





Original Article

Factors affecting disclosure time of sexual abuse in children and adolescents

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Abstract **Background:** The aim of this study is to determine the factors affecting early and delayed disclosure time of child sexual abuse (CSA). Early disclosure of CSA is considered to be crucial for child protection.

Methods: A total of 125 sexually abused children and adolescents, who had been evaluated by child adolescent psychiatry and forensic medicine specialists, were enrolled in this study. Files of medical and criminal data were analyzed retrospectively and synchronously by child adolescent psychiatrist and forensic medicine specialist authors who had evaluated victims using the standard procedures of Düzce University Faculty of Medicine Child Abuse Assessment Council. Univariate and multivariate logistic regression analyses were conducted to evaluate predictors.

Results: Delayed disclosers were found to be younger than early disclosers. Among the delayed disclosers, there were also more victims of intrafamilial CSA, fewer victims of penetration, and fewer voluntary disclosures. Multivariate logistic regression revealed that “younger age” and “intrafamilial CSA” were independent predictors of delayed disclosure of CSA.

Conclusions: The results of our study contribute to an understanding of the factors related to delayed disclosure and underline the need for age-appropriate education and prevention programs targeted to increase the awareness of sexual abuse, particularly intrafamilial abuse, and to promote voluntary disclosure in children and adolescents, especially for younger age groups. The education of potential recipients of CSA and further education of professionals is extremely important in order to support children and adolescents’ voluntary disclosure of CSA.

Key words child sexual abuse, child and adolescent, disclosure time, intrafamilial abuse.

Child sexual abuse (CSA) is defined 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.”¹ A recent meta-analysis of global CSA rates reported a combined prevalence of 11.8% with higher rates for females (18%) than males (7.6%).²

Sexually abused children face a serious dilemma in deciding disclosure. For children, abuse disclosure is considered to be a process, not an event.³ Children and young people often choose not to disclose sexual abuse.⁴ Even among children who eventually disclose, there are delays in disclosure for weeks, months, or even years.⁵ Several adult studies have reported that victims did not disclose CSA until adulthood.^{6,7} It has been claimed that CSA disclosure rates vary between 58% and 72% in adulthood and between 31% and 41% in

childhood.^{8,9} There are few studies focused on the factors related to disclosure time of CSA. These studies have been mostly conducted in adults and reported conflicting results on the relationship between the age of CSA and disclosure time. We have encountered only two studies related to predictors of delayed disclosure in a child and adolescent samples.^{5,9}

It is known that the possible explanations of the reasons why children delay disclosing sexual abuse have important implications for dealing with the issue of CSA from the perspectives of legal and medical professions as well as child protection.¹⁰ There is often a lack of physical evidence of sexual abuse, so the start of intervention depends mostly on children’s disclosure.^{5,11,12} Early disclosure may also reveal physical evidence of sexual abuse, if any. Early disclosure is crucial for ending the abuse, to utilize appropriate medical/psychiatric care, and to prevent perpetrators from further abuse of other children.¹³ Child sexual abuse victims have been reported to be able to avoid abuse incidents by saying that they will tell someone about the abuse.^{14,15}

Disclosure time of CSA and understanding the factors that influence delayed disclosure are therefore important in order

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to structure prevention and intervention programs. In this study, we aimed to investigate the disclosure time of CSA in our child and adolescent samples, and the factors influencing delayed disclosure in order to contribute to the understanding of delayed disclosure.

