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Abstract

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Bianca M. Harper

Lina Hartocollis, Ph.D

Sibling incest is an under-reported, under-researched social problem that devastates affected families and challenges social workers and other professionals who work with them. There is little research on family experiences and changes in family dynamics after sibling incest and even less on the reunification experiences of families after sibling incest. The purpose of this study was to gain insight into families' reunification experiences after sibling incest in order to promote continued healing and improve service delivery. A qualitative study, using semi-structured interviews was conducted with fourteen multidisciplinary professionals involved in family reunification after sibling incest. Grounded theory guided the analysis of interview data. Findings include themes of role of therapist, process of reunification, challenges of multidisciplinary team member collaboration, challenges of ensuring family safety, challenges of determining family readiness, clinical concerns, and lack of a road map. Findings suggest that the process of family reunification after sibling incest is complex and filled with many challenges for both the family and team members. Implications for theory, practice, and future research are also discussed.

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Moving Families to Future Health: Reunification Experiences After Sibling Incest

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**MOVING FAMILIES TO FUTURE HEALTH: REUNIFICATION
EXPERIENCES AFTER SIBLING INCEST**

Bianca M. Harper

A DISSERTATION

in

Social Work

Presented to the Faculties of the University of Pennsylvania

in

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Degree of Doctor of Social Work

2012

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SIBLING INCEST

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Dedication

This dissertation is dedicated to the families who allowed me to enter their world during a challenging and painful time. Your courage and resiliency inspires me.

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Chapter I: Introduction

Statement of the Problem and Purpose of the Study

Sibling incest is an under-reported, under-researched social problem that wreaks havoc on affected families and challenges social workers and other professionals who work with them. When an allegation or disclosure of sibling incest is brought to the attention of a child welfare agency or law enforcement agency, the victim and offender are often separated and prohibited from any contact pending the investigation. Not only is the family physically disrupted; but the parents have the enormous responsibility of emotionally supporting both siblings through the investigative process, the treatment process, and often the reunification process, while also addressing their own feelings about the sexual abuse that occurred within the immediate family.

Social workers and other professionals working with families in which sibling incest has occurred face the challenge of helping family members navigate the complex process of rebuilding their relationships with each other while ensuring the continued safety of the victim and the wellbeing of all the members of the family system. Yet there is little research on family experiences and changes in family dynamics after sibling incest is reported and intervention is received and even less research on the reunification experiences of families who experience sibling incest to help guide clinicians and involved professionals in their work.

This qualitative study explored families' experiences of reunification after sibling incest from the perspective of multidisciplinary team members who work with families where sibling incest has occurred. The aim of the study was to answer the following questions: What are family experiences of reunification after sibling incest? How can protective factors be increased

after sibling incest? How can family experiences promote continued healing and improve service delivery?

Background

Sexual Abuse of Children

Child sexual abuse is an international public health issue that crosses all racial, cultural and socio economic boundaries. Research estimates that one in four girls and one in six boys will be sexually abused by the age of eighteen (<http://www.cdc.gov/nccdphp/ace/prevalence.htm>). Seventy percent of reported sexual assaults are against children (Snyder, 2000). In 2010, there were 63,527 sexual abuse cases reported to child welfare agencies (<http://www.acf.hhs.gov/programs/cb/pubs/cm10/cm10.pdf>).

There are several definitions of child sexual abuse. The National Task Force on Juvenile Sexual Offending (1993) defined child sexual abuse as “sexual acts perpetrated on another without consent, without equality, or as a result of coercion” (p. 1592). In the definition consent is defined as “understanding what is proposed, knowledge of societal standards for what is proposed, awareness of potential consequences and alternatives, assumption that agreement or disagreement will be respected equally, voluntary decision and mental competence. Equality is defined as two participants operating with the same level of power in a relationship, neither being controlled nor coerced by the other. Coercion is defined as exploitation of authority, use of bribes, threats of force, or intimidation to gain cooperation or compliance” (p. 1592). The Office of Juvenile Justice and Delinquency Prevention (OJJDP) (2009) defined child sexual abuse as exposing a child to pornography, fondling over or under clothes, oral sex, vaginal intercourse, anal intercourse.

As societal awareness has grown, so has the reporting of child sexual abuse. However, research indicates that most child sexual abuse goes unreported due to the intense secrecy and shame associated with child sexual abuse. Secrecy and shame often lead to lack of disclosure by the victim (Finkelhor, 1980; Laviola, 1992).

Ninety percent of child sexual abuse is committed by someone related to the child or someone the child knows and trusts (Kilpatrick, Saunders & Smith, 2003). The Office of Juvenile Justice and Delinquency Prevention (OJJDP, 2009) found that juveniles account for 35.6 percent of child sex abuse crimes and juvenile sex offenders are more likely to have family members as victims than adult offenders. Approximately 70% of child sexual abuse offenders have 1-9 victims and 20% of child sexual abuse offenders have 10-40 child victims (Elliott, Brown, & Kilcoyne, 1995).

