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**Treating non-offending caregivers with a history of childhood sexual abuse and their sexually victimized children : a case study using object relations theory and trauma theory**

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Maytal Schmidt  
Treating Non-Offending Caregivers  
With a History of Childhood Sexual  
Abuse and Their Sexually  
Victimized Children: A Case Study  
Using Object Relations Theory and  
Trauma Theory

## **ABSTRACT**

Childhood sexual abuse is a horrific crime and prevalent social problem within our society that requires multiple levels of intervention. Sexual victimization and sexual offending of children is not a new phenomenon. Although literature is available on childhood sexual abuse, much less is known about non-offending caregivers of sexually abuse children who have their own history of childhood sexual abuse. A consistent finding across research on childhood sexual abuse and non-offending caregivers is the importance of the child-caregiver relationship in facilitating recovery for both the child and caregiver. This theoretical study examined the phenomenological experiences of non-offending caregivers whose children disclose sexual abuse and responds to the question, Why is object relations theory and trauma theory a best practice option in the treatment of non-offending caregivers and their sexually victimized child? An in-depth exploration and analysis of non-offending caregiver perceptions about their own victimization and reaction to their child's disclosure of sexual abuse, using object relations and trauma theory, offers a best practice approach for helping non-offending caregivers cope with past abuse, current distress, recovery and the preventative needs of their child. Using the Case of Mischa, this study shows how a child's disclosure of childhood sexual abuse to a non-offending caregiver with a trauma history of childhood sexual abuse greatly impacts the caregiver's somatic response to stimuli, internalized views of the self, capacity for interpersonal relatedness, conceptualization of power and trust and theoretical assumptions about the world.

**TREATING NON-OFFENDING CAREGIVERS WITH A HISTORY OF CHILDHOOD  
SEXUAL ABUSE AND THEIR SEXUALLY VICTIMIZED CHILDREN:  
A CASE STUDY USING OBJECT RELATIONS THEORY AND TRAUMA THEORY**

A project based upon an independent investigation,  
submitted in partial fulfillment of the requirements for  
the degree of Master of Social Work.

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2015

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## **CHAPTER I**

### **Introduction**

#### **Phenomenon**

Childhood sexual abuse is a horrific crime and a prevalent social problem within our society. Sexual victimization and sexual offending of children is not a new phenomenon. In 2013, Darkness to Light, an organization focused on ending childhood sexual abuse, reported “About 1 in 10 children will be sexually abused before they turn 18” (Townsend and Rheingold, 2013, p. 21). The trauma of childhood sexual abuse affects an individual not only during the event, but remains a constant throughout their lifetime, “the pervasive wound of abuse lies buried within the psyche” (Mannion, 2002, p. 143). It can affect the victimized child’s behavior, cognition, view of self, perception of others and interpersonal relatedness. Perpetrators of childhood sexual abuse are often people that are familiar to the child, which leads to fragmented notions of the self and others that the child has held.

When the child of an adult survivor of childhood sexual abuse experiences sexual abuse, the non-offending adult caregiver is greatly impacted. Most often, non-offending caregivers will experience retraumatization and retriggering of their own experience with childhood sexual abuse, how people responded to them and the support that they did or did not receive throughout their recovery process. More often than not, when a non-offending caregiver’s child is sexually abused, he or she becomes a secondary victim and is forced to recall their own traumatic event while attempting to support their child through his or her current and pressing trauma.

For over 20 years, researchers have studied the experiences of traumatized victims and the frequency of childhood sexual abuse. Only recently however has research begun to focus on non-offending caregivers of sexually abused children who have their own history of childhood sexual abuse. This lack of research produces a gap in gaining an in-depth understanding of non-offending caregivers of sexually victimized children. This theoretical study provides an additional lens for treating non-offending caregivers in an era where psychoanalytic therapies have been the dominant treatment model and will explore the impact that a child's disclosure of sexual abuse has on their non-offending caregiver who also has a history of childhood sexual abuse. I use the Case of Mischa to examine impairments and deficits that affect how a caregiver supports their child through their own experience of childhood sexual abuse. The current study is the result of my need for clarification and comprehensive understanding for treating non-offending caregivers with a history of sexual victimization, especially as I continue my ongoing work with victimized children and their non-offending caregivers. While I have many experiences with non-offending caregivers from my social work internship at a Child Advocacy Center in Colorado, the Case of Mischa stood out among the others and set me on this journey to develop further understanding and knowledge of non-offending caregivers as they experience the process of healing and recovery. This case will serve as a foundational base for my research.

### **Case of Mischa**

Mischa was one of my clients during my first year internship while enrolled at Smith College School for Social Work. This case is used throughout this thesis to illustrate how object relations theory and trauma theory can be used as a foundation to more effectively understand how non-offending caregivers of childhood sexual abuse are emotionally, psychologically,

intrapsychically and relationally affected when their child discloses experiences of sexual abuse. Below is a synopsis of Mischa's Case (Mischa is a fictitious name to protect her identity):

Mischa is a 35-year-old, able-bodied, Caucasian woman from Colorado. She identifies as heterosexual and currently lives with her male partner, Seeley, who is 37 years old. Mischa and Seeley do not strongly identify with any religious faith. They live in Section 8 housing with Mischa's son from a previous marriage, Zenith, who is 9 years old. Zenith is diagnosed with severe Asperger's Syndrome, functions at a low developmental level and experiences extreme meltdowns. Mischa is pregnant from Seeley, an intentional pregnancy. She does not currently have a job, relying on Seeley's wood working to economically sustain them. While Mischa and Seeley aspire to create their own motorcycle company, they lack monetary resources. Mischa and Seeley were referred to the Child and Family Advocacy Center to assist Mischa's son in a forensic interview after a report was made by law enforcement that their 26 year old, male neighbor repeatedly sexually and emotionally abused Zenith.

Mischa's presenting concern is the recent disclosure of her son's sexual assault. Mischa is angry, upset, helpless, depressed and self-blaming for her son's assault. Mischa struggles with "how to best support my son" through his disclosure, the perpetrator's potential arrest and court hearings. Mischa is contemplating having an abortion out of anger towards her son's perpetrator. She said that, although "I was excited to be pregnant, I could not fathom bringing another child into this perverse and depressing world." The focus of our conversations were not about her son's grooming and sexual abuse, but rather about her own personal upbringing, relationship with women, history of childhood abuse, her pregnancy and the decision of whether to have an abortion or not.



Mischa attended primary and secondary school, although she never attended college. She struggled to find and maintain a job due to her depression. Mischa had a miscarriage after giving birth to Zenith. Following the miscarriage, Mischa split from her partner. Mischa met Seeley in high school, although he was dating her best friend at the time. Seeley and Mischa rekindled their friendship 10 years after high school. Mischa and Seeley were best friends prior to becoming romantically involved.

Mischa had a traumatic past, filled with abuse, addiction and a lack of support. She was raised in a highly negligent home where she was rarely supervised. As a child, Mischa was sexually assaulted. None of her family members believed her so she felt forced to internalize her victimization. Over the course of her teens and 20's, Mischa battled with substance abuse. She was diagnosed with PTSD, Borderline Personality Disorder and depression. She has been on medications for more than 10 years. She is skeptical about her diagnosis and feels dependent on medications that she does not believe are helping her. She continues to struggle with irregular sleep and eating patterns. Mischa struggles to connect to and trust women. She has limited supports since she is not able to maintain close relationships.

It is around these identified treatment issues that the focus for this theoretical research emerged. I realize that treating non-offending caregivers and helping them to be supportive and understanding of their victimized children requires a multifaceted theoretical approach. This led me to conduct a thorough review of literature on non-offending caregivers, object relations theory, trauma theory and other available resources for this highly vulnerable population.

## **Need for Study**

A variety of literature exists on the effects of childhood sexual abuse. Available literature, however, lacks an analysis of how a parent's history of childhood sexual abuse informs his or her psychological functioning and response to awareness of their own child's disclosure about sexual victimization. Caregivers are central to the protection of children and to assisting in children's recovery, but researchers have failed to address their level of importance in the child's recovery process.

Literature in the context of childhood sexual abuse and non-offending caregivers has shifted over the last decade. Many theories about the causes and effects of childhood sexual abuse date back to Freudian psychoanalytic theory in which the child, most often a daughter, seduces her father and subsequently actively participates in the ongoing abuse. According to Sigmund Freud, the mother either consciously or unconsciously encouraged incestuous relationships between the father and daughter or, at the very least, failed to intercede once acknowledgement of the abuse was made. In the last half of the 20<sup>th</sup> Century as theories of human behavior moved from an intrapsychic perspective, emphasis has been placed upon a dysfunctional family system as the root cause for childhood sexual abuse. More recent research studies challenge the role ascribed to non-offending parents as co-colluding in the abuse and denounces the stereotyped views of non-offending caregivers previously presented in the literature.

The retraumatization experienced by a non-offending caregiver when their child discloses sexual violation is profound (Triarhos-Suchlicki, 2007). This area of research is lacking and requires further exploration. The importance of an interdisciplinary and multi-method approach

is pivotal; an interdisciplinary approach allows for the sharing of knowledge across sectors—psychosocial, health, legal/justice, and security.

### **Role of Non-Offending Caregivers**

As more and more research is presented on childhood sexual abuse and clinicians acknowledge the sociological and psychological impact of childhood sexual abuse, we have now come to realize the important role that supportive non-offending caregivers play in the rehabilitation of their sexually abused children. They are germane to the child's healing process. Parental response is important to a child's functioning following a disclosure. The strength and supportiveness of the relationship between the non-offending caregiver and her sexually abused child is important to the recovery process of the victimized child. Because the nature of the relationship between the non-offending caregiver and the child victim is of utmost importance to the child's recovery and psychological adjustment, social workers and clinical practitioners must ensure that immediate intervention is given to both the non-offending caregiver and the victimized child. When non-offending caregivers are overcome with re-traumatization and retriggering of their own childhood sexual abuse, they are not as effective in caring for their victimized child. Hence, intervention comes in the form of helping the non-offending caregiver believe, empathize with and render emotional support and protection to the victimized child and address the stress and instability that victimized children experience following both the abuse and disclosure. Interventions specific to the caregiver and child relationship helps the caregiver with her own re-victimization and address the fear of failure often felt by non-offending caregivers. Non-offending caregivers who have a child or children with a history of sexual abuse are a highly vulnerable population deserving of recognition and support. Without an understanding of how a child's disclosure impacts a primary caregiver who also has a trauma

history, victimized children may not receive the support that they need. Stigma surrounding childhood sexual abuse may persist, with caregivers being blamed for putting their children into risky situations.

### **Application to Social Work Practice**

This research will buttress social work clinical and macro practice. Childhood sexual abuse is inherently traumatic, yet many people close their eyes to its prevalence in our society. Providing research on this highly stigmatized topic can elucidate ways to support and empower this population. Education surrounding the reality and complexities of childhood sexual abuse is crucial for informing preventative care. Understanding the layers of trauma inherent in survivors of childhood sexual abuse can help direct educators, caregivers and social workers in how to openly speak with children about the reality of childhood sexual abuse so that it can be targeted and addressed if abuse occurs. Specialists in the field of childhood sexual abuse, district attorneys, sex crimes detectives, caseworkers, clinicians at-large, caregivers and child survivors of abuse may utilize data collected from this research. With improved prevention and intervention models, perhaps more childhood sexual abuse cases will be reported and families can receive necessary psychoeducational supports to enhance their healing process.

It is also important for social workers to have a greater understanding of how non-offending caregivers respond to their sexually victimized children and how their responses can impact the development of the child. Providing insight for the application of object relations theory and trauma theory with non-offending caregivers assists social workers in their facilitation of treatment.

## **Summary**

This chapter introduced the phenomenon of non-offending caregivers and addressed the importance of examining this vulnerable population. Current gaps in the literature, application to social work practice and an introduction to the two theories that serve as the foundation for this study were presented.

The next chapter, Chapter II, provides further introduction to the conceptualization and methodology of this study, defines the key terms used throughout this research and addresses biases and limitations to this study. Chapter III addresses the phenomenon of non-offending caregivers, provides a historical understanding of non-offending caregivers and gives a brief overview of current treatments in the United States. Chapter IV discusses Object Relations Theory, the significance of using object relations theory and real application to the “Case of Mischa.” Chapter V discusses Trauma Theory, the significance of using trauma theory and real application to the “Case of Mischa.” Chapter VI summarizes my research, discusses and analyzes my findings and provides suggestions for clinicians working with non-offending caregivers who have a history of childhood sexual abuse.

