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Childhood Disclosure of Sexual Abuse and Mental Health Outcomes in Adulthood: Assessing Merits of Early Disclosure and Discussion

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Abstract

Background: Empirical research on the impact of early disclosure of child sexual abuse (CSA) on survivor health is limited and mixed. One recent study found that early disclosure may actually be detrimental for abuse cessation and adult symptomatology (Swingle et al., 2016). The current study re-examined the effects of early disclosure and related variables on long-term mental health for men with histories of CSA.

Objective: The primary aims of this study were to: a) investigate whether early disclosure and response to early disclosure were related to mental distress in adulthood, and b) examine whether having an in-depth discussion and timing of that discussion were related to mental distress in adulthood.

Participants and Setting: Data were collected from a large, non-clinical sample of male survivors ($N=487$), ranging in age from 19 to 84 years, through an online, anonymous survey.

Methods: Hierarchical regression analyses were conducted by entering groups of variables in four steps: control variables, CSA severity, disclosure, and discussion.

Results: Overall, models explained between 24-28% of the variance in mental distress. None of the CSA severity variables reached significance. Both early disclosure ($\beta = -0.126$, $p = 0.003$) and response to first disclosure ($\beta = -0.119$, $p = 0.006$) were significant protective factors in Model 3. In the final model, having an in-depth discussion ($\beta = -0.085$, $p = < 0.036$) and years until discussion ($\beta = 0.102$, $p = 0.029$) were also related to mental distress.

Conclusions: Results support the merits of early disclosure and discussion on long-term mental health. Implications for future research and practice are presented.

Keywords

child sexual abuse; male survivors; disclosure; mental health

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Most secondary prevention programs designed to contain harmful effects of child sexual abuse (CSA) encourage children to report abuse. Many of these programs teach children to tell a trusted adult, to never keep the abuse a secret, and, if necessary, to keep telling until an adult takes protective action (National Sexual Violence Resource Center, 2011). Telling is presumed to advance the dual goals of child safety (i.e., abuse cessation) and psychosocial health and is often a necessary step to advance legal and therapeutic intervention (Paine & Hansen, 2002). Theories of recovery (Chouliara, Karatzias, & Gullone, 2014), healing (Draucker et al., 2011), and meaning-making (Harvey, Orbuch, & Weber, 1990) after traumatic events such as CSA identify disclosure as a critical ingredient for promoting survivor mental health across the life course.

Surprisingly, the empirical knowledge base on the merits of childhood disclosure for survivor mental health in adulthood is under-developed (O'Leary, Coohey, & Easton, 2010; Ruggiero et al., 2004). In terms of timing of disclosure, research is mixed. Some scholars have found that telling earlier is beneficial, as length of time until first disclosure is associated with worse psychological outcomes in adulthood (Easton, 2014; Ruggiero et al., 2004; Ullman, 2007). However, other studies have found that childhood disclosure may exacerbate (O'Leary et al., 2010) or be unrelated (Ullman & Filipas, 2005) to long-term mental health outcomes. Furthermore, most research on disclosure and mental health has involved female survivors (Easton, 2014; Ullman & Filipas, 2005). Due to gender-based differences on rates of silencing and barriers to disclosure (Easton, Saltzman, & Willis, 2014; O'Leary & Barber, 2008), more research is needed to understand the relationship for survivors of both genders.

The impact of childhood disclosure of CSA on abuse cessation and psychological outcomes in adulthood was examined in a recent study by Swingle and colleagues (2016). The study's clinical sample of predominantly female survivors ($N = 301$; 85.4% female) was divided into three groups based on disclosure while the abuse was occurring and abuse cessation: non-disclosure group ($n = 221$), abuse ended following disclosure ($n = 25$), and abuse continued despite disclosure ($n = 55$). Results indicated that participants in the third group (disclosure/abuse continued) scored higher on trauma and depression scales compared to the non-disclosure group; scores for the second group (disclosure/abuse ended) did not differ significantly from the other groups. Researchers concluded that disclosure may actually be detrimental to the well-being of the sexually abused child without abuse cessation and treatment, thereby challenging conventional wisdom that emphasizes early reporting.

Despite its important contribution to the literature, the study by Swingle and colleagues (2016) was limited by use of a clinical sample, high percentage of female, incest victims, and narrow conceptualization of disclosure types and timing. This brief report describes the current study which re-examines the merits of childhood disclosure (and other disclosure variables) for survivor mental health in adulthood among a large, non-clinical sample of men with histories of CSA ($N = 487$). After controlling for demographic background, childhood environment, levels of adult stressors, and CSA severity, this study examined: a) whether early disclosure (i.e., within one year of the sexual abuse) and response to early disclosure were related to mental distress in adulthood; and b) whether having an in-depth discussion and timing of that discussion were related to mental distress in adulthood.