According to the United States Department of Justice (1996) the annual monetary cost of intervention and treatment for one child who has been sexually abused is approximately \$14,000. The United States spends \$35 billion annually for costs related to child sexual abuse. These figures only account for reported cases. For the victims who never disclose, the economic cost due to social, economic, and mental health stressors is unknown. However, it is evident that the emotional, health, and economic impact of child sexual abuse is enormous (United States Department of Justice, 1996).

Putnam (2003) stated that most children who are sexually abused will be symptomatic at some point in their lives. Research indicates that sexually abused children are more likely to develop symptoms of Post Traumatic Stress Disorder and other anxiety symptoms, depression, eating disorders, and substance abuse problems compared to children who have not been

sexually abused (Kendler, Bulik, Silberg, Hetteema, Myers, & Prescott, 2000; McLeer, Dixon, Henry, Ruggiero, Escovitz, Niedda, & Scholle, 1998; Molnar, Buka & Kessler 2001; Rudd & Herzberger, 1999; Saunders, Kilpatrick, Hanson, Resnick, & Walker, 1999). Children who are sexually abused engage in high risk behaviors such as substance use, unprotected sex, delinquency, and crime more often than children who were not sexually abused (Acierno, Kilpatrick, Resnick, Saunders, de Arellano, & Best, 2000; Kilpatrick, Hanson, Resnick, & Walker, 1999; Noll, Shenk, & Putnam, 2009).

The effects of child sexual abuse are extensive and victims may have lifelong struggles overcoming the sexual abuse they experienced (Kendler, Bulik, Silberg, Hetteema, Myers, & Prescott, 2000; McLeer, Dixon, Henry, Ruggiero, Escovitz, Niedda, & Scholle, 1998; Molnar, Buka & Kessler 2001; Rudd & Herzberger, 1999; Saunders, Kilpatrick, Hanson, Resnick, & Walker, 1999). In addition to victim and offender recovery, the family must cope and heal from the sexual abuse that occurred and find a way to move forward as a family who has been traumatized and permanently altered. This is often an overwhelming task for families, particularly when the abuse occurs between siblings.

Sibling Incest

Intrafamilial sexual abuse is a pervasive, complex issue that raises many challenges for clinicians and researchers due to the entanglement of kinship and family dynamics. There have been conflicting findings regarding the dynamics of incestuous families, the victim-offender relationship in incestuous families, and the emotional impact of intrafamilial sexual abuse on the family. The terms incest and intrafamilial sexual abuse will be used interchangeably in this paper to refer to sexual abuse where the victim and the offender are part of the same immediate family.

Research has portrayed incestuous families in various ways. Courtois (2010) & DiGiorgio-Miller (1998) stated that incestuous families often contain emotionally and physically absent parents and unclear or inappropriate sexual boundaries. However, other research indicates that intrafamilial sexual abuse occurs in all types of families including those families who are viewed as “pillars of the community” (Rudd & Herzberger, 1999, p.918). These varied findings regarding the characteristics of incestuous families demonstrate the vast diversity of families who experience intrafamilial sexual abuse.

Research regarding intrafamilial sexual abuse has often focused on father-daughter sexual abuse (Finkelhor, 1980). Rudd & Herzberger (1999) referred to sibling sexual abuse as “...a blind spot in research” (p. 915). There are few statistics regarding the prevalence of sibling incest. Reasons for the lack of prevalence rates include lack of disclosure by the victim and lack of research studies (Carlson 2006; Finkelhor 1980, Laviola 1992). Celbis, Ozcan, & Ozdemir (2005) stated that sibling incest is “frequent but rarely reported” (p.38). Caffaro & Conn-Caffaro (1998) found brother-sister incest to be the most common type of intrafamilial sexual abuse. Mash and Barkley (2007) found sibling incest to be five times more likely to occur than parent-child incest.

Finkelhor (1979) stated that sibling incest may be less reported and therefore less researched due to it not being as disruptive to the family system as father-daughter sexual abuse. Courtois (2010) stated that another reason for lack of research may be due to it being unlikely that parents would report their offending child to child welfare or law enforcement. However, such parental decisions put victims of sibling incest at a higher risk for traumatization due to not feeling validated and supported by their parents. This lack of action on the parent’s part may also allow the sexual abuse to continue.

Other reasons for the lack of research on sibling incest include conflicting beliefs regarding the definition of sibling sexual abuse and its impact on the victim. Researchers have argued that sibling incest is difficult to define due to the fact that siblings may engage in sexual play due to normal sexual development and curiosity. Rudd & Herzberger referred to sibling incest as “sex play or harmless experimentation” (1999, p. 924). However, further research with victims of sibling incest found that the sexual abuse they experienced was well beyond “harmless experimentation” and often involved penetration, coercion and violence (Welfare, 2008).

Some research concluded that sibling incest is synonymous with father-daughter incest in regards to the dynamics of abuse and the victim experience. In a study by Cyr, Wright, McDuff, and Perron (2002), they found very little difference between sibling incest and father-daughter incest in regards to the characteristics of the abuse, family dynamics, and emotional distress of the victim.