## **CHAPTER II**

### **Conceptualization and Methodology**

In this chapter I provide a conceptual framework for this theoretical study. I provide the definition of terms that I use throughout the study, an overview of object relations theory and trauma theory and conclude by identifying potential methodological biases and both strengths and limitations of this study. This chapter provides a framework for this study.

#### **Conceptualization**

The purpose of this theoretical study is to respond to the question: Why is object relations theory and trauma theory a best practice option in the treatment of non-offending caregivers and their sexually victimized children. This question is relevant in an era where psychoanalytic theory and intrapsychic perspectives are dominant practices for treating non-offending caregivers.

This theoretical study stems from my quest for in-depth knowledge and understanding of best practice methodologies for working with non-offending caregivers and their sexually violated and traumatized children and to affirm why object relations theory and trauma theory can be used effectively to work with non-offending caregivers. This study will provide evidence-based practices that can be used by social work professionals who work with this highly vulnerable and stigmatized population.

Treating non-offending caregivers with sexually victimized children should be multidimensional, which suggests that intervention and support should include both non-

offending caretaker and child. Because both the non-offending caretaker and sexually victimized child have experienced sexual trauma, integrating a psychodynamic and relational approach to address this psychic disorganization will prove most helpful in addressing their trauma-induced anxieties. Object relations theory and trauma theory provide sensitive understanding of childhood traumatization and a conceptual and technical framework for treatment.

### **Definitions of Terms**

Defining key terms used in this research is integral for understanding this theoretical study. The terms childhood abuse, childhood sexual abuse, survivors of childhood sexual abuse, non-offending caregivers, secondary victims, intergenerational childhood sexual abuse, trauma, trauma symptomatology and the cycle of trauma are defined below.

- *Childhood abuse* encompasses physical, emotional and/or sexual maltreatment and/or neglect of a child.
- *Childhood sexual abuse* includes both boys and girls, ages 0-17, contact and non-contact sexual acts, any sexual act between an adult and a young child regardless of whether forced coercion is used, any sexual act between a teen and an adult who is significantly older regardless of whether force or coercion is used and forced or coerced sexual acts between two children when there is an age or power differential including unwanted or forcible peer abuse (Townsend and Rheingold, 2013, p. 11).
- *Survivors of childhood sexual abuse* are primary victims who cope with the trauma or setback from childhood sexual victimization perseveres after the abuse and is a survivor of the abuse.
- *Non-offending caregivers* refers to primary caregivers who parent children that have been abused and/or neglected by someone else. Non-offending caregivers are non-perpetrating

individuals and do not have to be biological parents, but rather primary caretakers of the identified children who themselves were sexually abused as children.

- *Secondary victim* is someone who experiences the feelings of trauma without directly undergoing the trauma, or vicarious traumatization. A secondary victim can be a loved one, a friend or an onlooker to a traumatic incident; they are injured as a direct result of witnessing or becoming aware of a crime.
- *Intergenerational childhood abuse* explains the increased likelihood that a child will be abused if their caregiver has an abuse history. Intergenerational abuse is influenced by “poverty, violence in the home and in the community, domestic violence, and teen pregnancy” (Robboy and Anderson, 2011, p. 4).
- *Trauma* is a subjective experience; the individual itself defines trauma. Trauma can result when someone’s choice is taken away or they are forced to do something that they do not desire to do. This can result in a feeling of betrayal of the self and an inability to protect oneself. It gives an individual an overwhelming sense of helplessness and terror. Trauma can have lasting effects.
- *Trauma symptomatology* explores the transmission of trauma from one generation to another. This “passing down” is likely in situations where trauma is unresolved (Robboy and Anderson, 2011).
- *Cycle of trauma* explains the cycle that an individual goes through as they process their trauma and develop coping skills. The cycle of trauma is ongoing and pervasive; one moment the survivor may be happy and content, and the next moment they may re-experience an element from their past trauma. It also explains the increased likelihood that an individual who has previously experienced trauma will come into contact with a



new traumatic incident. The induction of maladaptive coping mechanisms increases the chances that a survivor will engage in risky behavior or be a target for violence.

## **Methodology**

The omission in best practice applications for working with non-offending caregivers in crisis following their own child's disclosure of sexual abuse informs my theory. Towards this end, my thesis focuses on answering the question: Why is object relations theory and trauma theory a best practice option in the treatment of non-offending caregivers who have a history of childhood sexual abuse and their sexually victimized children? I postulate that the impact of the caregiver's personal trauma and child's disclosure of sexual abuse can be best understood through the melding of object relations theory and trauma theory. These two theories have merit because while object relations theory helps to understand interpersonal capacities and deficits and how external events become internalized, trauma theory reframes the experience of trauma from being pathologically "sick" to being "injured" and in need of healing. Both theories explore the ways that a survivor of childhood sexual abuse forms trauma bonds and how, as a result of their victimization, they navigate themselves, their relationships and their external world. These theories set the stage for understanding the re-traumatization and healing needed for non-offending caregivers who become secondary victims as onlookers of their child's abuse amidst their own victimhood as a child.

## **Introduction of Theories**

This study used object relations theory and trauma theory to explore the psychological functioning of non-offending caregivers who are survivors of childhood sexual abuse. Object relations theory and trauma theory challenge Freud's theory of the psychosexual stages and motivational drives. Utilizing these theories "reflects a shift toward an increased recognition of

the realities of childhood sexual and physical abuse and the impact such bodily trauma has on intrapsychic and interpersonal functioning in adult life” (Olio and Cornel, 1993, p. 513). These two theories help to explain how survivors uniquely experience childhood sexual abuse and how it affects them throughout life, especially for non-offending caregivers as they become aware of their own child’s experience of sexual abuse. Both theories situate the survivor within their environment and take into account their traumatic experience, internalizations and externalizations of themselves and others and the healing process.

**Object relations theory.** I used the work of Donald Winnicott, Object Relations Theory, because of its focus on the nature of the mother-infant relationship. Winnicott discusses specific ways that mothers facilitate an infant’s intrapsychic development by introducing seminal concepts such as the “good enough mother,” the holding environment and transitional phenomenon (Winnicott, 1958). The negotiation of hate and shame within the mother-infant relationship and the use of the object also are explored, as that is central to how non-offending caregivers respond to their sexually victimized children. The use of Object Relations Theory sheds light upon the mother’s subjectivity and how she negotiates the intersubjective process of separating her own trauma from that of her child.

**Trauma theory.** Trauma theory is used because of its focus on how traumatic occurrences are processed, exposed and reprocessed in an individual’s psyche. A traumatic event often leaves survivors emotionally and intellectually divided between what was felt or believed prior to the event and what is not known or believed after the event. This often causes a psychic separation in identity and consciousness that can leave a non-offending caregiver confused, frightened and disturbed. Trauma focused therapy reduces negative emotional and behavioral responses following childhood sexual abuse and encourages non-offending caregivers and their

victimized children to talk about their traumatic events in order to overcome them. In essence, trauma intervention helps non-offending caregivers to cope effectively with their own emotional distress and develop skills that support their victimized children.

### **Study Biases and Limitations**

My bias may be perceived as rooted in my experiences in working with non-offending caregivers in Colorado and my intervention practices. Also, a potential bias may be my previously established professional relationship with the agency with whom I collaborated to formulate my study. My emotional connection to these narratives and the agency may have hindered my openness to understanding different experiences. I recognize the risk in essentializing the experiences of non-offending caregivers who have a history of childhood sexual abuse.

My main limitation is access to numerous personal narratives from non-offending caregivers. Due to time constraints, I am limited in qualitative data recording experiences. Data and clinical observations are restricted to the agency in which I worked and the limited literature that exists on this specific population group.

An overarching bias and limitation comes from my subjective identity. As a white, Jewish, heterosexual, middle-class female in my 20's who is neither a non-offending caregiver nor a survivor of childhood sexual abuse, I view this population and topic through a subjective lens of my own experiencing. I identify as an ally to this community who is committed to eradicating childhood abuse through prevention education and clinical intervention.

## **Summary**

This theoretical thesis contains six chapters. Chapter I, the Introduction, discussed my research topic, my reasons for conducting this research and introduced the two theoretical frameworks that I have chosen to guide my literature review.

In this, Chapter II, I described how my study was conceptualized, my methodology as well as my definition of terms.

Chapter III discusses the phenomenon of non-offending caregivers, provides a historical understanding of non-offending caregivers and gives a brief overview of current treatments in the United States.

Chapter IV discusses Object Relations Theory, the significance of using object relations theory, and real application to the “Case of Mischa.” The “Case of Mischa” is used as a central case throughout this thesis and is used to show how each theoretical application is strategic to treatment.

Chapter V discusses Trauma Theory, the significance of using trauma theory and application to the “Case of Mischa.” As in Chapter IV, The “Case of Mischa” provides real application processes.

Chapter VI summarizes my research, discusses and analyzes my findings and provides suggestions for clinicians working with non-offending caregivers as they begin to process their own experiences with childhood sexual abuse along with their child’s experience and perception of their sexual abuse.

## **CHAPTER III**

### **Non-Offending Caregivers**

Perceptions of non-offending caregivers' responses to their children's sexual abuse have been heavily influenced by Sigmund Freud's psychoanalytic theory. Understanding how this theory conceptualizes mothers also requires understanding how psychoanalytic theory conceptualizes the victim, which in most cases was the daughter. Psychoanalytic theory presumed that the daughter seduced her father and then willfully participated in the enduring abuse. The mother was assumed to conspire by setting up the dynamics for the abuse to occur, know of the abuse occurrence and even allow the abuse to continue. The rationale for this belief was its continual manifestation. Clinicians refused to believe that sexual abuse in these situations could happen without the active participation of the child and the cooperation of the mother.

As theories of human behavior moved away from an intrapsychic (psychoanalytic) perspective in the late 20th century, incest and childhood sexual abuse began to be framed within a family systems context, where the mother was characterized as primary to a dysfunctional family system. She was presumed to set up the dynamics for the abuse and contribute to its continuation because of its alleged gain for her. While in the 21<sup>st</sup> Century we have learned that this most often is not the case, the historic bias against non-offending caregivers of sexually abused children still prevails in some settings.

## **Symptomatology of Non-Offending Caregivers**

Childhood sexual abuse greatly affects how one experiences their emotions, behaviors, themselves and others. Survivors often struggle with posttraumatic stress disorder (PTSD) and other behavioral, interpersonal and emotional deficits. This is seen in the Case of Mischa, who remained active in her PTSD and anxiety into her adult years. Often survivors of childhood sexual abuse experience immediate and ongoing somatic responses, problems with power and trust, and an internalization and externalization of negative views of themselves and others. For non-offending caregivers who have their own history of childhood sexual abuse, these challenges are compounded by their child's disclosure of sexual abuse. For example, as a result of Mischa's own experience with child victimization, she fears giving birth to another child and is contemplating an abortion to prevent raising another child in a "perverse and depressive world." She becomes a secondary victim to her child's sexual abuse and relives her own experiences of her abusive experiences. She lacks trust in relationships and has internalized views about herself.

Children who have experienced abuse often feel isolated from their external world, unsure of how to understand their abuse. Children often feel confusion, shame and guilt amidst a lack of feeling grounded. Childhood abuse disrupts norms and ways of relating to those who offend, most commonly, our loved ones. Individuals once trusted now become the very individuals they most hate. In turn children often feel a lack of safety and stability. According to Nisivoccia and Lynn (2012), children who have experienced violence "develop a range of physical, emotional, cognitive, and behavioral difficulties characterized by giving up of play, avoidance of closeness, lack of trust, fear of adults, shame and isolation" (Nisivoccia and Lynn, p. 206). Demographics related to the abuse "such as the age of the child during the initiation of the sexual abuse, severity of abuse, relationship to the abuse, accessibility of other relationship

resources, and the child's genetic constitution thus influence the extent to which the sexual abuse damages or compromises the child's ego development, sense of self, and internalized object relations" (Wells, Glickauf-Hughes and Beaudoin, 1995, p. 417). External factors such as societal response to abuse, parent attitudes and support systems directly impact the child's healing process.

A lack of healthy supports compounded by society's attempt to pretend childhood abuse does not exist prevents survivors from feeling validated and believed. These unsettling emotions frequently follow survivors into adulthood and into their own parenting. The most common parenting issues for non-offending caregivers who are survivors of abuse are issues of control, discipline, awareness—hyper vigilance and dissociation—prioritizing needs and healthy sexual development (*Blue Sky Bridge, Parenting Issues for Abuse Survivors, 2012*). Mental health and behavioral problems are likely to impair parent-child interactions. Children of adult survivors of childhood sexual abuse are often at-risk for abuse; therefore it is imperative that adults have access to resources and supports that allow them to process their own abuse and become protectors for their children.