Methods

Data Source

Using a cross-sectional design, this study was based on data collected through purposive sampling from three national organizations that serve men with histories of CSA: the Survivors Network of those Abused by Priests (SNAP), MaleSurvivor, and lin6.org (for more information on data source and recruitment, please see Easton, 2014). Each organization posted a study announcement on sections of their web site open to the general public. The announcement directed potential participants to a survey website with a welcome message, consent letter, and a set of eligibility screening questions. Eligibility criteria included self-identifying as male, being 18 years of age or older, and having been sexually abused in childhood (i.e., prior to 18 years of age). Eligible participants proceeded to complete an anonymous, online survey consisting of nearly 150 items. Recruitment took place during an eight-week period in the summer of 2010.

Human subjects approval was provided by institutional review boards at the University of Iowa (during data collection) and Boston College (during data analysis). Safeguards were included to protect participant safety and privacy (e.g., crisis hotline, therapist locator, community mental health center list). No compensation was provided for participation in the study. The estimated time for survey completion was 30 minutes.

Sample

Table 1 provides demographic background statistics. The sample consisted of 487 men with histories of CSA ranging in age from 19 to 84 years ($M = 50.34$, $SD = 10.83$). For educational level, the mean was 5.33, which equates to a two-year, associate's degree. Most participants self-identified as Caucasian (90.9%). Others reported African-American (1.0%), Native-American (1.0%), Asian (0.4%), Native American/Pacific Islander (0.4%), bi-racial (2.9%) or another race (3.3%). The mean number of recent stressors endorsed by participants was 2.27 ($SD = 2.10$); the mean number of childhood adversities was 1.87 ($SD = 1.76$).

Measures

Mental distress.—Mental health problems were measured using an adapted version of the Internal Mental Distress Scale (IMDS), part of the Global Appraisal of Individual Needs, a reliable and valid health screening instrument (Dennis, White, Titus, & Unsicker, 2008). IMDS is a count of symptoms of internalizing disorders (i.e., depression, anxiety, somatization, suicidality) experienced in the past 12 months. The measure has high internal consistency ($\alpha = 0.88$), generally increases with age, and detects differences in symptom patterns by gender, race, and age (Conrad, Conrad, Dennis, Riley, & Funk, 2009; Dennis et al., 2008). Participants who responded *yes* to any item received a score of 1 (*no* = 0). Endorsed items were summed to create a total score (range = 0 - 25), with higher scores indicating more mental distress. Cronbach's alpha for the index in the current sample was .90.

CSA characteristics.—To measure duration, participants were asked to estimate the length of time that the sexual abuse lasted using a six-point scale ranging from 1 (*one time only*) to 6 (*more than three years*). This variable was treated in all analyses as an ordinal variable, since one-point increases in value on the scale are not equivalent (e.g., the difference between *one time only* (1) and *less than one month* (2) is not equivalent to the difference between *one to three years* (5) and *more than three years* (6)). Penetration was measured with the following item: “Did the sexual abuse involve penetration of you or the abuser? (oral, anal or vaginal)”. Participants were also asked to indicate the total number of people who sexually abused them during childhood.

Disclosure of CSA.—Participants were asked their age when the sexual abuse started and age when they first told someone about the abuse. By subtracting responses to these items, we calculated years until each participant first told. Since we were interested in assessing the merits of early disclosure in childhood around the time of the abuse, we created a new variable titled early disclosure; participants who told within one year of the sexual abuse received a score of 1 (0 = *no*). Additionally, one item assessed response to first disclosure using a 5-point Likert scale ranging from 1 (*very unhelpful*) to 5 (*very helpful*).

Discussion of CSA.—The survey contained the following item: “Beyond telling someone that you were sexually abused, have you ever had an in-depth discussion with someone about the sexual abuse?” A variable titled ever discuss was created; participants who responded *yes* received a score of 1 (0 = *no*). Participants were then asked a follow-up question on timing of discussion: “About how old were you when you first had an in-depth discussion about the sexual abuse?” A new variable-- years until discussed-- was created by subtracting age at the time of the sexual abuse from age at first discussion.

Covariates.—Participants were asked to provide their current age and to select the highest level of completed education from an 8-point scale ranging from 1 (*less than high school diploma*) to 8 (*doctorate/professional degree*). An item assessed race based on six response choices. Due to small cell sizes, a new dichotomous variable was created (racial minority), which combined responses other than white/Caucasian.