In both father-daughter incest and sibling incest, the offender is often in an authority role and is someone who the victim loves and trusts. However, differences between father-daughter incest and sibling incest have been found. Research has indicated that father-daughter incest causes more emotional distress than other types of incest due to the father’s role of parent protector and caregiver and the dual relationship the father creates with his daughter when sexual abuse occurs (Cole & Putnam, 1992). More current research indicates that sibling incest is equally distressing to the victim and family. Monahan (1997) stated that sibling relationships are “one of the most important and enduring relational environments in the life of the family” (p.20). Due to this intimate connection, sibling incest can have a catastrophic impact on the victim and family system.

Rudd & Herzberger (1999) found sibling incest to be longer in duration than father-daughter incest. Rudd & Herzberger (1999) found that sibling incest often ended when the offender left home and that offenders used force and violence more often in sibling incest than in the father-daughter type. Cyr et al., (2002) found that penetration was more common in sibling incest than in father-daughter incest. Canavan, Meyer, and Higgs (1992) discussed secrecy in sibling incest as being “enforced through fear, coercion and threat” (p. 137). Regardless of conflicting beliefs about the dynamics of incestuous families and types of incest, it is well documented that any form of intrafamilial sexual abuse often causes psychological trauma to the victim (Cohen, Mannarino & Deblinger, 2006; Gil, 2006).

Contributing Factors to Sibling Incest

A number of factors contribute to the occurrence of sibling incest. Finkelhor (1985) discussed four preconditions that must be met in order for child sexual abuse to occur. The four preconditions include: motivation of the abuser to sexually abuse a child, the abuser overcoming internal inhibitions against sexually abusing a child, the abuser overcoming external inhibitions to sexually abusing a child, and the abuser overcoming the resistance of the child.

Courtois (2010) described 3 primary variations of older brother-younger sister incest that is believed to be the most common type of sibling incest. Courtois stated that brothers may sexually abuse a sister for sexual experimentation and learning, when the brother is socially awkward or neglected by a parent, or when the brother himself was a victim of sexual abuse.

Gil & Cavanaugh-Johnson (1993) stated that sibling incest occurs in chaotic home environments that are sexually charged. Gil & Cavanaugh (1993) explained that victims of sibling incest are often favored children. Worling (1995) found in a study of juvenile sibling

offenders that they were more likely to come from a negative family environment compared to nonsibling juvenile offenders.

Cavanaugh (2009) stated that problematic sexual behaviors in children may occur when children are exposed to sexually explicit media such as movies, internet sites, magazines, etc. as well as when children are exposed to sexual activity. Cavanaugh stated that children may sexually act out on other children when they live in a sexualized environment with little privacy and loose boundaries around sex.

Another contributing factor is lack of supervision between siblings. Older siblings often assist in caretaking and sibling supervision when the parent is unavailable. Parents may consider older siblings' role models and they are trusted due to being part of the immediate family system. This trust and faith in the older sibling to look out for his/her sibling's best interest often results in parents being blindsided when they learn that their own child sexually abused their other child. When an older sibling is in an authoritative role, the sibling relationship is altered, which often leads to the victim feeling powerless (Venziano, 2000). Celbis, Ozcan & Ozdemir (2005) stated that fear of the sibling as an authority figure "may have allowed the sexual abuse to begin but shame and hopelessness may allow it to continue" (p. 39).

Juvenile Sex Offenders

As the fields of child welfare and law enforcement increasingly recognize that children sexually abuse other children, research is being conducted to better understand prevalence of child sexual abuse committed by juveniles. Shaw & Lewis (2000) found that the majority of juvenile offenders commit their first sexual offense before age 15 and siblings are often the victim. Another finding of their study was that child victims of juvenile sex offenders are younger than victims of adult offenders. Ryan, Miyoshi, Metzner, Krugman & Fryer (1996)

found that in a study of 1,616 juvenile sex offenders, 38% of the victims were family members who resided with the victim in the family.

Sibling incest offenders possess unique characteristics that differentiate them from other juvenile sex offenders and impact prevalence rates, assessment, and treatment. O'Brien (1991) found in a study of sibling incest offenders and non-sibling juvenile sex offenders that sibling incest offenders had more sexual offenses, younger victims, and longer duration of sexual abuse than other juvenile sex offenders. Additionally, in a study by Nisbet & Siedler (2001) they found that sibling incest offenders had a higher rate of child welfare involvement and sexual abuse histories than non-sibling juvenile offenders.

Courtois (2010) discussed the complexity of sibling incest due to dysfunctional family patterns, intergenerational incest, and offender mental health. As discussed earlier in this chapter, many factors lead to sibling incest. Courtois identified concerning contributing factors to sibling incest including significant mental health issues of many offending brothers. Unless an offender is brought to the attention of law enforcement or child welfare, separated from the victim, and mandated to mental health treatment, he is likely to continue engaging in incestuous behaviors which perpetuates the intergenerational transmission of incest. Courtois stated that brothers who sexually abuse their sisters may continue to sexually abuse their own children and nieces. In a study of nieces who were sexually abused by their uncles, Courtois found that the uncles had a history of perpetration within the family system. These findings illustrate the intricacy of sibling incest cases and the need for comprehensive and tailored treatment.

As the research and knowledge base about juvenile sibling-incest offenders grows, it is important that this knowledge translate to practice. The multidisciplinary team that works with families who have experienced sibling incest must be aware of the unique needs and risk factors

in these families and stay informed about the literature and research on trauma in family systems in order to provide effective and appropriate support to incestuous families.