Non-offending caregivers may liken their own traumatic experience with that of their child, even if their experience was dissimilar. They may respond to their child in a way that they themselves wanted to be supported and were not. Incongruence in experience, remorse and shame also may lead the non-offending caregiver to be ineffective in understanding the full needs of their child.

Based on my clinical observations with clients in this population, somaticization of trauma, issues with power and control and deficits to internalization and externalization of the self and others are often heightened when a non-offending caregiver becomes aware of their own

child's sexual victimization. Re-traumatization and retriggering can be profound for these caregivers. The impact of childhood sexual abuse on an individual is discussed more fully later in this thesis.

**Somatic response.** Survivors of childhood sexual abuse have a somatic response to trauma. They may respond adversely to auditory, tactile or olfactory stimuli when these stimuli are registered as dangerous (Basham, 2001). Somatic responses can be broken down into primary and secondary responses. Primary responses may be posttraumatic stress disorder, dissociative disorders or Borderline Personality Disorder. Secondary responses can be substance abuse disorders, eating disorders, somatoform disorders or obsessive-compulsive disorder (Chu, 2011). These responses emerge when a survivor attempts to manage their distress resulting from a traumatic experience. The responses to childhood trauma are adaptive rather than pathological. Some of these behaviors were present with Mischa, especially as she struggled with addiction, depression and devaluing. In the absence of early interventions, survivors are at increased risk of depression.

It is common for survivors to have nightmares, flashbacks, and intrusive thoughts and/or re-experience their earlier trauma. Survivors may be hypervigilant and scared of themselves and others. Flooding, when a person becomes overwhelmed with emotions and feelings, may also occur. Survivors may experience numbness and avoidance to their experience. "During the abuse, the use of dissociation enables children to anaesthetize parts of their body and/or separate from them altogether, thus disconnecting themselves from the emotion and sensations of the abuse. This pervasive tendency to disconnect from feeling continues into adult life" (Olio and Cornell, 1993, p. 515). Chu (2011) adds to the discussion of the somatic reexperiencing that a survivor of childhood sexual abuse may endure: "The psychophysiologic responses to trauma—physical



sensations, injury, and autonomic and neurohormonal adaptations—are held in an enduring way in the body” (p. 25). Following childhood sexual abuse, a survivor may be overly aware or unaware of their body and its related sensations. They may have “been denied a form of love that is critical for self-soothing” (Marks, 1993, p. 1220).

Another common somatic response that adult survivors may experience is sexual dysfunction. Survivors may experience an inability to orgasm and a discomfort with specific erogenous zones. Sexual contact may be experienced as triggering, leading to flooding. This somatic disruption may be enhanced as a non-offending caregiver holds onto their own traumatic experience in addition to the numbing effects of their child’s sexual trauma. Survivors of childhood sexual abuse may also binge as a way to self-soothe. They may have an oral or anal fixation due to forced oral and anal sex. Chu (2011) explains, childhood “sexual abuse survivors can experience genital, anal, or throat pain, gagging, shortness of breath, and a sense of being crushed” (p. 25). They may either shy away from or ruminate over these parts of their bodies that were sexually violated. Overeating may be used to make one’s body “less attractive” in hopes of deterring the sexual abuse from occurring (Chu, 2011). Childhood sexual abuse affects the way that a survivor experiences their sexuality and primary relationships.

Even if non-offending caregivers have repressed their trauma or are in denial of childhood sexual abuse, upon hearing about their own child’s experience with sexual abuse, they may somaticize their response, reexperiencing their initial response to their own abuse as if it just occurred. Their somatization is experienced as a secondary victim or by vicarious traumatization through their child’s experience of sexual abuse.

When meeting with Mischa, she somaticized her pain. She was slumped, yawned and spoke slowly, occasionally reclining on the couch in a fetal position. She became flooded

throughout our sessions, overcome by emotions and painful memories. She presented as if she had just been sexually victimized herself. Her presentation may have been likened to how she responded to her own sexual abuse as she vividly relived her trauma through her child.

**Power and trust.** Survivors of childhood sexual abuse often feel powerless. The experience of sexual abuse strips an individual of their power, childhood, virginity, innocence and trust in others. A survivors' capacity for love and trust becomes permanently impaired when they are sexually victimized and simultaneously stripped of their agency and sense of control. Survivors often "feel controlled and victimized. They experience subjugation" (Howe, 2005, p. 203). Dysfunction in areas of power and trust is profound for adult survivors of childhood sexual abuse: "The violations of children's bodies, especially by people in positions of affection and authority, create deeply held difficulties with trust, intimacy, and dependency. This traumatization causes profound vulnerability and vigilance which continue into adulthood" (Olio and Cornell, 1993, p. 512). Childhood sexual abuse challenges the perception that children hold of people they once loved and trusted. To counter the power lost, survivors may yearn for a sense of control over themselves and others (e.g., relationship building). Non-offending caregivers may spend their lives trying to reclaim power that is once again lost when hearing that their child was hurt and they were not able to protect them. Non-offending caregivers may blame themselves for their child's experience of sexual abuse, believing that they had the power to prevent trauma from occurring to someone they love. Upon experiencing their child's trauma, non-offending caregivers may give up on the belief that they have any control in their life at all.

Mischa had a power complex that became exacerbated when her son disclosed sexual abuse. Already believing that she lacked control over her own life, Mischa expressed that any semblances of power that she once had vanished when her son was sexually violated. She felt

that since she could not even protect her son from the sexual molestation that she herself experienced, she lost all power to help someone else. Mischa's residential move and debate over whether or not to have an abortion was her last hope of expressing the control that she desired.

**Loss.** When a child experiences sexual abuse, they lose parts of themselves and others that cannot be regained. A child survivor may lose or feel like they lost their childhood, innocence, ability to trust openly, sense of self worth, feeling of safety, feeling in control of one's feelings, self-confidence, knowing what is a healthy interpersonal reaction in relationships, virginity, a healthy sexual drive, orgasm and a belief that bad only happens to bad people, among other things. "For each victim there are specific aspects of the abuse (loss of family, loss of the only person who 'loved' them, hopelessness and despair, etc.) that seem particularly unendurable" (Olio and Cornell, 1993, p. 514). When a non-offending caregiver confronts their own child's experiences with sexual abuse, they are not only reminded of the things that they lost, but also of the things that they continue to lose. They may experience the loss of their child's innocence and childhood and create a rift between the offender and the non-offending caregiver and their child. Mischa felt that she lost her innocence and childhood and, thus, had to become an adult before she was prepared to become an adult. When Zenith disclosed his own experiences with sexual abuse, Mischa regressed to a child, frantically trying to hold onto the pieces of childhood that were stolen from her, and now, from her son.

**Fear of Abandonment.** Seemingly losing power over their bodies and lives and losing trust in humanity, survivors of childhood sexual abuse may have a fear of abandonment. Fear of abandonment and other abandonment issues are symptomatic of adult survivors of childhood sexual abuse. The sense of abandonment and insignificance are serious emotions for survivors and their experiences stem from these fears. According to Chu (2011), survivors of childhood

sexual abuse's fear of abandonment and intense anger "may be understood as deriving from actual abandonment, maltreatment, and deprivation. The continuing expectation of being victimized and the recapitulation of abusive and failed relationships lead to a growing reservoir of bitter disappointment, frustration, self-hate, and rage" (p. 73). The perpetrator and familial members that may disregard the sexual abuse become a source of confusion for the survivor. The survivor feels that they can no longer utilize their supportive relationships.

The fear of abandonment and insignificance create a cycle of dysfunction in the survivor's life. This is translated into the survivor's need to make other people feel significant since the survivor needs to feel significant and validated by people. The survivor may give all of themselves so that people will not abandon them. However, the more survivors give of themselves, the more insignificant they make themselves; and the more insignificant they make themselves, the more they fear abandonment. The more they fear abandonment, the more insignificant they allow themselves to become in order to avoid being abandoned. Thus the vicious cycle begins that leads to dysfunctional behavior and lifelong pain. A fear of abandonment is also directly linked to a fear of annihilation.

**Internalization and view of self.** Survivors of childhood sexual abuse are likely to have a negative internal perception of themselves and others. They may internalize object representations of their past (Marks, 1993). The experience of childhood sexual assault negatively affects one's emotional capacity. "Many children who suffer sexual abuse experience pain, shame, fear and confusion [...] Sexual abuse impairs children's ability to understand emotions and regulate their arousal" (Howe, 2005, p. 203-205). Survivors struggle to merge their emotions with the physical pain that they endured. They may compartmentalize or dissociate from their emotional state. Survivors may, also, internalize messages from the perpetrator that

they are worthless, bad or deserving of the abuse. “Children may internalize aspects of the abusive interaction and, as a result, develop maladaptive representations of self and others that influence how they come to think about and make meaning of situations that occur in their lives” (Bedi, Muller and Thornback, 2013, p. 233). Survivors struggle to make sense of the sexual abuse that they incurred. “To make sense of what is happening to her, to anchor her experiences in a reasonable world, she may begin to make mental alterations of her view of reality [...] She may believe that she is bad, and that her experience is some sort of punishment for something she has done wrong” (Hansen, 1991, p. 1-2). This negative internalization may follow survivors into adulthood, affecting their adult romantic and social relationships. Additionally, this internalization of negative messages leads to an increased risk for suicide.

Lacking tools to fully understand the sexual abuse, survivors of childhood sexual abuse may blame themselves for the sexual abuse. “Given that most perpetrators deny responsibility for their behavior and discount the hurt and upset caused by it, victims often feel ashamed, believing that they were in some way responsible for the abuse” (Olio and Cornell, 1993, p. 515). Instead of turning aggression and anger outwards, survivors internalize their frustration. Childhood sexual abuse is “thought to result in the development of negative expectations of others and a sense of self as worthless and deserving of abuse” (Bedi, Muller and Thornback, 2013, p. 233). A victim personality may form. “In this state of consciousness the person often continues to feel powerless, and expects exploitation from the world” (Hansen, 1991, p. 2). The victim feels powerless and no longer knows what is safe or unsafe. They begin to think that they will continue to be exploited, not knowing when or how sexual re-victimization will occur.

A survivor’s self-esteem may also be compromised. “Survivors of abuse commonly attribute the trauma to themselves and develop a sense of victimization through having an unjust

world attribution” (Bedi, Muller and Thornback, 2013, p. 238). Their view of self and internalized view of the world is often tainted by the abuse they incurred. Perpetrator pathology “which repeatedly impinges on a child’s development (e.g. physical integrity, internal security, strivings for autonomy, object constancy) can be defensively internalized into the object relations structure and character development of the child” (Wells, Glickauf-Hughes and Beaudoin, 1995, p. 417). Hence, the perpetrator’s aim is to lure the child in by attacking their internal modes of operation and defense.

In a situation where a survivor is not believed, survivors may see themselves as deemed to a life of victimization and torment. According to Howe (2005), “children whose non-abusing caregiver believes them when they say they have been sexually abused and tries to protect them, appear to cope best with the abuse. Parents who neither believe nor support their children leave them to face both the aggressor and the trauma of the abuse alone [...] Their experience is that other people’s needs are more important than their own” (p. 203). This deepens the child’s fear that they are unlovable and forces the child to question whether they will ever be deserving of love (Mannion, 2002). This also addresses the abandonment issues discussed earlier in this thesis. Mischa is an example of a survivor that was forced to face both the aggressor and the abuse alone; Mischa still carries resentment for not being believed at the disclosure of her own abuse, as demonstrated through the following interaction.

Clinician: Hopefully this can become the process of recovery.

Mischa: It’s hard for me to process. I’m just glad that someone believes Zenith. When I was a young girl I was sexually molested and nobody believed me. I stopped telling people about it.

Clinician: And we hope that Zenith will be able to share all of the information that he needs to during this interview so that he doesn't need to keep anything a secret any longer.

Mischa: I'm just so glad that there is a place like this with so many people that believe Zenith and want to help him. I wish I were helped the way that Zenith is getting help.

Clinician: It's very common that when someone's child experiences abuse that a caregiver's own experiences with abuse can resurface and be triggering.

Mischa hopes that her son will get the services that she was denied. If he does not, her view of self will be threatened as she views herself as a continuation of the cycle of ignoring a child's concerns and trauma that her family perpetuated. Mischa wants her child to feel neither the abandonment nor internalization that she has grown to feel and experience.

Non-offending caregivers, who have a deficient view of themselves due to their sexual abuse, may blame themselves for the sexual abuse that their child endures. They may never escape the cycle of self-blame. Their weak internalization of a sense of self becomes exacerbated as they lose power and control over protecting their children from ills of the world.

