Electronic Physician (ISSN: 2008-5842) http://www.ephysician.ir
November 2017, Volume: 9, Issue: 11, Pages: 5705-5711, DOI: http://dx.doi.org/10.19082/5705

The comparison of spiritual health and self-esteem in women with and without sexual violence

Hedyeh Riazi[1], Shima Alaei[2], Mohammadali Emamhadi[3], Bashir Nazparvar[4], Fatemeh Salmani[5]

[1] Ph.D. of Reproductive Health, Assistant Professor, Department of Midwifery and Reproductive Health, Faculty of Nursing and Midwifery, Shahid Beheshti University of Medical Sciences, Tehran, Iran
[2] M.Sc. of Midwifery, Department of Midwifery and Reproductive Health, Faculty of Nursing and Midwifery, Shahid Beheshti University of Medical Sciences, Tehran, Iran
[3] M.D., Associate Professor of Forensic Medicine, Department of Forensic Medicine, School of Medical Sciences, Shahid Beheshti University of Medical Sciences, Tehran, Iran
[4] M.D., Assistant Professor of Forensic Medicine, Academic member of Legal Medicine Organization, Tehran, Iran
[5] Ph.D. of Biostatistics, Department of Biostatistics, Faculty of Paramedical Sciences, Shahid Beheshti University of Medical Sciences, Tehran, Iran

Type of article: Original

Abstract

Background and aim: Sexual violence is a serious public health problem which is common around the world. The aim of this study was to evaluate spiritual health and self-esteem in sexual violence victims.

Methods: This cross-sectional study was performed on 66 subjects in the group of sexual violence women and 147 subjects in the group of women with no experience of sexual violence who referred to Tehran Forensic Medical Center and the health centers of Shahid Beheshti University of Medical Sciences respectively, in 2015, in Tehran, Iran. Sexual violence was considered as vaginal or anal penetration. Paloutzian & Ellison spiritual health questionnaire and Rosenberg self-esteem scale were used for data collecting. Data were analyzed using IBM-SPSS version 21. The Kolmogorov Simonov test was used for normality distribution of variables. Descriptive and the Mann-Whitney tests were used to analyze the data. Statistical significance was set to $p<0.05$.

Results: Sexual activity in both groups was started at 20 years old. Most of the abused subjects were single (48.8%), with education level below diploma (55.2%), unemployed (67%) and with an average annual income of 200 million Rials ($7,000). Familiarity with the offender was mostly as friendship (42.4%), and the offence had occurred through deception (37.8%). No significant difference was found between the total mean scores of self-esteem in the two groups (M1: 21.89, M2: 21.02; $p=0.76$) while a significant difference was seen between the mean scores of spiritual health, which indicates a lower level of spiritual health in women with sexual violence (M1: 74.59 (2.03), M2: 86.39 (3.12); $p<0.001$).

Conclusion: The results of the present study highlight the importance of spirituality in sexual violence so policies to promote spiritual health are recommended to protect women.

Keywords: Rape, Sex offenses, Self-esteem, Spirituality

1. Introduction

Violence means behavior with rigor and anger; it refers to offenses with intense physical or sexual aspects (1). Violence against women is a global problem and in the sexual and reproductive health area, it involves any sexual activity without the consent of women, including rape, attempted rape or sexual activity with coercion (2), ranging from fondling to intercourse (3). Violent behavior, regardless of factors such as age, race, ethnicity and nationality, can affect all aspects of individual life (4) and create an abundance of complications from small scratches, chronic