This study examined family reunification experiences after sibling incest. The purpose of this study was to gain insight into the experiences of families' post-reunification, in an effort to arm multidisciplinary team members with knowledge that will help promote continued healing and improve service delivery.

Family Systems Theory

Family systems theory provides a framework for understanding the complex, intimate dynamics at play in incestuous families. Family systems theory examines how families function throughout the life cycle and how they handle change. Minuchin (1985) described the family as an interdependent system that is impacted by individual and group change. When incest is part of a family system it impacts the individual and overall functioning of the family. Minuchin et al. (1967) stated that unhealthy families maintain dysfunction. This is evident through the rigidity of families, closed family systems, and poor boundaries. These are all factors that contribute to sibling incest. This conceptual lens helps illustrate the ways in which dysfunctional family patterns begin and perpetuate and the importance of identifying, processing, and changing family dynamics that have led to sibling incest.

Additionally, family systems theory emphasizes the importance of family involvement in treatment. Gil (1993) stated that the family system must be examined in order to identify the etiology of the sexualized behaviors since these often originate in the family. Understanding family structure and family roles helps clinicians assess family needs and tailor treatment appropriately. Also, assessment helps multidisciplinary team members identify services and supports that will help families improve systemic functioning.

Family systems theory helps multidisciplinary team members identify contributory factors, anticipate and understand the impact of family disruptions that often accompany sibling incest such as the offending child being removed from the home, multiple agency mandates and restrictions being placed on the family, family vulnerability as a result of traumatic upset of the family system, and family desire to return to the comfort of their family norms.

Trauma Theory

Trauma theory provides an important organizing framework for understanding and responding to the dynamics and consequences of sibling incest. Trauma theory postulates that unresolved trauma can cause psychological, behavioral, and physiological impairments (van der Kolk, 1987). Trauma theory states that people who experience trauma, such as sexual abuse, have a diverse array of responses as well as ways of coping with the trauma (Berzoff, 2009; Courtois & Ford, 2009; Gil, 2006). While some victims of sexual abuse demonstrate resiliency many others experience emotional distress that varies in intensity and duration or both.

There are many factors that affect an individual's response to trauma. When sexual abuse occurs at an early age, a child's ability to develop trust, secure attachments, and a solid identity may be negatively impacted (Berzoff, 2009; Courtois & Ford 2009; van der Kolk 2005). Courtois & Ford (2009) stated that early, chronic, interpersonal trauma interrupts self and relational development and this disruption may lead to symptoms of complex trauma. Courtois and Ford (2009) stated that complex trauma "...has as its unique trademark a compromise of the individual's self-development" (pg. 16). Due to the intimate violation and betrayal by a family member, and familial response or lack thereof, intrafamilial sexual abuse often causes significant emotional distress for victims and families.

Psychological Impact of Intrafamilial Sexual Abuse

The unique family dynamics of intrafamilial sexual abuse present complex difficulties in coping and processing the sexual abuse the child has experienced. Courtois (1999) stated that incest often causes trauma due to the dysfunctional dynamics within the family system. Gil (2006) discussed child characteristics that may influence how a child experiences and copes with sexual abuse. Gil (2006) stated that sexual abuse is traumatic for a child if the child lacks a support system, is unable to appropriately express his/her feelings about the sexual abuse, and does not have healthy coping skills

Hindman (1989) discussed determining factors that affect how a child will cope with sexual abuse. Hindman's research showed that children who demonstrated severe trauma after being sexually abused met the following criteria: were under the age of twelve when the sexual abuse began, were sexually responsive during the sexual abuse, had intense feelings of terror during and in between episodes of sexual abuse, had a false perception of the offender, utilized unhealthy coping skills, and experienced a negative response when disclosing the sexual abuse. Hindman stated that the coping skills often seen in children who have been sexually abused are similar to defense mechanisms utilized by offenders. Both attempt to deny, rationalize and minimize the abuse in order to avoid the reality of the sexual abuse experience. Due to children being forced to engage in sexual activity that they are not developmentally able to process and due to their psychophysiological response, they develop coping mechanisms based on the information available to them.

Traumagenic Dynamics of Sexual Abuse

Finkelhor & Browne (1985, p. 531) discussed "traumagenic dynamics" referring to factors that determine how a child is impacted by the sexual abuse they experienced. These

factors, although common, may manifest themselves differently in each child. The dynamics include traumatic sexualization, feelings of powerlessness, betrayal, shame and stigma. Due to the child being prematurely sexualized, the child may exhibit sexual play with toys, peers, and adults in an attempt to process the sexual abuse.

