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Childhood Sexual Trauma: Impacts and Counselor Competencies

Eman. Tadros[1*], Shawn. Wunderlich[2]

[1] Department of Marriage and Family Therapy, Syracuse University, Syracuse, NY, U.S.
[2] Department of Clinical Counseling, Adler University, Chicago, U.S.

*** Corresponding author email address**: Emantadros@gmail.Com

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A B S T R A C T

Objective: The Rape, Abuse, & Incest National Network (RAINN) reports one in nine girls and one in 53 boys under 18 experience childhood sexual abuse. This review explores literature on childhood sexual abuse in the U.S., focusing on intrafamilial abuse and its impact on mental health, emphasizing the role of counselors.

Methods and Materials: A systematic review of relevant studies on childhood sexual abuse, risk factors, effects, therapy perceptions, and the common factors model was conducted, with a specific focus on intrafamilial abuse.

Findings: Risk factors, such as family dynamics, contribute to intrafamilial abuse, which results in long-lasting psychological effects like PTSD, depression, and anxiety. Survivors' perceptions of therapy vary, but effective treatment often involves strong therapeutic relationships. The common factors model emphasizes empathy and client-centered approaches in therapy.

Conclusion: Intrafamilial abuse requires specialized therapeutic interventions. Further research on the treatment of adult female survivors is necessary to improve therapeutic outcomes.

Keywords: *Child sexual abuse, Intrafamilial childhood sexual abuse, counseling, counselor competencies*

1. Introduction

Every nine minutes Child Protective Services finds evidence for a claim of child sexual abuse (RAINN, 2020). The RAINN (2020) indicates one in nine girls and one in 53 boys under the age of 18 have experienced childhood sexual abuse. Child sexual abuse is any sexual act, contact, or exploitation of a child (Murray et al., 2014). The Center for Disease Control (CDC) provides definitions for various types of sexual actions such as: abusive sexual contact (e.g., penetration and touching with no penetration) and non-contact sexual content (e.g., exposing children to sexual activity, taking sexual photos or videos of a child, sexual harassment, and trafficking) (Murray et al., 2014). These definitions may differ between cultures, making it hard to truly identify a universal term for child sexual abuse as well as a more specific statistic on the occurrence of childhood sexual abuse.

According to Hodges and Myers (2010), 67% of sexual assault victims are juveniles, with 34% of these victims being under age twelve. The same study showed that 15% of victims are younger than six (Hodges & Myers, 2010).

Furthermore, according to the National Center for Victims of Crime (2012), one in five girls and one in 20 boys experience childhood sexual abuse. The statistics on sexual abuse vary given the diverse definitions of child sexual abuse (National Center for Victims of Crime, 2012). Some definitions only include contact, while other definitions include non-contact. These statistics also may be misrepresented due to the abundance of children who do not disclose their abuse.

Perpetrators are typically family members (34%), acquaintances (59%), and strangers (7%) with 93% being known to the victim (RAINN, 2020). Family members are identified as perpetrators in nearly two thirds of child sexual abuse cases, with fathers and stepfathers being identified as the most commonly cited perpetrators in families (Hornor & Zeno, 2018). These rates may differ due to disclosure rates within families.

Tener (2018) interviewed 20 female survivors of IF-CSA and found the family to be the biggest barrier in disclosure, as family members attempt to conceal the abuse by: selecting the potential victim who is more likely to remain silent, perpetrator instilling a sense of power imbalance over the victim, presenting a fragile psychological identity for the perpetrator, offender presenting as two personas, and mothers reframing the incident as "natural". Additionally, results indicated family systems conceal the abuse through forming alliances where the victim is excluded; survivors reported disclosure would disrupt the family system and disrupt the normative family identity (Tener, 2018). The purpose of this paper is to investigate the prevalence and dynamics of CSA, particularly focusing on the complexities of disclosure within familial settings. By examining various definitions of CSA, analyzing data, and exploring the barriers to disclosure faced by survivors, the paper provides a comprehensive understanding of this major issue. Additionally, it highlights the role of family systems in concealing abuse and the need for further research to accurately capture the frequency and nature of IF-CSA.

2. Methodology

This study reviewed the literature of the experiences of women who had been sexually abused by a family member in childhood. The review utilized the EBSCO database that allowed for a variety of journal articles. The review utilized a funneling approach whereas the start of the search focused on childhood sexual abuse as a whole. It then narrowed to intrafamilial childhood sexual abuse to find statistics and supportive statements on the experience of IF-CSA as a whole. Additionally, the search focused on risk factors in families who have experienced IF-CSA as well as the implications and negative outcomes one may experience upon being sexually abused in childhood. Finally, qualitative studies were searched utilized the search "experiences of women" and "intrafamilial childhood sexual abuse" to find studies that focused specifically on how adult female survivors of intrafamilial childhood sexual abuse experienced treatment. Initially, a range of 10 years was utilized for studies, however, a snowball method took effect to find past research beyond 10 years. This was done to see how research has changed and if results had changed over time. There are very limited qualitative studies on the experiences of women who have experienced intrafamilial childhood sexual abuse. Because of this, the time range of 10 years was utilized, with many studies being older than 10 years. Newer research was not readily available specifically focusing on the treatment experiences of women who have experienced IF-CSA. This further solidified the need for a study to be conducted. Furthermore, recent research on IF-CSA was incredibly limited with many older studies being cited to support results of newer research. Many of the newer studies focus on evidence-based treatment and symptom reduction versus exploring the experience and impact of IF-CSA. Because of this, many studies cited throughout this review are beyond 10 years old further indicating the need for newer studies to be conducted on this population's experience.

