Barriers and facilitators to disclosing sexual abuse in childhood and adolescence

Barriers and facilitators to disclosing sexual abuse in childhood and adolescence: a systematic review

Abstract

Children and young people often choose not to disclose sexual abuse, thus preventing access to help and allowing perpetrators to continue undetected. A nuanced understanding of the barriers (and facilitators) to disclosure is therefore of great relevance to practitioners and researchers. The literature was systematically searched for studies related to child and adolescent disclosures of sexual abuse. Thirteen studies were reviewed and assessed for methodological quality. Results of the review illustrate the heterogeneous nature of these empirical studies. Findings demonstrate that young people face a number of different barriers such as limited support, perceived negative consequences and feelings of self-blame, shame and guilt, when choosing to disclose. Being asked or prompted, through provision of developmentally appropriate information, about sexual abuse facilitates disclosure. The review highlights the need for robust, longitudinal studies with more sophisticated methodology to replicate findings. The review identifies the need for developmentally appropriate school-based intervention programmes that facilitate children's disclosure by reducing feelings of responsibility, self-blame, guilt and shame. In addition, prevention programmes should encourage family members, friends and frontline professionals to identify clues of sexual abuse, to explicitly ask children about the possibility of sexual abuse and also to respond supportively should disclosures occur. Facilitating disclosure in this way is key to safeguarding victims and promoting better outcomes for child and adolescent survivors of sexual abuse.

Keywords: Barriers, facilitators, sexual abuse, children, adolescents.

Declaration: This research did not receive any specific grant from funding agencies in the public, commercial, or not-for-profit sectors.

1. Introduction

The World Health Organisation (WHO) defines childhood sexual abuse (CSA) as the 'involvement of a child in sexual activity that he or she does not fully comprehend and is unable to give informed consent to' (WHO, 1999 p. 15). The various types of experiences, which constitute CSA, are wide-ranging. In a recent meta-analysis of global CSA rates, Stoltenborgh *et al* (2011) identified a combined prevalence of 11.8% amongst 9,911,748 participants, with higher rates for females (18%) than males (7.6%). It is not clear whether this gender imbalance reflects gender differences in childhood sexual abuse prevalence or disclosure rates but does reflect the over-representation of females in the wider CSA literature. Varying prevalence rates by country were also noted, possibly reflecting true cross-cultural differences in CSA rates, and/or children's ability to disclose. Variations may also reflect disagreements about the definition of CSA as well as differences in its measurement and reporting.

Prevalence studies rely on sampled populations reporting their experiences of CSA, however, child sexual victimization is both under reported and under-recorded (Reitsema & Grietens, 2016). The act of disclosing CSA is key to halting abuse and instigating legal and therapeutic intervention (Paine & Hansen, 2002) yet not all children who are sexually abused disclose and as many as 60-70% delay disclosure into adulthood (London *et al,* 2007). Research studies on disclosure rates are predominantly retrospective, sampling adult populations. Critically, these studies are inherently at risk of confounding and selection/recall bias. More recently, there has been an increased focus on researching disclosure in child and adolescent populations. Some research has shown that only a third of victims disclose during childhood (Jonzon & Lindblad, 2004; London *et al,* 2007). Priebe and Svedin (2008) surveyed 4,339 high school children and found that 45% reported experiences of unwanted sexual abuse. Of these, only 65% of females and 23% of males had previously disclosed,

indicating that although some survivors of CSA disclose their experiences, many do not. What is striking is that studies such as these suggest that research can uncover first-time disclosures. Young people are therefore not spontaneously disclosing nor are they being explicitly asked about their experiences of sexual abuse. The possible adverse results of this secrecy are that many children are at risk of ongoing sexual abuse and that many perpetrators remain unidentified and therefore free to commit acts against other children. There is a growing body of research in the literature pertaining to predictors and processes involved in patterns of (non)-disclosure of CSA.

Demographic variables such as age and gender have been implicated in decisions to disclose. Some studies have identified age effects suggesting that younger children are more likely to delay disclosure than older children (e.g. Smith *et al,* 2000), although other studies have failed to replicate this pattern (e.g. Kellogg & Hoffman, 1995). Younger children are more likely to disclose to adults (Lamb & Edgar-Smith, 1994; Roesler & Wind, 1994; Arata, 1998; Palmer *et al,* 1999) whilst older children and adolescents are more likely to disclose to peers (Edgardh & Ormstad, 2000; Tang, 2002). Studies generally report higher disclosure rates for sexually abused females in comparison to sexually abused males. This may be an artefact of the under-representation of males in the CSA literature. These findings may also reflect gender variances in CSA prevalence data (Stoltenborgh *et al,* 2011) and/or gender differences more generally in help-seeking behaviour (Galdas, Cheater & Marshall, 2005). These factors may all derive from an (unconscious) binary view of women as victims and men as perpetrators, as espoused in feminist literature (e.g. Knight & Hatty, 1987). Other demographic variables such as disability have received some attention in the literature. Research suggests that children with disabilities are not only at greater risk of abuse than their typically developing counterparts (Jones *et al,* 2012) but they are also more likely to delay or fail to disclose. Hershkowitz *et al* (2007) examined forensic statements of 40,430

alleged abuse victims and found that regardless of age or gender, children with disabilities failed to disclose significantly more often than typically developing children. Moreover, delaying disclosure was found to be more likely when sexual abuse was suspected. In a qualitative study sampling 10 deaf and disabled people, Jones *et al* (2016) explored enablers of help-seeking following abuse. They found that disclosures were facilitated by supportive relationships and by other people's abilities to detect and respond to abuse. Despite what is known about disabled children being at increased risk of victimization, the population is under-researched and this remains a significant gap in the literature.

Research has also investigated the role of abuse characteristics on victims' decisions to disclose. For the most part, disclosure has been found to be more likely when the abuse is extra-familial (abuse that occurs out with the family) (Arata, 1998; London *et al,* 2007). However, not all studies agree; Lamb and Edgar-Smith (1994) found no association between abuse type and the likelihood to disclose in a sample of 60 adults who had been sexually abused as children. Other factors such as anticipated social reactions and fear of negative consequences such as disbelief, along with psychological constructs such as shame and self-blame have also been researched (Kellogg & Hoffman, 1997; Ullman, 2002). Despite the fact that these many factors have been to some degree implicated in a child's decisions to tell, there is limited consensus within the literature about an optimal set of conditions and factors that facilitate CSA disclosures. Indeed, a recently conducted literature review of adult disclosures of CSA concluded that the barriers and facilitators to disclosing sexual abuse involve a complex interplay between several intrapersonal, interpersonal and social factors, which are still only partially understood (Tener & Murphy, 2015).

Disclosing CSA in childhood may involve barriers and facilitators that are qualitatively different to those experienced by adults. Paine and Hansen (2002) concluded in their literature review that alongside a complex interplay between multifaceted internal and

external factors, cognitive and developmental barriers are important drivers in children and adolescents' decisions to withhold disclosure. Since Paine and Hansen's (2002) review, additional research investigating child and adolescent disclosures of CSA has been conducted, yet there remain opposing and contrasting findings. As such, no conclusive trends can be drawn from each of the individual studies published. This highlights the need to better understand the common findings across these studies with each study's methodological quality in mind.

McElvaney (2015) reviewed literature on delays, non-disclosures and partial disclosures of child sexual abuse in adult and child populations. As with Paine and Hansen's (2002) review, the author identified the intricacy and complexity involved in individuals' disclosure journeys. Given that disclosure is pivotal for a child to access help, it is important to understand the factors that facilitate a child's decision to tell. To the authors' knowledge, no published systematic reviews to date have examined studies investigating the barriers and facilitators to disclosing sexual abuse in childhood and adolescence. In synthesizing findings from these studies, the current review aims to address the following questions: 1) What barriers do children and adolescents face when disclosing sexual abuse? 2) What factors are associated with facilitating children and adolescents to disclose their experiences of sexual abuse?

