. History of sexual violence victimization or abuse was elicited with the violence and injury module of the Global school-based health survey questionnaire (GSHS), expanded version, developed by the World Health Organization (WHO) in collaboration with UNICEF, UNESCO, UNAIDS and technical assistance from CDC [35]. Supplementary items on the questionnaire enquired whether the victim reported the incidence of sexual violence victimization to anyone or not, and the reasons why disclosures was not made (the barriers to disclosure). The latter question was open-ended and multiple responses were allowed. All questions were anonymously completed by self-report and confidentiality was ensured during and after data collection.

2.1 Statistical Analysis

Out of the 220 participants, 189 questionnaires were adequately completed for analysis (85.9%). Descriptive statistics such as frequencies, percentages or mean values were computed for relevant variables using IBM-SPSS version 20. The prevalence of disclosure of sexual violence victimization was computed by determining the frequency of participants who reported/disclosed sexual violence victimization as a fraction of the total number of participants who had experienced sexual violence victimization, expressed in percentage. Using templates from previous research on this subject, open-ended responses to the questionnaire item eliciting barriers to disclosure of sexual abuse were grouped into categories and tabulated based on similarity of thematic content. The frequency and percentage of each category of barriers to disclosure were also computed among respondents who experienced sexual violence but did not report the incidence.

3. RESULTS

3.1. Prevalence of Sexual Abuse, Disclosure and Barriers to Disclosure

The mean age of the participants was 15.8 (±1.2) years, and 58.2% were males. Out of the 189 completed questionnaires, 42 (22.2%) of the respondents had a lifetime history of sexual violence victimization or sexual abuse. However, only 4 of the 42 adolescents (9.52%) who had been sexually abused reported the incidence to anyone (Fig. 1).

The major barriers to reporting of sexual abuse were stigma (78.9%), consideration of discussion about sex as taboo (73.7%), fear of parents/ authority figures (76.3%), mistrust of law enforcement agencies (71.1%) and fear of perpetrators (63.2%). (Table 1). Other reported barriers to disclosure include ignorance that the act constituted sexual abuse (34.2%), self-blame/guilt (31.6%) and fear of not being believed (36.8%).

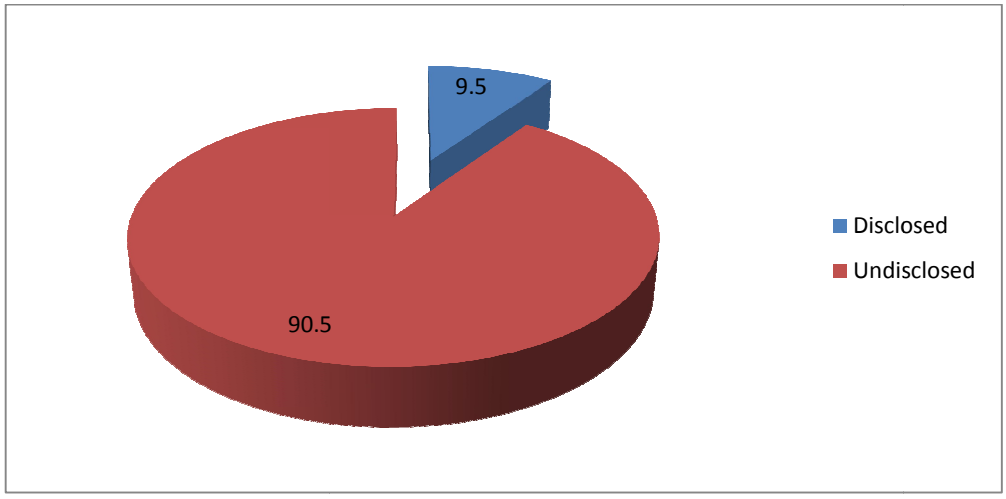

Fig. 1. Prevalence of disclosure of sexual abuse among the adolescents

Table 1. Self-reported barriers to disclosure by victims of sexual abuse (N=38)*

Barriers	n	(%)
Stigma	30	78.9
Fear of authority figures	29	76.3
Taboo	28	73.7
Mistrust of law enforcement agencies	27	71.1
Fear of perpetrator	24	36.2
Fear of not being believed	14	36.8
Ignorance	13	34.2
Self-blame	12	31.6