**Externalization and view of others.** In addition to negative internalization of self and other, survivors of childhood sexual abuse negatively externalize their view of self and other. They may be pessimistic and view the world as malevolent and bad. Caregivers may acquire maladaptive interpersonal patterns that "were initially adaptive responses, accurate perceptions, or conditioned reactions to abuse during childhood, but that elaborated and generalized over time to become contextually inappropriate components of the victim's adult personality" (Wells, Glickauf-Hughes and Beaudoin, 1995, p. 417). They may carry a negative perception of others as threatening, a source of danger that poses a threat to them. This may lead to survivors not

trusting others out of fear that they will be revictimized; they see danger everywhere. Paranoia that all people have the propensity to harm may prevail the minds of non-offending caregivers who feel that they have been let down by society. This may be especially true for survivors who were not believed by alleged loved ones and caregivers.

As a survivor's child experiences their own sexual abuse, they may feel affirmed in their view of others as bad. They may continue to externalize their perception of others and the world through negative talk and continued distrust in others. This is evident in the Case of Mischa in her struggle over whether or not to have an abortion, whether to allow her child to be born into a "bad" world. Below is a conversation between Mischa and me:

Clinician: It sounds like you are carrying a lot of guilt and shame. You're feeling a bit of relief, but you are carrying a lot of anger.

Mischa: Definitely. Remember how I told you that I'm a few weeks into my pregnancy?

Clinician: Yes.

Mischa: I decided that, because of all of this, I'm going to have an abortion.

Clinician: How did you come to that decision?

Mischa: I caused my son to have Asperger's and I can't imagine causing anything else to another child of mine. I can't imagine bringing another kid into this deranged world.

Clinician: Are you sure you're making the right decision?

Mischa: It's the only thing that I can control. I don't know what else to do.

This dialogue elucidates a conflict surrounding a view of the world that non-offending caregivers who have been sexually victimized may carry. Non-offending caregivers' perception of the world and others may be expressed through indirect channels, in this case, through the discussion



of an impending childbirth. They often blame themselves for their child's abuse and any other illness that they perceive is associated with the abuse.

An externalization of negative views of others may manifest in physical distancing from the root of the trauma. Non-offending caregivers may move to new homes, change schools or take their children out of programs in order to avoid the perpetrator and perpetrating environment. Instead of associating the trauma with the individual who perpetrated on their child, a non-offending caregiver may link all people associated with the offender as bad and needing to be avoided. Mischa is an example of someone who uprooted her family and moved residences in order to move further away from her son's offender.

**Stigma.** A non-offending caregiver often is faced with stigma around childhood abuse. Since childhood sexual abuse is so stigmatized, many people do not talk about it, choosing to pretend it does not exist. When acknowledged, a non-offending caregiver may feel blame by others for not protecting their child. Fearing stigma and shame, non-offending caregivers may choose not to share their child's experience with abuse or disclose their own trauma. Without help from others and outlets to process their emotions, non-offending caregivers may become less able to support themselves and their children through a tumultuous time; and unaddressed distress may inhibit a caregivers' ability to attend to their child's healing process. Parents' own maladaptive coping behaviors negatively impact the response and healing of the child. Triarhos-Suchlicki (2007) asserts

it is critically important to focus on how both maternal and paternal nonoffending caregivers react to their child's victimization because (a) caregivers are central to the protection of their children, (b) children construct their understanding of self, others, and events through their interactions with their caregivers, (c) child survivors get their

relationship abilities interrupted by the trauma and caregivers have to make up for that interruption, (d) caregivers are also distressed and may suffer relationship and social support problems, and (e) caregivers are instrumental to helping child sexual abuse survivors heal (p. 2).

Non-offending caregivers are essential to the healing of survivors of childhood sexual abuse. Without community recognition of the pervasiveness of childhood abuse and the inability to protect children 100 percent of the time, non-offending caregivers may not be fully available to help their children through the healing process.

It is important to note that “not all traumatic experiences impact individuals in the same way, and developing symptoms of psychopathology is not universal among survivors of childhood trauma” (Bedi, Muller and Thornback, 2013, p. 233). “There is a great diversity in the adult life difficulties of survivors of childhood abuse. These individuals demonstrate widely varied temperament styles, character defenses, and developmental disruptions” (Olio and Cornell, 1993, p 513). The impact and experience of childhood sexual abuse on an individual is not universal; every individual has their own subjectivity and thus internalize and externalize their experience of trauma differently.

### **Brief Overview of Current Treatments in the United States**

In recent years clinicians have experienced increased understanding and knowledge for the complexities of childhood sexual abuse. These complexities are heightened by the need to understand specific problems related to childhood sexual abuse in the context of multi-problem intervention that requires coordinated multi-disciplinary teams sensitized to the specific needs of victimized children. “Naming the problem or acknowledging the devastating effects of repeated childhood sexual abuse can help survivors to make sense of their distressing symptomatology

and begin the process of ameliorating their sense of shame” (Wells, Glickauf-Hughes and Beaudoin, 1995, p. 417). Treatment can help a survivor process their trauma and become more in tune with how the trauma has affected their behavior, emotions, maladaptive patterns and interpersonal behaviors.

The most common treatments traditionally used in the United States are individual psychotherapy and support groups that are specifically geared towards survivors of childhood sexual abuse. Individual psychotherapy, which covers a range of methodologies including play therapy, cognitive and behavioral therapy, expressive therapies and psychopharmacology, is used to reduce psychiatric symptoms and post traumatic stress disorder and to improve the overall functioning of children who have been sexually abused. Support groups often use meditation and grounding techniques to calm and center survivors, especially when survivors experience retraumatization or retriggering and allow children to confront their abuse in a group of peers struggling with the same issues and fears. Eye movement desensitization and reprocessing (EMDR), brain spotting, somatic experiencing therapy (SE) and hypnotherapy are trauma-based specializations that many clinicians offer to survivors in order to desensitize triggers and help survivors gain a better understanding of the traumatic event that they experienced. These latter treatments for survivors of sexual abuse are housed in the assumption that trauma cannot be erased simply by interventions that utilize left-brain functions like those used in traditional talk therapies. Because trauma is an occurrence that is embedded deep in the core of the brain and body, it is believed that the most effective treatments should integrate traditional therapy modalities with those that focus on calming the nervous system like yoga, mindfulness, imagery, expressive arts and eye movement desensitization and reprocessing. In this thesis I examine

literature on several treatment modalities that are utilized by professionals from a range of disciplines that treat victims of childhood sexual abuse.

Harper, Stalker, Palmer and Gadbois (2008) performed a study that looked at the efficacy of individual psychotherapy. They identified the importance and efficacy of clinicians' patience, understanding and respect of survivors' needs for control. They noted that the therapeutic alliance is pivotal in effecting change within the client. Harper et al. (2008) emphasized the importance of trauma informed practice to increase the clinician's ability to work collaboratively with adults. They concluded that a trauma-based approach serves to normalize symptoms and behaviors that have traditionally been pathologized and viewed as deviant. Therapists can help adult survivors manage intense feelings, devise healthy coping skills and maintain a positive self-regard; highlighting the therapeutic alliance is fundamental to serving adult survivors of childhood sexual abuse. The dyadic therapeutic relationship is an intervention that is proven to be helpful for adult survivors of childhood sexual abuse in processing and coping with their trauma history.

Support groups, on the other hand, provide a safe place for people with a shared experience to process their trauma and gather support from others. "In a group with peers who have similar fears" they can "feel a sense of relief that they are not 'the only ones'" (Webb, 2003, p. 167). Support groups allow for survivors to "identify strengths and new coping skills" in order to reduce repetition of maladaptive coping mechanisms and patterns (Webb, 2003, p. 184). Nisivoccia and Lynn (1999) support a group modality for addressing trauma. They reported, "The group becomes an ideal modality because it breaks isolation, deals with shame, raises self-esteem, helps children recognize effective limits, and enhances relatedness" (Nisivoccia and Lynn, 1999, p. 207). Groups are a natural helping and healing model. They have the capacity to

be holistic, to address all facets of one's identity and therefore to see how trauma is manifest in order to access one's resilient nature. Essentially, support groups provide an opportunity for survivors to engage in discussion and process where they receive affirmation from peers, reduce isolation felt by society at-large and acquire tools to modify behavior.

The aforementioned traditional therapies tend to focus on memories from the unconscious mind and then make meaning of these memories to develop further insight into the problem. Unlike traditional therapies, EMDR, brainspotting, hypnotherapy and SE move the survivor quickly to the trauma event and work on the releasing stages of trauma. Developed by psychologist Francine Shapiro in 1989, EMDR is a fairly new, nontraditional type of psychotherapy used for treating post-traumatic stress disorder. PTSD often occurs after experiences with military combat, physical and/or sexual assault or other trauma events. EMDR does not rely on talk therapy or medications, but instead uses a client's own rapid, rhythmic eye movements to dampen the power of emotionally charged memories of past traumatic events. "The EMDR therapy uses bilateral stimulation, right/left eye movement, or tactile stimulation, which repeatedly activates the opposite sides of the brain, releasing emotional experiences that are 'trapped' in the nervous system" (Boulware, 2006). EMDR desensitizes a client to traumatic events, allowing for reprocessing of memories and sensitization linked to those memories.

Brainspotting, developed by David Grand in 2003, is also a relatively new type of psychotherapy used with all areas of trauma, including survivors of war, natural disaster and abuse. Brainspotting is designed to help the individual access, process and overcome negative emotions and pain associated to trauma. Brainspotting helps the client "discharge the trauma and calm the nervous system" (Rocky Mountain Brainspotting Institute, 2014). Both brainspotting and EMDR attempt to help individuals reprocess negative events and retrain emotional reactions.

Hypnotherapy was developed by 18th century healer, Franz Anton Mesmer (1734-1815). Hypnotherapy offers clinicians a set of special techniques that complement traditional therapies to help abuse survivors integrate their traumatic experiences and change abusive patterns in their life in order to heal painful memories and events. With hypnosis, “the child, and later the adult, can remove herself from the trauma. Relaxation, calm, numbness, and a feeling of disappearance replace the horror of the terror” (Scharff and Scharff, 2008, p. 31). Additionally, hypnosis may be “used as a technique for bolstering ego strength, pain control, and containment functions rather than for recovering memories” (Wells, Glickauf-Hughes and Beaudoin, 1995, p. 427). Hypnosis helps survivors learn how to function as a whole individual; it is a tool for self-empowerment.

Somatic experiencing therapy (SE), developed by Peter Levine, is increasingly being used to help trauma victims, especially with symptoms of PTSD, recover. Somatic experiencing therapy mixes stress physiology, psychology, ethology, biology, neuroscience, natural healing practices and medical biophysics. According to Levine (1997), “Somatic Experiencing is a gentle step-by-step approach to the renegotiation of trauma [...] It is akin to slowly peeling the layers of skin off an onion, carefully revealing the traumatized inner core” (Levine, 1997, p. 120). This therapy borrows strategies from the classic “fight or flight” response to trauma in order to move a survivor forward from his or her “frozen” image or memory of their traumatic experience. When individuals encounter a traumatic situation, they may either fight back, escape, or fail to act on their urges, which “thwarts” the response. Somatic therapy stimulates the “not acting,” or being unable to act in order to help the survivor move beyond the fixated physiological states related to their abuse. SE therapy helps a victim rekindle empowerment, triumph and mastery

over their body through a resetting of the nervous system and restoration of inner balance and vitality.

These treatment approaches, in conjunction with other treatment modalities, help survivors of childhood sexual abuse process emotionally painful and traumatic events. These modalities help survivors move from emotional distress to calm resolutions of issues associated with their abuse. These treatments affect all facets of the survivor, including mental, emotional and physical health, allowing survivors to return to normalcy and health. These treatments result in the elimination of the targeted emotion, allowing for a negative response to be neutralized.

It must be noted that no one treatment is effective for all clients. Rather, each client needs a unique treatment that focuses on integration of the self. Wells, Glickauf-Hughes and Beaudoin (1995) explain that individualizing treatment “can be particularly useful in minimizing possibilities of decompensating reactions or ‘false memory’ constructions by clients (e.g., borderline or psychotic personality organization) who cannot sufficiently differentiate fantasy from reality or clients (e.g., histrionics) who are highly suggestible” (Wells, Glickauf-Hughes and Beaudoin, 1995, p. 417). Each client presents with his or her own unique history that requires individualized treatment.

## **Summary**

This chapter looked at the phenomenon of non-offending caregivers and focused on the psychological and intrapsychic impairments that result from surviving childhood sexual abuse. I explore the way that these deficits infringe on an adult survivor’s development and perception of themselves and others. I also provided an overview of current treatments available in the United States that enables a survivor’s healing and reprocessing of traumatic emotions linked to traumatic events.

