

**LASTING PSYCHOLOGICAL EFFECTS ON SURVIVORS
OF INTRAFAMILIAL CHILD SEXUAL ABUSE AND THE
AVAILABLE RESOURCES AND INTERVENTIONS IN
MASSACHUSETTS**

Honors Thesis

**Presented in Partial Fulfillment of the Requirements
For the Degree of Bachelor of Science in Social Work**

In the Maguire Meservey College of Health and Human Services
at Salem State University

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Commonwealth Honors Program
Salem State University
2021

Abstract

Individuals who experienced intrafamilial childhood sexual abuse (ICSA) as a child/adolescent often are impacted as adults by this experience. Many clients of social service agencies may have experienced ICSA as a child or adolescent, but it is unknown how knowledgeable social service agency workers are at recognizing the long-term symptoms and referring these clients for treatment. This research study (N=32) explored the variety of services survivors of ICSA are offered and professionals' perspectives on the level of effectiveness of these services. All three interventions studied in this research – Trauma-Focused Cognitive Behavioral Therapy, Therapeutic Programs, and Group Psychotherapeutic and Psychoeducational sessions or Individual Psychoanalytic Therapy - were deemed helpful by at least 91.30% of participants and referred by at least 52.38%. The goal of this study is to explore the variety of services survivors of ICSA are offered and professionals' perspectives on the level of effectiveness of these services. The findings from this study and previous research emphasize the importance of education on the topic as well as awareness of the local available resources and interventions. Taking these steps would positively impact survivors of ICSA because the individuals who work with this population would be more knowledgeable about the proper interventions, helpful services/resources, and the subject in general.

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Lasting Psychological Effects on Survivors of Intrafamilial Child Sexual Abuse and the Available Resources and Interventions in Massachusetts

Childhood sexual abuse is a significant problem that impacts tens of thousands of children each year. Childhood sexual abuse affected 57,329 children in just 2016 alone (RAINN, 2016). From the National Child Abuse and Neglect Data System, it was found that in 2006, approximately 8.8% of children were sexually abused in the United States (Singh et al., 2014). That does not include all of the many cases not being reported. Half of the perpetrators of childhood sexual abuse of young children (<6 years old) are family members. Intrafamilial childhood sexual abuse can have a particularly significant impact on children, leaving them with depression, anxiety, and even eating disorders, which often can continue into adulthood (Jay et al., 2018). Professionals working with survivors of intrafamilial child sexual abuse need be able to refer their clients to effective, accessible support services to help them treat and manage these long-term impacts of childhood trauma. However, it is unknown how aware professionals are of effective interventions or how confident they are in making these types of referrals. Therefore, this study of ICSEA will explore professionals' knowledge of and attitudes about the available mental health resources for child survivors of ICSEA.

Literature Review

There are many definitions of child sexual abuse. The definition that the Center for Disease Control (CDC) gives for child sexual abuse is, "the involvement of a child (person less than 18 years old) in sexual activity that violates the laws or social taboos of society and that he/she does not fully comprehend, does not consent to or is unable to give informed consent to,

or is not developmentally prepared for and cannot give consent to” (Centers for Disease Control and Prevention, 2020). Sexual abuse can involve physical contact activities such as penetration and non-penetration, and sexual abuse can also involve nonphysical activities such as, “intercourse, attempted intercourse, oral-genital contact, fondling of genitals directly or through clothing, exhibitionism or exposing children to adult sexual activity or pornography, and the use of the child for prostitution or pornography” (Singh et al., 2014). It can also involve “children looking at, or participating in the production of, sexual images, watching sexual activities, encouraging children to behave in sexually inappropriate ways, or grooming a child in preparation for abuse” (Working Together to Safeguard Children, 2019).