There were no exclusionary criteria in terms of location of study, however, minimal studies were used that are beyond 10 years old. This literature review took place from 2020-2021 with the majority of the studies being conducted in the United States with few being conducted in other countries.

3. Results

3.1. Incest

In the 1980s child sexual abuse became synonymous with incest, often referring to father-daughter sexual relationships (Hetherington & Nunnally, 2019). Incest is another word for intrafamilial sexual abuse (Brown et al., 2013), and intrafamilial sexual abuse is sexual abuse occurring between relatives (Brown et al., 2013). The word incest is a culturally relative term wherein the attitudes towards it differ internationally and culturally. The legality of incest differs internationally and within countries. In the United States

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laws regarding incest differ between states (Sharaby, 2019). For example, in Rhode Island there is no law regarding incest but in the Penal Code of Ohio incest only references parental figures. Furthermore, in New Jersey punishment would not occur if both individuals are older than eighteen and the act was consensual (Sharaby, 2019). Internationally, in Israel and Turkey there is no punishment for incest, however, in Hong Kong the punishment is imprisonment (Sharaby, 2019).While the term is not universal, the impact of the experience has the potential to be similar.

The most frequently cited form of intrafamilial sexual abuse is father-daughter abuse, although sibling sexual abuse has been estimated to occur three to five times more frequently making it the most prevalent type of IF-CSA (Thompson, 2009). Data was taken from the National Incident-Based Reporting System data from 2000-2007. Results found that sibling sexual abuse can be hard to identify due to the many definitions of siblings. Additionally, many definitions have left out same-sex experiences and instead focus on older brother-younger sister type (Yates & Allardyce, 2021). Further, sibling sexual abuse is often unrecognized and underreported as many victims do not disclose their abuse to others out of fear of retaliation.

The least cited form of intrafamilial sexual abuse is female to child. Female perpetrators occur in less than 3% of child sexual abuse cases. In cases of mother-son sexual abuse, the abuse is subtle and harder to distinguish between normal care and sexual touch (Cortoni et al., 2010). Mother-daughter sexual abuse is less known and rare (Greydanus & Merrick, 2017), though research further evaluate these assertions.

Father-daughter IF-CSA is the most cited type in literature. Atwood (2007) explored incest behavior as reported by young females in an online chat room in the United States (Atwood, 2007).

The sample consisted of 2,207 females who were survivors of IF-CSA, with 38% who experienced father-daughter sexual abuse, and 73.4% of them identified the abuse beginning under age 10. Additionally, 11% identified being survivors of stepfather-stepdaughter sexual abuse. Kristensen and Lau (2011) investigated sexual function in survivors of intrafamilial childhood sexual abuse in Denmark. The sample consisted of 158 females who had been sexually abused by a family member in childhood (Kristensen & Lau, 2011). They found the most common perpetrator for intrafamilial child sexual abuse was by the biological father with stepfather perpetrators being the second most cited in this study. Father-daughter sexual abuse may be perpetuated due to the power imbalances between father and child. In households where dysfunction is prevalent, specifically domestic violence, the power imbalance may appear to be exponential, compared to households that are not dysfunctional or where domestic violence does not occur. Clinicians should assess for power imbalances within client households, ensuring cultural implications are taken into consideration. Given the high rate of IF-CSA between father figures and daughters, clinicians must assess the family structure and ask about relationships between family members in the household (Greydanus & Merrick, 2017). Further research should be done on the family system within sexual abuse survivors to further evaluate risk factors for sexual abuse.

Sibling sexual abuse is another common form of sexual abuse (Falcao et al., 2014). A study on child-to-child sexual abuse found that 51% of cases were sibling incest (Shaw et al., 2000). Sibling sexual abuse is any sexual contact by one sibling to another (Falcao et al., 2014). This type of sexual abuse is not limited to intercourse and instead includes unwanted sexual advances, sexual leers, and forcing siblings to view porn (Kiselica & Morrill-Richards, 2007). Sibling sexual abuse includes a power differential, with highly intrusive sexual parties (Falcao et al., 2014), and is also more violent in nature (Kiselica & Morrill-Richards, 2007). Sibling sexual abuse occurs more frequently and over longer periods of time when compared to other forms of sexual abuse (Ballantine, 2012). Sibling incest effects are exacerbated by duration of abuse, extent to which coercion is used, perceptions of victims regarding complicity in the behaviors, and extent to which family provide support for victims upon disclosure (Ballantine, 2012). Brother-sister sibling sexual abuse is often ignored by research (Greydanus & Merrick, 2017) and little research has been done on the effects of brother-brother incest (Beard et al., 2013). Research on this population is limited, indicating the need for further studies on IF-CSA.