**Responses by participants (n=38) who had been sexually victimized but did not report the incidence*

3.2 Sample Responses from the Categories of Barriers to Disclosure Included

Consideration of discussion about sex as taboo: "How can I say it? ... Nobody talks about that in the open".., "No, It's a no-go area… you can't say it, it's forbidden" "…It is not something they expect you talk about… "Ha, it is not easy to start talking about it … it is not acceptable"

Stigma: "It is better to shut up because it is very shameful"…"when people know, everybody will start making jest of you or calling you funny names". "It is a disgraceful thing so you need to keep it to yourself"… "I can't stand the disgrace, people will be looking at you somehow … even the family's name will be stained". "People will look at you as a 'left-over".

Self-blame: "…Maybe it's my fault too, my skirt was short…" "People will ask me what I went to do in his house…" "Maybe I should not have collected the money and things he has been buying for me…"

Ignorance: "I'm not sure if it was rape… I also enjoyed it a little at first", "He eventually left me alone…He didn't enter (penetrate)"…

Fear of authority: "My parents will kill me if they know". "If my Father hear, I'm finished" "My mother has warned me to run away from boys, she told me she will send me out of the house if any man sleep with me"

Lack of confidence in legal system: "what difference would it make?" "Nothing will come out of it… it has happened to someone I know before"…"They will start asking stupid questions…they told my friend to 'show the evidence'

4. DISCUSSION

The current study assessed the prevalence of reporting of sexual abuse and barriers to reporting among adolescent victims of sexual abuse in Lagos, Nigeria. Less than a tenth of the sexually victimized adolescents reported to anyone. This finding is consistent with that of Wolitzky-Taylor et al. [23] who reported that only 11.5% of a national sample of college female students in the U.S.A reported incidents of sexual abuse. The low rate of reporting of sexual abuse has also been substantiated by other researchers in other parts of world [24,25,33,36-38]. Evidence has shown that there has been no significant improvement in the overall prevalence of reporting over the past two decades [22,37]. A study conducted in an urban setting inhabited by 2.5 million people in Nigeria showed that only 5 cases of rape was reported to the police in a whole year [39]. This under-reporting calls for concern considering the dire mental, physical and social consequences of sexual abuse. Furthermore, because of the high risk of recidivism of sexual abuse, non-reporting may increase the vulnerability of abused individuals to re-victimization and undermine the safety of the public.

In the current study, the culture of silence and taboo surrounding sexual issues played a major role in hindering disclosure of sexual violence victimization. This converges with previous evidence that socio-cultural values, myths and taboos regarding modesty, shame, preservation of virginity and filial obligations could hinder the reporting of sexual violence [40-42]. Traditionally, premarital sex is forbidden in many African cultures and loss of virginity under any circumstance is discrediting not only to the 'deflowered' individual, but also to the whole family [33]. Furthermore, pre-marital loss of virginity may prejudice chance of getting married and attract other social sanctions which may cause the victim to suffer alienation and distress. Victims of sexual abuse may be judged as being promiscuous, wayward or have character defects that attracted the perpetrator [33,43]. It is therefore not surprising that the considerations of these negative socio-cultural implications may discourage disclosure.

Other frequently reported barriers to disclosure of SVV in the current study including stigma, fear of authority figures, mistrust of law enforcement agencies, fear of perpetrators, ignorance that the act constituted sexual abuse, self-blame/guilt and

fear of not being believed substantiates previous findings in the literature [24,27,29,33]. Dumont et al. [28] reported that stigma-related factors, shame, humiliation, self-blame or guilt, fear of not being believed, fear of perpetrator and lack of confidence in the criminal justice system prevent reporting. A more recent study by McElvany et al. [27] reiterated that the major factors inhibiting disclosure of SVV in young people are shame, concern about the possible consequences of disclosure, self-blame, fear of not being believed and peer influences.