2. Methods

2.1. Protocol

A review protocol was developed and published before a full, systematic literature search was undertaken. Predefining a systematic review's method and scope in advance minimizes bias and maintains transparency throughout. The review protocol that was developed guided the systematic search of the literature to identify papers that met the

review's eligibility criteria. The systematic review protocol can be accessed on: http://www.crd.york.ac.uk/PROSPERO/display_record.asp?ID=CRD42016035672

2.2. Eligibility Criteria

Research about disclosures of sexual abuse in child and adolescent populations is growing, yet limited. As such, a decision was made not to apply a date restriction to the search. Articles that employed either a qualitative, quantitative or a mixed methods study design were considered eligible for inclusion. Studies were included if the principal aim was the investigation of disclosures of sexual abuse in child and adolescent populations: an operationalised inclusion criterion was set at a mean age for the sample of under 18.0 years. Studies that investigated disclosures of CSA made by a sample with a mean age of 18.0 years and above were excluded from the review. Studies adopting secondary data analysis strategies were also excluded. In addition, reviews, professional opinions and editorial publications were excluded.

2.3. Literature search strategy

An initial comprehensive literature review was conducted in order to ensure that no other systematic review on child and adolescent disclosures of CSA had been conducted. This revealed that an unpublished thesis had been carried out on child disclosures of CSA (Morrison, 2016), which adopted a different analytical method (meta-ethnography) including qualitative studies only (n=7). To the authors' knowledge, no other reviews have specifically and systematically examined the barriers and facilitators to disclosing sexual abuse in childhood and adolescence. The current review, therefore, is unique in its scope and as a result, complements and contributes to the extant literature in this field.

The literature search was initially conducted in April 2016 using the following databases: Ovid (PsycINFO (1806-2016), Medline (1946-2016) and EMBASE (1980-2016)), EBSCO (including CINAHL Plus (1990-2016) and ERIC) and ProQuest (PILOTS (1871-

2016), Social Services Abstracts and Applied Social Sciences Index and Abstracts (ASSIA) (1987-2016)). The same search strategy was adopted for each of the three databases. Weekly alerts were set up for each of the databases informing the authors of any new publications that met the current review's eligibility criteria.

2.4. Study Selection

Figure 1 (Moher *et al,* 2009) presents a flow chart detailing the individual stages of the literature search strategy. From the 2,668 records identified, 824 duplicates were removed. A total of 1,043 titles were screened for relevance and 929 articles were excluded, as they were deemed irrelevant to the review question. Thereafter, 115 abstracts were reviewed and assessed against the predefined eligibility criteria. Seventy-four articles were excluded at this stage. The remaining 41 articles were accessed in full and assessed for suitability. Eleven studies met all criteria for inclusion. Finally two manual searches, firstly through the included studies' references lists and secondly via Google Scholar were conducted. An additional two papers that were eligible for inclusion were identified. As such, the total number of studies included in the review was 13. Table 1 provides summary information for each of these 13 articles, which includes study design, sample, abuse and disclosure characteristics, data analysis strategy and main findings.

2.5. Assessment of Methodological Quality

Methodological quality criteria that ensured qualitative and quantitative designs were fairly evaluated were developed with reference to a range of published criteria and recommendations (CASP, 2014; CRD, 2009; SIGN, 2008; PRISMA, Liberati *et al,* 2009; Dingwall *et al,* 1998; Jeanfreau & Jack, 2010; Shenton, 2004).

Studies were rated on a total of 15 quality criteria items across five different dimensions: research questions/aims; sampling; methodology; data analysis and findings. Each quality criterion was assessed according to the following quality ratings, 'well covered'

(3 points), ‘adequately addressed’ (2 points), ‘poorly addressed’ (1 point) and ‘not addressed’, ‘not reported’ and ‘not applicable’ (0 points). An overall quality rating score was calculated for each of the 13 included studies to facilitate the synthesis of findings in light of their methodological rigor.

A total quality rating score was calculated for each study based on the core eleven-quality criteria. Studies were allocated a total quality rating score out of a possible 33 points; these are provided in Table 2. The nine articles that adopted a qualitative or mixed-study design were further assessed on an additional four quality criteria that are relevant for qualitative research: credibility, dependability, conformability and transferability. Out of a possible 12 points in this case, the nine studies were assigned a secondary quality rating score for the qualitative component to their methodology. This score is given in brackets under the ‘Overall Quality Rating Score’ column found in Table 2.

The first author appraised all of the 13 included studies. To minimize errors and reduce possible assessment bias, two independent reviewers individually assessed randomly selected studies on each of the 15 quality criteria. Agreement between raters on all items for each domain was sought before overall quality descriptors were assigned.

Figure 1: Flow chart detailing the systematic review search strategy.

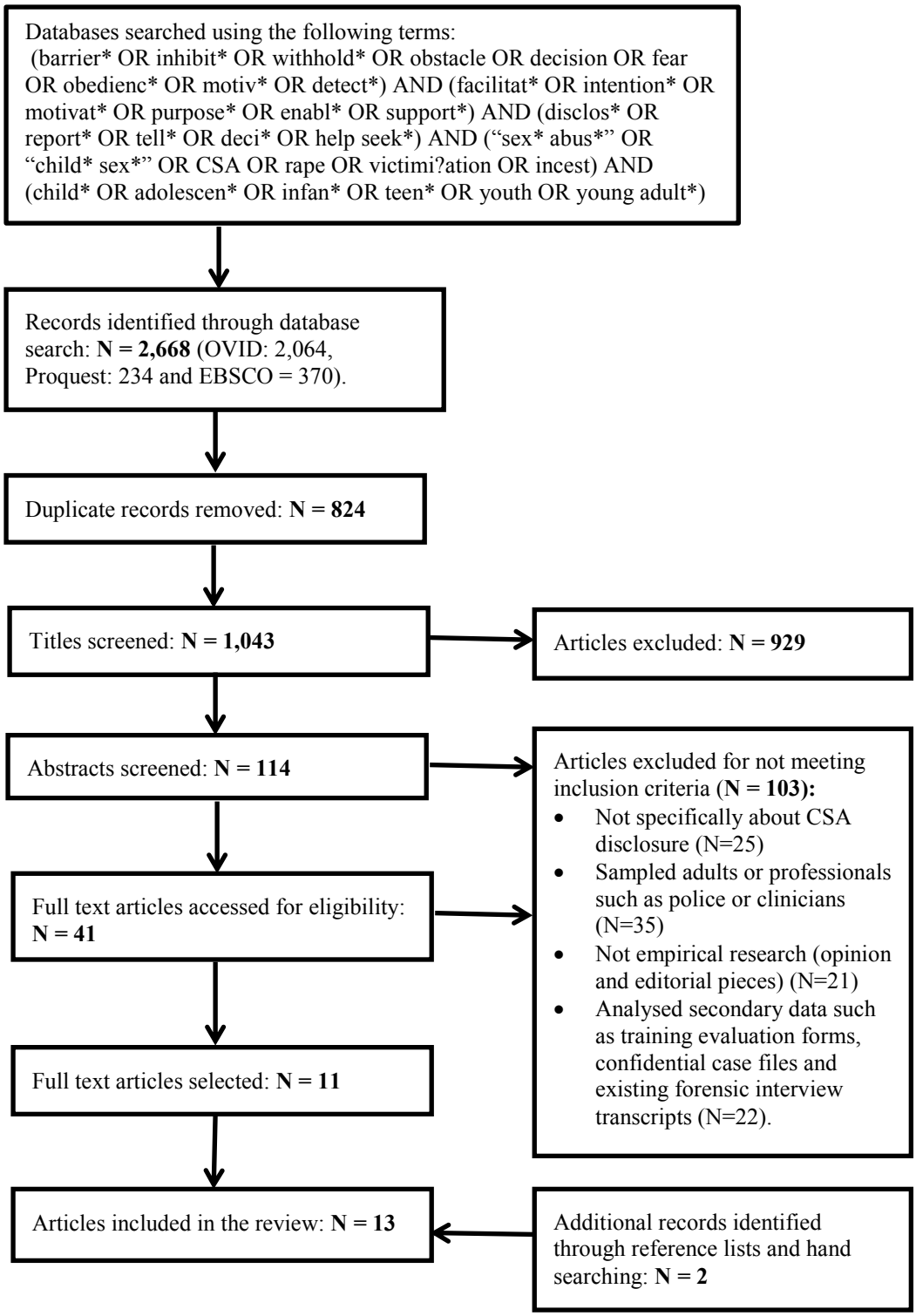
Databases searched using the following terms:
(barrier* OR inhibit* OR withhold* OR obstacle OR decision OR fear OR obedienc* OR motiv* OR detect*) AND (facilitat* OR intention* OR motivat* OR purpose* OR enabl* OR support*) AND (disclos* OR report* OR tell* OR deci* OR help seek*) AND ("sex* abus*" OR "child* sex*" OR CSA OR rape OR victimi?ation OR incest) AND (child* OR adolescen* OR infan* OR teen* OR youth OR young adult*)
Records identified through database search: N = 2,668 (OVID: 2,064, Proquest: 234 and EBSCO = 370).
Duplicate records removed: N = 824
Titles screened: N = 1,043
Articles excluded: N = 929
Abstracts screened: N = 114
Articles excluded for not meeting inclusion criteria (N = 103):
Not specifically about CSA disclosure (N=25)
Sampled adults or professionals such as police or clinicians (N=35)
Not empirical research (opinion and editorial pieces) (N=21)
Analysed secondary data such as training evaluation forms, confidential case files and existing forensic interview transcripts (N=22).
Full text articles accessed for eligibility: N = 41
Full text articles selected: N = 11
Articles included in the review: N = 13
Additional records identified through reference lists and hand searching: N = 2