One type of sexual abuse is extrafamilial childhood sexual abuse, which is sexual abuse where the perpetrator is not part of the family or family environment. Another form of sexual abuse is intrafamilial childhood sexual abuse (ICSA). ICSA is a form of sexual abuse that happens by an immediate family member such as a parent, sibling, aunt, or uncle. Although some children have a higher risk of ICSA, there is a possibility that any child could experience sexual abuse (Working Together to Safeguard Children, 2019). Childhood sexual abuse is very common. One in four girls and one in six boys is sexually abused before the age of 18 (TAALK, 2017). The frequency of childhood sexual abuse means that many clients of social service agencies may have experienced ICSA as a child or adolescent, but it is unknown how knowledgeable social service agency workers are at referring these clients for treatment (Ceccucci, 2018).

There are impacts child sexual abuse has on its survivors can be seen in a survivor’s physical health, mental health, and behavioral health. One of the most common clinical findings when studying the psychological effects on survivors of ICSA is depression, mood

dysregulation, suicide, and non-suicidal self-injury (NSSI) (Nelson, 2019; De Bellis et al., 2011; Seto et al., 2015). Survivors of intrafamilial childhood sexual abuse experience a wide variety of emotional and behavioral symptomology, such as self-blame and high-risk behavior commonly seen as suicidality and substance abuse. These symptoms can impact their ability to form meaningful relationships and develop self-confidence as they get older if it is not treated as soon as the symptoms present themselves (Nelson, 2019). As said, higher rates of suicidal behaviors, including death by suicide, are common among survivors of (Centers for Disease Control and Prevention, 2020). A history of childhood sexual abuse is a significant risk factor for adult suicide attempts. Men with a history of child sexual abuse are six times more likely to attempt suicide than men without a history of child sexual abuse. Women with a history of childhood sexual abuse have a nine times greater risk of a suicide attempt than women without a history of child sexual abuse (Centers for Disease Control and Prevention, 2020).

Intrafamilial childhood sexual abuse (ICSA) can cause long-term impacts on brain development. These long-term impacts can include PTSD, an activated biological stress response system, and adverse brain development (De Bellis et al., 2011). Other impacts of ICSA that affect a survivor's behavioral health include substance use disorders and risky sexual behaviors such as unprotected sex or sex with multiple partners. Survivors of childhood sexual abuse have a greater risk than those without a childhood sexual abuse history to experience revictimization in adolescence and adulthood (Centers for Disease Control and Prevention, 2020). Individuals who have experienced child sexual abuse are twice as likely to experience non-sexual intimate partner violence than those who did not experience childhood sexual abuse (Centers for Disease Control and Prevention, 2020).

Intrafamilial childhood sexual abuse (ICSA) and extrafamilial sexual abuse differ, as seen through the effects they typically inflict on survivors. Intrafamilial child sexual abuse is unique in that perpetrators often have easy access to children in the family, the abuse is framed by perpetrators as love or care, but may also involve threats towards loved ones, favorite belongings, or enjoyable activities (Seto et al., 2015). According to Seto et al. (2015), survivors of intrafamilial childhood sexual abuse experience greater negative consequences than survivors of child sexual abuse committed by people outside of the family. Some survivors of intrafamilial childhood sexual abuse believe that the abuse is their fault due to the perpetrator telling them it is their fault (Seto et al., 2015). According to the study done by Roberts and Colleagues (2004), intrafamilial child sexual abuse has been associated with certain outcomes in adulthood, including being part of a “nontraditional” family (having a single mother and stepfather), mental health issues, and teen pregnancy (Roberts et al., 2004).

Intrafamilial childhood sexual abuse can be complicated by the difficult feelings of dependency on the perpetrator and feelings of betrayal (Kristensen & Lau, 2007; Trickett et al., 2011). Another unique characteristic of ICSA is that it can occur repeatedly over long periods of time by the same perpetrator (Kristensen & Lau, 2007; Trickett et al., 2011). Often, the literature does not differentiate between intrafamilial and extrafamilial sexual abuse, leading to a lack of knowledge about the differences and similarities between these two phenomena. It is important to care about this gap in the literature to become more knowledgeable on both types of sexual abuse but also understand the differences in symptoms caused by each type of sexual abuse.