Corresponding author:
Assistant Professor Dr. Hedyeh Riazi, Department of Midwifery and Reproductive Health, Faculty of Nursing and Midwifery, Shahid Beheshti University of Medical Sciences, Postal code: 1996835119, Tehran, Iran.
Tel: +98.2188202512, Fax: +98.88202512, Email: h.riazi@sbmu.ac.ir
Received: September 17, 2016, Accepted: June 30, 2017, Published: November 2017
iThenticate screening: July 01, 2017, English editing: October 16, 2017, Quality control: November 02, 2017
This article has been reviewed / commented by three experts

disabilities and mental shocks to severe traumas and even murder (5). Although sexual violence is often hidden by victims, every year, 12 million people worldwide are exposed to it and in general, 12-25% of girls and 8-10% of boys under 18 suffer from sexual violence (6). There may be many different contributing elements, so, several personal and social factors should be considered in victims of violence. One of the most important factors is self-esteem, which refers to how people see themselves and how comfortable they are in their interactions with other people. (7). The results of studies are not in one direction in this area. It has been shown that women with lower self-esteem have been persecuted more, since they consider themselves passive, dependent, without self-confidence and undervalued and have a bad feeling about themselves and their family and social roles (8, 9). On the other hand, it is shown that women with high self-esteem are always representing themselves and are more prone to experience violence (10). Another factor is spiritual health which is an important aspect of human health and provides an integrated and harmonious relationship among the individual internal forces (11). Spirituality is a kind of self-transcendence, and can be described as an individualized awareness of one's inner self and a sense of conjunction with a powerful dimension (12). Some studies have shown that biological, psychological and social aspects cannot perform properly without spiritual health (13). It seems that spiritual health affects sexual violence. There is a significant relationship between religiosity and preventive behavior of crimes and violence. Thus, decreasing sexual violence requires practical emphasis on human values of prestige, dignity and equality of human beings (14). Most of the studies about violence in Iran are about domestic violence and non-partner sexual violence is not considered. Domestic violence studies in Iran showed that socio-cultural factors such as social life skills, addiction, marriage, friends, beliefs, literacy, employment, ethnicity, location of residency, age of women and history of psychiatric disorders in husbands have an influence on violence against women (15, 16). Iranian women with violence seem to have less mental health when compared to Armenian women (17). However, the question still remains; can spiritual health in women also be a factor in preventing violence against them? On the other hand, subjects such as self-esteem (especially in women) and spiritual health may differ due to the context of each community and there are few available studies in this field. As cultural and religious factors of each community have an important role in this area, this study was conducted to compare spiritual health and self-esteem in women with and without sexual violence.

2. Material and Methods

2.1. Research design and participants

This cross-sectional study was carried out in Tehran Forensic Medical Center and the health centers of Shahid Beheshti University of Medical Sciences in 2015. Inclusion criteria were Iranian women, over 15 years old, literate, not pregnant and not in puerperium. Exclusion criteria were women not filling the questionnaire completely. They were considered sexual violence victims if vaginal or anal penetration had occurred. Women with no experience of sexual violence were those who referred to family planning units of health centers. With considering the effect size as 0.43, a confidence as 95%, a power as 80% and r as 2 (the ratio of sample size in women without sexual violence to victim group), the sample size was calculated as at least 64 participants in the victim group. In the group of women without sexual violence, almost 2 times (at least 128) was considered. It was tried to reach the maximum number of specimens in each group so 66 and 150 women were recruited in the two groups respectively. Three participants in the group of women without sexual violence had incomplete questionnaires and were excluded from the study so 147 participants remained. The final sample size was 66 and 147 in the two groups. Multi-stage sampling was used to select the subjects without sexual violence. The health centers of Shahid Beheshti University of Medical Sciences were divided into three classes (Shemiranat, north Tehran and east Tehran) and three health centers were randomly selected from each class so as to take account of socio-economic differences. The samples were equally divided between the classes so 50 samples were allocated to each class. Women in the victim group were selected from Tehran Forensic Medical Center. The subjects were selected from all these centers through convenient sampling method, and based on the study inclusion criteria.