Methods

Children and adolescents with CSA who were evaluated between January 2015 and December 2017 in Düzce University Faculty of Medicine Child and Adolescent Psychiatry outpatient and Forensic Medicine clinics were included in the study. The sociodemographic characteristics and intellectual capacity of the victims, disclosure time of sexual abuse, and abuse characteristics such as intra or extrafamilial abuse, the presence of physical violence during the abuse, the presence of penetration, medical and forensic data on sexual abuse, were analyzed retrospectively and synchronously by the forensic medicine and child adolescent psychiatry specialists who had evaluated the victim through the standard procedures of Düzce University Faculty of Medicine Child Abuse Assessment Council. The Council primarily consists of forensic science and child and adolescent psychiatry specialists, and children are first evaluated by forensic science specialists to avoid any contamination by psychiatric evaluation. At this stage, forensic science specialists may require consultation with other medical specialists. Psychiatric evaluation is performed after the judicial evaluation. In the last stage, the experts participating in the evaluations create the schedule of appropriate treatment and support for the child. (In Turkey, Child Advocacy Centers have also started to be established in hospitals of the Ministry of Health and their number is increasing. The Child Advocacy Center aims to increase collaborative teamwork among relevant professionals to assess and relieve the trauma of children avoiding secondary traumatization of repeated interviews during the judicial process through a single forensic interview in a special room with mirror.)¹⁶ In our study, the disclosure time was counted from the last day of CSA as defined by Goodman-Brown *et al.*¹⁷ Victims of prior chronic CSA and cases with missing data about any of the examined factors were not included in the study and 125 children and adolescents could be enrolled. Delayed disclosure was defined as a disclosure late than 3 days. This acute period is known to be important for detecting, if any, physical evidence of CSA, starting appropriate medical and psychiatric care for the victim and preventing the assailant from further abuse.^{18,19} Ethical approval was obtained from Düzce University Faculty of Medicine Ethics Committee (No: 2018/43).

Statistical analyses

Descriptive values were computed as means \pm standard deviations (SDs), count and percentage frequencies according to types of variables. The distribution of continuous variables was examined with the Shapiro–Wilk test, and

those with normal distribution were analyzed using the independent samples *t*-test and one-way ANOVA, and those with non-normal distribution were analyzed by non-parametric methods (the Mann–Whitney *U*-test and the Kruskal–Wallis test). The relationships between categorical variables were examined using the Pearson χ^2 test. Also, univariate logistic regression analysis was used to evaluate whether delayed disclosure could be predicted by the significant results. The multivariate logistic regression model was subsequently conducted to further evaluate the strongest predictors. The significance level was accepted as $P < 0.05$ for all statistical analyses. SPSS software (IBM SPSS Statistics for Windows, Version 21, IBM Corp., Armonk, NY) was used to evaluate the data.

Results

Of the 125 cases included in the study, 100 (80%) were female and 25 (20%) were male. The mean age of all cases was 13.43 ± 3.27 years. Demographics and CSA characteristics of the sample are shown in Table 1. It was found that 88.8% of victims were living with family, 68% were from low socioeconomic status backgrounds, 88% had normal IQs, 72.8% were attending formal education. Although we excluded prior chronic CSA victims, 64% of victims had another history of CSA; 64.8% of victims had a psychiatric diagnosis; 16.8% of CSA cases were intrafamilial; 27.2% of CSA were accompanied by physical violence, and penetration occurred in 47.2% of CSA. We categorized the disclosures as voluntary or induced/incidental; 38.4% disclosures were voluntary. The mean value of disclosure time was 97.2 ± 211.8 days (range 1–1,800 days). Fifty-four victims were “early disclosers” (≤ 3 days) and 71 victims were “delayed disclosers” (> 3 days). When the mean ages of children and adolescents in the two different disclosure time groups were compared, the mean age of early disclosers was found to be 15.13 ± 2.30 years, and the mean age of delayed disclosers was found to be 12.14 ± 3.31 years. Delayed disclosers were found to be significantly younger than early disclosers ($P < 0.001$).