In addition to these factors, Schaeffer et al. [29] demonstrated that ignorance that sexual abuse was unacceptable, relationship with the perpetrator as a friend or family, and lack of ample opportunities for disclosure were obstacles to reporting. Many victims of sexual violence are uncertain if their experiences meet the criteria for a classical definition of rape [44]. A survey of parents' perception about sexual abuse in Nigeria revealed that the majority only considered sexual violence victimization of their children seriously when it involves vaginal intercourse [43]. Using principal component analysis, Cohn et al. [30] demonstrated that non-acknowledgement of abusive experience as rape is one of three principal barriers to reporting. As highlighted in literature reviews on this subject, perpetrators manipulate the psyche of the young vulnerable victim to make them feel responsible or deserving of the sexual violence [24,45]. Sexually victimized adolescents in Nigeria may even have greater vulnerability because socio-cultural sanctions against open discussion about sex and limited opportunities for sexual education will facilitate a milieu where misconceptions and myths thrive. Such myths include the belief that male sexual urge or need for sexual relief is uncontrollable [41]. A recent study of adolescents' belief about forced sex in South Africa revealed that forced sex was perceived as a sign of love and considered acceptable if the victimized female was financially dependent on the male perpetrator [46]. Forced sex was also perceived as an appropriate way to satisfy sexual urges or punish a female partner for wrong behavior [46]. These misconceptions may reinforce self-blame. Socialization into the culture of 'unconditional respect' for elders may present an additional conflict when the perpetrator is a familiar elderly person. This may result in a feeling of ambivalence which may be an obstacle to reporting [41].

Disclosure of sexual violence victimization has very important implications for seeking mental health interventions. Mental health problems associated with sexual violence victimization include suicidal behavior, anxiety, depression, post-traumatic stress disorder, low self esteem, social withdrawal, sleep disturbances, aggressive behavior, substance use disorders and risk taking behaviours [7-17]. Disclosure is an important initial step in the pathway to accessing prompt assessment for the presence of any of these possible mental health problems and initiation of timely interventions. Furthermore, disclosure impacts on the mental health outcomes of sexually abused victims. Disclosure of sexual assault has been shown to reduce the risk for depression, PTSD and delinquency [47]. A population based study by Rugierro et al. [48] showed that delayed disclosure of sexual abuse was associated with depression and PTSD. Disclosure was found to reduce the risk of mental health problems about five fold. Similarly, Cohn et al. [30] found that non-reporting of sexual abuse due to criminal justice concerns is associated with depression and post-traumatic stress disorder in victimized individual. Furthermore, social responses to disclosure may influence mental health outcomes. Negative responses can worsen feeling of shame and isolation while self worth can be enhanced by supportive responses. Negative responses to reporting or regrets of disclosure to persons or institutions have been associated with PTSD [49]. Finally, the mental health impact of sexual abuse are modulated by presence of protective factors such as social support, supportive responses to disclosure, self-esteem, family cohesiveness, resilience, adaptive coping strategies and pre-existing diathesis or vulnerability factors [50-54]. The relationship between sexual violence victimization, disclosure and mental health problems highlight the need for victims of sexual violence to undergo comprehensive mental health assessments in order to inform appropriate mental health interventions.

The limited sample size of the current study and the recruitment of participants by convenient sampling from a selected school may limit extrapolation of the results to the general population. Furthermore, responses of the participants may be influenced by social desirability. However, questionnaires were completed anonymously by self-report and participants were assured of confidentiality. The use of open-ended response format also

facilitated unrestricted communication of the adolescents' experiences.