The following chapter will provide an in-depth overview of Object Relations Theory. This theory will be applied to the Case of Mischa for direct application and understanding of the usefulness of this theory in understanding how non-offending caregivers with a history of childhood sexual abuse experience their child's sexual abuse.



## CHAPTER IV

### Object Relations Theory

#### Object Relations Theory

Object relations theory explores the ways in which individuals internally see and relate to themselves and others. The capacity to relate to others and oneself is often shaped through one's experiences in childhood (Flanagan, 2008, "Object Relations Theory"). According to Flanagan (2008) object relations theory "explores the process whereby people come to experience themselves as separate and independent from others, while at the same time needing profound attachment to others (p. 118). It refers to "internal representations of self and others, perspective taking, and quality of emotional engagement with others" (Bedi, Muller and Thornback, 2013, p. 233). Object relations theory looks at the "intermediate area between the subjective and that which is objectively perceived" (Winnicott, 1953, p. 256). The transitional space, or "phenomenon" comes to resemble a mental representation of the other through thinking and fantasizing. "A fundamental assumption within object relations theory is that the quality of the children's interactions with caregivers is internalized. Over time, these internalizations form templates that provide children with an internal processing system that influences the way they perceive, relate to, and experience themselves and others in the world" (Bedi, Muller and Thornback, 2013, p. 233). Object relations theory helps to explain how individuals who have experienced trauma relate to themselves and others. It helps to explain trauma bonds that form as a result of childhood sexual abuse.

I use this theory to focus on the interactions that people have with others and how they internalize these processes, which become part of the psychological realm. Through the process of experiencing mental representations of others and internal images of the self, object relations theory looks at how needs are met or not met. The basic tenants of object relations theory are threefold: the absolute human need for attachment, a child's inner world is shaped by internal representations of others and the human need to be alone and to be with others. The basic tenets of human interaction provide a lens of understanding for Mischa and her son's interactions with their respective abusers.

#### **D. W. Winnicott**

Donald Woods Winnicott (1891-1971) was an English pediatrician, psychiatrist and psychoanalyst and he was pivotal in the formation of object relations theory. Winnicott, like his peers—Fairbairn, Balint, Bowlby and Guntrip—believed that infants were wired for human interaction. Their collective theories that emerged from the British Psychoanalytic Society became known as object relations theory. Winnicott's early contributions were written in a Kleinian way, his roots in Klein herself. Winnicott worked a lot with children and young people. "His pediatric work and later psychoanalytic career led him to see the mother-infant relationship, and hence the earliest object relationship, as the core determinant of mental health or psychopathology" (Buckley, 1986, p. 149). Winnicott explored not only the relationship between baby and mother, but also the relationship between patient and analyst (Mitchell and Black, 1995).

Unlike Freud's belief that a client's difficulties stemmed from secrets and urges, Winnicott believed that a client's "difficulties stemmed from an internal division that removed and split off the sources of her own personal experience. The problem was not in desires,

conflicts or memories, but in the way experience in general was generated” (Mitchell and Black, 1995, p. 133). Winnicott highlights the importance of the quality of relationships and the balance between attachment and the capacity to be alone. “Winnicott was concerned with the quality of subjective experience: the sense of inner reality, the infusion of life with a feeling of personal meaning, the image of oneself as a distinct and creative center of one’s own experience” (Mitchell and Black, 1995, p. 124). At the crux of Winnicott’s theory is the experience of the self within the context of the other. From an object relations perspective, when a child experiences sexual abuse, they “face a formidable dilemma. On the one hand, she may have to renounce her abusive parents in order to view herself as good. On the other hand, she might maintain her connection with her parent, yet view herself as deserving of the abuse” (Basham, 2011, p. 461). Winnicott’s theory of object relations introduces the concepts holding environment, good enough mother one’s true self versus false self and the capacity to be alone. These concepts, which are applicable to sexual victimization, are discussed below.

### **Object Relations Theory Concepts**

**Holding environment.** A “holding environment,” termed by Winnicott, is a “physical and psychical space within which the infant is protected without knowing he is protected” (Mitchell and Black, 1995, p. 126). In a safe holding environment, the child is able to have the optimal “transitional experience.” In the transitional experience, the “creative self could operate and play” (Mitchell and Black, 1995, p. 128). In the transitional experience, the child can explore and learn about him or herself and their external world. It is in this space that the child can connect to self-expression within the context of other subjectivities.

**Good enough mother.** The good enough mother has the capacity for attunement. The good enough mother knows what the child needs when the child needs it. Overtime, as the

mother distances herself in order to focus on her own needs and failure, the infant acquires the capacity for frustration. Through the infant's frustration, mother and child begin to conceptualize their external reality. Winnicott believed that "drives and impulses could be gratified even with someone with whom the relationship is not all that important, whereas needs have to be met by a meaningful person, thereby placing the relationship at the center of the experience. For optimum development to take place, important needs have to be met, including the need to be seen and valued as a unique individual; to be accepted as a whole with both good and bad aspects; to be held tight and to be let go; and to be cared for, protected, and loved" (Flanagan, 2011, p. 121). This is what Mischa lacked during her years of childhood sexual abuse. Optimum development, thus, occurs when a child is sufficiently attuned to, loved, cared for and protected from external violence. This is rooted in the mother-child relationship or caregiver relationship.

When a child's needs are not met, as in the case of childhood sexual abuse, a child's development is impeded as they face the world alone. When one experiences childhood sexual abuse, their need to be seen and valued is stripped from them. They are no longer held tight, cared for, protected or loved. This is especially true if the offender was previously considered a loved one. Even if someone other than their primary caregivers perpetrates the abuse, the child's needs cannot be sufficiently met. Their need to not experience victimization has been violated and thus they experience impingement. When childhood sexual abuse occurs, the child experiences their holding environment as lacking a "good enough mother," filling them with persecutory anxiety.

Object relations theory is especially germane to the treatment of psychically disturbed children and their mothers. Winnicott's concepts of "good enough mother" and "holding environment" are especially relevant to psychotherapy and treatment of sexually victimized

children. Children often view their mothers as a “security blanket”; someone who will protect them, hold them, fulfill their needs and nurture them. Through the use of object relations theory, clinicians use an understanding of transitional objects and transitional phenomena to focus on familiar, inanimate objects that children use to strip off anxiety during times of stress, such as sexual victimization. This theory encompasses empathy, imagination and love between mother and child. When there is good enough mothering, generally a child can grow up in a healthy environment and will feel secure and protected. When this is lacking, children are at risk and may grow up lacking a “true self.” Because of their own victimization, non-offending caregivers often feel that their mothering was insufficient, as expressed by Mischa.

**True self versus false self.** When a child grows up in a healthy environment with satisfying relationships and is properly attuned to, they are able to develop a “true self.” “Feeling real is more than existing, it is finding a way to exist as oneself, and to relate to objects as oneself, and to have a self to retreat for relaxation” (Winnicott, 1971, p. 117). A true self is experienced as real. A true self is achieved when a child’s holding environment is safe; they exist in the transitional experience and a good enough mother supports them.

Object relations theory explains how the internal and external worlds “become divided within themselves and against themselves. The splits and fractures that clients know in themselves are built on compliance to ensure survival and lead to the inevitable development of a ‘false self’” (Mannion, 2002, p. 147). When a child is not properly attuned to, emotionally and physically, the development of their true self is thwarted and they, instead, develop a “false self.” A false self suppresses individuality and molds oneself to the needs of others. A false self allows a survivor of childhood sexual abuse to “keep the world at bay,” thereby protecting one’s true self (Winnicott, 1988, p. 108) A person with a false self may appear socially and professionally

“normal” yet they do not feel like themselves. They may experience a pervasive flatness and a lack of inner vitality (Segal, 2014). A person with a false self may experience himself or herself as disconnected and diffused.

A child who experiences sexual abuse develops a false self because they are not properly attuned to. Their need to be seen, valued, protected and loved is taken away from them. Even if adequately attuned to in infancy, a child that is violated develops new internalizations of the self that are denigrating. Their individuality and uniqueness becomes compromised.

**Capacity to be alone.** In his essay entitled “The Capacity to be Alone,” Winnicott (1958) explains that “the basis of the capacity to be alone is a paradox; it is the experience of being alone while someone else is present” (Winnicott, 1958, p. 30). It is when being alone that the child can “discover his own personal life” (Winnicott, 1958, p. 34). The capacity to be alone is a sign of emotional maturity. Winnicott explains that without the existence of a good object, one does not have the capacity to be alone (Winnicott, 1958). Since survivors of childhood sexual abuse view their offender and those that did not protect them from the abuse—often loved ones—as bad objects, survivors are more likely to lack the capacity to be alone. When non-offending caregivers hear of their child’s sexual abuse, they cannot model the ability to be alone since they themselves lack this capacity.

### **Object Relations Theory and the Case of Mischa**

Mischa grew up in a depressive and unstable home. Her family was preoccupied with their own well-being and therefore did not fully provide for Mischa. From an early age, Mischa saw herself as a victim. She felt alone growing up in an environment that lacked a holding environment. She was abused. She felt isolated; and in adulthood, her own son was sexually victimized. In therapy, Mischa presented as struggling with interacting and trusting others. Prior

to Seeley, she never experienced someone to soothe and reassure her. Mischa also struggled with guiding and calming herself. Because Mischa lacked the “good enough mother” or a safe holding environment, her capacity to grow was atrophied. Mischa’s needs were not met, so she could not “go on being” and be content and calm. She cannot experience herself and others as safe. Mischa’s lack of a transitional experience negatively affected her connection to self-expression within the context of other subjectivities.

Mischa views herself as weak and undeserving because she internalized the messages that her perpetrator and family had placed on her. She lost sight of herself and her own needs. Her needs are especially overshadowed by her desire to support and protect her son from further victimization.

Since Mischa was exposed to the external world before she was ready, she adapted in deficient ways. Instead of prioritizing herself, Mischa focused on satisfying and meeting the needs of others. She developed a fear of abandonment and created a vicious cycle that led to dysfunctional behavior and current pain. This can also be seen as a reflection of her false self. Mischa’s internalization of herself affects how she relates to others. Since she was not able to support herself when she experienced her own sexual victimization, she may doubt her ability to truly protect her son.

Mischa did not open up to women for years because she perceived women as untrustworthy and unsafe. These feelings are rooted in the negative experiences she had with her own mother regarding not believing or supporting her through the sexual victimization and recovery that she needed as a child survivor. Women caused Mischa pain so she learned to avoid this pain by avoiding women. As a result, Mischa formed a maladaptive capacity to maintain supportive and healthy relationships with women. Mischa’s struggle to create relationships with

women has hindered her support network. Mischa prefers to stay at home, furthering her feelings of depression and lack of self worth. Using object relations theory and concepts, as Mischa's clinician I was able to create a holding environment for her and act as her "good enough mother." This intervention allowed me to be one of the first women that Mischa confided in about her traumatic history. It also enabled Mischa to expose her true self. Concealing her true self behind painful memories, Mischa presented to others as her false self. Through continue therapy, Mischa's true self can be unraveled.

Mischa struggled both with a capacity to be alone and a capacity to be with others. Due to internalization of negative sentiments passed down by her perpetrator, Mischa fears being alone. She fears abandonment and ultimate annihilation. Perceiving her life as lacking power and social supports, Mischa may feel that her ultimate annihilation was precipitated and would come with little damage to others.

In order to not be abandoned or annihilated Mischa tries not to surround herself with others. It appears that she can only be present with Zenith and Seeley and chooses to be with them all the time. Object relations theory allows a clinician to understand the origin of Mischa's pain and distrust that lay in her traumatic life experiences, emotional deficits and patterns of internalized, emotionally destructive interactions of an individual with significant objects. This is especially true of the relationships or lack of relationships established during childhood, which are replicated in her social interactions in adulthood.

As a clinician, I am better able to understand the internal relationship between Mischa and her mother and Mischa's interpersonal behaviors and work towards modifying the internal structure of her personality. By focusing on Mischa's social interactions as a significant element in her development, object relations theory resembles a psychodynamic approach to an



emotional difficult that stemmed from childhood sexual abuse. My work with Mischa centered on helping her to identify her current as well as past relationship with her caregivers and how these relationships impact her current social interactions, including her relationship with her son. Using object relations theory, I emphasized the significance and dominance of interpersonal and emotional relationships in the process of Mischa's mental development.