Recent stressors were measured with an adapted, 12-item version of the List of Threatening Events Questionnaire (LTEQ; Brugha & Cragg, 1990). Instructions asked: “Have any of the following life events or problems happened to you during the past 12 months?” (e.g., serious illness, divorce, unemployment). Endorsed stressors were summed (range = 0 - 12), with higher scores indicating more recent stressors.

Childhood adversity (other than CSA) was measured using an adapted, eight-item version of the Child and Adult Stressors Index (Statistics Canada, 2002). Participants were asked, “Did any of the following things happen to you while you were under the age of 18?” (e.g., physical abuse, parental substance abuse, extended hospitalization). Responses to each event were summed to produce a total score (range = 0 - 8), with higher scores indicating more adversities.

Data Analysis

Data were cleaned and later imported into SPSS 24.0 for analysis. There was very little missing data for this study (i.e., < 3%). Diagnostic tests conducted prior to inferential testing found that assumptions were met for multivariate statistical analyses. After generating univariate analyses, hierarchical regression analyses (i.e., Ordinary Least Squares; OLS) were sequentially conducted with four models by entering clusters of variables. Model 1 contained demographic variables, childhood environment, and level of stressors in adulthood. In Model 2, CSA severity variables were entered. In Model 3, disclosure variables (i.e., early disclosure and response to early disclosure) were added. Finally, discussion variables (i.e., ever discuss and years until discussion) were entered in Model 4.

Results

Table 1 presents univariate statistics for key study variables. For CSA characteristics, the mean score for duration of sexual abuse was 4.32 ($SD = 1.78$). Slightly more than half of participants (54.8%) reported that the sexual abuse involved penetration. The mean number of abusers was 1.83 ($SD = 1.07$). The length of time until first disclosure ranged from 0 to 63 years with a mean of more than two decades (21.45 years; $SD = 14.70$). Only 8.2% of participants told someone within one year of when the sexual abuse started. The mean score for response to first disclosure was 3.23 ($SD = 1.44$), which corresponds to a “mixed” (i.e., somewhat helpful and unhelpful) reaction. Approximately three-fourths of the sample (75.1%) indicated that they had participated in an in-depth discussion about the sexual abuse at some point in their lives. The length of time from the sexual abuse until this in-depth discussion ranged from 0 to 72 years with a mean of nearly three decades (28.34 years; $SD = 11.25$ years). The mean score for mental distress was 12.51 ($SD = 6.26$), which corresponds to high levels of distress.

Results from OLS regression models are presented in Table 2. The first model reached significance ($F(5, 474) = 31.235, p < 0.001$); entered variables explained 24.0% of the variance in mental distress. The following control variables were significant: age ($\beta = -0.159, p < 0.001$), education level ($\beta = -0.098, p = 0.017$), recent stressors ($\beta = 0.399, p < 0.001$), and childhood adversities ($\beta = 0.108, p = 0.009$).

The second model was also significant ($F(8, 451) = 19.519, p < 0.001$), as 24.4% of variance in the dependent variable was explained. The same four control variables remained significant (i.e., age, education level, recent stressors, and childhood adversities), but none of the CSA severity variables were related to mental distress.

After adding two disclosure variables, the third model explained 25.9% of the variance in the dependent variable ($F(10, 442) = 16.803, p < 0.001$). Three control variables remained significant: age ($\beta = -0.147, p = 0.001$), education level ($\beta = -0.096, p = 0.024$), and recent stressors ($\beta = 0.361, p < 0.001$). Both early disclosure ($\beta = -0.126, p = 0.003$) and response to first disclosure ($\beta = -0.119, p = 0.006$) were negatively related to mental distress.

The final model was also significant ($F(12, 435) = 15.379, p < 0.001$). Variables in this model explained 27.9% of the variance in the dependent variable. Only two control variables

were significant: age ($\beta = -0.212, p < 0.001$) and recent stressors ($\beta = 0.367, p < 0.001$). Both disclosure variables remained significant: early disclosure ($\beta = -0.117, p = 0.006$) and response to first disclosure ($\beta = -0.113, p = 0.008$). Having an in-depth discussion of CSA was negatively related to the dependent variable ($\beta = -0.085, p = 0.036$). Conversely, the length of time until an in-depth discussion of CSA occurred was positively related to mental distress ($\beta = 0.102, p = 0.029$). Each additional year that it took to hold an in-depth discussion was associated with approximately one-tenth of a standard deviation increase in mental distress.