Table 1. Summary of characteristics and findings of included studies.

Authors (Year), Country	Study Design	Sample and Sampling Strategy	Sample Characteristics	Abuse Characteristics	Disclosure Characteristics	Data Analysis	Main Findings
Crisma *et al* (2004). Italy.	Qualitative.	General population. Volunteer Sampling	N=36. **Gender:** 35 females; 1 male. **Age:** <18 years (N=31) 18-21 years (N=4) >22 years (N=1).	**Type:** rape (N=23), attempted rape (N=2), fondling/touching (N=10) peeping (N=1). **Perpetrators:** all males; father, stepfather, grandfather or brother (N=8), other relatives (N=7), partners/friends (N=13). **Duration:** single episode (N=13), <1 year (N=5), >1 (N=18).	**Number:** none (N=7), 1 (N=12), 2 (N=8), 3 or more (N=9). **Recipient:** nobody (N=7), friends (N=15), parents (N=10), other family members (N=11), and professionals (N=12).	Not articulated.	**Barriers:** lack of information; desire for autonomy and maturity; wish to protect family members, limited support gained from professionals and adults.
Gries, Goh & Cavanaugh (1997). USA.	Quantitative. Cross-sectional	Foster children. Purposive Sampling	N=96 **Gender:** 47 females, 49 males. **Age:** mean= 8.3 years, range= 3-17 years.	**Type:** physical abuse (N=19), exposure to others (N=9), exposure to pornography (N=5), fondling (N=49), anal penetration (N=7), genital penetration (N=18), touching offender (N=14).	**Number:** disclosed prior to study (N=43), no prior disclosure made (N=53). **Recantation:** (N=9; 4 females, 5 males).	Pearson chi-squared.	More females than males disclosed during assessment; more males than females disclosed physical abuse. **Barriers:** younger children more likely to recant disclosure. **Facilitators:** personal history, CSA was worst experience and identification of body parts.
Mont'Ros-Mendoza & Hecht (1989). USA.	Qualitative	Clinical population: children known to heath care and child welfare systems. Purposive Sampling	N=8 **Gender:** 6 females, 2 males. **Age:** range 7-16 years.	**Frequency:** 1 occasion (N=7), multiple (N=1). **Perpetrators:** intrafamilial (N=4), extrafamilial (N=4).	**Recipient:** peers (N=5), adult friends (N=2) parents (N=1).	Systematic interpretive analysis. Content analysis.	**Facilitators:** relational factors (choice of trusted person) and being in a safe location (alone with recipient outside of home).

Hershkowitz *et al* (2007). Israel.	Mixed methods	Children who had made allegations of sexual abuse. Purposive Sampling	N=30 **Gender:** 12 females, 18 males. **Age:** mean = 9.2 years, range 7-12 years.	**Frequency:** single event (N=16) multiple (N=14). **Type:** sexual exposure or fondling over clothes (N=18), touching under clothes, including genital penetration (N=12), sexual touch over clothes (N=12) and under clothes (N=18). **Perpetrator:** familiar (N=18), stranger (N=12). **Threats:** no (N=20), yes (N=10). **Reward:** no (N=23) yes (N=7). **Age at onset:** 9 and under (N=15), over 9 (N=15).	**First recipient:** siblings or friends (47%), parents (43%) other adults (10%). **Latency:** between 1 week and 2 years (53%), up to 1 month (76%), up to 1 year (19.8%) > 1 year (6.6%). **Spontaneous** (57%) **Prompted** (43%) **Recantation:** 13%	Content analysis. Pearson chi-squared. Fisher's exact statistics.	**Barriers:** 10-12 year olds more likely to delay disclosure than 7-9 year olds. Unsupportive parental reactions; feelings of fear and shame; perpetrator was familiar, abuse was serious and repeated. **Facilitators:** receiving positive emotional support; being prompted.
Jensen *et al* (2005). Norway.	Qualitative	Clinical population: children known to heath care and child welfare systems. Purposive Sampling	N=22. **Gender:** 15 females; 7 males. **Age:** mean = 7.5 years, range 3-16 years	**Type:** sexual; fondling genitals (N=11), cunnilingus/fellatio (N=4), masturbation/ ejaculation (N=4), vaginal or anal intercourse (N=3) **Perpetrator:** all males, all family members.	**Recipient:** parents (N=18), peers (N=3) uncle (N=1).	Grounded Theory Interpretative Phenomenology.	**Barriers:** perceived negative consequences for suspected offender and family; perceived lack of support. **Facilitators:** contact with suspended offender as a trigger for disclosure, someone interpreting symptoms, joint focus of attention.
Kellogg & Houston (1995). USA.	Quantitative Cross-sectional	Clinical population: children known to heath care and child welfare systems.	N=345 **Gender:** 286 females, 59 males **Age:** mean = 17.92	**Type:** anogenital penetration (N=165), oral-genital contact/penetration (N=41), fondling (N=138). **Perpetrator:** adult family member (N=124), adult	**First recipient:** Friend (N=57), teen relative (N=20), adult relative (N=44), school personnel (N=5),	Pearson chi-squared ANOVA	**Barriers:** Positive feelings for the perpetrator and self-blame. **Facilitators:** The inability to contain the information, feeling tired of the sexual experiences, fear of negative consequences