Children may feel powerless because they were unable to stop the sexual abuse. Children may feel betrayed because the abuser is someone they know and love. Feelings of betrayal may also be a result of the child's parent not believing the child. Children often feel shame and guilt after being sexually abused because they feel that the abuse was their fault, they should have been able to stop it, and/or they should have told sooner. In addition if the child's family structure has been altered due to the sexual abuse, the child may feel guilty for changing the family system. Due to the intrafamilial relationship between the victim and the offender, the child may feel shame and stigma. Feelings of powerlessness, betrayal, shame and stigma may lead a child to withdraw and emotionally shut down. Children who are sexually abused often engage in self harm and other maladaptive, covert coping behaviors. Other children may cope with feelings of powerlessness, betrayal, and shame by acting out aggressively and acting as if they do not need anyone.

van der Kolk (2005) discussed "the inability of children to modulate when a caregiver is the source of distress for a child" (p. 403). This leads to numerous implications for the child in the development and utilization of healthy coping skills, processing of conflicting feelings toward the offender, and feelings of guilt. Not only is the child attempting to cope with feelings of shame, guilt and blame associated with sexual abuse but the child is also struggling with the betrayal of trust and the confusion of boundaries and roles with the offender (Hindman, 1989).

The child's feelings of attachment to the offender are often conflicted, and if the offender

lives in the home, there are additional stressors that impact the child's ability to self regulate and utilize healthy coping mechanisms. Children who have been sexually abused attempt to cope with the effects of traumagenic dynamics in various ways. They may demonstrate avoidance or engage in behaviors that make them feel like they are in control. Some of these behaviors include self abusive behaviors or sexually acting out with other children. van der Kolk (2005) stated that children who experience complex trauma exhibit impairment in affect regulation, dissociation, behavior control, self-concept and cognition. Moreover, these children often dissociate, compartmentalize their traumatic memories, and detach from their feelings.

Dissociation and Denial

Dissociation and denial are the most common defense mechanisms employed by children who have been sexually abused (Cramer, 1991; Cole & Putnam, 1992). Children may utilize dissociation in order to cope with having to be around the offender and this can lead to difficulties in developing intimacy and to more serious mental health issues. A primary reason for a child to utilize dissociation and denial is due to the immense emotional turmoil that a child experiences when he/she are sexually abused by a family member.

One of the most damaging effects of sexual abuse is "the loss of a trusted relationship with an emotionally significant person" (Cole & Putnam, 1992, p. 175). The emotional impact of sexual abuse is compounded when the offender is a family member because the child's sense of safety and trust has been overturned and the family, the typical source of emotional support for the child, is the cause of the child's suffering. This dual relationship that the offender creates requires children to implement defense mechanisms that are adaptive to their environment in order to psychologically survive the sexual abuse.

Levine (1992) stated that an individual must be able to recall all elements of an experience to have a complete memory and traumatic experiences such as child sexual abuse often are too emotionally overwhelming to recall all aspects of the abuse. A child may remember parts of the sexual abuse while dissociating other parts of the experience. This disconnect prevents the child from processing and healing from the trauma experience.

Cramer (1991) stated that denial and dissociation tend to remain constant in children who are sexually abused. Additionally, research has shown a correlation between children who rely on denial and dissociation and psychopathology (Cramer, 1991). Cramer stated that developing friendships and increasing social supports assist the child in increasing capacities to self regulate. However, if a child is sexually abused prior to age seven, ego organization is negatively impacted and the child's chances of developing social supports decrease. When a child does not develop social supports and does not have the opportunity for self regulation, they often demonstrate intense feelings of guilt and shame. The feelings of guilt and shame have negative repercussions on the child's self esteem, which often prevents the child from connecting with others and processing his/her feelings associated with the sexual abuse.

Self and Social Functioning

Cole & Putnam (1992) stated that intrafamilial sexual abuse has unique negative effects on self and social functioning, self regulatory processes and sense of security and trust in relationships. A child's ability to cope is impacted by the severity of both the physical and psychological trauma experienced when he/she is sexually abused by a family member.

van der Kolk (2005) discussed a child's ability to appropriately function in certain environments, but show signs of distress in others. Sexual abuse creates feelings of emotional

and physical helplessness in the child victim, since the abuser is typically older, physically stronger, and often an authority figure in the child's life. In addition, the secrecy and guilt involved prevents the child from telling someone about the sexual abuse. Due to intense feelings of helplessness children attempt to control other areas of their life. For example, a child that feels safe and supported at school may excel academically and give no indication to teachers or peers that he/she is being sexually abused.

Trauma is revisited by children at each developmental stage (Hindman, 1989; van der Kolk, 2005). Children whose ego development has been disrupted by sexual abuse have difficulty employing healthy defense mechanisms. Such children frequently demonstrate aggressive behavior, sexualized behavior, impulsive behavior, and self harming behavior due to the sexual abuse and such behaviors impact judgment, impulse control, and self esteem regulation. Due to these overt behaviors, sexually abused children may be labeled by peers and professionals based on their problematic behavior and ultimately may end up misdiagnosed with a conduct disorder. This combined stigmatizing experience impacts self and social functioning.

Betrayal Trauma

Freyd (1996) defined betrayal trauma as violation of a significant, trusted relationship when interpersonal trauma occurs. The offender betrays his/her role and relationship to the child. Freyd identified incest as the most severe type of betrayal trauma because it violates a significant, trusted relationship.