Interventions

Medical Assistance

If a child is referred immediately right after the occurrence of abuse, it is necessary to start with a medical evaluation and make medical interventions a priority (Seshadri & Ramaswamy, 2019). There are many types of examinations during this period. Two of these include forensic examination and a pregnancy tests (if the child is female). A forensic examination is normally requested by the police in order to document the abuse. A pregnancy test is important to ensure the child has not become impregnated by their abuser. If it is found the child is less than 20 weeks pregnant, discussions about abortion may be needed (Seshadri & Ramaswamy, 2019).

Cognitive Behavioral Therapy (CBT)

There have been many studies searching for ways to positively affect a survivor's daily functioning due to PTSD from their ICSEA, and one intervention very commonly used is Cognitive-Behavioral Therapy (CBT). CBT explores the relationship between thoughts, emotions, and behavior (Fenn & Byrne, 2013). Cognitive Behavioral Therapy is a type of talk therapy where an individual works with a mental health counselor in a structured way. In a limited number of sessions, CBT incorporates many "problem solving [strategies], and [we] borrow from many psychotherapeutic modalities, including dialectical behavior therapy, acceptance and commitment therapy, Gestalt therapy, compassion focused therapy, mindfulness, solution focused therapy, motivational interviewing, positive psychology, interpersonal psychotherapy, and when it comes to personality disorders, psychodynamic psychotherapy" (*What is Cognitive Behavior Therapy: Beck Institute*, n.d). Trauma-Focused Cognitive Behavioral Therapy is an established treatment for children who have experienced sexual abuse (Deblinger et al., 2010). In a study of sexual assault survivors, researchers found trauma-focused cognitive-behavioral therapy significantly improved the survivors' PTSD, depression, and

complex symptoms of PTSD (Resick et al., 2003). In another study, it was found that CBT with a trauma narrative proved more significant for post-treatment improvements than standard CBT without a trauma narrative (Deblinger et al., 2010).

Eye Movement Desensitization and Reprocessing (EMDR) & Electric Therapy (ECT)

EMDR is an effective intervention for ICSA survivors and a very interesting type of therapy. When starting a session, the client will be asked to focus on a specific event. “Attention will be given to a negative image, belief, emotion, and body feeling related to this event, and then to a positive belief that would indicate the issue was resolved. While the client focuses on the upsetting event, the therapist will begin sets of side-to-side eye movements, sounds, or taps. The client will be guided to notice what comes to mind after each set. They may experience shifts in insight or changes in images, feelings, or beliefs regarding the event. The client has full control to stop the therapist at any point if needed. The sets of eye movements, sounds, or taps are repeated until the event becomes less disturbing” (*Experiencing EMDR Therapy*, 2021). EMDR Therapy “changes maladaptive neural networks by connecting the traumatic memory with new information. The distressing thoughts and emotions are blended with new positive thoughts and emotions; embodied awareness allows frozen sensations in the body to resolve through healing movements” (Schwartz, 2019). In other words, EMDR trains your brain to think of your traumatic memories in a less traumatic way. One study compared the impact of EMDR and Electric Therapy on child sexual abuse survivors with PTSD symptoms (Edmond et al., 2004). The study found that there were visible differences in the two treatment groups in terms of success, however, they both helped the participants in the sense of client-therapist relationship (Edmond, et al., 2004). The researchers concluded that along with meeting regularly with a therapist, EMDR caused greater trauma resolutions and electric therapy caused survivors to

greater value their relationship with their therapist because they practiced effective coping mechanisms (Edmond et al., 2004).

Dialectical Behavior Therapy (DBT)

One other intervention commonly used to treat PTSD and depression in childhood sexual abuse survivors is Dialectical Behavior Therapy (DBT). DBT is a type of talking therapy. In DBT, dialectical strategies help both the therapist and the client get unstuck from extreme positions (*What is Dialectical Behavior Therapy (DBT)?*, n.d.). This type of therapy assesses the “situations and target behaviors that are relevant to our clients’ goals in order to figure out how to solve the problems in their lives” (*What is Dialectical Behavior Therapy (DBT)?*, n.d.). In a study that compared “individual ratings of trauma-related emotions and radical acceptance between the start and the end of DBT for PTSD” related to child sexual abuse, Görg et al. (2017) found that individuals with PTSD from childhood sexual assault significantly improved when they underwent DBT.