		Purposive Sampling		acquaintances (N=82), stranger (N=51) peer acquaintances (N=51) and peer family members (N=20). Gang-related (N=14) and more than one perpetrator (N=145).	nonrelative adult (N=14), other (N=3). **Latency:** mean = 2.3 years, median = 5-6 months.		of ongoing abuse, school intervention.
McElvaney *et al* (2012). Ireland.	Qualitative	Clinical population: children known to heath care and child welfare systems. Purposive Sampling	N=22. **Gender:** 16 females, 6 males. **Age:** range 8-18.	**Type:** Experiences ranged from sexual fondling to vaginal and anal penetration. **Perpetrator:** intrafamilial (N=11), extrafamilial (N=9) intra/extrafamilial (N=2).	Not articulated	Grounded Theory	The process of disclosure is conceptualised as tri-phasic: active withholding, pressure cooker effect and confiding.
McElvaney *et al (2014).* Ireland.	Qualitative	Clinical population: children known to heath care and child welfare systems. Purposive Sampling	N=22. **Gender:** 16 females, 6 males. **Age:** range 8-18.	**Type:** Experiences ranged from sexual fondling to vaginal and anal penetration.	**Latency:** range no delay to 9 years, 1 year (N=4), 2 years (N=5), 4 years (N=3), 7 years (N=2) 9 years (N-2). **Recipient:** N=15 peer.	Grounded Theory	**Barriers:** shame, self-blame, fears and concerns for self and others. **Facilitators:** being believed, being asked, and peer influence.
Munzer *et al* (2016). Germany.	Quantitative Cross-sectional	Clinical population: children known to heath care and child welfare systems. Purposive Sampling	N=42 **Gender:** 25 females, 17 males. **Age:** mean = 12.6, range: 6-12 years	**Type:** flashing/sexual exposure (N=25), rape (N=20), exposure to pornography (N=12), verbal sexual harassment (N=9), nonspecific sexual assault (N=6), statutory rape and sexual misconduct (N=4). **Perpetrator:** father (N=11), other adult men (N=13), grandfather (N=2),	**Latency:** mean=17 months, range=same day-10 years. **First recipient:** mother (N=18), father (N=2), peers (N=8), social worker (N=4), teacher (N=2) and police (N=1). **Formal recipient:** police (N=19), health care provider (N=14), counselor (N=8), judge (N=5), youth	Absolute and relative frequencies.	**Barriers:** shame, guilt/responsibility, self-blame, threats made by perpetrator, did not want to burden parents, protect the perpetrator.

				minor brother (N=2) and peer (N=22). **Frequency:** single event (N=16), repeated (N=24). **Number of victimizations:** Mean = 9.6; Range = 1-171 **Age at onset:** mean = 9.0, range = 4-6.	welfare service (N=5) none (N=15). **Intentional:** (N=25) **Prompted:** (N=2).		
Schaeffer *et al* (2011). USA.	Mixed methods	Clinical population: children known to heath care and child welfare systems. Purposive Sampling	N=191 **Gender:** 141 females, 50 males. **Age:** mean = 8.9 years.	**Type:** range from non-contact e.g. exposure to pornography, to fondling, to intercourse.	**Recipient:** mother (N=59), father (N=4), both parents (N=8), stepmother (N=1), grandmother (N=10), aunt (N=2), teacher (N=8), mental health provider (N=4), parent of another child (N=4), CPS worker (N=3), police (N=2), family friend (N=1) babysitter (N=1).	Grounded Theory. Pearson chi-squared.	11-18 year olds more likely to disclose to peer; 3-10 year olds more likely to disclose to adult. **Barriers:** threats by perpetrator, fears of the child, lack of opportunity, lack of understanding and relationship with perpetrator. **Facilitators:** disclosure as result of internal stimuli, outside influences and direct evidence of abuse.
Schonbucher *et al* (2012). Switzerland.	Mixed methods	Mixed sample: general population and children's hospital. Volunteer sampling	N=26 **Gender:** 23 females, 3 males. **Age:** mean = 17.0 years, range = 15.4-18.3 years.	**Type:** contact without penetration (N=14), rape (N=9). **Perpetrator:** all males, intrafamilial (N=8), stranger (N=6), adolescent perpetrators (N=13). **Age at onset:** mean = 11.7 years, range = 3-17 years.	**Latency:** immediate-within 24 hours (30.1%), delayed (65.4%). Not disclosed prior to interview (N=1). Range = days-years.	Inductive content analysis. Relative frequencies Fisher's exact	**Barriers:** to not burden others; lack of trust; guilt/shame; lack of understanding; fear of disbelief; fear of perpetrator; fear of parental sanctions and to not destroy family. **Facilitators:** extra-familial perpetrator; CSA one-off event; age of victim was over 12 years; perpetrator is a minor; parents living together.

Shalhoub-Kevorkian (2005). Israel.	Qualitative.	School children. Convenience Sampling and Volunteer Sampling.	N=628 (focus group) N=28 (interviews) **Gender:** 28 females.	**Type:** rape (N=22), attempted rape (N=6). **Perpetrator:** extended family (N=9), nuclear family (N=5), school peer (N=3), acquaintances (N=7) stranger (N=1).	Not articulated.	Not articulated.	**Barriers:** fear of losing familial support, being killed, violating family honor, ruining reputation, social shame and repercussions for self. Negative responses from professionals.
Søftestad *et al* (2013). Norway.	Qualitative	Children who had made allegations of sexual abuse. Purposive Sampling	N=13 **Gender:** 8 females, 5 males. **Age:** range: 7-15 years.	**Perpetrator**: father (N=5), mother (N=1), grandfather (N=1), older male cousins (N=3) and one older male foster brother (N=1).	Not articulated.	Grounded Theory.	Conversations on suspicion, receiving information, contributing in decision-making, sharing feelings, engaging in conversations on meaning making.

3. Results

Sample, abuse and disclosure characteristics for each study are detailed in Table 1. A total of 658 females and 421 males were sampled across all 13 studies. Ages of the included sample were reported differently between studies. Means were reported in seven articles. In these studies, the mean age of a total of 752 participants was 13.41 years. For the remaining studies, means were calculated using reported age ranges. Assuming that the ages of participants were uniformly distributed within the reported ranges, the adjusted mean was found to be 13.25 years. One study was excluded from this analysis (Crisma *et al,* 2004) because no upper age limit for their sample was defined.

3.1. Methodological strengths and limitations of included studies

The methodological rigour of studies varied. An overall strength of the studies was well-articulated research questions that were contextually developed. Studies aimed to understand the barriers and facilitators to disclosing sexual abuse or more generally, to explore the patterns of disclosure in child and adolescent populations. Only one study (Kellogg & Houston, 1995) merely alluded to its study aims. A further strength was in relation to their results; study findings were anchored in and accurately reflected the data. Qualitative studies made good use of quotations to demonstrate the codes and themes that had been developed. Only in a couple of studies was there evidence of over and under-analysis where findings appeared to over reach the data or conversely, where synthesis of data was inadequate (Shalhoub-Kevorkian, 2005). One general criticism of the included studies was in relation to confounding variables. Only two studies made reference to potential confounders, such as whether any previous disclosures had been made. No studies were considered to have covered their sampling strategy well. Four studies did not address this criterion at all insofar as eligibility criteria were not fully articulated and no references were

made to missing data, attrition rates and reasons for non-participation. Additional relevant information is outlined in Table 2.

3.2. Study Findings

Findings of the included studies can broadly be categorized into two groups, as per the review's research questions: to understand the barriers that children and adolescents face when disclosing sexual abuse and to identify the factors that are associated with facilitating them to disclose.