Characteristics of the sample and CSA by disclosure time is shown in Table 2. There were more victims of intrafamilial CSA in delayed disclosers compared to the early disclosers ($P < 0.001$). Furthermore, there was more penetration ($P = 0.046$) and voluntary disclosure ($P < 0.001$) in the early disclosers group compared to the delayed disclosers group. However, there was no significant difference between early disclosers and delayed disclosers in terms of gender ($P = 0.928$), living with family ($P = 0.548$), socio-economic status ($P = 0.204$), IQ ($P = 0.168$), formal school attendance ($P = 0.493$), prior sexual abuse ($P = 0.336$), psychiatric diagnosis ($P = 0.703$) or physical violence accompanying CSA ($P = 0.348$); 41 (32.8%) cases had PTSD; 33 (26.4%) cases had attention deficit hyperactivity disorder; 12 (9.6%) cases had major depression; 13 (10.4%) cases had acute stress disorder and 19 (15.2%) cases had adjustment disorder. There was

Table 1 Demographic and CSA characteristics of the sample

	<i>N</i>	%
Gender		
Male	25	20
Female	100	80
Living with family		
No	14	11.2
Yes	111	88.8
Low socio-economic status		
No	40	32.0
Yes	85	68.0
Low IQ		
No	110	88.0
Yes	15	12.0
Formal school attendance		
No	34	27.2
Yes	91	72.8
Prior sexual abuse		
No	45	36.0
Yes	80	64.0
Intrafamilial CSA		
No	104	83.2
Yes	21	16.8
Use of physical violence		
No	91	72.8
Yes	34	27.2
Use of penetration		
No	66	52.8
Yes	59	47.2
Psychiatric diagnosis		
No	44	35.2
Yes	81	64.8
Voluntary or not		
No	77	61.6
Yes	48	38.4

no significant difference between early disclosers and delayed disclosers in terms of psychiatric diagnosis, and there was more than one diagnosis in many of the cases, so we did not include psychiatric diagnosis in further analysis. Thirty-one (57.4%) cases voluntarily disclosed in the early disclosures group, and 17 (23.9%) cases voluntarily disclosed in the delayed disclosures group ($P < 0.001$). Voluntary rates according to age groups are shown in Figure 1. Voluntary disclosure rates clearly decreased in childhood (15.8%) and no victims in preschool-age voluntarily disclosed (0%). Voluntary disclosure rates also tended to decrease in late adolescence (50.0%) and the highest voluntary disclosure rate was detected in early adolescence (57.5%).

When we conducted univariate logistic regression analysis on the significant results, the age of the victim (years) (OR = 0.696; 95% CI: 0.597–0.812; $P < 0.001$), intrafamilial CSA (OR = 20.784; 95% CI: 2.69 – 160.62; $P = 0.001$), penetration (OR = 2.070; 95% CI: 1.008–4.250; $P = 0.046$) and whether disclosure was voluntary (OR = 4.281; 95% CI: 1.989–9.218; $P < 0.001$) were found to be predictors of delayed disclosure (Table 3). In multivariate logistic regression analysis, age of the victim (years) (OR=0.679; 95% CI: 0.562–0.821; $P < 0.001$) and intrafamilial CSA (OR=19.001;

Table 2 Demographic and abuse characteristics by disclosure time of CSA

	Early disclosure		Delayed disclosure		<i>P</i>
	<i>N</i>	%	<i>N</i>	%	
Gender					
Male	11	20.4	14	19.7	0.928
Female	43	79.6	57	80.3	
Living with family					
No	5	9.3	9	12.7	0.548
Yes	49	90.7	62	87.3	
Low socioeconomic status					
No	14	25.9	26	36.6	0.204
Yes	40	74.1	45	63.4	
Low IQ					
No	50	92.6	60	84.5	0.168
Yes	4	7.4	11	15.5	
Formal school attendance					
No	13	24.1	21	29.6	0.493
Yes	41	75.9	50	70.4	
Prior sexual abuse					
No	22	40.7	23	32.4	0.336
Yes	32	59.3	48	67.6	
Intrafamilial CSA					
No	53	98.1	51	71.8	<0.001
Yes	1	1.9	20	28.2	
Use of physical violence					
No	37	68.5	54	76.1	0.348
Yes	17	31.5	17	23.9	
Use of penetration					
No	23	42.6	43	60.6	0.046
Yes	31	57.4	28	39.4	
Psychiatric diagnosis					
No	18	33.3	26	36.6	0.703
Yes	36	66.7	45	63.4	
Voluntary					
No	23	42.6	54	76.1	<0.001
Yes	31	57.4	17	23.9	

All *p* values were generated using the Pearson Chi-square test. Bold values indicate $p < 0.05$.