Female perpetrators are less common and less frequently studied. Sexual abuse by mothers against their daughters include inappropriate sexual touch, unnecessarily watching the daughter bathe or dress, encouraging the daughter to inappropriately sexually touch the mother, or allowing the daughter to be sexually abused by others while the mother participates or watches. Hatchard et al. (2017) found in the United States, that 2.4% of participants reported being victims of child sexual abuse with only male perpetrators identified. Results also indicated that participants felt

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sexually abusive behaviors committed by the mother against their children were less damaging than being committed by the father, and that mother-daughter sexual abuse was also perceived to be the least criminal compared to mother-son, father-son, and father-daughter sexual abuse (Hatchard et al., 2017). More research should be done on female perpetrators of intrafamilial child sexual abuse and the implications to survivors.

3.2. Risk Factors

Studies have identified risk factors associated with of intrafamilial sexual abuse. One study compared types of intrafamilial abuse (e.g. brother-sister; father-daughter; step-father-step-daughter) and found 72.2% of brother-sister sexual abuse cases and 50% of father-daughter sexual abuse cases involved living with families with married parents (Cyr et al., 2002), indicating the need for additional research in this area. The same study found all families were in poor living conditions that were near or below the poverty line. Additionally, two-thirds of the parents completed high school in all groups except for fathers in brother-sister intrafamilial sexual abuse cases (52.9%) and mothers of stepfather intrafamilial sexual abuse (50%). Alcohol abuse was significantly higher in brother-sister incest (47.4%) family groups versus father (28.6%) and stepfather (4.8%) incest family groups (Cyr et al., 2002).

In sibling-incest relationships, many siblings begin with normative exploration and eventually progress to abuse with one sibling exerting power over the other (Ballantine, 2012). Sibling incest cannot be seen as an isolated problem, as incest generally stems from homes with dysfunction (Thompson, 2009). Common characteristics in families of sibling incest include: high levels of personal, social, and economic stress, substance use, exaggeration of patriarchal norms, and parenting skills consumed with high levels of frustration with harsh child rearing styles (Thompson, 2009). Further, co-sleeping/co-bathing with siblings, diminished maternal affection, and encouragement of nudity has been founded to be linked to sibling sexual abuse (Griffee et al., 2016). Additionally, when a family structure supports power imbalance, rigid gender roles, treatment of siblings differentiated from one another, and lack of parental supervision, sibling incest risk increases (Morrill, 2014).

In father-daughter sexual abuse cases, there was a high level of tolerance for father-daughter nudity (Beard et al., 2017). Incest was higher with parental verbal or physical fighting, single-mother households, or where the divorce/death of fathers resulted in a man other than the biological father in the home (Stroebel et al., 2012; Stroebel et al., 2013). Additionally, low maternal affection has been shown to be a risk factor for father-daughter incest (Stroebel et al., 2012). Beard et al. (2017) found mothers were not as affectionate to father-daughter victims compared to control groups. Additionally, a poor marital relationship between a female child's parents increased the risk the child would become a victim (Beard et al., 2017).

Further studies have found other factors influencing the risk of intrafamilial sexual abuse such as parental attitudes and responses, issues of betrayal, feelings of stigma and shame, and distorted belief systems (Ballantine, 2012). Additionally, if the parents come from a family where child sexual abuse was prevalent, the cycle may be repeated. Further research should be done on intergenerational child sexual abuse factors and stereotypes within the family to further understand how the cycle perpetuates. Furthermore, families characterized by chaos, who are emotionally volatile, and physically and emotionally violent, increase the risk of intrafamilial sexual abuse (Ballantine, 2012). This may be due to the power differential between family members. Additional research should be done on perceived power differentials between physically or emotionally violent family members versus those who are not violent to determine a connection with perpetuated sexual abuse.

3.3. Long Term Effects of Childhood Sexual Abuse

Lack of proper support and coping strategies to victims of CSA can increase risks of mental health symptomologies such as depression, substance use disorders, eating disorders, post-traumatic stress disorder, and anxiety (Hetherington & Nunnally, 2019; Nasim & Nada, 2013). They may also be prone to maladaptive behaviors such as: self-harm, suicidal ideation, inappropriate sexual activity, and emotion dysregulation (Ross & O'Carroll, 2004). Furthermore, their interpersonal relationships may suffer causing an increased rate of divorce and problems securing a healthy relationship in adulthood (Nielsen et al., 2017). Studies on adult survivors of CSA also suggest they may suffer from physical health diagnoses like obesity, ischemic heart disease, liver disease, lung disease, cancer or unwanted pregnancies (Hetherington & Nunnally, 2019; Ross & O'Carroll, 2004). Furthermore, Murray et al. (2014) agreed that survivors are at an increased risk for emotional concerns such as anger, guilt, shame, and family/marriage issues (Murray et al., 2008).