3.2.1 Barriers: Ten studies reported findings on the barriers of CSA disclosure. One study (Mont'Ros-Mendoza & Hecht, 1989) did not articulate findings about barriers but focused on the reported facilitators for disclosure instead. Two qualitative studies (Søftestad *et al*, 2013 and McElvaney *et al,* 2012) aimed to explore disclosure processes more generally. As such, they proposed an overall model of disclosure rather than identifying specific barriers and facilitators as experienced by children and adolescents.

Various barriers were identified yet some were more commonly identified than others. Six studies found perceived lack of understanding and limited support from adults (parents or professionals) to be impediments of disclosure (Crisma *et al,* 2004; Hershkowitz *et al,* 2007; Jensen *et al,* 2005; Schaeffer *et al,* 2011; Schonbucher *et al,* 2012; Shalhoub-Kevorkian, 2005). This finding is congruent with extant research, which has identified anticipated social reactions to be an important driving factor in an individual's decision to disclose (Ullman, 2002). Similar findings have been identified in adult retrospective studies (Allnock & Miller, 2013). These findings demonstrate that when disclosing sexual abuse, children and adolescents may be met with a lack of understanding and limited support from others. The fear and anticipation of these negative social reactions may impede young people from disclosing their experiences of abuse. This finding appears to fit with the second most commonly identified barrier: perceived negative consequences for the self and for others.

Studies found that children and adolescents feared negative consequences for themselves such as parental sanctions (McElvaney *et al,* 2014; Schonbucher *et al,* 2012), losing familial support, social-shame, ruining their reputation, violating the family honor and being killed (Shalhoub-Kevorkian, 2005). Children also feared negative consequences for the suspected offender (e.g. imprisonment) and for their family (e.g. family break-up) (Crisma *et al,* 2004; Jensen *et al,* 2005; McElvaney *et al,* 2014; Munzer *et al,* 2016; Schaeffer *et al,* 2011; Schonbucher *et al,* 2012). It is possible that relational and family dynamics such as the relationship between the alleged perpetrator and the victim (Schaeffer *et al,* 2011) as well as the victim's thoughts and feelings towards the suspected offender play a part in whether a child is impeded by a fear of negative consequences when choosing to disclose. Indeed, the child's love for (Kellogg & Houston, 1995; Munzer *et al,* 2016) and the need to protect (Crisma *et al,* 2004; Schonbucher *et al,* 2012) the alleged perpetrator were found as potential barriers to victims disclosing their experiences of sexual abuse. This may partially explain why previous research has identified that victims of intra-familial abuse are more likely to delay disclosure than victims of extra-familial abuse (Arata, 1998; Goodman-Brown *et al,* 2003; Hershkowitz *et al,* 2007; London *et al,* 2007; Smith *et al,* 2000). It may be that extant research views disclosure as a unidirectional process, ignoring the potential evolving, relational and interactional context within which disclosures occur (Reitsema & Grietens, 2016). Indeed, as Flåm and Haugstvedt (2013) describe, "children do not tell, delay, recant or reaffirm accounts of their sexual victimization in a vacuum" (p.634).

Six studies identified the child's emotional response to the abuse (guilt, shame, self-blame and responsibility for the perpetrator's actions) as important barriers to disclosure. Quantitative studies found children were significantly more likely to delay disclosing if they experienced feelings of guilt and shame (Munzer *et al,* 2016; Schonbucher *et al,* 2012). Kellogg and Houston (1995) found that children who delayed disclosure were significantly

more likely to believe that the abuse was their fault as much as it was the perpetrators'. This felt sense of responsibility along with feelings of self-blame and shame were also identified as barriers to disclosure in McElvaney *et al's* (2014) qualitative study. These findings appear to fit with psychological research and theory highlighting the role of constructs such as shame and guilt in CSA (Browne & Finkelhor, 1986; Romero *et al,* 1999; Ullman, 2002).

3.2.2 Facilitators: Children being prompted or being asked directly about possible abuse was the most commonly identified facilitator (Hershkowitz *et al,* 2007; Jensen *et al,* 2005; McElvaney *et al,* 2014; Søftestad *et al,* 2013). Of these studies, only Hershkowitz *et al* (2007) measured whether disclosures were spontaneous or prompted. The other three studies, qualitative in design, did not operationalize this disclosure characteristic yet identified this as an important facilitator. Children may not disclose simply because they are not asked (McGee *et al,* 2002). This facilitator fits with extant research, which has identified that disclosures are more likely to be made following a prompt rather than initiated by a young person (Kogan, 2004), particularly if the disclosure is received by a trusted person (Mont'Ros-Mendoza &Hecht, 1989). These relational factors suggest that close relationships may play an important role in facilitating young people to disclose sexual abuse (Priebe & Svedin, 2008).

Providing young people with information about sexual abuse that is developmentally appropriate is pivotal to facilitating disclosures. Kellogg and Houston (1995) found that a school-based intervention about unwanted sexual experiences supported victims to disclose. In addition, Søftestad *et al* (2013) emphasized the importance of a victim receiving information about sexual abuse to support them to engage in meaningful conversations during which disclosure of intra-familial abuse can be made. This echoes Crisma *et al's* (2004) findings, which suggested that a possible barrier to adolescents disclosing CSA is a lack of information, particularly about the possible risks of sexual abuse as well as the

support that is available. Other significant facilitators identified were if the victim did not feel any guilt or shame (Schonbucher *et al,* 2012), if the child received positive emotional support and understanding (Hershkowitz *et al,* 2007; McElvaney *et al,* 2012) and if the abuse was extra-familial (Schonbucher *et al,* 2012).

Study	1 Research question/aim	2 Sampling strategy	3 Power	4 Sampling Characteristics	5 Study design and method	6 Measures	7 Abuse characteristics	8 Disclosure characteristics	9 Confounding variables	10 Data analysis	11 Findings	12 Credibility (validity)	13 Dependability (reliability)	14 Confirmability (objectivity)	15 Transferability (generalisability)	Overall Quality Rating Score out of 33 (out of 12)
Crisma *et al* (2004)	W/C	A/A	A/A	P/A	A/A	N/AD	W/C	P/A	N/AD	P/A	A/A	P/A	P/A	P/A	A/A	20(5)
Gries, Goh & Cavanaugh (1997)	W/C	N/AD	N/AD	P/A	A/A	N/AD	P/A	P/A	P/A	W/C	W/C	N/APP	N/APP	N/APP	N/APP	19-
Hershkowitz *et al* (2007)	A/A	A/A	A/A	A/A	W/C	A/A	A/A	A/A	P/A	A/A	W/C	N/APP	N/APP	N/APP	N/APP	24-
Jensen *et al* (2005)	A/A	A/A	A/A	P/A	W/C	N/AD	A/A	P/A	N/AD	A/A	W/C	A/A	A/A	A/A	W/C	20(9)
Kellogg & Houston (1995)	P/A	P/A	A/A	W/C	W/C	P/A	P/A	P/A	N/AD	A/A	W/C	N/APP	N/APP	N/APP	N/APP	23-
McElvaney *et al* (2012)	W/C	N/AD	A/A	A/A	W/C	W/C	A/A	N/AD	A/A	W/C	W/C	A/A	A/A	A/A	A/A	25(8)
McElvaney *et al* (2014)	W/C	N/AD	A/A	P/A	W/C	W/C	P/A	P/A	P/A	W/C	A/A	A/A	A/A	A/A	A/A	22(8)
Mont'Ros-Mendoza & Hecht (1989)	W/C	A/A	P/A	P/A	W/C	W/C	P/A	P/A	N/AD	A/A	A/A	A/A	P/A	P/A	A/A	23(6)
Munzer *et al* (2016)	W/C	A/A	A/A	A/A	W/C	A/A	A/A	A/A	P/A	P/A	W/C	N/APP	N/APP	N/APP	N/APP	25-
Schaeffer *et al* (2011)	W/C	A/A	A/A	W/C	W/C	A/A	P/A	P/A	N/AD	W/C	W/C	A/A	A/A	A/A	A/A	25(8)
Schonbucher *et al* (2012)	W/C	A/A	A/A	W/C	W/C	A/A	W/C	A/A	A/A	W/C	W/C	P/A	P/A	A/A	A/A	28(6)
Shalhoub-Kevorkian (2005)	W/C	N/AD	P/A	P/A	A/A	P/A	P/A	N/AD	P/A	P/A	A/A	N/AD	P/A	N/AD	P/A	19(2)
Søftestad *et al* (2013)	W/C	P/A	P/A	A/A	W/C	W/C	P/A	N/AD	N/AD	W/C	W/C	A/A	A/A	A/A	A/A	23(8)

Table 2. Quality ratings for included studies

W/C=well covered; A/A=adequately addressed; P/A=partially addressed; N/AD=not addressed; N/REP-not reported; N/APP=not applicable.