Conclusion

Intrafamilial childhood sexual abuse affects thousands of children and families across the United States (RAINN, 2016). Intrafamilial childhood sexual abuse can cause short-term and long-term symptoms including mood dysregulation, non-suicidal self-injury, depression, anxiety, and PTSD (Nelson, 2019; De Bellis et al., 2011; Seto et al., 2015). As there are effective interventions for survivors of intrafamilial childhood sexual abuse (Seshadri & Ramaswamy, 2019; *What is Cognitive Behavior Therapy: Beck Institute*, n.d.; Fenn & Byrne, 2013; Deblinger et al., 2010; Resick et al., 2003; *Experiencing EMDR Therapy*, 2021; Schwartz, 2019; Edmond et al., 2004; *What is Dialectical Behavior Therapy (DBT)?*, n.d.; Görg et al., 2017), it is imperative

that individuals working with childhood sexual abuse survivors know of these services and refer these survivors accordingly. Therefore, this research study will explore the variety of services survivors of ICOSA are offered and professionals' perspectives on the level of effectiveness of these services.

Research Design

Participants

Participants are individuals over the age of 18 who work with survivors of intrafamilial childhood sexual abuse (ICSA) in Massachusetts. Examples of those working with childhood sexual abuse survivors include social workers, mental health workers, psychologists, nurses, and law enforcement workers.

Procedures

This study used a quantitative survey design to examine the various resources and interventions available to ICOSA survivors in Massachusetts. Convenience and snowball sampling was used. The researcher emailed a study advertisement that contained the survey link to personal contacts, posted personal social media pages, and reached out to faculty at the university, asking them to share the survey with their professional contacts.

Materials

The electronic survey used Survey Monkey. The survey instrument had multiple choice questions and one open-ended question. The university IRB approved this research project. The survey asked demographic questions about age, gender, and race/ethnicity. In addition, the survey asked where the participants work in Massachusetts, what their highest level of education is, and if they have continuing education on the subject of Intrafamilial Childhood Sexual Abuse

(ICSA), such as trainings, certificate programs, etc. The survey also asked the participants to select which listed interventions and resources they refer clients to in the state of Massachusetts.

Data Analysis

Data was downloaded from Survey Monkey and entered into an Excel spreadsheet. Descriptive statistics were used to explore demographic characteristics, workplace/education characteristics, and perceptions of the available mental health resources.

Findings

Demographic

The sample (N=32) ranged from 18-65+ years old, with 6.5% (n=2) 18-24, 45.2% (n=14) 25-34, 25.8% (n=8) were 35-44, 12.9% (n=4) 45-54, 6.5% (n=2) 55-64, and 3.2% (n=1) over 64. See table 1 below. Most (87.5%, n=28) participants were White or Caucasian, 3.1% (n=1) Black or African American, 6.2% (n=2) Hispanic or Latino, and 3.1% (n=1) American Indian or Alaska Native. See Table 1 below. Most participant (90.6%, n=29) were female and 9.4% (n=3) were male. See Table 1 below. In terms of education, 71.8% (n=23) reported their highest level of education was a Master's Degree, 12.5% (n=4) Bachelor's Degree, 9.3% (n=3) some college, 3.1% (n=1) Associates Degree, and 3.1% (n=1) PHD/Doctorate. See Table 1 below.

In terms of profession, the majority (96.4%, n=27) were social workers, with 9.3% (n=3) case managers, 3.1% (n=1) mental health workers, and 3.1% (n=1) in law enforcement. See Table 1 below. The majority worked at a Mental Health Agency (56.2%, n=18), 12.5% (n=4) at a Child Protection Agency, 6.2% (n=2) at a Law Enforcement Agency, 3.1% (n=1), 3.1% (n=1) in a hospital setting and 3.1% (n=1) at Early Intervention. Few (5.3%, n=6) chose to elaborate, with

3.1% (n=1) at a rape crisis center, 3.1% (n=1) in the schools, 3.1% (n=1) in a prison, 3.1% (n=1) had their own private practice, 3.1% (n=1) in a dual diagnoses nursing home, and 3.1% (n=1) at an Insurance Agency. See Table 1.