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3.4. Mental Health Disorders

Individuals who have a history of childhood sexual abuse are ten times more likely to be diagnosed with mental health disorders compared to non-childhood sexual abuse survivors (Sigurdardottir et al., 2012). Survivors of childhood sexual abuse may experience issues with body image. The body may be seen as the cause of the abuse they experienced, leading to feelings of vulnerability, shame, or betrayal (Kearney-Cooke & Striegel-Moore, 1993). The victim may feel their physical appearance played a role in their abuse, which can result in shame and guilt, overeating as a means to deter revictimization, intense feelings to lose weight to change their body, develop bulimia to purify their body as a means to be perfect (Kearney-Cooke & Striegel-Moore, 1993). Wonderlich et al. (2020) compared and contrasted the binge-purge behaviors of 20 sexually abused girls with 20 non-sexually abused girls between the age of 10 and 15 in the United States (Wonderlich et al., 2020). Participants who had been sexually abused had higher rates of body dissatisfaction, reported more dieting and purging behaviors, and ate significantly less when emotionally upset (Brewerton, 2007). Furthermore, in-depth reviews of risk factor literature suggests that studies have supported a correlation between childhood sexual abuse and eating disorders (Rahm et al., 2013). Eating disorders may be a way for the survivor to gain back control and minimize internal feelings of shame, however, survivors of child sexual abuse may also exhibit other disorders for this reason.

Childhood sexual abuse survivors may also experience drug and alcohol addiction as a way to gain back control and minimize internal feelings of shame. Survivors of CSA are more likely to misuse drugs and alcohol to cope with their anxiety (Cleary & Hungerford, 2015). Survivors may turn to alcohol (Fletcher, 2021) and other illicit substance dependence as a way to numb internal shame. Additionally, substances can provide increased levels in the brain resulting in moments of happiness and an ability to forget the abuse. Several studies indicate that those with addictions also have co-occurring post-traumatic stress disorder, specifically with individuals who experience childhood sexual abuse.

Those with a history of childhood sexual abuse are at risk for developing post-traumatic stress disorder (PTSD). Additionally, survivors are at risk for developing disturbances involving emotion regulation, interpersonal relationships, and self-concept which are considered criteria of complex PTSD (Wagenmans et al., 2018). Furthermore, participants with PTSD were significantly more likely to report the use of dysfunctional coping strategies (Coyle et al., 2014), due to a high level of stress, resulting in an adverse impact on brain development (Becker, 2015). There may be damage to the right hemisphere in the brain which plays a role in mediating emotional processing and regulating affective states (Becker, 2015). The neurological changes in the brain can also cause other diagnoses like anxiety and depression (Broadduss-Shea et al., 2018). This may also be a reason why survivors turn to substance use in that the ability to regulate their stress and impulsivity is hindered when experiencing a trauma.

Depression is another common symptom for survivors of childhood sexual abuse. Although depression can be a short-term effect (Fergusson et al., 2013) for some, symptoms remain long term. Further, Molnar et al. (2001) found women in the United States suffering from sexual abuse in childhood had an increased risk of developing depression at 1.8 times higher than those without sexual abuse (Molnar et al., 2001). This may be due to the internalization of the sexual abuse and related to feelings of shame and disgust (Aponte & Patrick, 2017). If the survivor experiences internalized feelings of shame and disgust, they may begin to isolate, have negative thoughts, and in return, may not take care of themselves which may further perpetuate depression.

Adults with childhood sexual abuse are also prone to an increased risk for anxiety disorders (Maniglio, 2013). Foster and Hagedron (2014) found that children feared they would be viewed as responsible for the abuse and felt they would be punished (Foster & Hagedorn, 2014). Fear of seeing the abuser again may contribute to long-term anxiety, which can be exacerbated around the holidays. Additionally, they may continue to be triggered every time they see the family member or hear their name. Further research could be done on understanding survivors experiences of seeing family members after the abuse and at periods of time after disclosure. This may give clinicians a better understanding on how to best support survivors within the family system and throughout events in which triggering family members may be present. Further research can be conducted to support survivors and their family members specifically on risks surrounding restoration of the family unit upon disclosure. Survivors may choose to cut contact with their families upon disclosing the abuse, especially if the disclosure was met with resistance. Further research can provide understanding of the needs of survivors when choosing to cut contact as well as the process of doing so. Opposite of this, would be if the survivor chooses to stay in contact with the family and

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the abuser. Studies should be conducted on this process, the needs of the survivor and family, and the risks associated with staying in contact so that further treatment interventions and education can be created to assist them.

3.5. Shame

Herman (2007) identifies shame as a relational experience as well as a complex form of mental representation. In talking about shame, Herman states that it is an acutely self-conscious state where the individual imagines the self in the eyes of another. It holds a desire to hide or escape. In extreme forms, shame is a reaction to being treated in a degrading manner such as feelings of humiliation, self-loathing, or disgrace. Furthermore, relationships of dominance and subordination are shameful. Herman goes on to state that when "methods of coercive control are used within primary attachment relationships, as occurs in the case of child abuse, the developing child learns nothing of ordinary social shame" (Herman, 2012).