5. CONCLUSION

In conclusion, the findings of the current study highlights a dire need for interventions to facilitate reporting of sexual abuse in order to make victimised individuals benefit from available health, social and legal interventions. Interventions targeted at improving reporting must address stigmatisation of sexuality, taboos reinforcing silence, mistrust of law enforcement agencies, and improve public awareness about sexual abuse, and promote culture-friendly sexual education. Societal norms and myths supporting sexual violence must also be reviewed. Furthermore, policies must be directed at ensuring easy access to prompt comprehensive medical, mental, legal and social interventions for victimised individuals.

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COMPETING INTERESTS

Author has declared that no competing interests exist.

REFERENCES

1. Krug EG, Dahlberg LL, Mercy JA, et al. editors. Sexual violence: world report on violence and health. World Health Organization; Geneva (Switzerland); 2002. Available:http://whqlibdoc.who.int/publications/2002/92415455615 eng.pdf
2. Pereda N, Guilera G, Forns M, et al. The prevalence of child sexual abuse in community and student samples: A meta-analysis. Clin Psychol Rev. 2009; 29(4):328–38.
3. Stoltenborgh M, Van Ijzendoorn MH, Euser EM, et al. A global perspective on child sexual abuse: metal-analysis of prevalence around the world. Child Maltreat. 2011; 16(2):79–101.
4. Anderson N, Paredes-Solis S, Milne D, Omer K, Marokoane N, Laetsang D, Cockcroft A. Prevalence and risk factors for forced or coerced sex among school going youth: national cross-sectional study in 10 south African countries in 2003 and 2007. BMJ Open. 2012; 2: e000754.
5. Okoro FI, Obozokhai O.Sexual harassment; the experience of out of school teenagers in Benin city Nigeria. African Journal of Reproductive Health. 2005;9(3):118-127.
6. Sexual assault in Lagos Nigeria: a five year retrospective review. BMC Women's Health. 2014;23;14:115.
7. Cheasty M, Clare AW, Collins C. Relation between sexual abuse in childhood and adult depression: Case-control study. British Medical Journal. 2006;316:198-201.
8. Ystgaard M, Hestetun I, Loeb M, Mehlum L. Is there a specific relationship between childhood sexual and physical abuse and repeated suicidal behaviour? Child Abuse and Neglect. 2004;28:863-875.
9. Gutierrez PM, Thakkar RR, Kuczen C. Exploration of the relationship between physical and/or sexual abuse, attitudes about life and death, and suicidal ideation in young women. Death Studies. 2000;24: 675-688
10. Maniglio R. The impact of child sexual abuse on health: a systematic review of reviews. Clin Psychol Rev. 2009;29(7): 647–57.
11. Roberts R, O'Connor T, Dunn J, Golding J et al. The effects of child sexual abuse in later family life; mental health, parenting and adjustment of offspring. Child Abuse and Neglect. 2004;28:525-545.
12. Briere J, Elliott DM. Prevalence and psychological sequelae of self-reported childhood physical and sexual abuse in a general population sample of men and women. Child Abuse and Neglect. 2003; 1205-1222.
13. Cutajar MC, Mullen PE, Ogloff JR, et al. Psychopathology in a large cohort of sexually abused children followed up to 43 years. Child Abuse Negl. 2010; 34(11): 813–22.
14. Mills R, Scott J, Alati R, et al. Child maltreatment and adolescent mental health problems in a large birth cohort. Child Abuse Negl. 2013;37(5):292–302.
15. Nanni V, Uher R, Danese A. Childhood maltreatment predicts unfavorable course of the illness and treatment outcome and depression: A meta-analysis. Am J Psychiatry. 2012;163(2):141–51.
16. Dube S, Anda R, Whitfield C, et al. Long term consequences of childhood sexual