2.2. Instrument and data collection

Paloutzian & Ellison spiritual health questionnaire and Rosenberg self-esteem scale were used for data gathering. The Paloutzian & Ellison spiritual health questionnaire was developed in 1982 (18) and consists of 20 items. The first 10 items measured religious health, while the next 10 items assessed spiritual health. The responses to these items were based on 6-degree Likert scale including "completely disagree", "disagree", "slightly disagree", "slightly agree", "agree", and "totally agree". In negative questions, scoring was done reversely. The range of total score was 20 to 120 and a higher score demonstrated a higher spiritual health (19). The validity and reliability of this questionnaire were approved in Iran, with a Cronbach's alpha of 0.82 (11) and it is used in other Iranian studies (20, 21). The ICC was measured 0.8 in the present study. The Rosenberg Self-Esteem Scale is a standard widely used

scale developed by Rosenberg in 1986, which includes 10 statements and is based on 4-degree Likert scale from "completely agree" to "completely disagree". Each alternative has a value ranging from zero to three. Thus, it presents a final score of zero to 30, where zero is the best value for self-esteem and 30 the worst one (22). This scale has been used in several studies (23, 24). Rajabi et al. measured the reliability and validity of the Rosenberg Self-Esteem Scale in Iran and reported adequate validity and a Cronbach's alpha of 0.84 (25). The ICC was measured 0.8 in the present study.

2.3. Ethics

The study was approved by the Deputy for Research of Shahid Beheshti University of Medical Sciences, Tehran, Iran and the ethics code was SBMU2.REC.1394.93. The research objectives were explained to all the participants. All of the participants were asked to sign informed consent forms and they were assured of confidentiality of their information.

2.4. Statistical analysis

Data analysis was performed using IBM© SPSS© Statistics version 21 (IBM© Corp., Armonk, NY, USA). The Kolmogorov Simonov test was used for normality distribution of variables. Descriptive and the Mann-Whitney tests were used to analyze the data. The p value less than 0.05 was considered significant in all analyses.

3. Results

Sexual violence victims and women with no experience of sexual violence were significantly different in terms of age ($p<0.001$), number of family members ($p<0.002$), and education level ($p=0.035$). Furthermore, there was a significant difference between these two groups in marital status ($p<0.001$), and occupation ($p<0.001$) (Table 1). Most of the women in the sexual violence group were single (70%) with an education level below diploma (55%), unemployed (67%) and with an average annual income of 200 million Rials. Sexual activity in both groups was started at 20 years old. Familiarity with the offender was mostly as friendship (42%), and the offence had occurred through deception (37%). The number of abuser men in 81% of cases was only one person. Most of the women (95.5%) had experienced sexual violence for the first time. The Mann-Whitney test results showed no statistically significant difference between the total mean scores of self-esteem in the two studied groups of women ($p=0.761$). However, there was a statistically significant difference between the mean scores of spiritual health of the two groups, which indicated lower spiritual health in sexual violence victims ($p<0.001$) (Table 2).

Table 1. Comparison of demographic characteristics in women with and without sexual violence

Variable		With sexual violence	Without sexual violence	p-value
Age (year); Mean (SD)		25.93 (8.09)	29.76 (7.55)	<0.001
Number of family members; Mean (SD)		3.83 (1.68)	3.34 (1.57)	<0.002
Onset age of sexual activity; Mean (SD)		20.56 (7.31)	19.77 (4.60)	0.42
Education level, n (%)	lower diploma	26 (39.4)	42 (28.57)	0.035
	Diploma	19 (28.78)	56 (38.1)	
	Postgraduate	21 (31.82)	49 (33.33)	
Marital status, n (%)	Single	46 (69.7)	33 (22.45)	<0.001
	Married	14 (21.21)	83 (56.47)	
	Divorced	4 (6.06)	21 (14.28)	
	Widow	2 (3.03)	10 (6.8)	
Occupation, n (%)	Housewife	17 (25.76)	62 (42.17)	<0.001
	Employed	49 (74.24)	85 (57.83)	

Table 2. Self-esteem and spiritual health score in women with and without sexual violence

Variable	With sexual violence			Without sexual violence			Mann-Whitney Test
	Mean	SD	CI	Mean	SD	CI	
Self-Esteem score	21.89	4.83	-23.08	21.02	4.77	-21.80	4692.500
			20.70			20.24	p=0.761
Spiritual health score	74.59	12.54	-77.67	86.39	13.64	-88.61	2235.500
			71.50			84.17	p<0.001