As referenced above throughout, shame is a common experience of those who have been sexually abused as children. Stroebel et al. (2012) utilized 1,521 adult women in their study in the United States which focused on father-daughter incest experiences. Results from this study found that participants experienced shame after hearing they engaged in sexual activity with their fathers in childhood which further caused them to feel damaged (Stroebel et al., 2012). This shame interfered with their enjoyment of sex with their partners in adulthood. When becoming adults with partners, they often did not discuss their childhood experiences as many learned to keep silent about what they were feeling which did not allow them to feel as though they could communicate to their partners during sex as adults.

McElvaney et al. (2022) in Ireland and Canada examined transcripts of 47 young individuals aged 15-25 whom experienced childhood sexual abuse. Of these participants, 23 experienced intrafamilial childhood sexual abuse, with an additional two who had experienced both intrafamilial and extrafamilial childhood sexual abuse (McElvaney et al., 2022). Results of this study identified three major themes: languaging implicit shame, avoiding shame, and reducing shame. Implicit shame was seen in why participants did not want to disclose their abuse as they felt it changed the way others viewed them. One participant noted an increased negative evaluation of self which was also seen in how others viewed her. Regarding avoiding shame, participants often hinted at abuse but did not often name the experience. This was seen as a means to protect oneself from experiencing shame. Participants noted feeling uncomfortable talking about it and worrying about others feeling uncomfortable when it was discussed. Finally, regarding reducing shame, participants found having opportunities to express their needs and emotions as well as receiving support and connection with others helped them to not feel as alone.

3.6. Maladaptive Behaviors

Adult survivors of childhood sexual abuse often engage in self-harm behavior (Crow & Bunclark, 2000). An experience of childhood sexual abuse is the strongest determinant of whether or not one will self-harm (Van der Kolk et al., 1991). Survivors who engage in self-harm may also tend to have an increase in body dissatisfaction, eating disorders, and suicidal ideation (Murray et al., 2008). Shame and guilt from childhood sexual abuse can contribute to suicidal urges (Kealy et al., 2017). Shame reflects experiences of having been devalued, giving the individual a sense of disgust towards self, and feelings of badness (Kealy et al., 2017). Results from one study indicated that self-conscious emotions were associated with a frequency of suicidal ideations in women with a history of child sexual abuse (Kealy et al., 2017).

Sexual trauma in children often affects a child's physical development, causing earlier maturation and inappropriate experiences with sexuality (Underwood et al., 2007). Survivors may also exhibit interpersonal issues causing sexually based anxiety (Sigurdardottir et al., 2012). Studies show that childhood sexual abuse is associated with earlier pubertal onset and earlier sexual activity (Hotte & Rafman, 1992). In fact, female childhood sexual abuse survivors experienced menarche earlier than those who were not survivors of CSA (Boynton-Jarrett et al., 2014; Wise et al., 2009). Boynton-Jarrett et al. (2014) utilized a sample of 68,505 participants that were enrolled in the Nurses' Health Study II to study the association between childhood physical abuse and sexual abuse on early menarche. Over 57% of the women in this cohort reported a history of either physical or sexual abuse with 8% experiencing sexual abuse only, 36% experiencing physical abuse only, and 13% experiencing both physical and sexual abuse sometime in childhood in the United States. Results indicated that participants who experienced unwanted sexual touch were at a 20% increased risk for early menarche while those who experienced forced sexual activity saw a 49% increased risk for early menarche

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(Boynton-Jarrett et al., 2014). While there is a clear correlation between sexual abuse in childhood and early menarche, researchers cannot assess for causality.

Wise et al. (2009) conducted a multivariable log-binomial regression on data from 35,330 participants in the Black Women's Health Study in the United States. This study was conducted to estimate risk ratios for the relation of childhood physical and sexual abuse with early age at menarche. The results of this study also found sexual abuse was positively correlated with early menarche with a risk of early menarche being linked to frequency of sexual abuse incidents (Wise et al., 2009). This study aligns with earlier studies conducted that found an association between sexual abuse in childhood and early menarche.

Earlier sexual activity also increases the likelihood of teenage pregnancy (Underwood et al., 2007). Due to a lowered sense of attractiveness and self-evaluation, survivors may be more likely to engage earlier in these behaviors than those without a trauma history. On the other hand, a survivor may experience negative self-schemas that include beliefs related to sexuality which could cause lower sexual responsiveness (Colangelo & Keefe-Cooperman, 2012). Sexual encounters may trigger memories of abuse causing survivors to withdrawal sexually from their partners leading to further interpersonal relationship issues (Sigurdardottir & Halldorsdottir, 2013). These statements are conflicting, which shows the complexity and the individuality of the way each of the survivors respond to the abuse. This is important for practitioners to understand how to begin assessing for these issues during treatment.