4. Discussion

The current review has demonstrated that children and adolescents face a number of different barriers and facilitators when disclosing sexual abuse. There appears to be, however, common threads amongst these factors. From the included studies, findings suggest that the optimal condition for a disclosure is for an individual to directly ask the child about their experiences and that this individual provides active listening and support, minimizes the child's feelings of guilt and shame and reduces their fear of negative consequences. With this in mind, this review recommends that prevention and intervention programmes should be developed both for the victims of sexual abuse and also for potential recipients of victims' disclosures. The impetus would be on reducing feelings of responsibility, self-blame, shame and guilt as experienced by young people. Programmes encouraging children to disclose should exist alongside programmes encouraging family members, friends and frontline professionals to identify clues of sexual abuse, to directly ask children about the possibility of sexual abuse and to also respond supportively should disclosures occur.

4.1. Current state of the evidence

Disclosure is best understood as a multifaceted process that is still not fully understood. What complicates the picture further is a lack of standardization across studies and this systematic review demonstrates the heterogeneity of the research to date. Included studies varied in measures selected and types of data analyses employed. Moreover, various recruitment procedures were used and different samples were studied. It is uncertain whether the samples included in this review are representative of child and adolescent survivors of sexual abuse as a whole (Olafson & Lederman, 2006). The majority of studies sampled young people who had disclosed their experiences of CSA. This sampling bias means that children who have been sexually abused but have not yet disclosed are under-represented in the research sample. The barriers and impediments to disclosure that these silent children

face may be different to those that are felt by children and young people who have disclosed their experiences of abuse. Moreover, many studies sampled children who were known to health care and child welfare systems. As these young people were receiving support following their disclosures and formal allegations, one might hypothesize that retrospective, hindsight bias plays a significant role in how children and adolescents recall the barriers and facilitators that they faced when deciding to tell. It is important to interpret findings within the parameters of the population that is being sampled; therefore study findings should be interpreted in light of the possibly biased sampling strategies adopted. In addition to this, abuse and disclosure characteristics varied between studies and the young people sampled were culturally diverse. Whilst this may appropriately illustrate the heterogeneous nature of sexual abuse and its victims more generally, it prohibited explicit like-for-like comparison of study findings. This demonstrates that the current state of the research is predominantly at an exploratory stage and that there remain significant gaps in the available evidence.

4.2. Limitations of the studies

Studies varied in their methodological rigour. Despite some areas of strength, many studies had similar shortcomings, which may have contributed to the heterogeneity of findings. Some previous research has implicated variables such as age, developmental stage, gender, perpetrator and the type of abuse (intra vs. extra-familial) in a child's decision to disclose, so the inconsistent reporting of these in the current sample lends uncertainty to the validity of some of the findings. Without future research that adequately controls for these possible confounding variables, firm conclusions about the predictors of disclosure cannot be made at this stage. Only findings from studies published in English were identified and synthesized. This may reflect the fact that few studies have been conducted in non-English speaking countries. If this is the case, the concern is that there is a gap in the evidence base relating to cross-cultural variations in disclosure processes. Studies not carried out in English

may articulate interesting findings about the disclosure journeys of children and adolescents out-with Western culture. This seems a particularly important gap in the literature to address given that child abuse should be understood as a 'global problem deeply rooted in cultural, economic and political practices' (WHO, 2002) and that cultural differences are reflected in global CSA prevalence data (see Stoltenborgh et al, 2011).

4.3. Strengths and limitations of the review

A particular strength of the current review is that it employed a rigorous search strategy and secondary searches using Google Scholar and manual searches through reference lists provided confidence that eligible papers were not missed. Moreover, the review included studies of all methodological design. Reducing the review's inclusion criteria to only qualitative or quantitative papers might have limited the number of studies eligible for inclusion, thereby limiting the breadth and depth of findings the review could have drawn from. Regarding its limitations, the review was written qualitatively. This was due to the heterogeneity in the included studies' methodologies. As such, quantitative analysis was not possible. To draw more definitive conclusions about the possible predictors of timely disclosure of childhood sexual abuse, it would be necessary to conduct a systematic meta-analysis. However, this would be dependent on further quantitative developments within the research field. In this context, the current review adds to the understanding of the barriers and facilitators that children and adolescents face when disclosing experiences of sexual abuse.

4.4. Implications for research

This systematic review highlights a need for more rigorous empirical research on child and adolescent disclosures of sexual abuse that includes designs and sampling strategies that permits detailed analysis of mechanisms of disclosure. Specifically longitudinal designs that incorporate all know factors may contribute to the evidence-base by obtaining data throughout a child's disclosure journey rather than at a single, retrospective point in time. It

may be helpful to truncate the child and adolescent age range of 0-18 years into smaller age bands to empirically research more age-specific patterns of disclosure. In addition, there is also scope to develop research that investigates the efficacy of interventions aimed at facilitating disclosures in children who would otherwise remain silent.

4.5. Clinical implications

Child sexual victimisation is underreported and under-recorded (Reitsema & Grietens, 2016) and there may not be any clear signs that a child or adolescent has been sexually abused. The detection of sexual abuse often relies on disclosure, which the current review has argued is a complex and multifaceted process. Barriers may impede a child or young person from telling someone about their experiences. Whilst it is important to understand what these barriers are, it is perhaps even more important to understand specific factors that facilitate a child's disclosure. Improving our understanding of what helps children tell can inform how individuals and services support more children to disclose. For example, this review recommends that developmentally appropriate information should be communicated to children via school-based programmes, perhaps as part of the education curriculum. Specifically, these interventions should reinforce that sexual abuse is wrong and that children and young people are neither responsible nor to blame. Reducing potential feelings of guilt and self-blame, which have been identified as significant barriers of disclosure, may encourage children and adolescents to disclose their experiences of sexual abuse.

The current review recognizes the risk for children disclosing intra-familial abuse. Research has demonstrated that abuse of this nature may result in disclosure latency and even non-disclosure in child and adolescent victims. Protocols need to be established that ensure those receiving disclosures know how to respond and react in order to minimize the perceived and actual harm to the child's position within the family. That said the complexity and sensitivity of managing these disclosures warrant further thought and research.