Due to the offender betrayal, a child attempts to avoid painful memories of the offender. Freyd (1996) stated that this avoidance is necessary in order for a child to be able to be around the offender on a regular basis. The child attempts to detach him/herself from the negative

feelings towards the offender because those feelings threaten the perceived relationship between the child and the offender. Berzoff (2009) described the dynamic as an “idealized tie” (p. 426). Berzoff stated that the child may take on the responsibility for the sexual abuse so he/she can continue to believe that he/she has a healthy, loving bond with the offender. De Young & Lowry (1992) defined this distorted relationship between victim and offender as *traumatic bonding*. DePrince (2005) found that betrayal trauma before age 18 was correlated with pathological dissociation and revictimization.

When children, who have been sexually abused by a family member, are asked about their feelings towards the offender, they often state both positive and negative attributes. For example, children may state that they felt scared when the offender sexually abused them but they miss them. Children are often very loyal to the offender and become very guarded and anxious when questioned about their relationship. However, it is unclear if the child’s anxiety stems from loyalty to the offender, fear of the offender, and/or feelings of guilt and responsibility for the sexual abuse.

Offender Loyalty

Courtois (2009) stated that families often have “divided loyalty” to both the victim and the offender (p. 18). Offenders are often held in high esteem by the family due to their relationship and role within the family. The way the family views the offender and the way the child views the offender may be very different. In addition, if the family shows love and loyalty towards the offender, the child often will not disclose the sexual abuse or if the family finds out about the sexual abuse the victim may not be believed. McVeigh (2003) stated that victims of

intrafamilial sexual abuse often recant when they feel responsible for breaking up the family and/or are not emotionally supported by a parent.

An additional conflicting factor for children is that many offenders are not threatening or violent when they are sexually abusing the child, but in fact may be extremely attentive, gentle and loving. When offenders are not sexually abusing the child, he/she often treat the child very well and meet the child's emotional needs, which contribute to the child's mixed emotions toward the offender. Yet, in Hindman's study (1989), ninety-two percent of children disclosed feelings of terror even when the offender was not violent. The discrepancy between the offender's words and actions increase the severity of the emotional trauma the child experiences. When an offender is saying loving words to a child while sexually abusing them, the child has difficulty processing the mixed messages of the incestuous experience.

Grooming Behaviors

Children can have great difficulty distinguishing appropriate and inappropriate behavior by the offender if the offender utilizes grooming behaviors to gain the child's trust and constantly tests boundaries. Courtois & Ford (2009) defined grooming behaviors as "false, acts of apparent kindness and encouragement" (p.4). Grooming behaviors may include "accidents" or games used to confuse a child. For example, the offender may "accidentally" walk in on the child when he/she is bathing or getting dressed. The offender may ask the child to engage in games such as "house" or "doctor" that are initially innocuous but become ever more intrusive and abusive. The offender may test the child's knowledge and attitude about sexual behavior. With each grooming behavior the offender assesses the child's comfort level and response. The offender may bribe the child with money, gifts, and/or outings. As the offender slowly crosses

the line, boundaries are blurred and the child may be unaware that the behavior and/or conversation that the offender is having him/her engage in is not okay. If the offender recognizes the child's emotional distress or hesitancy to engage in inappropriate activities and/or discussions, the offender may minimize the situation and tell the child that it was just a game or they were just playing. Offenders may use children's' anxiety to their advantage by telling them that if they tell their parents about what they talked about or did with the offender, they may get in trouble or upset the family. These grooming behaviors lay the foundation for the emotional trauma that the victim experiences. Offenders determine what they need to do to gain the child's trust and loyalty so that the sexual abuse can occur in secrecy and the child will be hesitant to tell someone (Hindman, 1989).

It is important to note that offenders often groom parents in order to gain their trust. For example, an offender may demonstrate trustworthiness and responsibility and may volunteer to watch the child. Parents may welcome and appreciate the offender's willingness to care for their child. As a result parents' feelings of betrayal, shame, and guilt often mirror the victim's feelings. In addition to these emotional stressors, parents may experience additional losses. Massat & Lundy (1998) found that in a study of parents whose child was sexually abused the parents' experienced additional stressors related to relationships, finances, job performance, and living situation. The emotional effects of intrafamilial sexual abuse can be devastating. The strain on the family system is vast, and for this reason it is essential that professionals understand the experiences of these families as they attempt to recover from sibling sexual abuse.

Summary and Research Questions

Due to the multiple ways that children and families are psychologically impacted by sibling incest, it is imperative that the victim, offender, and family receive the necessary emotional support they need to heal. Throughout the treatment process, professionals working with families must be constantly aware of the complex issues that families must address in order to move forward and rebuild their family. It is important for the multidisciplinary team to have an accurate perspective of the issues that families face throughout and after reunification.

The purpose of this study is to understand how families experience the reunification process in order for the treatment team to provide appropriate support and services. In the following sections I will describe family treatment after sibling incest and the reunification process. I will also discuss the research methodology of my study.

Chapter II: Family Treatment and the Process of Reunification

Due to the fact that most sexual abuse goes unreported, families often attempt to cope with the sexual abuse quietly within the family system. For families who are brought to the attention of child welfare and/or law enforcement, they have outside support to help ensure child safety by monitoring victim and offender contact and treatment. Regardless of whether the abuse is brought into the open or remains a family secret, sibling sexual abuse presents many challenges due to the disruption of the family system.