4. Discussion

The aim of this study was to compare spiritual health and self-esteem in sexual violence victims as the first study in this area in Iran. According to the findings, no significant difference was found in self-esteem between the women with and without sexual violence, while there was a significant difference between the mean scores of spiritual health, which indicates a lower level of spiritual health in women with sexual violence. The spiritual health in victims was less than in the women without violence experience. Explaining this finding, one can say that failure to adhere to the ethics is one of the important individual factors affecting the incidence of sexual violence. Spirituality leads to moral development. In fact, people's beliefs are supported with moral values and spirituality (26). Spirituality is effective on people's emotional states and mental health (27), and low mental health is shown in women with violence (17). Spirituality is so important that interventions are even used to enhance it for healing the victims of sexual abuse (28). Pezzella et al. did not find any association between religion and general health, but did find an inverse relationship between religion and risky behavior such as substance abuse, and extramarital and unprotected sex (29). Chamratrithirong et al. also showed that there is a positive association between parental spirituality and prevention of adolescent risk behaviors (30) and another study in Iran indicates that religion has a role in preventing risk taking behaviors such as sexual risk taking (31). It seems that spirituality and religious behaviors have a protective role in women from exposure to inappropriate circumstances. Measures to increase spiritual health are harming reduction strategies in this field. So, including spirituality in preventive programs for example in schools, in the level of families or public programs, offers important directions for improving public health. No significant difference was found between the two groups in self-esteem. It may be supposed that women with high self-esteem are so self-reliant that they never think any danger could threaten them. Khosravi et al. showed that women subjected to violence have lower self-esteem than other women (32). Lower self-esteem can lead to lack of value ability, vulnerability, social problems and high-risk behaviors; also, it diminishes the victim's defensive power (33). In Kim's study, adolescents who had experienced sexual abuse showed lower self-esteem (34). These are consistent with other studies (35, 36). Our finding is not in accordance with other studies and it might be due to our limited number of subjects in the victim group. Also, another reason could be due to differences in cultural context, samples, study environment, and differences in the data collection tools. According to the different results, it seems that further research needs to be done in this area.

In this study, the majority of abused women were single, while the non-abused women were married. This is consistent with an Adeleke et al study (37). It seems that nowadays the freedom of single girls and their social encounters have increased compared to the past, feeling of freedom as well as loneliness put them at greater risk. Sometimes, it is believed that in terms of personality, the victims who provide sexual violence context are often single women and widows that observe less moral or social obligation in their personal life (38). It seems that psychological support and providing a support network could be an appropriate alternative for untrusted relationships in these women. Familiarity with the offender in the majority of abused women was as friendship, and the number of offenders was mentioned as one by most of the victims, which were in agreement with the findings of McDowall study that the perpetrator had been a known person in most cases (39). Black et al. showed that uncle and stepfather were guiltier in the crimes among adolescent victims, while former friends or close friends were higher as offenders among the female victims (6). Regarding the rape location, more rapes occurred in the invader's home, and crime had occurred by deceiving. Also, more than 95% of the victims had no history of rape. In the study by Black et al., the invasion process had often happened in public places. Although sexual crimes among teenagers have been more common in the residencies of the offenders which can be due to social and cultural differences. According to the results, the education level in victims was lower than non-victims which were in agreement with the findings of other studies (15, 40, 41). Ali et al. identified that most women in middle and lower socioeconomic groups are exposed to physical, sexual and psychological violence (42). So, the level of education has a positive relation with sexual violence occurrence. Perhaps this can be explained as women with higher education are less faced with sexual harassment, which may be due to their knowledge and more participation in social activities. Higher education levels reinforce a person's ability to make correct decisions. The limitation in the current study was the small sample size in the victim group because of the lack of available samples in this sensitive field. The strength of this study was considering sexual violence from the aspect of issues such as spiritual health and self-esteem for the first time.