Most importantly, the current review has identified that prompting or asking children directly about their experiences of sexual abuse facilitates disclosure by providing them with permission to tell. There appears to be a need to raise awareness of this with possible recipients of disclosures such as family members, and frontline professionals such as teachers and general practitioners. This is in line with the World Health Organization's (2006) publication: 'Prevention Child Maltreatment: a guide to taking action and generating evidence', which advocates the need for training programmes for (prospective) parents in the prevention of child maltreatment. Interestingly, the guidance argues that training programmes aimed at health care professionals are required only for interventions for adult survivors (aged ≥18 years). To extend on this guidance, the current review recommends that training programmes aimed at potential recipients, including healthcare professionals, should educate individuals about how to identify specific behaviours that may indicate the presence of sexual abuse in children across all developmental stages (and not just in adulthood). Prevention programmes should aim to develop skills in recipients explicitly asking children in ways that are developmentally appropriate. In addition, there is also scope for raising awareness amongst the general population with the use of public awareness campaigns aimed at supporting non-professionals, victims' families, friends and peers to know how to ask.

Along similar lines, prevention strategies and training programmes should also educate individuals about what to do if someone tells. Supportive and helpful responses to a disclosure could go some way in reducing potential feelings of guilt and shame. Given that these have been identified as significant barriers of disclosure, recognizing and minimizing feelings of guilt and shame may support child and adolescent victims to disclose more readily and with more confidence, This is of utmost importance given that timely disclosure is key to safeguarding children against (re)-victimisation whilst also increasing the likelihood of better outcomes for child and adolescent survivors of sexual abuse.

5. References

* Indicates studies included in the current systematic review.

Allnock, D., & Miller, P. (2013). No one noticed, no one heard: a study of disclosures of childhood abuse. NSPCC (2013) Accessed at: https://www.nspcc.org.uk/services-and-resources/research-and-resources/2013/no-one-noticed-no-one-heard/?_t_id=1B2M2Y8AsgTpgAmY7PhCfg%3d%3d&_t_q=no-one-noticed-no-one-heard&_t_tags=language%3aen%2csiteid%3a7f1b9313-bf5e-4415-abf6-aaf87298c667&_t_ip=10.99.66.5&_t_hit.id=Nspcc_Web_Models_Pages_ResearchReportsPage/_991e6e3d-ec71-4591-b012-d835457d8f33_en-GB&_t_hit.pos=1. On 17th May 2017.

Arata, C. M. (1998). To tell or not to tell: Current functioning of child sexual abuse survivors who disclosed their victimization. *Child Maltreatment*, *3*(1), 63-71. doi:10.1177/1077559598003001006

Browne, A., & Finkelhor, D. (1986). Impact of child sexual abuse: A review of the research. *Psychological bulletin*, *99*(1), 66. doi:10.1037/0033-2909.99.1.66

* Crisma, M., Bascelli, E., Paci, D., & Romito, P. (2004). Adolescents who experienced sexual abuse: Fears, needs and impediments to disclosure. *Child abuse & neglect*, *28*(10), 1035-1048. doi:10.1016/j.chiabu.2004.03.015

Centre for Research and Dissemination (CRD) (2009) Systematic Reviews: CRD's guidance for undertaking reviews in health care. Accessed at: https://www.york.ac.uk/media/crd/Systematic_Reviews.pdf on 15th February 2017.

Critical Skills Appraisal Programme (CASP) (2014). Accessed at: http://media.wix.com/ugd/dded87_a02ff2e3445f4952992d5a96ca562576.pdf on 15th February 2017.

Dingwall, R., Murphy, E., Watson, P., Greatbatch, D., & Parker, S. (1998). Catching goldfish: quality in qualitative research. *Journal of Health Services Research & Policy*, *3*(3), 167-172. doi:10.1177/135581969800300308

Edgardh, K., & Ormstad, K. (2000). Prevalence and characteristics of sexual abuse in a national sample of Swedish seventeen-year-old boys and girls. *Acta paediatrica*, *89*(3), 310-319. doi:10.1111/j.1651-2227.2000.tb01333.x

Flåm, A. M., & Haugstvedt, E. (2013). Test balloons? Small signs of big events: A qualitative study on circumstances facilitating adults' awareness of children's first signs of sexual abuse. *Child abuse & neglect*, *37*(9), 633-642. doi:10.1016/j.chiabu.2013.06.007

Galdas, P. M., Cheater, F., & Marshall, P. (2005). Men and health help-seeking behaviour: literature review. *Journal of advanced nursing*, *49*(6), 616-623. doi:10.1111/j.1365-2648.2004.03331.x

Goodman-Brown, T. B., Edelstein, R. S., Goodman, G. S., Jones, D. P., & Gordon, D. S. (2003). Why children tell: A model of children's disclosure of sexual abuse. *Child abuse & neglect*, *27*(5), 525-540. doi:10.1016/S0145-2134(03)00037-1

* Gries, L. T., Goh, D. S., & Cavanaugh, J. (1997). Factors associated with disclosure during child sexual abuse assessment. *Journal of Child Sexual Abuse*, *5*(3), 1-19. doi:10.1300/J070v05n03_01

Hershkowitz, I., Lamb, M. E., & Horowitz, D. (2007). Victimization of children with disabilities. *American Journal of Orthopsychiatry*, *77*(4), 629. doi:10.1037/0002-9432.77.4.629

* Hershkowitz, I., Lanes, O., & Lamb, M. E. (2007). Exploring the disclosure of child sexual abuse with alleged victims and their parents. *Child abuse & neglect*, *31*(2), 111-123. doi:10.1016/j.chiabu.2006.09.004

Jeanfreau, S. G., & Jack Jr, L. (2010). Appraising qualitative research in health education: guidelines for public health educators. *Health promotion practice*, *11*(5), 612-617. doi:10.1177/1524839910363537

* Jensen, T. K., Gulbrandsen, W., Mossige, S., Reichelt, S., & Tjersland, O. A. (2005). Reporting possible sexual abuse: A qualitative study on children's perspectives and the context for disclosure. *Child abuse & neglect*, *29*(12), 1395-1413. doi:10.1016/j.chiabu.2005.07.004

Jones, C., Stalker, K., Franklin, A., Fry, D., Cameron, A., & Taylor, J. (2016). Enablers of help-seeking for deaf children and disabled children following abuse and barriers to protection: a qualitative study. *Child & Family Social Work*. doi: 10.1111/cfs.12293

Jones, L., Bellis, M. A., Wood, S., Hughes, K., McCoy, E., Eckley, L., ... & Officer, A. (2012). Prevalence and risk of violence against children with disabilities: a systematic review and meta-analysis of observational studies. *The Lancet*, *380*(9845), 899-907. doi:10.1016/S0140-6736(12)60692-8

Jonzon, E., & Lindblad, F. (2004). Disclosure, reactions, and social support: Findings from a sample of adult victims of child sexual abuse. *Child maltreatment*, *9*(2), 190-200. doi:10.1177/1077559504264263

* Kellogg, N. D., & Huston, R. L. (1995). Unwanted Sexual Experiences in Adolescents: Patterns of Disclosure. *Clinical Pediatrics*, *34*(6), 306-312. doi:10.1177/000992289503400603

Kellogg, N. D., & Hoffman, T. J. (1997). Child sexual revictimization by multiple perpetrators. *Child Abuse & Neglect*, *21*(10), 953-964. doi:10.1016/S0145-2134(97)00056-2

Knight, R. A., & Hatty, S. (1987). Theoretical and methodological perspectives on domestic violence: Implications for social actions. *Australian Journal of Social Issues,* 22, 452–464.