3.7. Interpersonal Hindrances

Relationships can be extremely difficult for survivors of CSA. These individuals may experience interpersonal issues including higher rates of divorce, and feelings of low self-worth which may hinder maintaining monogamy or staying in a healthy relationship (Sigurdardottir et al., 2012). Research identifies attachment relationships between parent/caregiver and child, as well as adult romantic partners, as critical components in relationship maintenance (Walker et al., 2009). Having a history of sexual abuse is correlated to more negative perceptions of intimate relationships, self, and negative emotional experiences within relationships (Nielsen et al., 2017). Further, marital quality has been predicted by four factors: childhood and family of origin facts, adult individual characteristics, social contexts, and couple interactional processes like positive communication; however, when individuals have a history of CSA, each of these factors can be impacted resulting in a lower marital quality (Walker et al., 2009).

When studying conflict resolution styles of individuals who have experienced IF-CSA, researchers found females in heterosexual relationships may experience distorted expectations of future relationships (Knapp et al., 2016). These individuals also have a heightened loss of trust in others causing additional issues in committed relationships. Further, conflict resolution styles in IF-CSA heterosexual couples compared to non-IF-CSA heterosexual couples were negatively correlated to relationship satisfaction and stability, with hostility being the only difference in conflict resolution style (Knapp et al., 2016). Therefore, females who have experienced IF-CSA may be more likely to have a hostile or volatile conflict resolution style, further showing relationship issues that occur from this experience. Additionally, this study focused on couples who were in the early years of their relationship (e.g., 4.5-4.9 years) and identified the relationship as stable. Thus, suggesting the need for research that accounts for relationships of other sexual orientations, and couples with high distress, to further assess the symptomology and impacts of IF-CSA.

Further, the repetitive nature experienced by CSA survivors disrupts the mental development necessary for healthy emotion regulation and relationship formation (Wagenmans et al., 2018). Survivors experience an inability to trust others which will continue to affect the quality of intimate relationships in adulthood (Colangelo & Keefe-Cooperman, 2012). Women, specifically, expressed a lack of trust and chronic fear of rejection (Nielsen et al., 2017) and have a sense of isolation in relationships (Jones-Smith, 2018). If the victim has a supportive parental involvement following disclosure of the abuse the, effect of CSA on relationships later in life can be decreased (Godbout et al., 2014).

3.8. Intrafamilial Childhood Sexual Abuse Effects

Adult survivors of intrafamilial childhood sexual abuse may experience additional mental and physical health issues that differ from childhood sexual abuse survivors. Intrafamilial childhood sexual abuse accounts for many social, emotional, and cognitive issues like mood and anxiety disorders, dietary changes, hyperactivity, attention deficit disorder, and post-traumatic stress disorder (Gonzalez, 2017). The individual's response to the abuse is often related to "severity, availability of social support, and

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attributional styles regarding cause of negative life events" (Ross & O'Carroll, 2004). Further, survivors experience mental health issues differently depending on the type of intrafamilial sexual abuse they experience.

Father-daughter sexual abuse survivors are more likely to endorse psychological injury and have a listener react with horror when they disclose to another (Beard et al., 2017). This may lead the survivor to refrain from disclosure further increasing isolation and shame and refrain from seeking treatment. Additionally, a study comparing victims of childhood sexual abuse with a control group found victims of father-daughter sexual abuse had significantly higher reports of being distant, estranged, or angry at one or both parents, having nightmares, and having experienced psychological treatment (Stroebel et al., 2012). This study, conducted by Stroebel et al (2012) in the United States, was among the first study on father-daughter incest that utilized an anonymous self-administered survey that allowed the victims and other participants to enter their own data. It had a sample size of 1,521 adult women with 19 having been sexually abused by their father, 241 being sexually abused by someone other than their father, and the remaining 1,261 served as a control group. The age at which father-daughter incest began ranged from age five to a median age of eight (Stroebel et al., 2012). Results indicated that 84% of the victims of father-daughter incest felt distant from both parents or distant from father and close to mother in high school. Results of this study correlate to a qualitative study done in the United States by Eisikovits (2017) at al. Participants in this study consisted of twenty Jewish Israeli women who were interviewed between 2008 and 2009. Results found that five of the twenty participants were completely disconnected from their entire family of origin. Four of the women from this study only saw the perpetrator at family events to which they report increased stress and emotional pain. Additionally, twelve of the participants had complete physical disconnection from the perpetrator. The results of this study highlight family dynamics of intrafamilial childhood sexual abuse and how the survivor responds interpersonally with the family upon disclosure and beyond (Eisikovits et al., 2016).

Many survivors of intrafamilial childhood sexual abuse experience difficulty with sex and sexual functioning with many sexually abused children feeling betrayed by the body. This can lead survivors to engage in sexual activity with those who are abusing them and/or others (Vera-Gray, 2023). When studying sexual satisfaction, sexual partner intimacy, and depression scores, survivors of father-daughter sexual abuse had significantly higher scores indicating a higher dysfunction (Stroebel et al., 2012). However, in brother-sister sexual abuse, females experience feeling like "damaged goods" which causes further psychological harm (Beard et al., 2013). Additionally, sibling sexual abuse survivors are found to manifest PTSD, severe depression, suicidal ideation, dysthymia, anxiety, dissociation disorders, eating disorders, compulsions, flashbacks, distorted beliefs, and memory problems (Ballantine, 2012).