5. Conclusions

The most important finding of this study was the higher spirituality in women without sexual violence. Designing and implementing comprehensive intervention strategies that prevent risk factors among women are needed. Policies to empower women in various aspects such as education, employment, decision making and spirituality can lead to

reduced vulnerability to sexual violence. Psychological intervention programs that will further enhance psychological aspects of women such as spirituality or self-esteem through individual or group counseling for empowering individuals in these fields is recommended.

Acknowledgments:
This article is derived from Shima Alaei's MSc thesis in midwifery from Shahid Beheshti University of Medical Sciences, supervised by Dr. Hedyeh Riazi. The authors would like to express their gratitude to all the colleagues who helped conduct the study as well as the Health Deputy, Tehran Forensic Medical Center manager, the Deputy of Research of School of Nursing and Midwifery, Shahid Beheshti University of Medical Sciences for their encouragement and financial support, the colleagues at the community health centers and Forensic Medical Center and all the participants who cooperated in conducting this study.

Conflict of Interest:
There is no conflict of interest to be declared.

Authors' contributions:
All authors contributed to this project and article equally. All authors read and approved the final manuscript.

References:

1) Kulczycki A, Windle S. Honor killings in the Middle East and North Africa A Systematic review of the literature. Violence against women. 2011; 17(11): 1442-64. doi: 10.1177/1077801211434127. PMID: 22312039.
2) Grace KT. Caring for women experiencing reproductive coercion. J Midwifery Womens Health. 2016; 61(1): 112-5. doi: 10.1111/jmwh.12369. PMID: 26762543, PMCID: PMC5579411.
3) Mohammadi E, Lamyian M, Eslami M. Experience of healthcare providers to deal with victims of sexual assault: A Qualitative Research. Journal of Qualitative Research in Health Sciences. 2014; 3(1): 37-50.
4) Emam HM, Jalilvand M, Hadian M. Comparing evaluation of emotional intelligence in women victims of violence with control group. Scientific journal of forensic medicine. 2009; 15(53): 14-20.
5) Amenu D, Hiko D. Sexual assault: Pattern and related complications among cases managed in Jimma university specialized hospital. Ethiop J Health Sci. 2014; 24(1): 1-12. doi: 10.4314/ejhs.v24i1.1. PMID: 24591793, PMCID: PMC3929922.
6) Blake Mde T, Drezett J, Vertamatti MA, Adami F, Valenti VE, Paiva AC, et al. Characteristics of sexual violence against adolescent girls and adult women. BMC Womens Health. 2014; 14: 15: 1-7. doi: 10.1186/1472-6874-14-15. PMID: 24450307, PMCID: PMC3910688.
7) Brown JD. Self-esteem and self-evaluation: Feeling is believing. Psychological perspectives on the self. Psychology Press. 2014; 4: 27-58.
8) Etesamipour R. Comparison of spouse abuse, low self-esteem and sexual disorders in married women in city and village. J Research Health. 2012; 2(2): 191-9.
9) Van Zalk MHW, Van Zalk N. Violent peer influence: The roles of self-esteem and psychopathic traits. Dev Psychopathol. 2015; 27(4pt1): 1077-88. doi: 10.1017/S0954579415000693.
10) Orth U, Robins RW. The development of self-esteem. Curr Dir Psychol Sci. 2014; 23(5): 381-87. doi: 10.1177/0963721414547414.
11) Jahani A, Rejeh N, Heravi-Karimooi M, Hadavi A, Zayeri F, Khatooni A. The relationship between spiritual health and quality of life in patients with coronary artery disease. Islamic Life Center Health. 2013; 1(2): 17-21. doi: 10.5812./ilch.8575.
12) Rohani C, Abedi HA, Omranipour R, Langius-Eklof A. Health-related quality of life and the predictive role of sense of coherence, spirituality and religious coping in a sample of Iranian women with breast cancer: a prospective study with comparative design. Health Qual Life Outcomes. doi: 10.1186/s12955-015-0229-1.
13) Eslami AA, Rabiei L, Khayri F, Rashidi Nooshabadi MR, Masoudi R. Sleep quality and spiritual well-being in hemodialysis patients. Iran Red Crescent Med J. 2014; 16(7): e17155. doi: 10.5812/ircmj.17155. PMID: 25237580, PMCID: PMC4166099.
14) Salas-Wright CP, Vaughn MG, Hodge DR, Perron BE. Religiosity profiles of American youth in relation to substance use, violence, and delinquency. J Youth Adolesc. 2012; 41(12): 1560-75. doi: 10.1007/s10964-012-9761-z.
15) Razaghi N, Ramezani M, Tabatabaei Nejad SM, Parvizy S. Socio-cultural contexts of domestic violence against women: A qualitative study. J Kermanshah Univ Med Sci. 2013; 17(8): 509-19.

