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Childhood Sexual Abuse and Therapy with the Perpetrator

By

Patricia K. Thurmer, BSW, LSW

MSW Clinical Research Paper

Presented to the Faculty of the
School of Social Work
St. Catherine University and the University of St. Thomas
St. Paul, Minnesota
in Partial Fulfillment of the Requirements for the Degree of
Master of Social Work

Committee Members

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The Clinical Research Project is a graduation requirement for MSW students at St. Catherine University/University of St. Thomas School of Social Work in St. Paul, Minnesota and is conducted within a nine-month time frame to demonstrate facility with basic social research methods. Students must independently conceptualize a research problem, formulate a research design that is approved by a research committee and the university Institutional Review Board, implement the project, and publically present the findings of the study. This project is neither a Master's thesis nor a dissertation.

Abstract

Victims of childhood sexual abuse can develop mental illness or maladaptive behaviors due to the traumatization. Although individual, group, and family psychotherapy are offered to victims of intrafamilial sexual abuse, few approaches include sessions where rebuilding a relationship between the perpetrator and the victim is emphasized. Given the importance of approaches to include the perpetrator, the focus of this qualitative research is to gain an understanding of how a clinician can help intrafamilial child sexual abuse victims rebuild and heal the relationship with their perpetrators. Individual, family, and group therapy are ways of delivering therapeutic services. Within these sessions, clinicians utilize a variety of approaches, techniques, and conceptual frameworks to guide their interventions. This study found that the child victim of intrafamilial sexual abuse must want to rebuild the relationship with his/her perpetrator, and that there is no identified preferred therapeutic approach in order to accomplish this task. This study also established the importance of individualized therapy sessions for the victim prior to therapy involving the perpetrator. For social workers, this study is imperative due to the fact that the child may remain in contact with his/her perpetrator following allegations of intrafamilial sexual abuse.

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Childhood Sexual Abuse and Therapy with the Perpetrator

Sexual violence in the United States has become an endemic with someone being sexually abused every 2 minutes. On average there are 207,754 new victims age 12 and up each year (Statistics, Rape Abuse and Incest National Network). Of sexual abuse reported, 15% of abuse victims are under the age of 12 with 29% of victims being between the ages of 12 and 17, and 44% being under the age of 18 (Statistics, Rape Abuse and Incest National Network). Startling statistics state that 1 in 4 girls and 1 in 6 boys will be sexually abused before the age of 18. Although the Rape Abuse and Incest National Network believe there are few reliable statistics portraying the reality of intrafamilial sexual violence, the United States Department of Justice report that from 2005 to 2010, in 78% of sexual assaults the perpetrator was known to the victim with 6% of the time the perpetrator being a relative or a family member. The United States Department of Justice also found that between 2005 to 2010, 55% of sexual assaults occurred at or near the victim's home with another 12% of rapes occurring at a friend's, acquaintance, or relative's home (Planty, M., Langton, L., Krebs, C., Berzofsky, M., & Smiley-McDonald, H., 2013). This study will focus on intrafamilial sexual abuse.

Historical Context of Child Abuse

For centuries disclosure of child intrafamilial sexual abuse has left the child with no intervention. Children who disclosed abuse were rarely supported and believed. They faced negative reactions from others ranging from being punished for "telling lies" to being told to keep quiet, causing the child to feel betrayed and abandoned by his/her family (National Child Traumatic Stress Network, 2009). The first attempt to protect

children was in 1874 when the New York Society for the Prevention of Cruelty to Children was established. Then in 1877, several societies to end cruelty to animals joined forces with New York Society for the Prevention of Cruelty to Children to create the American Humane Society. During this time society compared the physical well-being of children as comparable to the physical well-being of animals. The American Human Society began a world-wide crusade to end the physical sufferings of children based on the first recognized physical abuse case of Mary Ellen Wilson (First Case Of Child Abuse, 2011).

However, children's rights were not fully recognized until the 1970's. The 1970's represented an era of change surrounding the rights and protection of women and children. During this time child sexual abuse victims began to seek help from rape crisis centers. The rape crisis centers helped to generate public awareness around childhood sexual abuse, which led to the Child Abuse Prevention and Treatment Act becoming a federal law in 1974. This act gave authority to the Child Protection Services in each state to receive, investigate and legally act on the reports of alleged incest as well as child physical and sexual abuse and neglect. The need for mental health assessments and treatment for the victims of intrafamilial sexual violence and their families arose from the family issues Child Protection personnel were encountering (Adams-Tucker, 1984).

Childhood Sexual Abuse Symptoms and Definition

According to the American Psychological Association (2013),

There is no universal definition of child sexual abuse. However, a central characteristic of any abuse is the dominant position of an adult that allows him or her to force or coerce a child into sexual activity. Child sexual abuse may include fondling a child's genitals, masturbation, oral-genital contact, digital penetration, and vaginal and anal intercourse. Child sexual abuse is not solely restricted to physical contact; such abuse could include noncontact abuse, such as exposure, voyeurism, and child pornography (p. 3).

Childhood sexual abuse can cause psychological damage and maladaptive behaviors that can remain throughout one's lifetime. It is important to state that not every individual sexually abused as a child will develop a mental illness, and an individual may develop a mental illness as a child or as an adult; symptoms can occur or be identified as an adult. Common symptoms for children who have been sexually abused include: withdrawal, irritability, developmental regression, low self-esteem, self-mutilation, phobias, school problems, poor hygiene/excessive bathing, relationship problems, sexual aggression, and suicide (Child Sexual Abuse, Rape Abuse and Incest National Network, & Pfeifer, 2010). The Adverse Childhood Experiences (ACE) study by Kaiser Permanente and the Centers for Disease Control and Prevention confirmed earlier investigations that, "found a highly significant relationship between adverse childhood experiences and depression, suicide attempts, alcoholism, drug abuse, sexual promiscuity, domestic violence, cigarette smoking, obesity, physical inactivity, and sexually transmitted diseases" (van der Kolk, 2005, p.402). The maladaptive behavior of sexual promiscuity can be attributed to the fears children possess. Girls who have been sexually

abused often times have a deep fear of men who resemble their father; however, this is met with seductive behavior directed at the very men they fear. This fear can be paired with the idea that men only want sexual contact with them and nothing more (Sroufe & Fleeson, 1986). Gaining attention through sexual contact is how a child gets his/her emotional needs met because it is how he/she learned to get those needs met through his/her prior sexual abuse relationship.

Sexual abuse as a child may result in significant problems in mental, emotional, behavioral, and relational functioning (Pfeifer, 2010). Most common psychological effects in trauma survivors are Depression and Post-Traumatic Stress Disorder (PTSD) (Kimbrough, Magyari, Langenberg, Chesney, & Berman, 2010 p. 18). Children who are traumatized may experience characteristics of criteria found in the Diagnostic Statistical Manual TR Four for Depression and PTSD such as dissociation, flashbacks and nightmares, disorientation in time and space, and depersonalization and derealization (van der Kolk, 2005). Children who have experienced these symptoms have been described as being “out of touch’ with their feelings, and often have no language to describe internal states” (van der Kolk, 2005, p.405). Children who have experienced sexual abuse may not be able to articulate how it has affected them emotionally and psychologically. Other mental health symptoms that may occur but are less common include: anxiety, substance abuse, lack of self-efficacy, sleep issues, somatic complaints/somatoform, borderline and antisocial personality, and sexual disorders (Kimbrough et al., 2010, & van der Kolk, 2005). Children who are traumatized have difficulty trusting other individuals’ reliability and predictability. This is often portrayed

through distrust and suspicion causing problems with intimacy leading to social isolation (van der Kolk, 2005).