95% CI: 2.078–173.750; $P = 0.009$) continued to be significant (Table 3).

Discussion

Our study identified several factors related to delayed disclosure, showing that among the delayed disclosers there were younger children and adolescents, more victims of intrafamilial CSA, fewer victims of penetration, and fewer voluntary disclosures. With further analysis, we found that “younger age” and “intrafamilial” CSA were predictors of delayed disclosure in our child and adolescent sample.

In our study, we found that 16.8% of CSA were intrafamilial. In Turkey, the general rate of sexual abuse was reported to be 13.4% and intrafamilial sexual abuse was reported to be 1.8% in a study conducted on 1,955 female high school students.²⁰ The intrafamilial to extrafamilial sexual abuse ratio reported in clinical CSA evaluations was

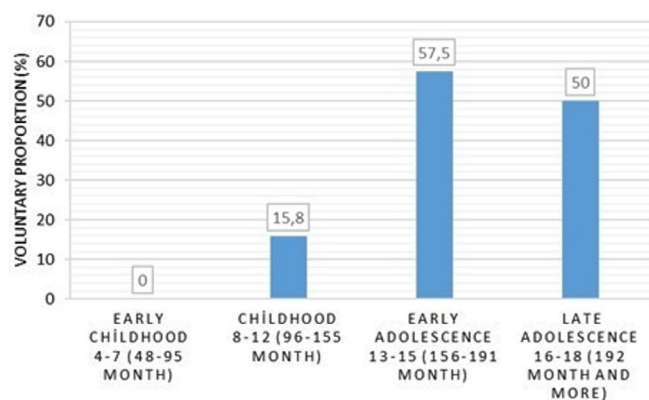


Fig. 1 Voluntary disclosure proportion (%) according to age groups.

highly variable: 9.7%, 14.5%, 15.6%, 23.6%, and 31.1%.^{21–25} Variations may be due to socio-economic differences in the samples.

There are few studies investigating the factors about disclosure time of CSA. These studies have been mostly conducted in adults and have contradictory results on the relationship between the age of CSA and the time to disclosure. Consistent with our findings, some of these studies conducted in adults reported that younger children were more likely to delay CSA disclosure than older children.⁶ Similarly, the importance of cognitive and developmental barriers in children adolescents' disclosure was highlighted in a literature review.²⁶ However, previous studies have also indicated that older children are more likely to delay the disclosure of CSA.^{4,27} Moreover, some of the studies have found no significant relationship between age and disclosure time of CSA.^{8,28}

We have encountered only two studies related to the predictors of delayed disclosure in children and adolescent samples. In one of these two studies,⁹ McElvaney *et al.* investigated the relationship between age of the child at the time of disclosure and delay in disclosure and whether there is a relationship between particular psychosocial factors possible to influence the disclosure (feeling distressed, being believed, fear, contact with the alleged perpetrator, etc...) and age at the time of disclosure. They found that children were more likely to disclose within the developmental period (0–4 years, 5–8 years, 9–12 years, 13–14 years, 15–17 years) when they experienced the abuse than within any other period and no

specific psychological or other factors were predictive of early disclosure.⁹ That study only investigated the association between developmental period and disclosure time as a period and did not distinguish early or delayed disclosure time in days. In our study, we investigated disclosure time in more detail (days).