4. Discussion

4.1. Clinical and Policy Implications

Counselors are likely to encounter clients with a history of childhood sexual abuse, yet many report feeling unprepared to address this issue effectively which can hinder the trust of the client. This paper consistently highlights the clinical implications throughout with an emphasis on preparedness, trauma-informed approaches and the development of trust and safety in the therapeutic relationships with survivors of childhood sexual abuse. This section outlines more specific, actionable steps that can be easily implemented to assist this population as well as several policy changes that can be implemented to support counselors and improve care for these clients.

Prevalence rates for childhood sexual abuse are alarmingly high and this increases the likelihood that therapists will encounter an individual in therapy who has a history of childhood sexual abuse. Research gives evidence to insufficient counselor preparedness in working with this specific population (Foster, 2017; Nixon & Quinlan, 2021). This unpreparedness has the potential to further harm clients (Adams & Riggs, 2008) and due to this populations' inability to trust others, if the clinician is not prepared to work with this population, these clients will sense this and further hinder their ability to trust the clinician and further work on treatment. Thus, counselors should work to increase preparedness for working with IF-CSA survivors. They should engage in training to increase knowledge and skills in addressing IF-CSA. Counselors and counselors-in-training should build a comfortability and confidence in discussion sexual abuse topics. Graduate school programs should implement criteria and requirements for increasing knowledge on IF-CSA treatment so that graduate students will feel more comfortable and confident in addressing this population post-graduation.

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A qualitative study explored the discomfort with assessing for sexual abuse history (Nixon & Quinlan, 2021). This study was a qualitative study featuring 12 Australian psychologists. Participants indicated that they did not inquire about sexual abuse histories consistently due to not knowing what to do, the discomfort that comes from asking the questions, as well as fear of negative outcomes. They emphasized that their training in sexual abuse inquiry was inadequate, and they advocated for the development of a framework for sexual abuse training. Similarly, a systematic review was completed by Read et al. (2018) to discover how often sexual abuse inquiry was occurring within therapy. They found 21 studies with many cases of child abuse being un-identified by mental health providers further showing the lack of preparedness to inquire and work with this population (Read et al., 2018). From these studies, it is clear that counselors should incorporate consistent inquiry practices about abuse history. They should make it routine to inquire about a history of sexual abuse during the intake process and throughout therapy. Counselors should engage in training to increase competency in trauma-informed approaches to ensure clients feel safe when discussing these topics and they should be developing a framework to ask about abuse in a way that reduces the discomfort for both clinician and client. If counselors are not inquiring about sexual abuse history, clients may not feel the need to bring it up, especially if they are not attending therapy directly due to the abuse. This leaves a large piece of the clients past experiences unknown and unexplored which could hinder their ability to heal.

One specific policy change that can be implemented is that of curriculum reforms in graduate programs as well as standardized sexual abuse inquiry protocols. Policy changes could require graduate and doctoral counseling programs to include mandatory training on trauma-informed approaches with an emphasis on childhood sexual abuse. This ensures counselors-in-training are better equipped to handle these cases once they have graduated and are in the field, thus increasing preparedness and competence. If a policy was introduced to mandate standardized protocols for routinely inquiring about sexual abuse the inconsistency issue that has been found from research would be managed more effectively. This would ensure abuse histories are being identified and appropriately addressed.

Treatment considerations are important when helping clients who have experienced CSA and IF-CSA. With inconsistent treatment paradigms and studies focused mainly on residential and inpatient programs, it may be confusing for providers when attempting to identify an effective treatment plan for these clients. Due to the multifaceted process of recovery, symptomology, and the individuality of the experience, it is important to understand how survivors experience psychotherapy (Chouliara et al., 2012). Parry and Simpson (2016) found that survivors identified the therapeutic process as a means for forming a trusting and healthy relationship with others and self-identifying an importance for developing safety and a sense of self. Researchers found that the ability to develop trust, safety, and equality with others helped them to recover, and the development of trust allowed for the maintenance of relationships outside of therapy (Parry & Simpson, 2016). Additionally, Farber et al., (2014) found that self-disclosure of the therapist facilitated a sense of being understood, accepted, emotionally connected, and increased self-awareness of the client (Farber et al., 2014). Counselors can use self-disclosure strategically to help clients feel accepted and supported in the process, allowing for further disclosure and healing from the client.

Beyond the already mentioned, counselors need to focus in building a trusting relationship Their focus should be on establishing and maintaining trust with clients and prioritize the creation of a safe space where clients can feel comfortable sharing the experiences, especially at their own pace (Tadros & Daifallah, 2025). They should be aware of the importance of equality in the therapeutic relationship so that clients can feel trusting of the relationship as well. Additionally, counselors should promote safety and self-development. They should be incorporating interventions aimed specifically at developing a sense of safety and self-awareness in clients (Parry & Simpson, 2016). Counselors can facilitate healing by helping clients understand their own experiences and emotions while encouraging healthy relationships with themselves and others. Finally, counselors should ensure they are tailoring treatment plans to the individual. They need to recognize the individuality of each survivor's experience and symptoms ensuring they are adapting treatment plans to fit the clients' needs (Chouliara et al., 2012). These action items are designed to support counselors to build competency in working with survivors of childhood sexual abuse and foster a relationship that prioritizes trust, safety, and healing.