Discussion

The primary aim of the current study was to examine associations between early disclosure of CSA (and other aspects of telling) and mental health in adulthood for survivors. Results indicate that early disclosure (i.e., within one year of the sexual abuse) was a powerful protective factor against mental distress, accounting for approximately a three-unit decrease in symptoms. This finding is consistent with results from some empirical studies based on large, non-clinical samples (Easton, 2014; Ruggiero et al., 2004; Ullman, 2007), but is inconsistent with findings of other studies (e.g., Swingle et al., 2016). The contrasting results may be due to sample differences (i.e., clinical versus non-clinical) or measurement issues. For example, Swingle et al. (2016) used a narrow definition of early disclosure (i.e., as the abuse was occurring), whereas other studies had an expanded notion of early disclosure (e.g., within one month; Ruggiero et al., 2004).

The current study supports conventional wisdom underlying secondary prevention programs, which encourage children to tell someone about the sexual abuse in a timely manner. Admittedly, early disclosure may introduce short-term problems (e.g., family disruption and conflict) or fail to end the abuse (Swingle et al., 2016). It should also be noted that there may be valid reasons for delayed reporting in individual cases (e.g., personal safety). While the decision-making process surrounding disclosure is highly complex (Alaggia, 2004; 2010) and should be respected as much as possible, results from this study suggest that early disclosure is associated with improved long-term mental health for male survivors.

Despite the potentially devastating effects of sexual abuse on the child, a helpful response to disclosure may be a powerful antidote that helps re-establish trust and attachment, promotes self-efficacy and mastery, ensures child safety, and connects the child to additional support resources. Unfortunately, many male survivors of CSA receive an unhelpful response to first disclosure, which discourages subsequent disclosures (Easton et al., 2014). In this study, receiving a helpful response to first disclosure acted as a protective factor for mental health. In an optimal situation for harm reduction, a child tells an adult about the sexual abuse shortly after its onset and receives a constructive response. Public health campaigns for caregivers and training programs for professionals (e.g., teachers, medical providers, counselors) should underscore the importance of responding to children's stories of sexual abuse in a timely, helpful manner.

Beyond telling someone or reporting the sexual abuse, having an in-depth discussion about the traumatic experience was negatively related to mental distress in this study. The finding

is consistent with one of the few prior studies that examined this association (O'Leary et al., 2010). Furthermore, the timing of the in-depth discussion is important; each additional year until the discussion commenced was associated with an increase in mental distress symptoms. These findings suggest that disclosure should be conceptualized as a broader, multi-faceted process (i.e., telling, reporting, discussing) that occurs in different stages across the life span, rather than a one-time event. Theories of recovery often include discussing sexual abuse as a critical step in the healing process (Chouliara et al., 2014; Draucker et al., 2011; Harvey et al., 1990). These discussions may afford survivors opportunities for cognitive processing of the abuse experience, which has been linked to psychosocial adjustment (Simon, Feiring, & McElroy, 2010) and post-traumatic growth (Easton, Coohey, Rhodes, & Moorthy, 2013).

Several limitations of the dataset (e.g., cross-sectional design, selection bias, retrospective self-report) have been discussed elsewhere (please see Easton, 2014). The current study was also limited by its focus on long-term mental health as the primary outcome. Other priorities, such as abuse cessation, childhood safety, family well-being, and short-term mental health, should be examined in future studies and considered when assessing merits of early disclosure of CSA. Additionally, while data were collected from one of the largest non-clinical samples of male survivors to date, generalizability was limited due to non-probability sampling strategies. During recruitment, men were included if they self-reported a history of CSA and sought online survivor support services. As such, participants were not necessarily representative of male survivors in the general population, as indicated by under-representation of men with diverse racial and ethnic backgrounds. Future studies with samples that are representative of the U.S. population are needed. Inclusion of both men and women would allow for replication studies with direct gender comparisons.

Another limitation was that the era in which the abuse occurred may have confounded the relationship between years until in-depth discussion and mental health outcomes in this sample. The level of public awareness of sexual abuse of boys/men, including both social attitudes and knowledge, as well as the availability of recovery resources, has changed dramatically over the past few decades. As such, the experience of sexual abuse disclosure and recovery may be substantially different for someone abused in the 1970s, compared to another person abused in 2000s. Future studies should consider the possibility of cohort effects in assessing relationships between disclosure timing and mental health.