In summary, object relations theory takes into account the devastating effects of actual traumatic events as they influence child development. Object relations theory is helpful in understanding childhood sexual abuse since "sexual abuse is not just a deeply traumatic event or series of events. It happens within a relational structure" (Mannion, 2002, p. 144). It addresses the clinical developmental consequences resulting from childhood sexual abuse. It is summarized best by Prior (2004) when he wrote: "This theory attempts to go beyond description of the symptomatic effects of sexual abuse, toward an explanation of why sexual traumatization produces certain central effects and not others, why it so profoundly affects the child, how it distorts the dynamics and structure of the child's psyche, and how sexual traumatization can be understood in relation to neglect and the child's underlying relational needs" which allows therapy to begin and the sexually victimized child or adult to move towards the healing process (p. 5).

### **Implications for Social Work Practice with Sexually Traumatized Adults**

Winnicott's objects relations theory is helpful for understanding the phenomenon of non-offending caregivers with a history of childhood sexual abuse whose children disclose their own sexual abuse. Object relations theory "can help therapists and their clients understand the underlying ruptured attachment issues, the terror of annihilation" (Wells, Glickauf-Hughes and Beaudoin, 1995, p. 417). This theory can inform the way that clinicians engage with clients who

are survivors of childhood sexual abuse and continue to be placated by the memories of their own traumatic abuse in addition to that of their children's. Social workers will be able to use object relations theory, in combination with other behavioral interventions, to more effectively work with sexually traumatized clients, especially clients caught in the web of intergenerational abuse.

### **Summary**

This chapter provided an in-depth overview of Winnicott's object relations theory and its application to survivors of childhood sexual abuse. The Case of Mischa was used to illustrate how object relations theory applies to clinical applications with sexually traumatized clients. The following chapter will look at the Case of Mischa through the lens of trauma theory. It will start with an overview of trauma theory and its key concepts, followed by direct clinical application to the Case of Mischa.

## **CHAPTER V**

### **Trauma Theory**

Neurologist Jean Martin Charcot, a French physician who worked with traumatized women in the Salpêtrière hospital during the late 19th Century, was the first to investigate the relationship between trauma and mental illness. Charcot noted that traumatic events could induce a hypnotic state in women and he was the first to “describe both the problems of suggestibility, and the fact that hysterical attacks are dissociative problems—the results of having endured unbearable experiences” (van der Kolk, Weisaeth and van der Hart, 1996, p. 50). He identified a link between trauma and dissociation as a tool to cope with experiences that are felt as unmanageable. Charcot worked with women who suffered violence, rape and sexual abuse and through hypnosis, helped his clients to remember their trauma, a process that culminated in the abrogation of their symptoms (Herman, 1992). He noticed that traumatic events directly influenced a client’s personality development, behavior and affect. The study of trauma was further explored during World War I, more specifically, the experience of “shell-shock” that veterans experienced during and after wartime. Hypnosis was reintroduced in World War II to treat trauma. Contemporary trauma theory grew out of a deepened understanding of grief, war, abuse, addiction and rape. In 1980, PTSD was officially added to the Diagnostic and Statistical Manual of Mental Disorders (Basham, 2011). The addition of PTSD into the DSM affirmed the realness of trauma experienced by survivors of natural disasters and interpersonal violence. The descriptors of trauma theory are closely aligned with the emotional trauma of childhood sexual

abuse and because of its similarity and resulting pain; trauma theory was selected as one of the theoretical frameworks for this study.

Contemporary trauma theory is viewed as a fundamental shift in thinking from the idea that those who have experienced psychological trauma, such as childhood sexual abuse, are either “sick” or deficient in moral character and alludes to the reframe that they are “injured” and in need of healing. According to Judith Herman (1992), “traumatic events overwhelm the ordinary systems of care that give people a sense of control, connection and meaning [...] Traumatic events are extraordinary, not because they occur rarely, but rather because they overwhelm the ordinary human adaptations to life” (p. 33). Traumatic events overwhelm an ordinary system of care and disrupt a person’s behavior, affect and cognition.

Trauma theory examines resiliency. It looks at fragmentation that can result from someone dissociating parts of his or her identity that are too hard to process. Trauma theory also helps a clinician explore how to help clients integrate their self and their disparate parts. Trauma theory according to Bessel van der Kolk (2014), proposes the challenge of how to gain knowledge of one’s internal sensations and feelings. van der Kolk further explains that trauma theory does not propose learning to accept the traumatic events, but rather to become in tune with one’s body.

Chu (2011), author of *Rebuilding Shattered Loves: Treating Complex PTSD and Dissociative Disorders*, thoroughly analyzes the complexities of trauma. Chu looks at complex posttraumatic stress disorder (PTSD) in survivors of childhood abuse. In the chapter “Derailed: Childhood Trauma, Attachment, and the Development of the Self,” Chu furthers his analysis of complex trauma by employing attachment theory to explore the relational disturbances in adulthood that result from childhood trauma. Chu posits that people that are exposed to persistent,

chronic and severe trauma experience dysregulation, more specifically, dysfunction of emotions, behaviors and relationships. The presence of trauma and relational disturbances during childhood dictate relational deficiencies in adulthood. PTSD and Borderline Personality Disorder (BPD) characterize these traumatic responses (Chu, 2011).

### **Trauma Theory Concepts**

**Trauma.** Trauma has been defined by many theorists and clinicians; however all definitions highlight the *extraordinary* nature of traumatic events that demarcate them as “trauma.” Figley (1988) “refers to trauma as an emotional state of discomfort and stress resulting from memories of an extraordinary catastrophic experience that shatters the survivor’s sense of invulnerability to harm, rendering him acutely vulnerable to stressors” (Basham, 2011, p. 443). Trauma strips an individual of power and a theoretical understanding of why the trauma occurred. Trauma can influence all facets of one’s life. Trauma can be replayed in “images, behaviors, feelings, psychological states, and interpersonal relationships” (van der Kolk, 2014, p. 7). Trauma can be retriggering for individuals, even when no clear conscious reminder has taken place.

It is important to note “not all people react to a horrific event in the same way. Some respond to traumatic stressors with a temporary traumatic stress response. Others respond to traumatic stressors with long-term negative effects” (Basham, 2011, p. 444). One incident that may be devastating to one individual may be painful, yet manageable to another individual. Protective and risk factors play a large role in establishing whether an event or accumulation of events will lead to long-term negative effects.

**Victim-victimizer-bystander dynamic.** Survivors of childhood sexual abuse are often victimized by people they know and love. It is not uncommon for a bystander to be present at the

time of abuse, or to hear about it after the event and not take action. “Not only does the pattern appear in day-to-day life in interactions with other people, but trauma survivors internalize this victim-victimizer-bystander relationship template, which guides their vision and way of relating to the world” (Basham, 2011, p. 456). When a non-offending caregiver becomes an adult and finds out that their child was also sexually abused, their internal narrative about the victim-victimizer-bystander dynamic becomes ever-present. The non-offending caregiver may feel guilt for having been a bystander. They may feel guilt for having been an innocent bystander and hopeless for lacking tools to take action against the abuse.

**Trauma bonds.** Trauma bonds are emotional bonds that are created between perpetrator and victim. These bonds are especially apparent in relationships where the perpetrator is someone that the victim loves or loved. It is not uncommon for a victim of childhood sexual abuse to create a strong connection with their abuser. “In order to hold onto a positive internalized image of the offending caretaker, they often blame and hate themselves for the abuse so that they can maintain an idealized tie to their offender” (Basham, 2011, p. 457). This tie can manifest in a close relationship when the offender is not a caretaker. Offenders may make their victims feel that they deserve the abuse because they are the most loved or cherished. The victim becomes torn between simultaneously loathing and loving the person that hurts them out of claimed love. In adulthood, survivors of childhood sexual abuse may gravitate towards abusive partners since they unconsciously emulate the relationship between them and their offender. Communicating feelings may be hard for a survivor, disabling them from escaping the detrimental cycle of abuse. This is especially true since, often, survivors of childhood sexual abuse are warned to suppress all feelings surrounding the abuse (Basham, 2011, p. 460).

Survivors may vacillate between a complete shutdown of verbal expression and extreme outbursts of rage that mimic the victim-victimizer-bystander scenario.

**Spectrum of trauma.** Trauma affects each survivor of childhood sexual abuse differently. Some survivors are more supported or resilient, while others become highly fragmented. The spectrum of trauma, from minor to most severe, is Generalized Anxiety Disorder, Acute Stress Disorder, Post Traumatic Stress Disorder and Dissociative Identity Disorder (DID). One is more likely to develop PTSD if they start to organize their life around trauma. According to Basham (2011), there are a few factors that determine the likelihood that an individual will develop PTSD:

(1) a higher degree and intensity of exposure to violence; (2) a higher degree of physical violation; (3) longer duration and greater frequency of abuse; (4) a more heightened sense of unpredictability and uncontrollability; (5) a closer, familial relationship with the offender; (6) younger age; (7) an unsupportive social environment that inflicts stigma shame, and guilt (p. 450).

Hence, the development of PTSD does not discriminate across race, gender, class, religion and ability. Reactions to PTSD, however, are culturally determined.

A diagnosis of Acute Stress Disorder highlights a duration of symptoms up to a month, while a diagnosis of PTSD exceeds one month (APA, 2013). The diagnostic criteria for Dissociative Identity Disorder includes a disruption of identity characterized by two or more distinct personality states, recurrent gaps in the recall of information and the symptoms cause clinically significant distress and impairment in important areas of functioning (APA, 2013). The spectrum of trauma is complex.

**Legacy of unresolved trauma.** “This transmission process can be understood through the lens of trauma theory, where secondary trauma sets the stage for a contagion [...] Disowned and disavowed parts of an internal are projected into and enacted by those individuals who are relating directly with the traumatized family member” (Basham, 2011, p. 443). Even if the non-offending caregiver is not directly abused, secondary trauma helps to explain how they are affected by the trauma that their child experiences. Childhood sexual abuse does not only affect the child, but also affects family members when disclosure occurs, as well as other members within the child’s environment.

**Resilience.** The ways in which a trauma, such as childhood sexual abuse will affect a child, and later their adult life, is dictated by a variety of factors. “Constitutional hardiness, sociocultural factors, family and community support, and preparation/education regarding trauma-related effects may all mediate the potentially negative effects of trauma” (Basham, 2011, p. 448). People are predisposed to resilience due to protective factors. These factors protect against psychopathology and promote healthy coping. Resilience of the victim allows for survival, especially as the child victim moves into adulthood and raises his or her own children.

**Denial.** Sexual victimization causes the child survivor to view the perpetrator as frightening. Unable to reconcile their need for and fear of the perpetrator, especially when the perpetrator is a loved one or authority figure, the child survivor may experience denial or dissociation. “In order to survive such emotionally overwhelming and physically over-stimulating experiences, these children use denial and dissociation as primary psychological coping strategies” (Olio and Cornell, 1993, p. 514).

Denial is the “process that occurs when ‘the victim’s feeling ‘this can’t be happening to me’ becomes ‘this didn’t happen to me’ [...] Denial assists in the maintenance of everyday



functioning by providing a means of self-protection from these deeply disturbing experiences” (Olio and Cornell, 1993, p. 514). Denial is also used to sometimes make the traumatic event ‘go away.’ In other words, if one denies that the traumatic event ever happened, then one can believe it is as if it never happened.

**Dissociation.** Dissociation is the disruption of the integration of the self. Dissociation occurs when a child has limited coping skills and splitting appears to be the easiest way to cope with painful memories. Splitting, while adaptive in childhood, is maladaptive in adulthood. “The use of dissociation follows a continuum ranging from abrupt, momentary disruptions to chronic impairment of consciousness and identity” (Olio and Cornell, 1993, p. 515). Dissociations lead to a paralysis of access to thoughts, feelings, normal abilities and judgment. When dissociating, one does not have access to all areas of their behavior, affect, sensation and knowledge at the same time. Someone with a less secure attachment style is more likely to experience dissociation as a result of trauma.

More specifically, dissociation is composed of depersonalization and derealization. According to the Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition (2013), depersonalization is “persistent or recurrent experiences of feeling detached from, and as if one were an outside observer of, one’s mental processes or body” (p. 272). Depersonalization is composed of “experiences of unreality, detachment, or being an outside observer with respect to one’s thoughts, feelings, sensations, body, or actions” (p. 302). An example of depersonalization is when a person feels as if they are in a dream or that time is moving slowly. The DSM 5 defines derealization as “persistent or recurrent experiences of unreality of surroundings” (p. 272). Derealization may present within a client as if the world around them is distant or distorted.

Depersonalization and derealization are dissociative symptoms that can manifest following a traumatic event, such as childhood sexual abuse.