Most participants worked in Worcester County (28.1%, n=9), Middlesex County (25.0%, n=8) or Essex County (21.9%, n=7), with 9.4% (n=3) in Suffolk County, 6.3% (n=2) in Plymouth County, 3.1% (n=1) in Bristol County and 3.1% (n=1) in Norfolk County. See Table 1 below. Most participants (68.8%, n=22) had graduated or stopped attending school since 2011, with 18.8% (n=6) between 2001-2010, 6.3% (n=2) between 1990-2000, and 6.3% (n=2) before 1990. See Table 1.

Table 1*Demographics (N=32)*

Variable	N<32	%
Age		
18-24	2	6.5%
25-34	14	45.2%
35-44	8	25.8%
45-54	4	12.9%
55-64	2	6.5%
65+	1	3.2%
Race		
White or Caucasian	28	87.5
Black or African American	1	3.1%
Hispanic or Latino	2	6.2%
American Indian or Alaska Native	1	3.1%
Gender		
Female	29	90.6%
Male	3	9.4%
Level of education		
Some College	3	9.3%
Associate's Degree	1	3.1%
Bachelor's Degree	4	12.5%
Master's Degree	23	71.8%
PHD/Doctorate	1	3.1%
Profession		
Social Worker	27	96.4%
Case Manager	3	9.3%
Mental Health Worker	1	3.1%
Law Enforcement Worker	1	3.1%
Location of work		
Worcester County	9	28.1%
Middlesex County	8	25%
Essex County	7	21.9%
Suffolk County	3	9.4%
Plymouth County	2	6.3%
Bristol Counting	1	3.1%
Norfolk County	1	3.1%

Participant Knowledge/Confidence

More than half of the participants (56.3%, n=18) had attended a continuing education workshop or program on the subject of intrafamilial childhood sexual abuse (ICSA), while 43.8% (n=14) had not. Almost half (46.9%, n=15) had continuing education on child survivors of ICSA, while 53.1% (n= 17) did not. Participants reported working with less than one child survivors of ICSA each month (38.7%, n=12), 1-5 survivors (41.9%, n=13), 6-10 survivors (12.9%, n=4), and 6.5% (n=2) 11-15 survivors.

No participants strongly agreed that there was a vast amount of supports and programs available for survivors of ICSA in the state of Massachusetts, while 9.4% (n=3) agreed, 28.1% (n=9) somewhat agreed, 9.4% (n=3) were neutral, 18.8% (n=6) somewhat disagreed, 31.3% (n=10) disagreed, and 3.1% (n=1) strongly disagreed. In terms of being able to offer survivors of ICSA an adequate amount of resources, only 6.5% (n=2) strongly agreed, 25.8% (n=8) agreed, 12.9% (n=4) neither agree nor disagree, 48.4% (n=15) disagreed, and 6.5% (n=2) strongly disagreed.

Of the provided resources, participants were most likely to choose The Massachusetts Children's Alliance (50%, n=12) as a good resource, followed by The Massachusetts Adolescent Sex Offender Coalition (MASOC) (50%, n=12), Sexual Assault Prevention and Survivor Services (SAPSS) (41.6%, n=10), and Group Therapy (75%, n=18). Table 2 shows the complete list of services listed in the survey, along with the percentages each service received by the participants. In terms of referring clients, 79% (n=15) stated they refer clients to Crisis Counseling, 72.4% (n=21) refer to individual therapy, 65% (n=13) refer to group therapy, and 52.1% (n=12) refer to Dialectical Behavior Therapy. See Table 2.