Individual, group, and family psychotherapy are utilized to help work through the mental stress to prevent or treat any mental illnesses caused from being sexually abused. A multimodal approach that incorporates individual, group, and family therapy help to establish a support system that breaks the isolation, “that facilitates sexual abuse and inhibits disclosure” (Nichols, 2013, p.49). Integrating therapeutic services through the multimodal approach also helps develop family cohesiveness.

Within psychotherapy sessions many different therapy approaches are used such as Restorative Justice Strategy, Developmental Play Therapy, Mindfulness Meditation-Based Stress Reduction (MBSR), and Decision Dialogue, among others, to help heal the victim and the family. Although, individual, group, and family psychotherapy are offered to victims of intrafamilial sexual abuse, few approaches include sessions where rebuilding a relationship between the perpetrator and the victim is emphasized.

Using approaches and techniques that include the perpetrator is important because contact may persist between a child and his/her perpetrator. Often the perpetrator is not criminally charged for the sexual abuse because of lack of evidence. Lack of evidence may include the child’s inability to articulate the abuse. When this occurs the court often orders the child to have visits with his/her perpetrator or the perpetrator is allowed to return to the home (Hewitt, 2007). When reunification is planned it allows for the family and the clinician to work together to improve the family’s functioning through gradually opening communication lines in therapy (Nichols, 2013).

Given the importance of approaches to include the perpetrator, the focus of this qualitative research is to gain an understanding of how a clinician can help intrafamilial child sexual abuse victims rebuild and heal the relationship with their perpetrators. In some instances the perpetrator is part of the therapeutic process. This research will examine the dynamics a clinician considers when the therapeutic goal includes rebuilding the relationship between the child victim and his/her perpetrator. Additionally, this research will identify what therapeutic approaches and techniques clinicians are utilizing in these cases.

Literature Review

Impact of Sexual Victimization on Individuals and Families

When an individual is sexually abused by someone related to him/her it is known as incest (Statistics, Rape Abuse and Incest National Network) or intrafamilial sexual abuse. Perpetrators who are family members often have the greatest opportunity to be sexually involved with a child because they have the greatest access to them (Atwood, 2007). When intrafamilial sexual abuse has occurred the family may not be able to provide a child with the sense of safety, and children often have limited resources outside of the family making it harder for him/her to recover from the abuse (Incest, Rape Abuse and Incest National Network). Perpetrators are opportunistic individuals and usually groom the child before they abuse them. The grooming process is done by building trust with their victim through individualized attention and affection, by giving gifts or money, by doing favors, and through demanding secrecy while they begin to violate their

boundaries (Atwood, 2007). When the perpetrator demands secrecy, van der Kolk (2005) states:

that children experience a crisis of loyalty and organize their behavior to survive with their families. Being prevented from articulating what they observe and experience, traumatized children will organize their behavior around keeping the secret, deal with their helplessness with compliance or defiance, and acclimate in any way they can to entrapment in abusive or neglectful situations (p.404).

Children try to maintain what they know as familiar because it is experienced as safer even if it is a source of terror. Being able to predict the actions of another individual may allow one to feel safer whereas unpredictable behavior can cause fear and anxiety (van der Kolk, 2005).

Children victimized by a family member often feel conflicted by the abuse. Often they are, “tormented by self doubt, self blame, fear of the abuser, and distress over what their disclosure had done to the family” (The National Child Traumatic Stress Network, 2009, p.2. They may not want the abuse to continue, but fear reporting it because they do not want their loved one to get into trouble (Atwood, 2007; McNevin, 2008).

For example, families where intrafamilial sexual abuse is occurring often have a:

characteristic of secretiveness, including, of course, the intrafamilial sexual abuse secret shared between father and daughter to the exclusion

of the others. Girls have great difficulty in talking about the incest in treatment, a testimony to the power of their aspect of the relationship, since disclosure represents betrayal, even in cases where the father is hated (Sroufe & Fleeson, 1986, p.68).

Children may also fear being doubted because they are often told that no one will believe them. They may not report the abuse out of embarrassment or fear that they will be viewed as being the one at fault. Also, they are often protective of their abuser and may enjoy the special attention they are receiving aside from the sexual abuse (Atwood, 2007; McNevin, 2008).

Family dynamics can change when intrafamilial sexual abuse has occurred and disclosure has taken place. A child may feel betrayed by other family members for not preventing or intervening in the sexual abuse (Atwood, 2007; Nichols, 2013). Even if the particular family member did not know the abuse was occurring the child may believe some signs of the abuse should have been noticed. When non-abusing parents are aware of the sexual abuse taking place there are many reasons as to why they do not intervene. They may be reliant on the perpetrator for shelter or money; they may believe they have to allow the incest to continue in order to keep their partner; if they were also victims of intrafamilial sexual violence, they may think it is normal; and they may blame the child for the abuse believing the child was “asking for it” (Incest, Rape Abuse and Incest National Network).

Some of the literature suggests that when intrafamilial sexual abuse takes place between a daughter and her father the mother may become resentful towards the daughter

and blame her for the abuse. In the intrafamilial sexual abuse relationship the daughter may take the role of the wife/mother by being the father's "lover" and possibly disciplining her younger siblings, or taking the role of homemaker. This can lead to maladaptive parental and marital roles in the intrafamilial sexual abuse families (Boatman, Borkan, Schetky, 1981). If the child becomes the perpetrator's "lover" the marital role of sexual intimacy is removed from the non-offending parent. The child's role in the family can change from being a child to being an adult through taking on parental responsibilities causing maladaptive parental roles.

Therapy Considerations

Clinicians must take several factors into consideration prior to attempting to rebuild and heal the family. Foremost, the risks of the child remaining in the home and the possibility of not being protected must be taken into consideration prior to therapy due to the risk of the child being punished for revealing the abuse in therapy (Boatman et al., 1981) as well as the possibility of the abuse to continue (Nichols, 2013). Risks of the child being protected can be determined by assessing and exploring both parents' mental health status along with investigating the non-offending parent's ability to empathize with his/her child as well as his/her ability to be assertive. The family's cultural and parental personal beliefs regarding sex is also examined as well as the child's ability to seek help if he/she is again threatened with abuse (Powell & Ilett, 1992). The parental factors assessed determine the ability of the parents to fully understand the detrimental effects the abuse has had on their child, which may limit their ability to recognize and respond to signs that additional abuse may occur. If the parents are unable to empathize with their child's feelings regarding the abuse they may in turn cause further harm to

their child (Powell & Ilett, 1992). Children turn to their parents for support, and if their parents are unable to empathize with their feelings their emotional needs will not be met and they may internalize the abuse as their fault. Also, the child may not receive mental health services to help heal from the abuse due to the parent's lack of understanding the importance of working through and healing from the abuse.

It is important to understand the family's cultural background and personal beliefs regarding sex because it may reveal underlying attitudes that could contradict the family's willingness and ability to protect the child in the future (Powell & Ilett, 1992). For instance, if a female is sexually abused and she comes from a culture that values female virginity she may feel as if she is "damaged goods", has disgraced her family, or whom no one will want to marry leading to an increase in secrecy from herself and possibly her family as well (The National Child Traumatic Stress Network, 2009). The clinician should understand if intrafamilial sexual abuse has occurred for generations and is accepted by the family, or if the family holds the belief that the abuse should never be discussed outside of the family (Powell & Ilett, 1992).