Additional policy recommendations include the need for mandatory continuing education, support for trauma-informed supervision and mentorship, and funding for CSA-specific resources. Currently, counselors must obtain a specific amount of continuing education credits with many

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states requiring specific continuing education being completed. Policies should require ongoing education and training in trauma-informed care as well as very specific strategies for working with CSA survivors. This ensures practitioners are able to maintain high levels of competence in working with this population. Alongside mandated continuing education on trauma-informed practices, specific to CSA survivors, a policy mandating new counselors to receive trauma-informed supervision or mentorship when working with this population could help reduce discomfort around discussing sexual abuse and offering emotional support in the therapeutic process with the counselor and client. Finally, policies could work to allocate funding to create various resources like webinars, workshops, training manuals, etc to assist counselors in developing the skills and confidence to work with this population. The resources would improve preparedness in counselors and assist in effectively supporting these clients while mitigating potential harm. This policy could also assist in allocating funding for further research in treating this population, focusing on the lived experiences of these clients. This is discussed further in the future directions section.

4.2. Future Directions

This review only focused on female identified survivors and did not take into account other gender identities. It would be important for future research and reviews to include other gender identities as each group may have differing experiences. Additionally, the review focused mainly on qualitative studies whereas quantitative studies may give further validity and insight into how counselors can assist those who have experienced IF-CSA. Finally, it would be important to consider all cultures and geographical locations. The majority of the studies in review consisted of studies conducted in the United States. It is imperative to include other countries and cultures as cultural identity could impact the experience of survivors and their perception of therapy, especially if mental health treatment is stigmatized.

Gaining a deeper understanding of clients' perspectives on treating intrafamilial childhood sexual abuse (IF-CSA) will enhance clinicians' confidence and effectiveness in their treatment approaches. Studies have shown that many clinicians feel unprepared to work with this population, which can inadvertently harm clients due to the clients' sensitivity to trust issues (Adams & Riggs, 2008; Day et al., 2003; Nixon & Quinlan, 2021). Clinicians need to be well-versed in the intricacies of treating IF-CSA to establish trust and facilitate effective therapy.

Counseling programs play a crucial role in this regard. Incorporating coursework that focuses on trauma work related to childhood sexual abuse, including prevalence rates, risk factors, and treatment types, can better prepare future counselors. Additionally, education on boundaries, family dynamics, and techniques for confronting abusers will equip students with practical tools for therapy. This enhanced training will result in counselors who are confident and competent in working with this population, leading to better client outcomes.

Further research on counselor competency in treating childhood sexual abuse is essential. Understanding the therapy process from the clients' perspectives will highlight what is effective and what needs improvement. This knowledge can inform clinicians about the best treatment practices and necessary adjustments to their approaches. Awareness of successful strategies and areas needing development will help build a more effective therapeutic environment for survivors, encouraging them to disclose their experiences and work through their trauma.

Although extensive research exists on the needs of this population, there is limited information on their therapy experiences and what works best for them. Gathering insights directly from survivors will not only provide valuable information for counselors and educators but also empower clients to voice their needs. Understanding the complexities of trauma and the specific needs of IF-CSA survivors will lead to better-informed practice, encouraging more survivors to seek therapy and feel empowered in their treatment journeys. This will ultimately improve outcomes for both current and future clients. In addition, further research should address the complexities of disclosure during therapy and the societal stereotypes that hinder it. Accurate statistics on the prevalence of family-perpetrated child sexual abuse are necessary to understand the full scope of the issue and improve support mechanisms for survivors (Hodges & Myers, 2010; National Children's Advocacy Center, 2018; RAINN, 2020).

5. Conclusion

Counselors need to adapt a nuanced and trauma-informed approach to treatment when working with those who have experienced intrafamilial childhood sexual abuse. The psychological and interpersonal consequences of IF-CSA emphasize the importance of a tailored, trauma-informed

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approach to treatment. Counselors must be adequately prepared through very specific training that addresses emotional and psychological needs of this population. It should focus on creating a safe, trusting, and supportive therapeutic environment as these are fundamental aspects of the therapeutic process. Counselors must also be equipped with skills to handle sensitive disclosures and support survivors in navigating their trauma. Future research should continue to explore perspectives of survivors, especially across diverse genders and cultures, to inform best practices and improve outcomes. By postering a deeper understanding of the unique needs of those who have experienced IF-CSA, clinicians can better support their healing journey and ensure they feel heard, understood, and empowered throughout the therapeutic process.

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Declaration of Interest

The authors of this article declared no conflict of interest.

Ethical Considerations

Not applicable.

Transparency of Data

In accordance with the principles of transparency and open research, we declare that all data and materials used in this study are available upon request.

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Authors' Contributions

All authors equally contributed in this article.

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