Table 2*Resources (N=30)*

	Good Resource f (%)	I Refer Clients Here f (%)
The New England Adolescent Research Institute (NEARI)	10 (33.3%)	4 (13.3%)
The Massachusetts Adolescent Sex Offender Coalition (MASOC)	12 (40%)	3 (10%)
The Massachusetts Children's Alliance	12 (40%)	1 (3.3%)
Individual Therapy	24 (80%)	21 (70%)
Group Therapy	18 (60%)	13 (43.3%)
Dialectical Behavior Therapy (DBT)	20 (66.7%)	12 (40%)
EMDR	17 (56.7%)	7 (23.3%)
Sexual Assault Prevention and Survivor Services (SAPSS)	10 (33.3%)	4 (13.3%)
Crisis Counseling	16 (53.3%)	15 (50%)
Family Advocacy Center	16 (53.3%)	8 (26.7%)

Participants were asked to name other resources that were not listed on the survey. Fourteen (43.75%) participants answered this question, and 18 (56.25%) participants chose not to respond to the question. Six (42.85%) participants stated either “n/a” or “I don’t know” or “nothing additional in my area.” One (7.14%) participant stated speaking with and to other survivors, 1 (7.14%) participant stated support groups, 1 (7.14%) participant stated Sexual Assault Nurse Examiner (SANE) and Sexual Assault Reimbursement Unit (SARU) nurses, the District Attorney’s office, and family support groups. One (7.14%) participant stated family therapy and trauma treatment, 1 (7.14%) participant stated My Life My Choice and the Rape, Abuse & Incest National Network (RAINN), 1 (7.14%) participant stated partial programs and CPT, 1 (7.14%) participant stated Victims of Crime and Loss at Lahey and Victims of Crime Act (VOCA), Seeking Safety groups. Lastly, 1 (7.14%) participant stated parent education.

Of the provided interventions, participants chose trauma focused CBT (96.3%, n=26) as helpful, followed by Group psychotherapeutic and psychoeducational sessions or individual psychoanalytic therapy (95.2%, n=20), and therapeutic programs (91.3%, n=21). The table below shows the complete list along with percentages of interventions used in the study. Participants were most likely to refer clients to refer clients to trauma focused CBT (63%, n=17), followed by therapeutic programs (56.5%, n=13), and 52.3% (n=11) using a combination of group psychotherapeutic and psychoeducational sessions and individual psychoanalytic therapy. See Table 3.

Table 3*Interventions (N=28)*

	Helpful Intervention	I Refer Clients to This
	f (%)	f (%)
Trauma-focused cognitive behavioral therapy	26 (93%)	17 (60.7%)
Therapeutic program	21 (75%)	13 (46.4%)
Group psychotherapeutic and psychoeducational sessions or individual psychoanalytic therapy	20 (71.4%)	11 (39.2%)

Participants were asked to state other interventions that they believe are helpful to survivors of intrafamilial childhood sexual abuse (ICSA). Ten (31.25%) participants answered and 22 (68.75%) skipped the question. Out of the ten participants who answered, 4 (40%) participants either stated “Most were already listed,” “I don’t know,” “same as previous answer,” or “N/A.” One (10%) participant stated motivational interviewing for processing the experience, and positive affirmations, 1 (10%) participant stated peer support, 1 (10%) participant stated DBT, 1 (10%) stated cognitive processing, relational processing, relationship building and support, and PTSD symptom management. One (10%) participant stated mind/body work such as yoga, dance, and meditation, and the one (10%) last participant stated art therapy.

Out of 18 participants who stated they had continuing education on the subject of ICOSA, 38.9% (n=7) disagreed that there is a vast amount of supports and programs available for survivors of ICOSA in the state of Massachusetts, while 27.8% (n=5) somewhat agreed, 16.7% (n=3) somewhat disagreed, 11.1% (n=2) agreed, and 5.6% (n=1) neither agreed nor disagreed. See Table 4. Out of the 14 participants who stated they did not have extra knowledge on the subject of ICOSA, 28.6% (n=4) somewhat agreed that there is a vast amount of supports and programs available for survivors of ICOSA in the state of Massachusetts, while 21.4% (n=3) somewhat disagreed and 21.4% (n=3) disagreed, 14.3% (n=2) neither agreed nor disagreed, 7.1% (n=1) agreed and 7.1% (n=1) strongly disagreed. See Table 5. Of the 18 who stated yes, 35.3% (n=6) disagreed and 35.3% (n=6) agreed they are able to offer survivors of ICOSA an adequate amount of resources, while 17.7% (n=3) neither agreed nor disagreed and 11.8% (n=2) strongly agreed. See Table 4. Of the 14 who stated no, 64.3% (n=9) disagreed they are able to offer survivors of ICOSA an adequate amount of resources, while 14.3% (n=2) agreed, 14.3% (n=2) strongly disagreed, and 7.1% (n=1) neither agreed nor disagreed. See Table 5.