abuse by gender of victim. Am J Prev Med. 2005;28:430–8.
17. Omigbodun O, Bakare K, Yusuf B. Traumatic events and depressive symptoms among youth in Southwest Nigeria: A qualitative analysis. Int J Adolesc Med Health. 2008;20 (3):243-53.
18. Lalor K, McElvaney R. Child sexual abuse, links to later sexual exploitation/high-risk sexual behavior, and prevention/treatment programs. Trauma Violence Abuse. 2010;11(4):15.
19. Classen C, Palesh O, Aggarwal R. Sexual revictimization: a review of the literature. Trauma Violence Abuse. 2005;6:103–29.
20. Fergusson D, Horwood J, Lynskey M. Childhood sexual abuse, adolescent sexual behaviours and sexual revictimization. Child Abuse Negl. 1997; 21:789–803.
21. Homma Y, Wang N, Sawyc E, et al. The relationship between sexual abuse and risky sexual behavior among adolescent boys: A meta-analysis. J Adolesc Health. 2012;51(1):18–2.
22. Wolitzky Taylor 2011Wolitzky-Taylor KB, Resnick HS, McCauley JL, Amstadter AB, Ruggiero KJ, Kilpatrick DG. Is reporting of rape on the rise? A comparison of women with reported vs. unreported rape experiences in the National Women's Study-Replication. Journal of interpersonal violence. 2011;26 (4):807-32.
23. Wolitzky-Taylor KB, Resnick HS, Amstadter AB, McCauley JL, Ruggiero KJ, Kilpatrick DG. Reporting rape in a National sample of college women. J Am Coll Health. 2011;59(7):582-587
24. Paine ML, Hansen DJ. Factors influencing children to self-disclose sexual abuse. Clin Psychol Rev. 2002;22:271–95.
25. Ulman SE. Social reactions to child sexual abuse disclosures: A critical review. Journal of Child Sexual Abuse. 2003; 12(1):89-121.
26. Resnick HS, Holmes MM, Kilpatrick DG, et al. Predictors of post-rape medical care in a national sample of women. Am J Prev Med. 2000;19(4):214–219.
27. McElvany R, Greene S, Hogan D. To tell or not to tell? Factors influencing young people's informal disclosures of child sexual abuse. Journal of Interpersonal Violence. 2014;29 (5):928-47.
28. Du Mont J, Miller KL, Myhr TL. The Role of 'Real Rape' and 'Real Victim' Stereotypes in the Police Reporting Practices of Sexually Assaulted Women. Violence Against Women. 2003;9(4):466–486.
29. Schaeffer P, Leventhal JM, Asnes AG. Children's disclosure of sexual abuse: learning from direct enquiry. Child Abuse and Neglect. 2011;35(5):343-352.
30. Cohn AM, Zinzow HM, Resnick HS, Kilpatrick DG. Correlates of reasons for not reporting rape to the police: results from a national telephone household probability sampling of women with forcible or drug or alcohol facilitated or incapacitated rape. Journal of Interpersonal Violence. 2013; 28(3):455-73.
31. Priebea G, Svedinb CG. Child sexual abuse is largely hidden from the adult society: An epidemiological study of adolescents disclosures. Child Abuse Negl. 2008;32:1095–108.
32. Smith K, Bryant-Davis T, Tilman S, Marks A. Stiffled voices: barriers to help-seeking behavior for South African childhood sexual assault survivors. J. Child Sex Abuse. 2010;19 (3):255-74.
33. Okonkwo JEN, Ibeh CC. Female sexual assault in Nigeria. International Journal of Gynecology and Obstetrics. 2003;83:325-326.
34. Fry DA, Messinger AM, Rickert VI, O'Connor MK, Palmetto N, Lessel H, Davidson LL. Adolescent relationship violence: Help-seeking and help-giving behaviours among peers. J Urban Health. 2014;91(2):320-324.
35. Center for Disease Control and Prevention. The Global School-based Student Health Survey. Available:http://www.cdc.gov/gshs/questionnaire/index.html Accessed Febuary 2012.
36. Fisher BS, Daigle LE, Cullen FT, Turner ME. Reporting sexual victimization to the police and others: Results from a national-level study of college women. Crim Just Beh. 2003;30(1):6–38.
37. Rennison, C.M.Rape and Sexual Assault: Reporting to the police and medical attention, 1992-2000, Washington, DC: U.S. Department of Justice, Bureau of Justice Statistics; 2002. NCJ 194530
38. Malhotra N, Sood M. Sexual assault—a neglected public health problem in the developing world. Int J Gynecol Obstet. 2000;71(3):257.
39. Okulate GT. Interpersonal violence cases reported to the police: A Nigerian study. Journal of Interpersonal Volence. 2005; 20(12):1598-610.