Once the clinician has deemed therapy to be appropriate, it is necessary for the child to be willing to participate in therapy with his/her perpetrator. The clinician, family and court should not force the child into attending therapy with his/her perpetrator because it could cause additional harm (Server & Janzen, 1982). It is the clinician's responsibility to be honest with the child, to explain the process of therapy and how therapy can be beneficial to him/her as well as exploring what led to the disclosure of intrafamilial sexual violence (Adams-Tucker, 1984; Boatman et al., 1981). Nichols (2013) states:

When working with abused children, it's helpful to explain that the more they talk about what happened, the less troubling their feelings are likely to be. However, it's essential to let *them* decide when and how much to open up (p.50).

It is essential that the clinician keep in mind that the child and the family may have experienced many interactions with varying professionals. They may be feeling anxiety, anger, fear and shock due to the disclosure of the abuse (Adams-Tucker, 1984).

During the therapy sessions experts recommend clinicians to be aware of his/her body language and how it may be perceived by the child. Further victimization can occur if the clinician's body language is passive and in an analytic posture as well as if the therapist responds in silence to the child anger, sadness or fear regarding the abuse. This can lead to the child feeling hopeless and helpless (Adams-tucker, 1984; Boatman et al., 1981). It is important that the child's affective responses to the sexual abuse are supported and promoted at all times. Using phrases such as, "I can see you are very mad at what your father did. A father should not do that to his daughter" can alleviate further victimization (Adams-Tucker, 1984, p.511). When exploring feelings a child may have regarding his/her victimization the clinician should reiterate the fact that the abuse was not his/her fault. Children need this consistent reassurance (Nichols, 2013). Monitoring feelings throughout the session(s) and seeking consultation with colleagues is crucial for the clinician to do, in order to avoid over identifying with the child. It is vital that the clinician not jump to conclusions of how the child is feeling, and to accept the child's feelings in order to teach the child to do the same (Boatman et al., 1981).

When the child speaks of body parts that were violated during the abuse or body parts that he/she were forced to touch sexually, they should be named by the child and the clinician should refer to those body parts using the same language. If this is not done the clinician runs the risk of stifling discussion with the child (Adams-Tucker, 1984). Throughout therapy the clinician must always keep in mind the health and adjustment of the child (Hewitt, 2007).

Therapy Approaches

Common therapy approaches include using a combination of individual, family and group therapy. Individual sessions are used with a client to help relieve his/her feelings of guilt and responsibility for the abuse (Server & Janzen, 1982). These sessions allow for a child to make sense of what has happened to him/her and to help him/her with his/her destructive feelings (Boatman et al., 1982). To gain an understating of what the abuse means to the child and how the child has coped with the abuse the clinician should ask future oriented questions. Future oriented questions include what the child expects and wants from his/her family as well as therapy. These questions allow the clinician insight around any denial or thought distortions a child may have regarding his/her perpetrator, the abuse, and if he/she believes the abuse will continue. These questions can also give the clinician an idea about which direction the therapy should go and an estimate of length (Adams-Tucker, 1984). In order to transform destructive feelings and thought distortions the clinician works with the client to help restore his/her self-esteem, to help him/her regain control of their life, and to help reinstate normal emotional development. Also, individual sessions allow the clinician to gain an understanding of the child's perception of the family and to validate his/her feelings (Boatman et al., 1982).

Family sessions may be utilized in conjunction with individual sessions to help heal and rebuild the family. Healing a family requires time and professional intervention in order to reach a healthy and safe resolution for every person involved (Server & Janzen, 1982). Hewitt (2007) suggests that these sessions begin after a contract has been made with the victim, the perpetrator, and the non-offending parent identifying what is an appropriate or OK touch and what is not. The idea of creating a contract around appropriate touches is to create an environment where the child can feel safe and to change the previous dynamic in the relationship. After the contracts have been made and discussed gradual contact between the child and the perpetrator in the family sessions is made. Gradual contact is used to prevent the child from feeling overwhelmed (Hewitt, 2007).

During family sessions the allegations of sexual abuse are directly addressed which can help to assist the family into gaining an understating into their family dysfunction, which may have led to the sexual abuse (Hewitt, 2007; Server & Janzen, 1982). It is important that the abuse does not become misdirected to blame the child or the non-offending parent because it can create feelings of guilt and other stressors within the home (Powell & Ilett, 1992). However, Attwood (2007) believes that family therapy can be problematic when working with a victim of incest because of its systemic approach viewing incest as a family issue which may relieve the perpetrator of responsibility, and may place responsibility on the non-offending parent or even the victim. This form of therapy may end up blaming the victim.

Group therapy is used along with individual and family therapy. Group therapy has the potential for offering peer support in regards to isolation and fears of deviancy. Individuals in group therapy are able to relate to one another and do not have the burden of dealing with their “secret” alone. Individuals are encouraged to speak about their abuse to help overcome shame and secrecy (Boatman et al., 1982; Pfiefer, 2010). Group therapy allows for individuals to overcome their mistrust of adults and their fear of intimacy in regards to disclosure of personal feelings with adults (Pfieffer, 2010). Group therapy is used as an additional support system and healing environment for the individual.

Therapy Approaches without the Perpetrator

One intervention used with children is Developmental Play Therapy (DPT) during individual sessions. DPT is based on theories of attachment. This form of therapy allows the child to build a new attachment to the adult clinician through the use of play and physical body contact so the child can learn and relate to other people in a productive and satisfying manner (Mitchem, 1987). Also, “Using play as a way to interview a young child between the ages of 2-5 is developmentally age appropriate for their sensorimotor phase of cognition and allows for motoric enactment of what happened during the abuse” (Adams-Tucker, 1984, p.509). A common consequence of sexual abuse for a child may lead him/her to have no or few personal boundaries for his/her body or others. Traumatized children rarely speak impulsively regarding their fears. They often have little insight into how the abuse they experienced affects the way in which they feel and act. Children communicate their abuse through interpersonal enactments in their play (van der Kolk, 2005, p.405). DPT can help a child talk about his/her fears through play, and the clinician can address the play reenactment with the child’s fears and feelings.

Games are utilized in play therapy to build appropriate boundaries and allow children who are preoccupied with sexual trauma to gain dialect and understanding of their feelings and family situation (Boatman, Borkan, Schetky, 1981; Mitchem, 1987). DPT was found to increase cooperation and playfulness at home as well as in therapy (Mitchem, 1987; Sheinberg & True, 2008) as well as decrease behavioral problems, improve the child's self-concept, and emotional adjustment (Sweeney & Landreth, 2011).

Another form of therapy that does not include the perpetrator is Mindfulness Meditation-Based Stress Reduction (MBSR). This approach was used in adults but there is no research to support its applicability to children. MBSR is used in conjunction with individual psychotherapy and focuses on the moment-to-moment, non-judgmental attention and awareness of what is happening around in one's environment. This form of therapy is, "thought to increase clarity, attention, calmness, and emotional well-being" (Kimbrough et al., 2010 p.19). Kimbrough and colleagues found that MBSR used in a case study of 27 adult childhood sexual abuse survivors decreased an individual's trauma spectrum symptoms such as depression, psychological distress, anxiety, sleep and somatic complaints (Kimbrough et al., 2010, p. 18). Kimbrough and colleagues (2010) found that MBSR reduced the symptom of avoidance or the ability to withdraw from traumatic thought or feelings within PTSD. Avoidance is believed to be the core psychosocial process underlying the development and continuation of PTSD.