Out of 18 participants who stated they had extra knowledge on the subject of ICOSA, 27.8% (n=5) worked in Worcester County, 27.8% (n=5) worked in Essex County, 16.7% (n=3) worked in Middlesex County, 11.1% (n=2) worked in Suffolk County, 5.6% (n=1) worked in Norfolk County, 5.6% (n=1) worked in Bristol County, and 5.6% (n=1) worked in Plymouth County. See Table 4. Out of 14 participants who stated they did not have extra knowledge on the subject of ICOSA, 35.7% (n=5) worked in Middlesex County, 28.6% (n=4) worked in Worcester County, 14.3% (n=2) worked in Essex County, 7.1% (n=1) worked in Franklin County, 7.1% (n=1) worked in Suffolk County, and 7.1% (n=1) worked in Plymouth County. See table 5.

Table 4*Participants with Continuing Education on the Subject of ICSA (N=18)*

	N<18	%
Vast Amount of supports and programs in MA		
Strongly Agree	0	0.0%
Agree	2	11.1%
Somewhat Agree	5	27.8%
Neither agree nor disagree	1	5.6%
Somewhat Disagree	3	16.7%
Disagree	7	38.9%
Strongly Disagree	0	0.0%
Confident in offering adequate amount services in MA		
Strongly Agree	2	11.8%
Agree	6	35.3%
Neither agree nor disagree	3	17.7%
Disagree	6	35.3%
Strongly Disagree	0	0.0%
Location of Work		
Worcester County	5	27.8%
Essex County	5	27.8%
Middlesex County	3	16.7%
Suffolk County	2	11.1%
Norfolk County	1	5.6%
Bristol County	1	5.6%
Plymouth County	1	5.6%
Franklin County	0	0.0%

Table 5*Participants without Continuing Education on the Subject of ICSEA (N=14)*

	N<14	%
Vast Amount of supports and programs in MA		
Strongly Agree	0	0.0%
Agree	1	7.1%
Somewhat Agree	4	28.6%
Neither agree nor disagree	2	14.3%
Somewhat Disagree	3	21.4%
Disagree	3	21.4%
Strongly Disagree	1	7.1%
Confident in offering adequate amount services in MA		
Strongly Agree	0	0.0%
Agree	2	14.3%
Neither agree nor disagree	1	7.1%
Disagree	9	64.3%
Strongly Disagree	2	14.3%
Location of Work		
Worcester County	4	28.6%
Essex County	2	14.3%
Middlesex County	5	35.7%
Suffolk County	1	7.1%
Norfolk County	0	0.0%
Bristol County	0	0.0%
Plymouth County	1	7.1%
Franklin County	1	7.1%

Discussion

The lasting psychological effects on survivors of intrafamilial childhood sexual abuse (ICSA) is well documented (e.g., De Bellis et al., 2011; Kristensen & Lau, 2007; Trickett et al., 2011; Roberts, 2004; Jay et al., 2018). According to De Bellis et al. (2011), sexual abuse can result in PTSD, it can activate biological stress response systems, and it can also contribute to adverse brain development in survivors of sexual abuse. As well, ICSA can be complicated by the difficult feelings of dependency on the perpetrator and feelings of betrayal (Kristensen & Lau, 2007; Trickett et al., 2011). Nelson (2019) explains how one can come to understand a survivor's fear and self-blame symptoms due to this abuse. Although in this study the types of interventions available for the survivors appears to be generally well known, it appears based on this study's findings and the literature, the confidence level in referring clients to these interventions and services/resources in Massachusetts is lower.