Kogan, S. M. (2004). Disclosing unwanted sexual experiences: Results from a national sample of adolescent women. *Child abuse & neglect*, *28*(2), 147-165. doi:10.1016/j.chiabu.2003.09.014

Lamb, S., & Edgar-Smith, S. (1994). Aspects of disclosure mediators of outcome of childhood sexual abuse. *Journal of Interpersonal Violence*, *9*(3), 307-326. doi:10.1177/088626094009003002Liberati, A., Altman, D. G., Tetzlaff, J., Mulrow, C., Gøtzsche, P. C., Ioannidis, J. P., ... & Moher, D. (2009). The PRISMA statement for reporting systematic reviews and meta-analyses of studies that evaluate health care interventions: explanation and elaboration. *PLoS Med*, *6*(7), e1000100. doi:10.1371/journal.pmed.1000100

London, K., Bruck, M., Wright, D. B., & Ceci, S. J. (2008). Review of the contemporary literature on how children report sexual abuse to others: Findings, methodological issues, and implications for forensic interviewers. *Memory*, *16*(1), 29–47. https://doi.org/10.1080/09658210701725732

* McElvaney, R., Greene, S., & Hogan, D. (2012). Containing the secret of child sexual abuse. *Journal of interpersonal violence*, *27*(6), 1155-1175. doi:10.1177/0886260511424503

* McElvaney, R., Greene, S., & Hogan, D. (2014). To tell or not to tell? Factors influencing young people's informal disclosures of child sexual abuse. *Journal of interpersonal violence*, *29*(5), 928-947. doi:10.1177/0886260513506281

McElvaney, R. (2015). Disclosure of Child Sexual Abuse: Delays, Non-disclosure and Partial Disclosure. What the Research Tells Us and Implications for Practice. *Child Abuse Review*, *24*(3), 159-169. doi:10.1002/car.2280

McGee H, Garavan R, deBarra M, Byrne J, Conroy R. (2002). The SAVI Report. *Sexual Abuse and Violence in Ireland. A national study of Irish experiences, beliefs and attitudes concerning sexual violence*. Dublin: Liffey Press, 2002.Moher, D., Liberati, A., Tetzlaff, J., Altman, D. G., & Prisma Group. (2009). Preferred reporting items for systematic reviews and meta-analyses: the PRISMA statement. *PLoS med*, *6*(7), e1000097. doi:10.1371/journal.pmed.1000097

* Mont'Ros-Mendoza, T., & Hecht, M. L. (1989). Factors Facilitating the Disclosure of Sexual Abuse by Children and Adolescents. Paper presented at the Speech Communication Association (75th, San Francisco, CA, Nov 18-21, 1989).

Morrison, S. E. (2016). Legal disclosure of childhood sexual abuse: what can professionals tell us? D Clin Psy thesis http://theses.gla.ac.uk/7582/1/2016morrisondclinpsy.pdf on 15th February 2017.

* Münzer, A., Fegert, J. M., Ganser, H. G., Loos, S., Witt, A., & Goldbeck, L. (2016). Please tell! Barriers to disclosing sexual victimization and subsequent social support perceived by children and adolescents. *Journal of interpersonal violence*, *31*(2), 355-377. doi:10.1177/0886260514555371

Olafson, E., & Lederman, J. C. S. (2006). The state of the debate about children's disclosure patterns in child sexual abuse cases. *Juvenile and family court journal*, *57*(1), 27-40. doi:10.1111/j.1755-6988.2006.tb00112.x

Paine, M. L., & Hansen, D. J. (2002). Factors influencing children to self-disclose sexual abuse. *Clinical psychology review*, *22*(2), 271-295. doi:10.1016/S0272-7358(01)00091-5

Palmer, S. E., Brown, R. A., Rae-Grant, N. I., & Loughlin, M. J. (1999). Responding to children's disclosure of familial abuse: What survivors tell us. *Child welfare*, *78*(2), 259. Retrieved from https://search.proquest.com/docview/213803715?accountid=10673 on 17th May, 2017.

Priebe, G., & Svedin, C. G. (2008). Child sexual abuse is largely hidden from the adult society: An epidemiological study of adolescents' disclosures. *Child abuse & neglect*, *32*(12), 1095-1108. doi:10.1016/j.chiabu.2008.04.001

Reitsema, A. M., & Grietens, H. (2016). Is anybody listening? The literature on the dialogical process of child sexual abuse disclosure reviewed. *Trauma, Violence, & Abuse*, *17*(3), 330-340. doi:10.1177/1524838015584368

Roesler, T. A., & Wind, T. W. (1994). Telling the secret: Adult women describe their disclosures of incest. *Journal of interpersonal Violence*, *9*(3), 327-338. doi:10.1177/088626094009003003

Romero, G. J., Wyatt, G. E., Loeb, T. B., Carmona, J. V., & Solis, B. M. (1999). The prevalence and circumstances of child sexual abuse among Latina women. *Hispanic Journal of Behavioral Sciences*, *21*(3), 351-365. doi:10.1177/0739986399213009

* Schaeffer, P., Leventhal, J. M., & Asnes, A. G. (2011). Children's disclosures of sexual abuse: Learning from direct inquiry. *Child abuse & neglect*, *35*(5), 343-352. doi:10.1016/j.chiabu.2011.01.014

* Schönbucher, V., Maier, T., Mohler-Kuo, M., Schnyder, U., & Landolt, M. A. (2012). Disclosure of child sexual abuse by adolescents: A qualitative in-depth study. *Journal of Interpersonal Violence*, *27*(17), 3486-3513. doi:10.1177/0886260512445380

Scottish Intercollegiate Guidelines Network (2008). SIGN 50: A guideline developer's handbook.

* Shalhoub-Kevorkian, N. (2005). Disclosure of child abuse in conflict areas. *Violence Against Women*, *11*(10), 1263-1291. doi:10.1177/1077801205280180

Shenton, A. K. (2004). Strategies for ensuring trustworthiness in qualitative research projects. *Education for information*, *22*(2), 63-75. doi:10.3233/EFI-2004-22201

Smith, D. W., Letourneau, E. J., Saunders, B. E., Kilpatrick, D. G., Resnick, H. S., & Best, C. L. (2000). Delay in disclosure of childhood rape: Results from a national survey. *Child abuse & neglect*, *24*(2), 273-287. doi:10.1016/S0145-2134(99)00130-1

* Søftestad, S., Toverud, R., & Jensen, T. K. (2013). Interactive Regulated Participation: Children's perspectives on child–parent interaction when suspicion of child sexual abuse is raised. *Qualitative Social Work*, *12*(5), 603-619. doi:10.1177/1473325012454913

Stoltenborgh, M., van IJzendoorn, M. H., Euser, E. M., & Bakermans-Kranenburg, M. J. (2011). A global perspective on child sexual abuse: meta-analysis of prevalence around the world. *Child maltreatment*, *16*(2), 79-101. doi:10.1177/1077559511403920

Tang, C. S. K. (2002). Childhood experience of sexual abuse among Hong Kong Chinese college students. *Child abuse & neglect*, *26*(1), 23-37. doi:10.1016/S0145-2134(01)00306-4

Tener, D., & Murphy, S. B. (2015). Adult disclosure of child sexual abuse: A literature review. *Trauma, Violence, & Abuse*, *16*(4), 391-400. doi:10.1177/1524838014537906

Ullman, S. E. (2002). Social reactions to child sexual abuse disclosures: A critical review. *Journal of child sexual abuse*, *12*(1), 89-121. doi:10.1300/J070v12n01_05

World Health Organisation (1999). Report of the consultation on child abuse prevention 29-31 March 1999 WHO, Geneva. Website: accessed at: http://apps.who.int/iris/handle/10665/65900 on 15th February 2017.

World Health Organisation (2002). Child Abuse and Neglect Factsheet. Accessed at: http://www.who.int/violence_injury_prevention/violence/world_report/factsheets/en/childabusefacts.pdf?ua=1 on 15th February 2017.

World Health Organisation (2006). Preventing Child Maltreatment: A guide to taking action and generating evidence. Accessed at: http://apps.who.int/iris/bitstream/10665/43499/1/9241594365_eng.pdf on 21st February 2017.