40. Fontes LA, Plummer C. Cultural issues in disclosures of child sexual abuse. J Child Sex Abuse. 2010;19:491–518.
41. Lalor K. Child sexual abuse in sub-Saharan Africa: A literature review. Child Abuse and Neglect. 2004; 28;439-460.
42. Ekabua JE, Agan TU, Iklaki CU, Ekanem EI, Itam IH, Ogaji DS. Risk factors associated with sexual assault in calabar, South-Eastern, Nigeria. Niger J Med. 2006; 15(4):406-8.
43. Ige OK, Fawole OI. Preventing child sexual abuse: Parents perceptions and practices in Urban Nigeria. Journal of Child Sexual Abuse. 2011;20: 695-707.
44. Patterson D, Greeson M, Campbell R. Understanding rape survivors decisions not to seek help from formal social systems. Health Soc Work. 2009;34 (2):127-36.
45. Murray LK, Nguyeh A, Cohen JA. Child sexual abuse. Child Adolesc Psychiatr Clin N Am. 2014;23 (2):321-337.
46. DeVries H, Eggers SM, Jinabhai C, Meyer-Weitz A, Sathiparsad R, Taylor M. Adolescents' beliefs about forced sex in Kwazulu-Natal South Africa. Arch Sex Behav. 2014;43(6):1087-95.
47. Broman-Fulks JJ, Ruggiero KJ, Hanson RF, Smith DW, Resnick HS, Kilpatrick DG, Saunders BE. Sexual Assault Disclosure in Relation to Adolescent Mental Health: Results from the National Survey of Adolescents. Journal of Clinical Child and Adolescent Psychology. 2007;36(2):260-266.
48. Ruggiero KJ, Smith DW, Hanson RF, Resnick HS, Saunders BE, Kilpatrick DG, et al. Is disclosure of childhood rape associated with mental health outcome? Results from the National Women's Study. Child Maltreatment. 2004;9:62–77.
49. Jacques-Tiura AJ, Tkatch R, Abbey A, Wegner R. Disclosure of sexual assault: Characteristics and implications for posttraumatic stress symptoms among African American and Caucasian survivors. J Trauma Dissociation. 2010;11(2):174-92.
50. Jonzon E, Lindblad F. Risk factors and protective factors in relation to subjective health among adult female victims of child sexual abuse. Child Abuse Negl. 2006; 30:127–43.
51. McClure F, Chavez D, Agars M, et al. Resilience in sexually abused women: risk and protective factors. J Fam Psychol. 2008;23(2):81–8.
52. Fassler IR, Amodeo M, Griffin ML, et al. Predicting long-term outcomes for women sexually abused in childhood: contribution of abuse severity versus family environment. Child Abuse Negl. 2005; 29:269–84
53. Peleikis DE, Mykletun A, Dahl AA. The relative influence of childhood sexual abuse and other family background risk factors on adult adversities in female outpatients treated for anxiety disorders and depression. Child Abuse & Neglect, 2004;28:61-76.
54. Esposito CL, Clum GA. Social support and problem-solving as moderators of the relationship between childhood abuse and suicidality: Applications to a delinquent population. Journal of Traumatic Stress. 2002;15 (2):137-146.

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