As discussed by Sheinberg & True (2008) a therapeutic intervention clinicians may use is Decision Dialogue. This approach is used within family therapy without the perpetrator to provide the family with the child's perspective on the abuse. Prior to discussing the issues in the individual sessions the therapist first talks with the child about

the positive aspects of the family as well as positive individual aspects to decrease feelings of disloyalty to the family, and to attempt to make the child feel comfortable. Otherwise the child may internalize that the therapist only thinks of him/her as a person with problems. Decision Dialogue involves one-on-one sessions with the child(ren) and parent(s) in combination with family counseling sessions to rebuild attachments between family members. The individual sessions are what drive the family sessions. During individual sessions the child makes the decision about what will be brought up in the family session and if he/she addresses the issue(s) or if the clinician does; this is known as the decision dialogue. Individual sessions also focus on the child's hesitation to being open with his/her caregivers, helping the child articulate that hesitation, and allowing the clinician to understand the family dynamics. This form of therapy allows for a neutral environment, respects the child by bringing his/her perspective back to the family, and views the family as the primary sources of healing (Sheinberg, & True, 2008).

Therapy Strategies Used with the Perpetrator

A strategy, used to rebuild the relationship between children and perpetrators is called Restorative Justice (McNevin, 2010). Restorative Justice is used in family therapy along with individual sessions. Prior to initiating this form of therapy the therapist meets with the victim to discuss what questions or statements the victim would like to make to the perpetrator as well as what reactions and comments to expect from the perpetrator. Role playing with the therapist and the victim is utilized in preparation. The clinician also contacts the perpetrator to ensure they want to participate and are appropriate to participate in therapy (McGlynn, Westmarland & Godden, 2012).

This strategy aims at restoring a balance where conflict has occurred while giving the victims a voice to their experience, and placing the responsibility of the abuse on the perpetrators. Restorative Justice can relieve responsibility of the abuse children may feel by allowing them to hear the perpetrator take responsibility and hear how they manipulated, coerced, overpowered and forced them to keep the abuse a secret. The child is not expected to forgive his/her perpetrator (McNevin, 2010). Shapland, Atkinson, Atkinson et al, (2008) found that Restorative Justice strategy produced positive results in terms of victim and offender satisfaction and reduced reoffending rates (McGlynn et al., 2012).

Conceptual Framework

A successful framework to use in rebuilding and healing a family of intrafamilial sexual violence is one that incorporates the family as a whole. It is important to include the parents in therapy because, “Parents frequently contribute to the original trauma and always influence the course of their child’s recovery” (Hopkins, 1986, p.68). The Family Systems Theory recognizes that, “family members are interconnected such that each individual affects all others, who in turn affect the first member in a circular chain of influence” (Walsh, 2011, p.154). This approach utilizes key members who can activate needed change within the family through individual and family sessions. The clinician focuses on:

[t]he relationships and systematic patterns in assessment and intervention. Therapists consider (a) how family members may contribute to and are affected by problem situations, (b) how they can be

resources in solving problems, and (c) how family bonds functioning can be strengthened for greater being and positive growth... Family interventions aim to modify dysfunctional patterns, tap family resources, facilitate communication and problem solving, and strengthen both individual and family functioning (Walsh, 2011, p.154).

This theory allows for the non-offending parent(s) along with the offending parent or sibling (s) to initiate positive change within the family. While helping a family where intrafamilial sexual abuse has occurred, the clinician holds the perpetrator accountable for the abuse and maintains the victim as blameless; otherwise a family system approach can run the risk of blaming the child. This theory fits well with the therapy approaches discussed in the literature review because it views the family as having the ability to repair the family.

Another approach is the Eco-Structural Theory approach to family therapy. This theory is based on three basic principles: family members are interdependent; patterned interactions in the family continue over time; and interventions are targeted to change the patterned interactions. (Theoretical Basis, 2011). When intrafamilial sexual violence is occurring in the home and after disclosure of intrafamilial sexual violence the entire family is affected; it is not only the victim and the perpetrator. Family dynamics often change after the disclosure of intrafamilial sexual violence (Atwood, 2007). In order to reestablish healthy family dynamics and the child's mental health the entire family, if appropriate, should be involved in therapy. Szapocznik & Coatworth (1999) and Bronfenbrenner's (1977) theory maintains that families are the most influential and

strongest force in development of children and adolescents, as stated in the Theoretical Basis (2011) of Family Centered Treatment. This theory states that patterns of family interaction often become habitual and influence the behavior of each family member. The interactions used within family therapy are targeted to change the patterns of interaction (Theoretical Basis, 2011). The demanding of secrecy and inadequate parental and marital roles are the patterned interactions that must be changed in a family where intrafamilial sexual violence has occurred (Atwood, 2007; Boatman, Borkan, Schetky, 1981). The Eco-Structural Theory stresses the importance of emotional experience as well as the emotional expression (Theoretical Basis, 2011). Therapy approaches discussed in the literature review emphasize the importance of the child sharing his/her perspective on the abuse he/she has endured while maintaining the blame for the abuse on the perpetrator. This theory when applied allows for the child to express his/her thoughts while working to correct incestual patterned behavior (Boatman et al., 1982; McNevin, 2010; Sheinberg, & True, 2008).

Methods

Research Design and Sampling

For the purpose of this research, a qualitative interview was conducted. A qualitative method was selected in order to gain in depth answers surrounding the therapeutic approaches helping professionals utilize to help rebuild and heal a family of intrafamilial sexual abuse. Three clinicians were interviewed. Each respondent interviewed has experience working with children and/or adolescent victims of intrafamilial sexual abuse and healing the relationship with their perpetrator. The respondents were selected based on availability and location using the website

Psychology today (www.psychologytoday.com). I also used snowball sampling.

Snowball sampling is a probability technique that, “involves identifying some members of the population and then having those individuals contact others in the population” (Marlow & Boone, 2005). I used my professional connections within the state to find potential interviewees. I sent out emails to individuals selected from Psychology today, and the names gathered from snowball sampling. Interviews were conducted in the month of March.

The clinicians interviewed in this study provide therapeutic services to individuals ranging from infancy to eighteen years of age. All respondents serve both female and male clients from varying socioeconomic status and race. The average length of therapy ranges from a minimum of three months up to ten months with a few cases lasting over a year or more. The respondents in this study received his/her clients through referrals from Child Protection, court, Social Workers, schools, other mental health agencies, and parents who have another child in therapy at the agency in which the respondent is working.

Protection of Human Subjects

Prior to an interview, a consent form was given to the respondent (see Appendix A). This form was modified to include information about the current study. It complies with the exempt-level University of Saint Thomas (UST) Institutional Review Board (IRB) and Protection of Human Subject guidelines including adequate explanation of confidentiality along with anonymity of the respondent during the research process, the voluntary nature of the study, the procedures of the study, along with identifying no clear

risks or benefits involved with the study to the respondent. The respondent's name was omitted from field notes, transcription of the interview, and this report. My phone and email information was given to the respondents to allow them to contact me with any concerns or questions they had regarding the interview.