Parental Responsibility

The parent has the enormous responsibility of emotionally supporting both the victim and the offender through the intervention, treatment and reunification processes while also addressing his/her own feelings about the sexual abuse that occurred within the immediate family. These parental responsibilities raise additional challenges for parents in meeting the unique needs of both the victim child and the offender child. If the offender requires more of the parent's time due to various factors such as out of home placement, treatment requirements, legal issues, the victim may feel that he/she is not as supported by his/her parent as the offender. Parents may have conflicted feelings towards the offender who is their biological child. Due to this relationship, a parent may feel obligation and responsibility to support both his/her children. Parents may feel empathy for the victim and anger towards the offender. Despite their ambivalence, parents often want to keep their family together which often leads to a desire for reunification (Wiehle, 1990).

Importance of Parental Support

The ability of a child victim to process his/her sexual abuse experiences and develop healthy coping skills depends on multiple factors such as family support, cultural view of sexual

abuse, child's relationship to the offender and developmental considerations (Gil, 2006).

Research consistently shows that the most important factor in a child's ability to effectively cope with sexual abuse and successfully complete treatment is the belief and support of a parent.

Frazier, West-Olatunji, St. Juste, and Goodman (2009) stated that level of maternal support is directly related to psychological functioning of children who have been sexually abused. van der Kolk (2005) stated that the primary determining factor that impacts a child's ability to heal from sexual abuse is parental support. Due to this critical factor, it is important for a parent to be actively involved in the victim's therapy and individual therapy when needed. Once the victim and the parent have met individual therapy goals, joint parent-child sessions often occur (Cohen et al., 2006). Parental support and parental involvement are crucial to the healing of the victim and the family.

Investigative and Therapeutic Process

Allegations and disclosures of sibling incest are made in a variety of ways. Allegations are made by a concerned party such as a parent, family member, friend, teacher, or anyone who has reason to suspect that sibling incest occurred. In rare instances, the victim discloses to someone who then makes a report to the child abuse hotline or law enforcement.

When a disclosure or allegation is made to a child welfare agency or law enforcement agency, the victim and offender are often separated and prohibited from any contact pending the investigation. DiGiorgio-Miller (1998) discussed the importance of the offender being placed out of the home while both the victim and offender receive treatment. Gil (2006) and Roizner-Hayes (1996) emphasized the importance of the offender to be placed outside the home after the victim has disclosed abuse to support the victim and help him/her understand that the offender is solely responsible for the abuse. It may be difficult for the child to fully process and cope with the

sexual abuse he/she experienced if he/she is forced to face the offender at home. Juveniles who are convicted of sexual abuse are rarely incarcerated but rather mandated to treatment. The parent is typically involved in both the victim and the offender treatment. A multidisciplinary team including child welfare workers, law enforcement, offender treatment providers, victim and family therapists and victim advocates often assist the family throughout the investigation, treatment and reunification process.

While the offender is participating in treatment, the victim and parent are often receiving treatment simultaneously. If the parent is exhibiting significant emotional distress he/she may receive individual therapy. If the parent has a solid support system and is utilizing healthy coping skills, weekly check-ins with the victim's therapist may be an adequate amount of support for the parent (Cohen et al., 2006). Some parents require more intensive treatment if the stress of the sexual abuse is too overwhelming. I (like many other clinicians) have found in my practice that parents with unresolved child sexual abuse histories often need additional therapeutic support to process their own trauma history in order to be able to emotionally support their child through treatment.

Treatment Approaches

The treatment approach utilized with each family member involved must meet the individual needs of the client and be able to address the complex family issues that the family is facing due to the sibling incest (Phillips-Green, 2002). Gil (2006) described traumatized children as a subset of abused children, and this distinction requires clinical knowledge and awareness of clinical differences in order to provide appropriate therapeutic support to children who have

experienced trauma. Just as the dynamics of incest present investigative and intervention challenges, they also present treatment challenges.

Trauma informed treatment is often utilized with families who have experienced sexual abuse. There are various forms of trauma focused treatment. However, trauma focused cognitive behavioral therapy is an evidence based practice model that has proven to be effective in the treatment of child sexual abuse (Cohen et al., 2006). Trauma focused expressive therapies have also proven to be effective for children and families who have experienced sexual abuse (Gil, 2006). There are many other therapeutic interventions that are being utilized such as Trauma Adaptive Recovery Group Education and Therapy (TARGET) (Ford & Russo, 2006), a nonexposure treatment approach that utilizes skill building and experiential exercises to help children process and cope with trauma and Attachment Regulation and Competency (ARC) (Kinniburgh, Blaustein, Spinazzola, & van der Kolk, 2005), a phase-oriented treatment approach, as well as Multisystemic Therapy (MST) (Kira, 2010). Additionally, there are multiple offender treatment interventions that will be described later in the chapter.