**The assumptive world.** Janoff-Bulman proposes the theoretical frame of the shattering of the assumptive world. Janoff-Bulman proposes three concepts about the world and self: the world is meaningful, the world is benevolent and the self is worth and invulnerable. When trauma occurs, one or more of these worldviews becomes shattered; “the victimization is likely to define the world and self-assumptions of the child” (Janoff-Bulman, 1991, p. 86). The aforementioned concepts no longer makes sense to the individual. They are replaced by a conceptualization of the world that is formed through the lens of sexual victimization. This is in stark contrast to humanity’s need to understand why bad things happen to good people. If we cannot create systems of meaning, then we are left with a random distribution of good and evil which supports the belief that bad things are equally likely to happen to “good” and “bad” people. Essentially, trauma can shatter one’s sense of meaning, purpose and security.

### **Trauma Theory and the Case of Mischa**

Mischa’s diagnosis of Borderline Personality Disorder is most likely linked to her trauma history, rather than a predisposition to a personality disorder. Mischa’s sexual victimization caused her to disassociate. For years, she went through life tapping into maladaptive coping mechanisms that quelled her anxiety around her sexual abuse, without directly addressing the abuse itself. Mischa would disconnect herself or disassociate from her emotional state in order to survive. For Mischa, dissociation allowed her to ignore her abuse and minimize its pain. When I saw Mischa, she dissociated in our sessions. When she talked about her childhood sexual abuse, she became a different person. Mischa would physically and emotionally distance herself from the experience. Her body collapsed as she resumed the fetal position, laying down on the couch

and presenting as if she were a young child, returning to the state of its occurrence. When Mischa talked about the traumatic experience, she spoke as if she was not the person that endured the physical and emotional pain, but rather that it was someone else. A part of Mischa wanted to deny the sexually abusive event.

Mischa met the DSM 5 diagnosis for posttraumatic stress disorder due to exposure to a traumatic event, intrusion and avoidance symptoms, negative alterations in cognition and mood and alterations in arousal and reactivity. This is evidenced by direct exposure to childhood sexual abuse and indirectly learning that a close relative was violently assaulted; recurrent, involuntary and intrusive memories; traumatic nightmares; dissociative reactions in the form of flashbacks; prolonged distress after exposure to trauma; marked reactivity to trauma-related stimuli; avoidance of trauma-related thoughts and feelings; persistent negative beliefs about herself and the world; persistent distorted blame of self and others; persistent negative emotional state; diminished interest in activities; hypervigilance; sleep disturbance that has functional significance and has exceeded one month (APA, 2013).

Mischa's view of herself as undeserving and guilty of her own and her son's abuse, is reflective of her negative belief about herself. Her apprehension to trust others and view the world as deranged, shows Mischa's negative belief about the world. Mischa's persistent depressive symptoms are manifest in feelings of fear, horror, anger, guilt and shame. These emotions reflect her negative emotional state. Mischa's perception and emotional state are compounded by her being both a primary victim to her own childhood sexual abuse and a secondary victim due to her son's experience with childhood sexual abuse.

An example of Mischa's alterations in mood and reactivity is her fear of not knowing when she and her family would be victimized. Mischa's worldview of safety and invulnerability

was shattered when she was sexually abused, leaving her with the belief that it was inevitable that she, or the people that she loved, would be sexually victimized against their will. Mischa no longer felt safe since both she and her son were sexually violated. Her struggle to decide whether or not to have an abortion is indicative of one of the many ways that Mischa's life was being controlled by her fears. Over time, Mischa began to rethink her decision to have an abortion as indicated in the following interaction.

Mischa: Remember how I was saying that I was going to get an abortion?

Clinician: Yes. How are you feeling about that decision? I want to make sure that you are making the most educated decision. That's a big decision to make and even harder since you are in crisis.

Mischa: Well, I talked with Seeley a lot about it. I think that we have decided to have the baby. I've loved Seeley for so long and have wanted a baby with him forever. I was able to recognize that just because something horrific and unacceptable happened to Zenith, it doesn't mean that we have to stop our lives. We can't let Adam continue to stop our lives. For so long I was blaming myself and now I am seeing that I didn't do anything wrong. It's Adam's fault, not mine. And I won't let him infiltrate my life any longer.

Clinician: Wow! It sounds like a weight has been lifted off your shoulders.

Mischa: It feels like a weight has been lifted off my shoulders.

As Mischa was spiraling downhill upon discovery of her son's sexual victimization, she no longer felt able to care for herself. Before Mischa could process her pain, her basic needs had to be met. She needed to eat and sleep regularly before she could regain a sense of control over her life. The order of priority of needs, however, became muddled by the state of crisis that Mischa

and Zenith lived. Mischa's understanding of the sanctity of life was altered through her and her son's traumatic sexual abuse.

Additionally, Mischa lacked object constancy. She vacillated between hating and loving the person that brought her pain. More specifically, Mischa could not hold onto both love and hate at the same time. Her perpetrator and her son's perpetrator, people she once loved, she now hates. She struggles to see good in the perpetrators, and instead, sees them as not human.

Mischa may have bonded with her perpetrator, just like Zenith connected with his perpetrator. Zenith, despite feeling incredibly vulnerable and unsafe around his perpetrator, enjoyed spending time with his perpetrator and playing video games. His perpetrator, their neighbor, would lure Zenith into the sexual abuse by telling Zenith that he cared about him. He would say that he could convey his affection to him by playing video games. Childhood sexual abuse, unbeknownst to Mischa, persisted, since she believed that Zenith enjoyed spending time with the neighbor. The trauma bond blurred the reality of the sexual abuse, making it more difficult for Mischa to recognize that abuse was happening. The fact that the sexual abuse was happening next door to Mischa made the shame and guilt even more pronounced, since she believed that she should have known enough to stop the childhood sexual abuse from occurring.

The use of trauma theory in the Case of Mischa provides understanding of how non-offending caregivers create a trauma narrative of their experience and then process these feelings around their trauma narrative. Instead of focusing on intrapsychic or genetic issues, trauma theory looks at the interpersonal environment of an individual. "Trauma can disable a person and lead to shattered assumptions and shattered lives" (Basham, 2011, p. 470). Trauma theory helps to understand how trauma affects someone in order to reframe the trauma experience to provide renewed strength and hopefulness to the individual. Trauma theory is applied to expand

understanding of psychological functioning in relation to the traumatic event; and is used in both individual and group therapy formats. This treatment initially is often with the non-offending caregivers and child victim, as well as during the later stages of therapy as previously described in the Case of Mischa.

### **Implications for Social Work Practice with Sexually Traumatized Adults**

This theoretical research suggests that in treating adults and children that have been sexually traumatized in childhood, it is important to include psychological interventions that address deficiencies caused by sexual trauma, especially cognitive impairment, fear and over-activation of PTSD symptoms that increase traumatic memories (e.g. flashbacks or nightmares associated with the abuse). Clinical practitioners that treat traumatized adults and children, through a trauma theory lens, can more effectively help sexually traumatized victims assign appropriate emotional meaning to traumatic experience as well as to the events that occur in daily life that may be triggering. The use of trauma theory can also eliminate learned fear responses and behaviors resulting from the trauma, which are essential for full remission of PTSD symptoms.

The application of trauma theory has both cognitive processing and exposure that specifically addresses deficits discussed in the Case of Mischa. Specifically, cognitive processing allows one to examine and reframe the meaning of the traumatic event; exposure techniques, aforementioned in Chapter 3, decondition learned fear reactions to thoughts and discussions about the trauma. This knowledge provides credence to the suggestion that clinicians should incorporate trauma theory in their interventions with adults and children who have experienced childhood sexual abuse in order to eradicate intrusive symptoms that persist in the aftermath of traumatic events.

## Summary

Trauma theory and object relations theory help explain how an individual becomes dis-integrated and split as a result of severe trauma, especially childhood sexual abuse. Combined, the theories explore the ways that a client can regain or discover their true self in order to live a meaningful life that is void of traumatic responses linked to a traumatic incident. These theories help to explain the recovery process that a non-offending caregiver with a history of childhood sexual abuse goes through. Depending on the individual, the traumatic event, one's protective factors and risk factors, a survivor may experience the recovery process as manageable or tumultuous. Object relations theory and trauma theory explore the ways that a traumatic event, like childhood sexual abuse, affects survivors' behavior, cognition, views of themselves, others and the world and interpersonal capacities. Combined, these theories provide a nuanced framework for understanding the phenomenon of non-offending caregivers who have a history of childhood sexual abuse. The combination of object relations theory and trauma theory yields a more complex assessment of the phenomenon addressed throughout this thesis.

The next chapter will provide recommendations for clinicians working with non-offending caregivers of children that have recently disclosed childhood sexual abuse who have their own history of childhood sexual abuse. Increased care should be taken when working with this highly marginalized and stigmatized population.

## **CHAPTER VI**

### **Recommendations**

This final chapter offers insight into how clinicians can use Object Relations Theory and Trauma Theory as a foundational base for working with non-offending caregivers who have their own history of childhood sexual abuse. I inform that clinicians should evaluate which tools and approaches work best for each client as each client is unique and presents with his or her own traumatic histories and symptomatology. Hence, this chapter should serve as a guide. Also, when working with clients from a multicultural perspective, special attention is needed for understanding cultural differences and implications for practice.

### **Defining Best Practice**

Treating non-offending caregivers and their sexually victimized children require multiple levels of intervention in order to provide the safety, recovery, and supportive measures needed for their healing process. Although much literature exists on child abuse, perpetrators and statistics of abuse occurrence, much less is known about treating non-offending caregivers and their sexually abused children. However a consistent finding across studies about childhood sexual abuse, non-offending caregivers and child trauma is the importance of the child-caregiver relationship in facilitating recovery (Elliot and Carnes, 2001; Scheeringa and Zeanah, 2001). Sexual abuse is traumatic for both the child and the caregiver, and its effect on the caregiver-child relationship can be monumental. Interventions are needed to help non-offending caregivers to more effectively respond, cope, support, protect and participate in their child's recovery and



healing process. This theoretical study examined the phenomenon of non-offending caregivers in an attempt to understand best practice methodologies for working with this population group and their sexually violated and traumatized children, and to affirm why object relations theory and trauma theory are viable best practice options to use in working with non-offending caregivers whose children have been sexually abused.

Research shows that working with non-offending caregivers who have a history of childhood sexual abuse poses added challenges for clinicians (Kim, Trickett and Putnam, 2010). Clinicians that work with non-offending caregivers especially need to attend to the emotional, behavioral and interpersonal dynamics of the non-offending caregiver as well as dynamics between the caregiver and clinician. Understanding the goals of treatment with non-offending caregivers who have a history of childhood sexual abuse is necessary in guiding clinicians that work with this population. Additionally, clinicians should evaluate the current level of functioning of a client prior to the onset of therapy. Wells, Glickauf-Hughes and Beaudoin (1995) suggest

Clients must have sufficiently developed psychic structures (e.g., object constancy, observing ego) to withstand the anxiety created by retrieving traumatic memories without retraumatizing the individual or subjecting the individual to a situation which can overwhelm an already weakened ego and lead to decompensation or destructive acting out (p. 426).

Once clinicians have evaluated a client's state of functioning and their capacity for change, a clinician can then begin working with a client. Assessing sufficient psychic structures creates a safety buffer for the work that will take place between clinician and client.

Olio and Cornell (1993), suggested, “The main goal of treatment is the integration of self and affective experience” (p. 512). Clinicians should aim to guide and support the client in integrating the different pieces of their identity that have been fragmented through the sexual abuse and its aftermath with emotions related to their trauma. Integration can be attained through a deepened understanding of “What happened and how it happened needs to be uncovered, understood and felt” (Olio and Cornell, 1993, p. 520). Integration of the self and one’s affect allows for the formation of a true self.

Focusing on attachment and relational needs and changing maladaptive behaviors also can accomplish integration. Chu (2011) explained that the clinician should guide the client through a phase oriented treatment model that consists of: (1) Establishing safety, stabilization, control of symptoms, and overall improvement in ego functioning; (2) Confronting, working through, and integrating traumatic memories; and (3) Continued integration, rehabilitation, and personal growth (p.112). Overall, clinicians should encourage and assist clients in regaining “a sense of empowerment while reclaiming all the parts of themselves and their experiences” (Olio and Cornell, 1993, p. 521). Empowerment and reclamation of the true self marks a reprocessing of traumatic events. Referring to the Case of Mischa, this shows that even in the midst of extreme distress and grief, Mischa is determined, or vested, to protect her son. This speaks to how maternal supportive responses can be intertwined with numerous factors that include coping with the caregivers’ own sexual abuse, current levels of stress, and their emotional state even after the sexual disclosure of their child. There is a period of psychological adjustment after hearing of one’s child’s sexual abuse and for the non-offending caregiver; this period of distress may interfere with their immediate attempt to attend to their child’s healing and recovery

process, which often stems from their need to stabilize their own emotions and pain first. The therapeutic alliance between clinician and client is of utmost importance here.