In the other study with a sample of 218 CSA cases, Goodman-Brown *et al.* emphasized the relationship between age, perceived responsibility for the abuse and perceived negative consequences of disclosure and showed that all of these three variables predicted delayed disclosure.⁵ They stated that older children felt more responsibility for the abuse, and fear of negative consequences of disclosing, and eventually delayed disclosure. The authors also stated that the intrafamilial type of abuse was also associated with delayed disclosure. Although we found contradictory results with respect to the age of the victim, we found similar results concerning the type of CSA. The conflicting result might be related to methodological differences and different characteristics of samples. In fact, it is stated in a review that there might be an inverted U-shaped relationship curve between age (x-axis) and disclosure rates (y-axis), indicating that rates of disclosure decrease in both younger children and older children. In that study, London *et al.* argued that disclosure rate of younger children is low due to lack of awareness of CSA and disclosure rate of older children is also low due to increased awareness of the consequences of disclosure.²⁹ Similarly, we also found that voluntary disclosure rates clearly decreased in childhood and tended to decrease in late adolescence. In our study, no preschool-age victims disclosed voluntarily and the highest voluntary disclosure rate was detected in early adolescence. However, when we analyzed further whether voluntary disclosure predicted early disclosure, we found that early disclosure was not predicted by voluntary disclosure and that the only predictors were younger age and intrafamilial CSA. These results may be interpreted as indicating that children at a younger age tend to delay voluntary disclosure and cases of CSA in younger children may likely to be detected incidentally or by induction. Consistent with this, it was reported in the literature on CSA cases concerning young children that the CSA usually emerged through ways other than the direct report of the victim.^{30,31} This fact has been explained with younger age, memory recalling difficulties, loyalty and dependence on the abuser, requests to keep CSA a secret,³² and disbelief from the informal disclosure recipients.³³ It has been

Table 3 Univariate and multivariate logistic regression analyzes for delayed disclosure

	Univariate			Multivariate		
	OR	95% CI	P	OR	95% CI	P
Age (year)	0.696	0.597–0.812	<0.001	0.679	0.562–0.821	<0.001
Intrafamilial CSA	20.784	2.69–160.62	0.001	19.001	2.078–173.750	0.009
Penetration	2.070	1.008–4.250	0.047	1.469	0.488–4.420	0.494
Voluntary	4.281	1.989–9.218	<0.001	1.936	0.744–5.038	0.176

Bold values indicate $p < 0.05$.

determined that preschool children need more external support and prompting to recall memories.³⁴ Noticeable behavioral changes, such as overly sexualized behavior or symptoms of post-traumatic stress, or a clear reluctance towards meeting someone were indicated to be possible causes for concern.^{35,36} Child pornography and social media use in the abuse of children and adolescents are other important concerns that need careful attention.³⁷ It is known that, pedophilic abusers generally do not use force for actions; rather, they show pornographic pictures, videos etc., try innocent touching and then attempt indecent touching. They have been shown to perform this kind of manipulation and desensitization.^{38,39} In line with these data, Karakaya *et al.* reported that the most frequent behaviors accompanying the abuse have been identified as deception and threat rather than physical force.⁴⁰ As a result, children become confused and Özbaran *et al.* reported that most victims of CSA have ongoing problems related to false beliefs about their experience of sexual abuse and themselves.⁴¹ On the other hand, voluntary rates tended to decrease in late adolescence in our study. As concluded in the literature,^{5,29} this may be explained by older adolescents' reluctance to disclose due to fear of the consequences.

In a recent study, the most common reason for not disclosing a sexual experience (with a person at least 5 years older) was defined as not considering the experience serious enough.¹³ This issue might also be the underlying factor of delayed disclosure in younger children in our study. In this context, studies evaluating child abuse prevention programs reported significant improvement in the awareness levels of abuse in children and adolescents.^{42,43} Thus, improvement in the awareness levels of younger children is important in order to lead to more voluntary disclosures. Consistent with this, educational programs targeting preschool personnel and primary caregivers were defined to be helpful.³⁵ In fact, schools have been identified as ideal environments for child abuse prevention programs as educators are expected to be able to provide information to help children become aware of abuse, teach skills that reduce the risk of child abuse, normalize the disclosure, and shed light on the way to disclose CSA.⁴⁴⁻⁴⁸