Findings from this study suggest that many service providers working with child sexual abuse survivors perceive Trauma-focused Cognitive Behavior Therapy (CBT) and Eye Movement Desensitization and Reprocessing (EMDR) as being a helpful intervention available to survivors of intrafamilial childhood sexual abuse (ICSA). This reflects the literature which supports these interventions as evidenced based practices. For example, one study found that cognitive-behavioral therapy significantly improved the survivors' PTSD, depression, and complex symptoms of PTSD (Resick et al., 2003). One study on EMDR for individuals with PTSD showed that along with meeting regularly with a therapist, EMDR caused greater trauma resolutions (Edmond et al., 2004). Not surprising, 66.7% (n=20) perceived Dialectical Behavior Therapy (DBT) as a helpful intervention. This is supported by Görg et al.'s 2017 study that

found that individuals with PTSD from childhood sexual assault significantly improved when they underwent DBT.

When it comes to confidence in the ability to offer survivors of intrafamilial childhood sexual abuse (ICSA) an adequate amount of resources, half of participants said they disagreed, meaning they were not very confident. This may reflect a general need within the professional to research and understand said interventions, resources, and services. Ceccucci (2018) explored the confidence of nurse practitioners working with child sexual abuse survivors in New York, finding that although nurse practitioners see value in pursuing specialist referrals for child sexual abuse survivors, they do not have access to the appropriate resources, or they are not aware of the availability of these resources within the community they work. These findings reflect the literature, and suggest that in Massachusetts, as in New York City, there may be a lack of appropriate resources and interventions in their area for child sexual abuse survivors.

Limitations

As with all research studies, this project has limitations. First, a limitation of this study is the small sample size. This study is examining the lasting psychological effects on survivors of ICSA, and the services/interventions available to them in Massachusetts. To obtain information for the study, participants were limited to individuals that work in law enforcement, forensic social workers, forensic nurses and practitioners that work with this population or are knowledgeable on the subject. While this helped to make the researcher's work more concise, it was challenging to recruit a large amount of these specific workers.

Second, there was a lack of geographic diversity in the sample. Some regions of Massachusetts were not represented by research participants. Seven counties, most in western

Massachusetts and in the Cape Cod region, were not represented. This may mean that there is a bias in the findings for more urban settings with better access to resources.

Third, another limitation of this study was that the researcher used non-probability sampling. This means the researcher could not generalize their findings to all professionals in Massachusetts who fit the eligibility requirements.

Implications

Individuals who work with survivors of intrafamilial childhood sexual abuse (ICSA) in the state of Massachusetts can use the findings of this study to consider their own advances in knowledge as well as services and interventions for survivors of ICSA. These advances can include continuing their education on the topic of ICSA, whether it be through trainings, getting a higher degree in social work or other related fields, or researching the subject independently. The findings from this study and previous research (e.g. Ceccucci, 2018) emphasize the importance of education on the topic as well as knowing which resources and interventions are available in the area. Taking these steps would positively impact survivors of ICSA because the individuals who work with this population would be more knowledgeable about the proper interventions, helpful services/resources, and the subject in general. In turn, this will make referring clients more precise and create a more positive outcome for survivors of ICSA. Since survivors of ICSA can potentially suffer from PTSD, teen pregnancy, and a poorer psychological well-being, it is imperative that they are referred to the correct type of intervention (Roberts et al., 2004). In addition to understanding the importance of continuing knowledge, individuals and agencies who work with survivors of ICSA can use the findings in this study to train entering workers on the importance of said knowledge.

Conclusion

Intrafamilial Childhood Sexual Abuse (ICSA) effects tens of thousands of children and families in the United States every year (RAINN, 2016). Child sexual abuse leaves lasting psychological effects on its survivors, including depression, to substance abuse disorders, to suicide (Nelson, 2019; De Bellis et al., 2011; Seto et al., 2015). Although the effects of childhood sexual abuse are well known, the available services, resources, and interventions in the state of Massachusetts may not be. The findings of this study suggest that Dialectical Behavioral Therapy and Trauma-focused Cognitive Behavioral Therapy are very well known and referred to for these survivors. These analyses add to the literature by increasing the general understanding of what types of services/resources and interventions practitioners believe are helpful to clients, as well as how confident practitioners in Massachusetts are in referring clients to said services/resources and interventions.

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