### **Therapeutic Alliance**

Bedi, Muller and Thornback (2013) suggest that clinicians use a relational approach and validate a client's traumatic experiences. They argue, "The major goal of therapy should be to facilitate the ability to trust and feel safe in the presence of another person (Bedi, Muller and Thornback, 2013, p. 239). Often survivors of childhood sexual abuse lack trust in others and a feeling of safety throughout their life. The therapeutic relationship can help facilitate the creation of new beliefs about the self, others and the world, dismantling tainted worldviews.

The therapeutic alliance is pivotal in effecting change within the client. The therapeutic space is transformative in that it creates a "corrective interpersonal experience" (Olio and Cornell, 1993, p. 512). In order to be transformative, the clinician must be their authentic self. The clinician should bring their entire self into sessions and be cognizant of their own counter-transferential response to a client. Additionally, clinicians should create a holding environment—a safe physical and psychological space—for the client in order for spontaneity to occur. "It becomes the therapist's responsibility to provide containment, structure, and support to facilitate the processing of the fragmented images, affect, and the repressive elements that surface as the survivor re-experiences the abuse during the integration process" (Olio and Cornell, 1993, p. 516). The clinician should strive to be a good enough mother and recreate the transitional experience that the child was not able to experience during the abuse. This is especially important since clients seek safety in their clinician and in the therapeutic alliance. In creating a safe space for the client, it is important that the clinician understands and respects the survivor's need for control. When recalling a trauma, "a 'swap' during which the non-

judgmental accepting and holding presence of the therapist is internalized as a ‘good object,’ allowing an ‘emptying out’ of the black painful feelings and memories lying within the client” (Mannion, 2002, p. 146). Within the therapeutic alliance, the client can regain control that was violently stripped away from them in their experience of childhood sexual abuse. This was demonstrated in the Case of Mischa.

Once trust and rapport have been built, the clinician should proceed with therapy based on the client’s overt and covert cues. This will help to avoid re-traumatizing the client. Using the cues given by the client, the clinician should actively and affectively engage with the client, providing empathy and validation. “The transference expectations victims may bring to the therapeutic process, which include failure to protect, abandonment, indifference and even assault, can be intensified by the therapist’s silence and passivity” (Olio and Cornell, 1993, p. 516). Active engagement creates a safe environment that challenges the client, as they are ready to be challenged. A clinician, however, should not fish for information. Fishing for information increases the chances of creating false memories. In the case of a client that dissociates and is fragmented, a clinician should not ask for different parts of one’s fragmented self to become present. This will encourage splitting which can be harmful to the client. Instead, create co-consciousness. Additionally, a clinician should not explore a client’s trauma history too early in the therapeutic process. Timing is critical.

By remaining calm, the client has a reflection, or role model, of how to exist amidst fear. This is also helpful in helping the client to tolerate ambiguity and not knowing why or how the sexual abuse occurred. Often, the worldviews of survivors of childhood sexual abuse have been shattered. Aiding a client in creating new ways of understanding how bad things can happen to young children and good people requires being present in the discomfort and processing feelings

linked to unanswered questions. “It is important for the therapist to hold the centrality and significance of the abuse experiences” (Olio and Cornell, 1993, p. 514). This is especially important since clients may feel that they are exaggerating their traumatic experience. Grounding clients in their own sensation of their bodies can also be helpful in tapping into a client’s confusion, frustration and animosity. Often survivors carry trauma in different parts of their body, causing distress and blocks in the body. By grounding clients, the clinician can help a client become less numb and become more in tune with their physical bodies.

### **Integration of Object Relations Theory and Trauma Theory**

This study examined Object Relations Theory as a tool to emphasize interpersonal relations, primarily in the family and especially between the caregiver and child victim; and Trauma Theory to assist non-offending caregivers in reframing from irrational and negative thoughts and beliefs related to their sexual victimization.

Object Relations Theory is effective in providing insight into the need for more parent- and family-focused interventions in families that have been affected by sexual abuse. This theory allows clinicians to address issues of self-blame, guilt, betrayal, hopelessness, and traumatic sexualization. It also allows clinicians to focus on the caregiver’s experience of the abuse and on overall family dynamics and social functioning. Through the use of Object Relations Theory, I as a clinician was better able to help Mischa prepare for her son’s treatment and decrease her own feelings of post-traumatic stress due to the abuse event. Most importantly, my intervention improved Mischa’s overall family functioning, which is often an ingredient overlooked in the literature on childhood sexual abuse treatment.

The blending of Object Relations Theory and Trauma Theory with current knowledge of PTSD and dissociation helps clinicians understand abuse survivors’ behaviors and patterns.

Generally treatment occurs in phases. Three phases of treatment are important to childhood sexual abuse recovery. Phase-oriented treatment uses ego supportive and ego modifying psychotherapy. Early phase treatment focuses on self-care and self-esteem. It is important to encourage self-care so that when a survivor is re-traumatized, they can fall back on healthy coping tools rather than self-harming tactics. The acquisition of grounding techniques helps an individual to limit intrusive thoughts, acknowledge the significance of their trauma and exist in a present state of functioning. Self-care is especially imperative for adult survivors of childhood sexual abuse who are caring for their children that have just disclosed sexual abuse. Modeling respect for their own bodies and their minds is helpful for non-offending caregivers, as they go through their own process of disgust and self-hatred. Focusing on the development of self-esteem and self-respect also limits the likelihood that a survivor turns to acting out to self-soothe. Encouraging verbal expression, or venting, of feelings can help a survivor externalize their emotions rather than internalize them, helping to build self-esteem and self-respect.

Middle phase treatment focuses on working directly with the survivor's traumatic memories. More specifically, the focus is on "emotional processing, cognitive change, and achieving a sense of mastery concerning the trauma" (Chu, 2011, p. 123). In this phase, crisis is avoided. New meaning is brought to traumatic events, allowing for a reprocessing of trauma in the brain. It is in this phase that the client shifts from victimhood to survivorship. In this process, ideally, the client is able to relinquish self-blame as their sense of self is enhanced.

The last phase of treatment allows the client to "proceed with their lives relatively unencumbered by their past" (Chu, 2011, p. 128). An empowered sense of self leads to higher self-regard and increased clarity on who they are as a survivor. The last phase marks a rebuilding of shattered lives.

It is important to integrate the caregiver when providing treatment for a childhood survivor of sexual abuse. “The major protective factor to help children survive sexual abuse is a caregiver who believes the allegations, and is able to help the child think accurately about his or her feelings and where the blame actually lies” (Howe, 2005, p. 204). Child abuse is never the child’s fault. Integrating a supportive caregiver in treatment of a child survivor diminishes the chances that a child will develop PTSD or maladaptive coping mechanisms in response to their traumatic experience/s.

By using Object relations theory and trauma theory I was able to work with Mischa on issues related to shock, anger, disbelief, ambivalence and sadness regarding both her and her son’s abuse event. I was able to become the “good-enough mother” in a holding environment which she never had during her own childhood in order to help her deal with her own shame and guilt about her sexual abuse and the trauma of learning of her son’s sexual victimization by a trusted neighbor. Object relations theory allowed me to help Mischa negotiate the intersubjective process of separating her own trauma from that of her son. Trauma theory allowed me to help Mischa talk about her traumatic events in order to overcome them, which in essence allowed her to cope more effectively with her own emotional distress and develop skills in therapy to support her victimized son.

### **Theoretical Strengths and Weaknesses**

The internal lives of non-offending caregivers and their sexually victimized children are complex; and the depth of their disturbance is often overlooked in research and goes un-addressed. Even more important is recognition that no one therapy is sufficient enough to treat all sexually traumatized victims alike. We, as clinicians, see these victims vacillate between defensiveness and anxiety. The subjectivity of survivors of childhood sexual abuse cannot be

overlooked and not all clinicians can work with this population group. Object relations theory and trauma theory with sexually victimized children goes beyond symptomology of childhood sexual abuse to include why sexual victimization presents certain central effects in some victims and not others, why sexual trauma profoundly affects children, how their realities are distorted, and how sexual victimization is understood in relation to neglect and the victim's underlying relational needs.

Additional strengths of this research are its examination of non-offending caregivers of sexually victimized children and the potential effectiveness of object relations theory and trauma theory in working with this population. In choosing these two approaches, however, others were inevitably omitted. Also while I was able to draw from a large body of knowledge, I acknowledge that it is not exhaustive and is limited by time, scope and my choice of research. Another limitation of this research is its emphasis on primarily the female non-offending caregiver. Nevertheless because of the lack of empirical research on these treatment approaches with this population, this study is deemed theoretical. A next step is to conduct empirical research on treatment outcomes related to these two approaches.

### **Considerations for Clinical Practice**

The combination of these therapies allowed me, as a clinician, to work with Mischa in areas of attachment, parenting, psychological functioning, “good-enough mothering” and to help her mend her psychic separation in identity and consciousness that left her confused, frightened, and disturbed following her own episodes of abuse. By doing so, I was able to help Mischa cope effectively with her own emotional distress and assist her in developing the skills needed to support her sexually victimized son. This increased awareness and targeted intervention can guide other clinicians to better assess the needs and systemic influences of non-offending



caregivers and their sexually victimized children and, ultimately, facilitate their healing and recovery process. Object relations theory and trauma theory integration in clinical practice with non-offending caregivers and their sexually abused children can critically enhance the healing process and provide the protective and empowerment skills to prevent future victimization of children.

Clinicians should be mindful of their roles and behaviors within their therapeutic relationships with non-offending caregivers and victimized children. Clinicians can act as conduits for re-establishing trust in relationships. Clinicians should, however, be wary of the potential for reenactments. As clinicians, we function in different roles for the client, sometimes multiple roles within any given session. Clinicians can function as the client's mother, father, sibling, friend or even perpetrator. Through changing the role of the clinician, the client is able to sort through emotions and challenges that the client has not processed directly with the individual in which the clinician represents. While the clinician may function as the mother or father or loved one, the clinician may also be perceived as the perpetrator. The clinician may be both the provider of care and the instigator of harm. In these instances, it is imperative that the clinician identifies the reenactment and flesh out what transpired. According to Basham (2011), "enactments are inevitable. However, it is very important to understand the nature of the countertransference enactments to both strengthen the empathic connection with our clients, to repair therapeutic ruptures when enactments occur, and to minimize the occurrence of enactments as best as possible (p. 467). These roles are all inclusive of clinical practice.

Additionally, implications for clinical practice are how clinicians perceive their clients and how clients may be speaking to what they think the clinician wants to hear, rather than in an authentic way that reveals their true self. "It is also important for survivors to feel safe enough to

claim the entire range of their feelings, impulses, and actions” (Wells, Glickauf-Hughes and Beaudoin, 1995, p. 419). The clinician must be attuned to not only the content, but also the process and non-verbal communication. This is especially true in situations where the client may be acting out through self-harming behaviors. The clinician should validate the pain that the client feels, rather than condemn the unhealthy behavior in which the client is engaging (Chu, 2011). The client may be looking for the clinician to respond to these behaviors in the way that their non-supportive family or perpetrator has. Thus, the clinician must respond in a way that soothes and comforts the client, affirmation that the client may have never previously received. If the behavior worsens, the clinician may need to create a crisis plan or intervene. Similarly, it is important that the clinician sees the client as a whole self whose experience of the world has been fragmented, rather than seeing the client as having multiple personalities or parts.

When working with this population, clinicians should be mindful of their own countertransference. Compassion fatigue is common for mental health professionals working directly with severe trauma. “These responses may involved full-blown PTSD symptomatology, including the hyper-arousal-numbness pendulum, affect dysregulation, startle reactions, and reexperiencing, including flashbacks and nightmares” (Basham, 2011, p. 466). Clinicians should utilize supervision, peer supervision and self care in order to reduce the risks of vicarious traumatization and feelings of despair and powerlessness.

## **Conclusion**

Non-offending caregivers enter treatment with complex and layered trauma from their own childhood sexual abuse. Clinicians must understand how this trauma impacts current behaviors and functioning and treat these clients with patience and empathy. Clinicians also must honor, respect and draw upon the incredible resilience that so many survivors of abuse possess.

This research drew upon two evidence-based theoretical approaches to demonstrate their effectiveness in treating non-offending caregivers and their sexually victimized children. The Case of Mischa was used to illustrate how these theories can be used, with expected outcomes of treatment. The hope for my research is that it provides alternatives and confidence for clinicians to better serve this vulnerable population and to help non-offending caregivers and their sexually abused children take back their lives and recapture meaning, competence, self worth, value, and self-efficacy in their lives.

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