Data Collection and Analysis Technique

The interview began after the respondent agreed to participate and signed the consent form. The interview was carried out in a face-to-face meeting with a semi-structured format; the interview was audio recorded, and lasted approximately 30 minutes. Preceding the interview the set of questions that was asked of the respondents was approved by Dr. Lance Peterson (see Appendix B). This process was taken to ensure the UST IRB and Protection of Human Subject guidelines were met of asking open-ended, neutral questions. The interview began by asking respondents for information related to their professional background; followed by questions regarding the current demographics of those they are currently serving and how the clients are referred to them. Then, more specific questions were posed about his/her understanding of rebuilding a relationship between victim and perpetrator, and what therapy approaches are used to rebuild the relationship. The audiotaped interviews were recorded using a digital recorder, which was kept at the writer's home in a secure, locked file. The audiotape of the interview will be destroyed one year from the date of the interview after the completion of the transcription, coding process and research presentation. Transcriptions of the interviews were kept in a password-protected file on the writer's computer. This process was taken to ensure the UST IRB and Protection of Human Subject guidelines of confidentiality.

Grounded theory was used to analyze this data. Grounded theory involves inductive and deductive reasoning with the use of raw data that is coded with themes and little word changes around the central research question (Berg, 2012, p.358). The transcript was read by the researcher and the codes that emerged were written down in the margins of the document alongside the corresponding respondent quotes. Following the coding process the researcher organized the differing codes. The differing codes were categorized based on similarities, which resulted in four themes.

Findings

There were a total of 25 different codes identified from the three interviews. From the 25 different codes four themes were formed incorporating the varying codes associated with the theme. The themes are: therapeutic process, therapeutic approaches, therapy interventions, and clinical considerations. The four identified themes will be addressed individually and outlining the codes incorporated within the theme.

Therapeutic Process

The 'therapeutic process' was identified through the analysis of the interview data. This theme incorporates how a client is referred to the clinician, demographics of the clients currently being served, average length of therapy, the percentage of intrafamilial sexual assault victims each respondent is serving, and how each respondent defines rebuilding the relationship between the victim and the perpetrator.

The respondents differed in the amount of intrafamilial sexual abuse cases he/she provides services to. One respondent stated, *I'd say probably it averages maybe 10% for intrafamilial*. Another respondent indicated the number of cases he/she provides services

to as; *I would say about 20%*. The final respondent stated, *Probably not very much, but I've had a few cases that I have seen more long term but not a high number of them*

Corresponding with the literature, the clinicians in this study highlighted the significance of the child determining how the relationship would be rebuilt and allowing him/her to define it. One respondent stated, *Whatever it means to me is what it means to the client, so like if that's around forgiveness or if that's around figuring out a different way to relate, if that's around coming to terms of what happened, or really not having much of a relationship or redefining what that relationship is or what that looks like. I'm open to any of those things but it needs to be whatever the client, especially the child, the victim needs*. It is necessary for the clinician, the perpetrator and the non-offending parent(s) to have the capacity to empathize with the child (Powell & Ilett, 1992) and to be open in allowing the child to decide the direction of his/her therapy. Doing so assists the clinician in not causing further harm to the child because the child is a willing and active participant in therapy (Server & Janzen, 1982).

This theme was found in the beginning of the interviewing process among all respondents. This theme illustrates the codes of the cliental the respondents are currently serving, the average length of therapy, the percentage of intrafamilial sexual assault clients, and how each respondent defines the rebuilding of the relationship.

Therapeutic Approaches

The theme 'therapeutic approaches' was related to the respondents' comments of the multiple therapeutic approaches used to rebuild a relationship between a child victim of intrafamilial sexual abuse and his/her perpetrator. The clinician should empower the

child to address his/her feelings regarding the sexual abuse. In this example the therapist refers to utilizing techniques found in Decision Dialogue in a family therapy session, *I coach and encourage my client. I also do more of problem solving so how do you think this session should occur and if they don't have an idea I'll ask them if they want suggestions for what I have experienced worked in the past to see if any of those options worked, but my preference would be that the client bring it up.* This quote relates to the Eco-Structural basis of influencing the developmental change of the child through his/her family as well as the significance of emotional experience and emotional expression (Theoretical Basis, 2011). This use of Decision Dialogue Therapy empowers the child to discuss his/her feelings with his/her family because the family is viewed as the primary source of healing (Sheinberg, & True, 2008).

The Family Systems Theory concept of homeostasis needs to be addressed in therapy. Homeostasis in families where intrafamilial sexual abuse has occurred is maintained as patterns of family interactions that often become customary and sway the behavior of other family members through the demand of secrecy, and inadequate parental and marital roles (Atwood, 2007; Boatman, Borkan, Schetky, 1981; Theoretical Basis, 2011). Guiding a family to recognize how they maintain their homeostasis is a challenge task as stated by one respondent, *Homeostasis is such a powerful thing in the family system, to remain the same even though at one time; however, they are working together and communicating; it may have worked at one time or maybe just a couple times but they are so entrenched that system of homeostasis that is probably the biggest obstacle to have them recognize, that there are other options to communicate, to problem solve, to resolve conflict.*

Due to the power differences present in families that contribute to homeostasis by allowing the child who lacks authority set the tone for therapy may upset the family's equilibrium. The following quote from one respondent demonstrates how a clinician can embrace the idea of respecting the decision to disrupt the family's homeostasis, *I never want to be the adult in the room and as the therapist assume that I have the control and have the kid ever feel like it's just up to me what things get brought up or how they get brought up. Really if this is about healing and moving forward it needs to be their decision about when it happens and when it doesn't. Maybe they are overall ready for it but today they're not, and I think that is really important to reevaluate and to reassess and come to an agreement again over and over again every time we meet.*

To affectively change the homeostasis the perpetrator must assume accountability for the abuse. By accepting responsibility the perpetrator is expected to change the family patterns that fostered the facilitation of the sexual abuse and operate differently than accustomed to. One respondent highlighted this idea, *I think that it is really about evaluating what their intentions are, and to find out how prepared they are to hear some really hard things about the realities of what has happened; so if I get any sense that the perpetrator is like defensive or not willing to be accountable or if they are trying to profit off their own experience, that to me would be like a red flag that maybe it's not appropriate yet and I would refer them back to like someone else for more therapy, or maybe I would meet with them individually for a while before I brought the child into it.*

The therapeutic strategy Restorative Justice requires the perpetrator to admit accountability for the sexual abuse. This therapeutic strategy is suited for altering the homeostasis of a family.

All respondents indicated that they provide individual, group, and family therapy sessions. Other therapy modules acknowledged by the respondents were Trauma-Focused Cognitive Behavioral Therapy, Cognitive Behavioral Therapy, Narrative Therapy, Mindfulness Based Relaxation, Developmental Play Therapy, and Art Therapy. Some of these modules are the theoretical framework of the respondent's orientation. Not all modules were addressed in the literature review.

Therapeutic Interventions

The process of how individuals talk with one another is an important aspect of the Family Systems Theory. Throughout family therapy a clinician should observe the communication between the child, the non-offending parent(s), and the perpetrator and how other members of the family respond. The Family Systems Theory views the members of the family to be interconnected; consequently, poor communication by one member of the family can have negative effects on others. The following quote from one respondent illustrates the clinician's awareness of the communication among family members, *I'm always going to be watching how other people in the room, rather if it's the perpetrator or other witnesses, how they are responding to whatever is happening to that child, because if it's not being done in a therapeutic way then I would want to slow down again and reevaluate.* Another respondent stated, *I assess and work with the family to make sure that its safe for this discussion to occur in the family and that their key point or emphasis should be seeking to understand the client and to hear the client and to truly be feeling empathy.*

If a member of the family was not responding to meet the child's needs the clinician should intervene in order to prevent causing harm. The child needs validation of his/her feelings as well as reassurance that the abuse was not his/her fault (Nichols, 2013). The following quote from a respondent illustrates the impact good communication can have on a family, *Just being able to state what had happened with understanding with the memory of this incident and having it validated by, for instance, a mother or brother or stepfather as another family member witnesses is powerful; the process of validation I think is what I work for to establishing successful cohesiveness, and that it's not avoided, the topic is not avoided it can be discussed and that it needs to be within the family.*

Discussing the abuse within the family strongly corresponds with the Eco-Structural Theory. Referring to the theoretical basis that family members are interdependent, and witnessing the acknowledgement of the sexual abuse within the family targets the change for the patterned interactions. The discussion of the abuse within the family also parallels the Family Systems Theory with the belief that it needs to be discussed in the family because the family has the power to repair themselves.