16) Nouhjah S, Latifi SM, Haghighi M, Eatesam H, Fatholahifar A, Zaman N, et al. Prevalence of domestic violence and its related factors in women referred to health centers in Khuzestan Province. J Kermanshah Univ Med Sci. 2011; 15(4): 278-86.
17) Navabakhsh M, Khaghani Fard M. Sociological Study of Violence against Married Women from Iran and Armenia. Sociological and Psychological women's studies. 2015; 13(4): 64-91. doi: 10.22051/jwsps.2015.2241.
18) Park CL, Paloutzian R, Park C. Religion and meaning. Handbook of the psychology of religion and spirituality. 1st ed. New York: The Anilford press; 2005: 295-314.
19) Yseminajad P, Golmohammadian M, Yosefi N. Study the relationship of spirituaul health and job involvement in academic staff. Quarterly Journal of Career & Organizational Counseling. 2011; 3(8): 110-25.
20) Seyedrasooly A, Rahmani A, Zamanzadeh V, Aliashrafi Z, Nikanfar AR, Jasemi M. Association between perception of prognosis and spiritual well-being among cancer patients. J Caring Sci. 2014; 3(1): 47-55. doi: 10.5681/jcs.2014.006.
21) Sadat Aghahosseini S, Rahmani A, Abdollahzadeh F, Asvadi Kermani I. The relation between awareness of cancer diagnosis and spiritual health among cancer patients. J Caring Sci. 2012; 1(2): 67-72. doi: 10.5681/jcs.2012.010.
22) Sinclair SJ, Blais MA, Gansler DA, Sandberg E, Bistis K, LoCicero A. Psychometric properties of the Rosenberg Self-Esteem Scale: overall and across demographic groups living within the United States. Eval Health Prof. 2010; 33(1): 56-80. doi: 10.1177/0163278709356187.
23) Poorgholami F, Javadpour S, Saadatmand V, Jahromi MK. Effectiveness of self-care education on the enhancement of the self-esteem of patients undergoing hemodialysis. Glob J Health Sci. 2016; 8(2): 132-6. doi: 10.5539/gjhs.v8n2p132.
24) Saffari M, Pakpour AH, Burri A. Cross-cultural adaptation of the male genital self-image scale in Iranian men. Sex Med. 2016; 4(1): e34-42. doi: 10.1016/j.esxm.2015.12.005.
25) Rajabi Gh, Bohlol N. Measuring reliability and validity of the Rosenberg Self-Esteem Scale between freshman student of Chamran University. Educational and Psychological Research Journal. 2007; 2(8): 33-48.
26) Ghani SA, Abdullah S, Akil SMS, Nordin N. Muslim adolescent moral values and coping strategies among muslim female adolescents involved in premarital sex. Procedia Soc Behav Sci. 2014; 114: 637-43. doi: 10.1016/j.sbspro.2013.12.760.
27) Sharifnia SH, Hojjati H, Nazari R, Qorbani M, Akhoondzade G. The effect of prayer on mental health of hemodialysis patients. Iranian Journal of Critical Care Nursing. 2012; 5(1): 29-34.
28) Draucker CB, Martsolf DS, Roller C, Knapik G, Ross R, Stidham AW. Healing from childhood sexual abuse: a theoretical model. J Child Sex Abus. 2011; 20(4): 435-66. doi: 10.1080/10538712.2011.588188.
29) Pezzella FS, Vlahos S. The moderating influence of religion on the behavioral health of formerly incarcerated men. J Relig Health. 2014; 53(6): 1873-84. doi: 10.1007/s10943-014-9847-x.
30) Chamratrithirong A, Miller BA, Byrnes HF, Rhucharoenpornpanich O, Cupp PK, Rosati MJ, et al. Spirituality within the family and the prevention of health risk behavior among adolescents in Bangkok, Thailand. Soc Sci Med. 2010; 71(10): 1855-63. doi: 10.1016/j.socscimed.2010.08.020.
31) Ameri Z, Mirzakhani F, Nabipour AR, Khanjani N, Sullman MJ. The Relationship Between Religion and Risky Behaviors Among Iranian University Students. J Relig Health. 2016. doi: 10.1007/s10943-016-0337-1.
32) Khosravi R, Raghibi M, Nikmanesh Z. Investigating the relationship of women's being exposed to violence and their psychological traits in Zahedan. Biannual Journal of Applied Counseling. 2012; 2(1): 35-48.
33) Karsli TA, Anli I. Viewpoint to rape and self-esteem in a Turkish late-adolescent population. Procedia Soc Behav Sci. 2011; 30: 501-4. doi: 10.1016/j.sbspro.2011.10.098.
34) Kim BN, Park S, Park MH. The relationship of sexual abuse with self-esteem, depression, and problematic internet use in Korean adolescents. Psychiatry Investig. 2017; 14(3): 372-5. doi: 10.4306/pi.2017.14.3.372. PMID: 28539957, PMCID: PMC5440441.
35) Krahé B, Berger A. Longitudinal pathways of sexual victimization, sexual self-esteem, and depression in women and men. Psychol Trauma. 2017; 9(2): 147-55. doi: 10.1037/tra0000198. PMID: 27669161.
36) Enejoh V, Pharr J, Mavegam BO, Olutola A, Karick H, Ezeanolue EE. Impact of self esteem on risky sexual behaviors among Nigerian adolescents. AIDS Care. 2016; 28(5): 672-6. doi: 10.1080/09540121.2015.1120853. PMID: 26674246.