Finally, this study did not examine what constitutes a helpful response to disclosure of CSA. Some possibilities include listening to and believing the survivor's story, promoting safety (i.e., ending the sexual abuse), reporting to authorities (e.g., Child Protective Services, law enforcement), providing emotional support, connecting survivors to clinical resources, and helping survivors with cognitive distortions about self-blame or self-worth (Easton, Leone, Sophis, & Willis, 2015). Through the voices of survivors themselves, future studies should investigate and identify disclosure responses that promote healing.

Despite these limitations, the current study strengthened the knowledge base on outcomes of disclosure of CSA in several ways. Most extant research is based on predominantly or exclusively female samples (Easton, 2014; Ullman & Filipas, 2005); this study expanded our

understanding of sexually abused boys. Recent research has established that CSA can impact mental health across the life course and into late life (Easton & Kong, 2017). This study was one of the first to examine associations between childhood disclosure and long-term mental health for male survivors. Results provide empirical evidence supporting prevention efforts aimed at early disclosure and telling. Although more research is clearly needed, these findings also provide a rationale for expanding options for sexually abused children to engage in discussions and process the traumatic experience.

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Table 1.

Descriptive Statistics for Sample and Key Variables (N=487)

Variable	%	Mean (SD)	Range
Age		50.34 (10.83)	19 - 84
Education Level		5.33 (1.78)	1-8
Racial minority (% yes)	9.1		
Recent Stressors		2.27 (2.05)	0 - 12
Childhood Adversities		1.87 (1.76)	0 - 8
Duration		4.32 (1.78)	1 - 6
One time only	15.1		
Less than one month	2.8		
One month to < 6 mos.	12.3		
6 months to < one year	10.2		
One year to < three years	23.6		
More than three years	36.0		
Penetration (% yes)	54.8		
Number of Abusers		1.83 (1.07)	1-4
Years until Disclosed		21.45 (14.70)	0-63
Early Disclosure (% yes)	8.2		
Response to First Disclosure		3.23 (1.44)	1-5
Very unhelpful	20.5		
Somewhat unhelpful	6.4		
Mixed	29.8		
Somewhat helpful	15.7		
Very helpful	27.5		
Ever Discuss (% yes)	75.1		
Years until Discussed		28.34 (11.25)	0-72
Mental Distress		12.51 (6.26)	0 - 25

Table 2.

Hierarchical Regression Analyses Predicting Mental Distress

	Model 1		Model 2		Model 3		Model 4	
	<i>B</i> (S.E.)	β	<i>B</i> (S.E.)	β	<i>B</i> (S.E.)	β	<i>B</i> (S.E.)	β
Age	-0.091 (0.023)	-0.159 ***	-0.079 (0.024)	-0.140 **	-0.083 (0.024)	-0.147 **	-0.120 (0.027)	-0.212 ***
Education Level	-0.345 (0.144)	-0.098 *	-0.332 (0.148)	-0.095 *	-0.336 (0.148)	-0.096 *	-0.276 (0.148)	-0.079
Minority	-0.736 (0.889)	-0.034	-0.998 (0.917)	-0.046	-1.046 (0.938)	-0.047	-1.229 (0.932)	-0.055
Recent Stressors	1.211 (0.126)	0.399 ***	1.213 (0.135)	0.381 ***	1.150 (0.135)	0.361 ***	1.171 (0.134)	0.367 ***
Childhood Adversities	0.385 (0.146)	0.108 **	0.304 (0.151)	0.086 *	0.288 (0.151)	0.081	0.276 (0.150)	0.078
CSA Duration			0.259 (0.147)	0.074	0.191 (0.148)	0.054	0.191 (0.147)	0.055
CSA Penetration			1.045 (0.533)	0.084	0.863 (0.536)	0.069	0.911 (0.532)	0.073
Number of Abusers			0.289 (0.250)	0.049	0.227 (0.250)	0.039	0.179 (0.250)	0.031
Early Disclosure					-2.824 (0.960)	-0.126 **	-2.605 (0.949)	-0.117 **
Disclosure Response					-0.506 (0.183)	-0.119 **	-0.481 (0.182)	-0.113 ***
Ever Discuss							-1.209 (0.576)	-0.085 *
Years until Discuss							0.056 (0.026)	0.102 *
Constant	15.513 (1.492) ***		12.886 (1.757) ***		15.608 (1.916) ***		16.441 (1.935) ***	
Adjusted R ²	0.240		0.244		0.259		0.279	
Change in Adjusted R ²			0.004		0.015		0.020	

Notes: *B* = unstandardized regression coefficients, S.E. = standard errors, β = standardized coefficients. Significance levels are denoted as:

* $p < 0.050$

**

$p < 0.010$

$p < 0.001$.