Clinical Considerations

The theme 'clinical considerations' combines the codes of family dynamics and memory impact on the child. Issues related to family dynamics can be better understood using the theoretical perspective of the Family Systems Theory. This theory incorporates a family structure which refers to the way a family interacts with one another. It is organized through subsystems or smaller units of the family. Repeated family

transactions create expectations and established patterns within these subsystems. The family structure is reinforced by the rules created from the expectations. It is vital for the clinician to attempt to understand the child's family structure as well as the varying subsystems. The structure of the family may only be evident when a clinician observes the family interact amongst themselves (Nichols, 2013). The clinician in the following quote describes her committed effort into understanding the family dynamics, *I am always looking at all the different intersections of different relationships, so when you're talking about a whole family system there are so many different relationships to consider within that family; and so you know; you're not just looking at the victim, the perpetrator, you're looking at every other individuals in that family witnessing that, and how does it affect their relationships and I think that if you're talking about really cohesive family and it's just really complicated; so you have to be very aware and have good rapport with everybody individually and get really good understanding of each individual relationship.*

In order for the clinician to begin to understand the subsystems of the family he/she must first build rapport with each member of the family. Once a relationship is established with the family members a clinician will have a better understanding of the family's expectations, rules, and communication process. However, a clinician must remain aware of the power dynamics within the family,

I think it is really important to remember the power dynamic; like you have to keep in mind of that child, so really, that's the story that I would want to make sure gets the most voice and the most recognition; that's the one I would be most concerned about.

Keeping the child's story as the focus empowers the child to share his/her story. Permitting the child to explore and express any feelings openly related to the abuse with his/her support system is important regardless of his/her memory capacity. One respondent commented *I don't push the kids if they can't remember; that is I take them for their word*. Taking the child for his/her word and not discrediting the child due to lack of memory validates the child's experience and feelings. This can be reparative in the child's self-doubt, self-blame and potentially decreasing any feelings of shame which may feed the negative family cycle. Another respondent stated, *...the parent and I are working collaboratively to reinforce those skills and probably the most significant part after all that is the narrative piece where the client has either written or drawn and tells their story, and it also entails me prepping the parent or guardian so they don't react to what they hear but instead put aside their emotional reactions, but are able to express empathy and support for their child*.

Referring to the importance of "prepping the parent" strongly corresponds to the Eco-Structural Theory. In this case, the clinician refers to the significance of the collaboration of work between the child, the parent(s), and the clinician in psychoeducation regarding the trauma, modeling appropriate self-regulation and coping skills, and being able to express empathy to the child, implying that this is a necessary part of changing the family dynamic. The family dynamic changes when the child is expected to share his/her trauma story, and the parent(s) is expected to accept the story.

All respondents commented on the importance of paying attention to the family dynamics and the affect it has on the child. The memory of the child's victimization, in

these clinicians' opinion, does not negatively affect the ability of the child to heal from the abuse or to rebuild the relationship with his/her perpetrator.

Discussion and Implications

Researcher's Interpretation of Findings

The four themes identified above were a good representation of the interviews conducted. Themes included: therapeutic process, which outlined how each respondent received his/her clients, the demographics of the clientele, average length of therapy, the percentage of intrafamilial sexual assault victims each respondent is serving, and how each respondent defines rebuilding the relationship between the victim and the perpetrator. The respondents worked with clientele varying in age ranges which allowed for different therapeutic modules to be applied.

Defining what rebuilding a relationship between the victim and his/her perpetrator had different meanings from each respondent, but all responses incorporated the social work value of self-determination. It is the responsibility of the clinician to help the client define what rebuilding the relationship between him/her and his/her perpetrator means while making sense of his/her victimization. Once the definition is determined it allows for the clinician to outline a course of treatment incorporating the child's family structure. This theme established the roots of the research, which allowed other themes to be formed.

The second theme of therapeutic approach was identified by the respondents through the different therapeutic approaches communicated used to heal and rebuild a relationship between a child victim of intrafamilial sexual violence and his/her

perpetrator. These therapeutic approaches included: Restorative Justice Strategy, Decision Dialogue, Mindfulness Therapy, Play Therapy, Art Therapy, Cognitive Behavioral Therapy, and Trauma Focused Cognitive Behavioral Therapy. All respondents stated that they do not utilize only one particular therapeutic approach, but they may use multiple therapeutic modules based on the client's needs. This researcher found this theme to demonstrate the important aspect of how a clinician provides services to rebuild and heal the relationship between the victim and the perpetrator.

The third theme of therapy interventions was a key component of rebuilding a relationship. Incorporated in this theme are the skills clinicians use throughout the therapeutic process such as building rapport with the client, validating the client's feelings, identifying what the client would like to achieve from a session, and determining if it is appropriate if the a perpetrator attends a therapy session with the client. The respondents stated that they assess the client's wellbeing and safety continuously throughout the therapeutic relationship in order to prevent causing harm to the client.

The final theme of clinical considerations builds upon therapeutic approaches and interventions. This theme includes the client's family dynamics and the impact of a client's memory of his/her victimization on the therapy process. All respondents declared the memory of the client's victimization to be irrelevant in rebuilding the relationship between the perpetrator and the victim. One respondent suggested that if the client remembered his/her victimization in great detail it would cause him/her more harm than good because anxiety could be provoked due to fixating on the details of the abuse. Also all respondents stated that they would not challenge a client to remember more than what

he/she is capable of. Believing in the child's trauma narrative aids in empowering the child to honor and work through his/her feelings associated with the abuse. The work conducted in therapy is to help reduce the psychotic symptoms caused by the memory the client has. Therapy is not solely for the purpose of uncovering new memories although it may occur.

A clinician working with a child victim of intrafamilial sexual abuse and his/her family must take into account how the family structure and family dynamics affect the therapeutic process. One respondent commented on the significance of how individuals relate to one another within a family. Without considering the dynamics of a family the clinician risks not establishing rapport with individuals, and positively progressing therapy. Another respondent commented on the importance of building rapport with every individual involved in family therapy in order to gain an understanding of the subsystems within the family. These subsystems establish rules, expectations, and how individuals communicate with one another ultimately affecting the child's capacity to manage any mental health symptoms and his/her ability to rebuild a relationship with his/her perpetrator. The likelihood of a therapeutic rupture occurring increases the chance with more individuals involved in therapy. Incorporating all members of the family and their unique family structure in the therapeutic process and upholding the child as the designated client can be a daunting and challenging task for a clinician.