Bicanic *et al.* investigated the predictors of delayed disclosure of rape in female adolescents and young adults and found that the combination of the younger age category (12–17 years), penetration, and closeness to assailant contributed significantly to the prediction of delayed disclosure. The authors highlighted that adolescents are more likely to delay disclosure than adults and emphasized the importance of interventions targeted to promote disclosure for younger age groups.¹⁹ In our study, we reached a similar conclusion at this point. Considering the penetration factor, we found in our children and adolescent sample that early disclosures were significantly older and were significantly more affected by penetration, and this penetration was not a predictor of delayed disclosure. However, similar to Bicanic *et al.*,¹⁹ we found that intrafamilial CSA was more likely to be delayed. In literature, delays in disclosure are reported to be longer for intrafamilial abuse^{5,10,49} and the dynamics of intrafamilial sexual abuse are

often suggested as the explanation for delayed disclosure.^{6,19} It is known that decreased awareness of the abuse may be a protective mechanism that helps the child to sustain the attachment with the abusive caregiver.⁵⁰ This issue increases the importance of understanding the clues of psychological distress, questioning, and listening to the child appropriately and supportively. Studies have emphasized the need for children to be asked direct questions to promote their disclosure and questions targeted at the reasons for psychological distress were identified as a promoting factor.^{10,51} It has also been highlighted that children's fears of the negative consequences of disclosure need to be understood and contained by the people in their environment (parents, family members, teachers, peers etc.) to facilitate their disclosure. In this context, increased awareness and education are considered to be key factors to be able to question the children appropriately.¹⁰ Structured education programs targeted at awareness and appropriate approach to CSA for family members, teachers and peers are therefore needed. There is also a need for education programs in a similar context for health professionals. Direct questions and reassurances regarding the children's fears were reported to facilitate disclosures.³⁵ It is known that direct questions generally include “yes/no” questions, “mandatory choice” questions and “wh-word” questions. The National Institute of Child Health and Human Development (NICHD) structured protocol highlights the benefit of maximizing invitations by direct questions that refer to “what happened” and that ask the child to “tell more” about the details previously mentioned.⁵² It was also reported that young children could successfully be encouraged to provide information about CSA, particularly when recall questions were reinforced with “how did you feel?” and “what did you think?” questions,⁵³ which are also “wh-word” questions directly related to the abuse. It was stated that reference to subjective content in questions demonstrated the recipient's interest and thus helped younger children about their difficulties in “reflective awareness of their affective or cognitive internal states.”^{53,54}

Our study has some limitations. First, there was a disequilibrium of gender in our study. However, our sample represents the profile of CSA victims. Second, the data were retrospectively drawn from files. Third, we could not evaluate the psychological factors such as feeling distressed, being believed etc. The complexity of the disclosure process and the multilevel factors influencing the disclosure process are highlighted in previous studies.⁵⁵⁻⁵⁷

Among the strengths of this study is that we conducted our study with children and adolescents. Another strength is that our sample consisted of victims evaluated by a child abuse assessment council. Our study is important to identify the relationship between younger age and delayed disclosure in children and adolescents and also to emphasize the relationship between intrafamilial CSA and delayed disclosure of CSA in children and adolescents.

In conclusion, the results in our study indicate that there is an urgent need for age-appropriate education and prevention programs targeted to increase the awareness of sexual abuse,

particularly intrafamilial abuse, and to promote voluntary disclosure in children and adolescents, especially for younger age groups. In addition, the education of potential recipients and further education of professionals is extremely important in order to support children and adolescents' voluntary disclosure of CSA.

Disclosure

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All the expenses of the study were met by the authors.

Author contributions

N.Y. designed the study, performed clinical evaluations, collected and analyzed the data, wrote the manuscript. A.E., B.B.,Ç.Y.,M.S.Ç. performed clinical evaluations, collected and analyzed the data, critically reviewed the manuscript. All authors read and approved the final manuscript.

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