37) Adeleke NA, Olowookere AS, Hassan MB, Komolafe JO, Asekun-Olarinmoye EO. Sexual assault against women at Osogbo southwestern Nigeria. Niger J Clin Pract. 2012; 15(2): 190-3. doi: 10.4103/1119-3077.97316.
38) Beichner D, Spohn C. Modeling the effects of victim behavior and moral character on prosecutors' charging decisions in sexual assault cases. Violence Vict. 2012; 27(1): 3-24. doi: 10.1891/0886-6708.27.1.3. PMID: 22455181.
39) Macdowall W, Gibson LJ, Tanton C, Mercer CH, Lewis R, Clifton S, et al. Lifetime prevalence, associated factors, and circumstances of non-volitional sex in women and men in Britain: findings from the third National Survey of Sexual Attitudes and Lifestyles (Natsal-3). Lancet. 2013; 382(9907): 1845-55. doi: 10.1016/S0140-6736(13)62300-4. PMID: 24286789, PMCID: PMC3898964.
40) Bekele T, Kaso M, Gebremariam A, Deressa W. Sexual violence and associated factors among female students of Madawalabu University in Ethiopia. Epidemiology. 2015; 5(190): 1-8. doi: 10.4172/2161-1165.1000190.
41) Kharamin SA, Gorji R, Amini K. The prevalence rate of post-traumatic stress disorder (PTSD) in the rape victims of Kohgiloyeh and Boyairahmad province during (2011-2012). SJFM. 2012; 18(2): 99-106.
42) Ali TS, Abbas A, Ather F. Associations of controlling behavior, physical and sexual violence with health symptoms. J Women's Health Care. 2014; 3(202): 1-6. doi: 10.4172/2167-0420.1000202.