Relevance of Researcher's Findings and Literature Review

Three similarities emerged between the researcher's findings from the interviews and the literature reviewed. First, there is no identified preferred therapy approach to

rebuild a relationship between a victim and his/her perpetrator. This is supported through the many different therapy approaches addressed in the literature along with the respondents stating they do not utilize one specific approach, and often times it is a combination of multiple therapy approaches. Clinicians will also use a therapeutic approach that is deemed the best approach by the agency they work for. For example two of the respondents use the Trauma Focused Cognitive Behavioral Therapy model because that is the theoretical perspective of the agency. Clinicians working with children and adolescent victims of intrafamilial sexual violence integrate mindfulness techniques during therapy sessions to reduce psychotic symptoms such as anxiety, which is similar to the Mindfulness Meditation-Based Stress Reduction approach. Those serving clients twelve years and younger incorporate Developmental Play Therapy as a therapeutic module to help the client express his/her feelings and tell his/her story, “Children communicate their abuse through interpersonal enactments in their play” (van der Kolk, 2005, p.405). Although the respondents did not name Restorative Justice as a strategy they use their comments of the perpetrator assuming responsibility and allowing the victim to have his/her voice heard are the core values of this approach.

The second similarity is the importance of individualized therapy sessions prior to therapy with the victim and the perpetrator. The literature states that the victim must first begin to work on his/her own healing through therapy prior to rebuilding a relationship with his/her perpetrator. The clinician works with the client to help restore his/her self-esteem, to help him/her regain control of their life, and to help reinstate normal emotional development (Boatman et al., 1982). This is supported in the interview where the respondent states the importance of building rapport with the therapist, decreasing

negative symptomology, the significance of planning for the therapy session with the perpetrator, and assessing the safety of the client.

The final similarity found is that the victim must want to rebuild a relationship with his/her perpetrator. If the victim does not want for this to take place it may cause more harm to the victim (Server & Janzen, 1982). The literature acknowledged no need to rebuild a relationship if the victim saw no need. Respondents from the study stated they would not attempt to rebuild the relationship if the client did not want to or if it was unsafe for the client. They also discussed the importance of the child identifying what it means to rebuild the relationship with his/her perpetrator.

Implications of Research Findings

The research question addressed a child rebuilding a relationship with his/her perpetrator. The literature found on how to effectively rebuild a relationship between a sexual assault victim and his/her perpetrator was not specific to only children. Not all therapeutic approaches were researched such as Trauma Focused Cognitive Behavioral Therapy, Art Therapy, Narrative Therapy, and Cognitive Behavioral Therapy due to time constraints. Some of the findings related to therapy approaches were used on adults and not children. There is a lack of research done in the area of Mindfulness Based Stress Reduction approach and the Restorative Justice Therapy strategy and their effectiveness on children.

Another implication of the research is the number of people interviewed for the study. There were only three individuals interviewed. The research found this to be due to time constraints, lack of specialized individuals in the metropolitan area, and lack of

interest of the study from prospected interviewees. One of the individuals interviewed stated he did not provide therapy to the perpetrator and the victim. The results from his interview were kept due to the relevance of his experience working with child victims of intrafamilial sexual abuse and the non-offending family members. Initially another respondent also stated he did not provide therapy to a child victim and his/her perpetrator until he was asked if he ever worked with a victim who experienced sibling sexual abuse, to which he replied yes. The researcher did not think to ask the first respondent this question when he said he did not provide therapy to the victim and his/her perpetrator.

Reflecting on this experience the researcher would have made additional emails and follow up calls to potential interviewees to increase the number of individuals in the study. Also the researcher would have called the Child Protection Service department in a local county, and asked where they referred their child victims of intrafamilial sexual abuse to for therapy, and then contacted the clinicians provided for an interview.

This study did contribute to the field of Social Work by assessing how clinicians make sense of family systems in the context of helping victims of intrafamilial sexual violence rebuild a relationship with their perpetrator. This study found that clinicians working with this population use a family system based theoretical approach when assessing a child and his/her family's appropriateness to begin or continue therapy as well as the therapeutic approach utilized. Similarly this study demonstrated a wide range of therapeutic approaches a clinician can and does employ throughout the course of child's treatment. Respondents identified therapeutic approaches not found in the literature review. Also the respondents of this study were found to not follow one particular therapy approach and in fact integrate many aspects of varying modules into a

child's treatment. Every child should have the right to define the rebuilding process with his/her perpetrator and to have a clinician who tailors his/her approach specifically for that child and his/her family. Also this builds upon the previous research of the importance of the perpetrator assuming responsibility for the sexual abuse.

Implications for Future Research

Little research has been done on how to effectively rebuild a relationship between a child victim of intrafamilial sexual abuse and his/her perpetrator. Several different therapy approaches are used to help a victim to heal from the repercussions of his/her victimization. However, not all interventions include the child's perpetrator or the family. The lack of involving the child's family in therapy debilitates the chances of regaining family cohesiveness and changing the negative patterned interactions that facilitated the sexual abuse. Not including the child's perpetrator in therapy when there is a chance of reunification leaves the child without the opportunity to have the family's functioning improve through gradual openings of communication in therapy (Nichols, 2013).

Further research is needed to determine if individualized approaches may be useful as an early intervention such as Developmental Play Therapy (Mitchem, 1987) to strengthen a family session with the perpetrator and/or family. The family session could be strengthened by the clinician sharing with the family the child's feelings and fears that were portrayed through play reenactments during an individual Developmental Play Therapy session (Boatman, Borkan, Schetky, 1981; Mitchem, 1987). More research is needed to determine if the child's dialect and understanding of his/her feelings and family

situation gained through the use of games (Boatman, Borkan, Schetky, 1981; Mitchem, 1987) can be a stepping block in developing insight into why the abuse occurred.

Additionally, therapy approaches identified in the literature pertaining to only adults should be further reviewed to see if they may also be applicable for children, such as Mindfulness Stress Based Reduction Therapy (Kimbrough et al., 2010). Clinicians in this study providing therapy to children and adolescents are utilizing mindfulness as a source of relaxation to decrease negative symptomology, to help the client feel in control of his/her body, and to help the client identify a safe place within his/her mind.

References

- Adams-Tucker, C. (1984) Early treatment of child incest victims. *American Journal of Psychotherapy*, 38 (4), 505-516.
- Atwood, J. D. (2007) When love hurts: preadolescent girls' reports of incest. *The American Journal of Family Therapy*, 35, 287-313. doi: 1080/01926180701389644.
- Berg, B. L., Lune, H. (2012) *Qualitative research methods for the social sciences* (8th ed.). New York: Pearson.
- Boatman, B., Borkan, E., Schetky, D. (1981) Treatment of child victims of incest. *The American Journal of Family Therapy*, 9 (4), 43-51.
- Child Sexual Abuse, (2009) Rape Abuse and Incest National Network. Retrieved from www.rainn.org.
- Coping with the Shock of Intrafamilial Sexual Abuse- Information for Parents and Caregivers, (2009) The National Child Traumatic Stress Network. Retrieved from www.NCTSN.org.
- First Case Of Child Abuse, (2011) Private Family Matter. Retrieved from privatefamilymatter.com/first-case-of-child-abuse.
- Hewitt, S. K., (2008). Therapeutically managing reunification after abuse allegations. *Journal Of Child Sexual Abuse*, 17(1), 17-19.
- Hopkins, J. (1986) Solving the mystery of monsters: steps towards the recovery from trauma. *Journal of Child Psychotherapy*, 12 (1), 61-71.
- Incest, (2009) Rape Abuse and Incest National Network. Retrieved from www.rainn.org.

- Kimbrough, E., Magyari, T., Langenberg, P., Chesney, M., & Berman, B. (2010) Mindfulness intervention for child abuse survivors. *Journal of Clinical Psychology*, 66 (1),17-33. doi: 10.1002/jclp.20624.
- Marlow, C. R., & Boone, S. (2005) *Research methods for generalist social work* (4th ed.) Thomson Learning Inc.: Brooks/Cole
- McGlynn, C., Westmarland, N., Godden, N. (2012) 'I just wanted him to hear me': sexual violence and the possibilities of restorative justice. *Journal of Law and Society*, 39 (2), 213-240.
- McNevin, E. (2010) Applied restorative justice as a complement to systemic family therapy: theory and practice implications for families experiencing intra-familial adolescent sibling incest. *Australian & New Zealand Journal Of Family Therapy*, 31(1), 60-72.
- Mitchum, N.T. (1987) Developmental play therapy: a treatment approach for child victims of sexual molestation. *Journal of Counseling and Development*, 65, 320-321.
- Nichols, M. P. (2013) *Family therapy: concepts and methods*. (10th ed), Allyn & Bacon, 49-125.
- Pfeifer, N. (2010) Group art therapy with sexually abused girls. *South African Journal of Psychology*, Volume 40(1), 63-73.

- Planty, M., Langton, L., Krebs, C., Berzofsky, M., & Smiley-McDonald, H., (2013) Specialreport: female victims of sexual violence 1994-2010. *U.S. Department of Justice Office of Justice Programs Bureau of Justice Statistics*, NCJ 240655
- Powell, B. M, & Ilett, M. (1992) Assessing the incestuous family's readiness for reconstitution. *The Journal of Contemporary Human Services*, 417-423.
- Server, J., & Janzen, C. (1982) Contraindications to reconstitution of sexually abusive families. *Child Welfare*, 61(5), 279-288.
- Statistics, Minnesota Collation Against Sexual Abuse. Retrieved from www.mncasa.org.
- Statistics, (2009) Rape Abuse and Incest National Network. Retrieved from www.rainn.org.
- Sheinberg, M., True, F. (2008) Treating family relational trauma: a recursive process using a decision dialogue. *Family Process*, 47 (2), 173-195.
- Sroufe, A. L., & Fleeson, J. (1986) Attachment and the construction of relationships. In W Hartrup & Z. Rubin (Eds.), Relationship and Development, 51-71.
- Sweeney, D. S., Landreth, G., (2011) Child-centered play therapy. In C. Schaefer (2nd Ed.) Foundations of Play Therapy, 129-152.
- Theoretical Basis, (2011) Family Centered Treatment: a practitioner developed practice and evidenced based model of treatment. Retrieved from <http://familycenteredtreatment.com/fct-model/theoretical-basis.html>

Understanding Childhood Sexual Abuse, Prevention, and Recovery, (2013) American Psychological Association. Retrieved from

<http://www.apa.org/pubs/info/brochures/sex-abuse.aspx>

van der Kolk, B. A. (2005) Developmental trauma disorder toward a rational diagnosis for children with complex trauma histories. *Psychiatric Annals*, 35(5), 401-408.

Walsh, F. (2011). Family therapy. In J. Brandell, Theory and Practice in Social Work (2nded.), 153-178.

Appendix A

CONSENT FORM

**UNIVERSITY OF ST. THOMAS
GRSW682 RESEARCH PROJECT
IRB TRACKING NUMBER: 401219-1**

How a Childhood Sexual Assault Survivor Rebuilds a Relationship with His/Her Perpetrator

I am conducting a study about childhood sexual assault. I invite you to participate in this research. You were selected as a possible participant because of your expertise in providing therapy to sexual assault survivors. Please read this form and ask any questions you may have before agreeing to be in the study.

This study is being conducted by: Patricia Thurmer, a graduate student at the School of Social Work, Saint Catherine University/University of St. Thomas and supervised by Dr. Lance Peterson.

Background Information:

Although individual, group, and family psychotherapy are offered to victims of incest, few approaches

include sessions where rebuilding a relationship between the perpetrator and the victim is emphasized.

This is important because contact may persist between a child and his/her perpetrator. Often the

perpetrator is not criminally charged for the sexual assault because of lack of evidence. Lack of evidence

may include the child's inability to articulate the abuse. When this happens the court often orders the

child to have visits with his/her perpetrator or the perpetrator is allowed to return to the home. Given the importance of approaches to include the perpetrator in therapy sessions, the focus of this qualitative report is to gain an understanding of how a helping professional such as a social worker or therapist can help child sexual assault victims rebuild a relationship with their perpetrators. This report aims at understanding what common therapy approaches are used to rebuild the relationships in a family, and to see if therapists are utilizing the same approaches as discussed. If you agree to be in this study. There is no compensation for participating in this study.

Procedures:

If you agree to be in this study, I will ask you to do the following things: to participate in a taped interviewing lasting 30-45 minutes. The interview will be transcribed, and the findings will be presented as a workshop.

Risks and Benefits of Being in the Study:

This study anticipates minimal potential risks. Some questions may be somewhat uncomfortable to answer. Please understand that you can skip any question that is sensitive or uncomfortable..

The study has no direct benefits.

Confidentiality:

The records of this study will be kept confidential. Research records will be kept in a locked file at the researcher's home. I will also keep the electronic copy of the transcript in a password protected file on my computer. I will delete any identifying information from the transcript. Findings from the transcript will be presented to the public in a workshop. The audiotape and transcript will be destroyed by August 1, 2013.

Voluntary Nature of the Study:

Your participation in this study is entirely voluntary. You may skip any questions you do not wish to answer and may stop the interview at any time. Your decision whether or not to participate will not affect your current or future relations with St. Catherine University, the University of St. Thomas, or the School of Social Work. If you decide to participate, you are free to withdraw at any time without penalty. Should you decide to withdraw, data collected about you will still be used for the purpose of this study.

Contacts and Questions

My name is Patricia Thurmer. You may ask any questions you have now. If you have questions later, you may contact me at 763-227-0474, or you may contact Dr. Lance Peterson at 651-962-5811. You may also contact the University of St. Thomas Institutional Review Board at 651-962-5341 with any questions or concerns.

You will be given a copy of this form to keep for your records.

Statement of Consent:

I have read the above information. My questions have been answered to my satisfaction. I consent to participate in the study and to be audiotaped.

Signature of Study Participant

Date

Print Name of Study Participant

Signature of Researcher

Date

Appendix B

How does a helping professional help a child victim of sexual assault rebuild a relationship with his or her perpetrator?

1. Are you currently licensed, and if so what license to you hold?
2. How long have you been practicing?
3. How long have you been working with child sexual assault victims?
4. How long have you been working with this agency?
5. Can you explain your current role?
6. How much of your work is with families who have experienced intra familial violence?
7. What are the different demographics of those whom you are currently serving?
8. How are your clients referred to you?
9. What is the average age of an individual when you begin working with them?
10. How long on average do you work with your clients?
11. Do you work with children who have been removed from their home and the perpetrator?
12. Do you work with children who have not been removed from their home and their perpetrator? If so, is the perpetrator removed from the home?
13. What do you identify as rebuilding the relationship?
14. When do you decide, or how do you decide when it's appropriate to begin this process?
15. What kind of transformation do you need to see in the child and/or the perpetrator in order to begin this process?

16. What different therapy approaches or techniques does a practitioner use to begin the rebuilding of the relationship process?
17. How does the practitioner know when to use these skills?
18. What tells you that a relationship is progressing in a positive direction?

19. What impact does a client's memory of their victimization have on the rebuilding process?
20. What are the challenges in developing family cohesiveness after intra familial sexual abuse as occurred?