Although many treatment approaches are focused on either the victim or the offender, some approaches are tailored towards the family system. Giarretto (1982a) developed “A Comprehensive Child Sexual Abuse Treatment Program (CSATP) for incestuous families. The program is comprised of three components: development and ongoing support of a multidisciplinary team, volunteer staff to support family needs, and self-help groups for parents and children. The multidisciplinary team includes professionals involved with the case such as court staff, probation officers, mental health clinicians, etc. Volunteers help families with community resources such as transportation, employment, as well as providing mentorship to the

children. Giarretto (1982) stated that CSATP along with individual therapy provides the support families need to meet treatment goals and reunify with low recidivism rates.

Madanes (1990) created another early treatment model for incestuous families that emphasized repentance and reparation. Madanes recommended a sixteen step reparation process that focused on offender confrontation and responsibility. The primary goals of Madanes' treatment model are to address offender cognitive distortions, eliminate secrecy, and establish family safety. Despite there being various sexual abuse treatment models for victims, offenders, and families, there continues to be a lack of evidence based practice and clinical consistency regarding effective treatment for incestuous families.

Treatment Goals

The goals of therapy for the victim and parent are typically to process and cope with the sexual abuse and to develop a safety plan to ensure victim and family emotional and physical safety. More specifically, the victim's goals may include, but are not limited to: reduce trauma response symptoms, address traumagenic dynamics, develop healthy copings skills, demonstrate understanding of personal boundaries and healthy relationships, and develop a safety plan (Center for Sex Offender Management, 2005; Cohen et al., 2006, Gil, 2006). A study by Welfare (2008), found that in order to recover, victims of sibling incest needed to feel validated and that the abuser was being held accountable by the family.

Treatment goals for the parent and other immediate family members may include: process feelings about the sexual abuse, hold the offender responsible for the abuse, develop and implement victim and family safety plan, utilize healthy coping skills, demonstrate of healthy boundaries in relationships, educate the family about the impact sexual abuse may have on the

victim and the family unit, learn ways to support the victim and utilize open communication within the family (Center for Sex Offender Management, 2005; Cohen et al., 2006). Welfare (2008) found that parents needed to feel confident that their offending child would get the help he/she needed and needed their family to reunify in order to heal from sibling incest.

Juvenile sex offender programs were originally based on adult sex offender programs and then began to be modified to address the needs of juvenile sex offenders (Hanson & Bussiere, 1989; Phillips-Green, 2002). As more is learned about the unique treatment needs of juvenile sex offenders, numerous treatment protocols have been developed. Juvenile sex offender treatment programs vary, however, a typical juvenile sex offender model is described below.

The offender's treatment is often intensive and may take place in an outpatient setting or residential treatment facility. There are numerous treatment goals for the offender that often include: identify and change cognitive distortions, demonstrate empathy for the victim and acknowledge the harm caused to the victim and family, identify risk factors associated with the sexual abuse, develop and utilize effective coping skills, develop safety plan, and satisfy all treatment and legal requirements (Center for Sex Offender Management, 2005). Welfare (2008) found that parents needed to be emotionally supportive, confrontational with the offender, and hold the offender accountable in order for the offender to recover.

Sex offender research demonstrated a correlation between disrupted attachment and sex offending (Friedrich & Sim, 2006). As a result of the correlation, sex offender treatment programs often focus on the importance of family relationships to aid in juvenile sex offender recovery. Welfare (2008) found that successful offender recovery is dependent on the support of one or both parent(s). The emphasis on family connection often leads to a goal of family reunification.

Reunification Process

In addition to family reunification as a goal of juvenile sex offender treatment, reunification is often the goal of child welfare agencies who attempt to preserve families based on the premise that children should be raised by their biological parent whenever safe, appropriate and possible. The Adoption Assistance and Child Welfare Act of 1980 (PL96-272) made child welfare agencies focus on reunification of abused children with their biological parents. As a result, most abused children are reunified with their biological family within one year (<http://www.childwelfare.gov/supporting/preservation/policy.cfm>). The shared belief between child welfare agencies and juvenile sex offender treatment programs of maintaining relationships and reunifying children with their family of origin often leads to family reunification after sexual abuse has occurred.

Reunification is an attempt to bring a family back together after child abuse has occurred. As discussed in the previous section, reunification is often incorporated into treatment goals and facilitated by members of the multidisciplinary team such as clinicians, child welfare workers, and/or judges. Reunification consists of reestablishing communication and familial relationships. In regards to sibling incest, reunification may be a conversation in writing and/or in person amongst the victim, offender, and immediate family members about the sexual abuse that took place. If safety is a concern, victims and offenders may not live together again or have future contact with one another. In cases where safety is established, victims and offenders may have ongoing contact with one another, supervised or unsupervised, and may eventually reside together again (Center for Sex Offender Management, 2005; Schwartz, 2011). Although reunification looks different for different families, it is frequently a desired goal of families, child welfare, and the court system. The reunification process is further detailed later in this chapter.

Controversy exists regarding family reunification after intrafamilial abuse and maltreatment has occurred. This controversy stems from varied beliefs about causes of child maltreatment, families' ability and commitment to change, risk of revictimization, and effectiveness and availability of the child welfare system and the judicial system to monitor families who reunify.

Gelles (2001) stated that family reunification programs are ineffective due to numerous factors such as not appropriately identifying and/or addressing causal factors of child maltreatment, poor program implementation, and inaccurate risk assessments. Gelles warned of the potential repercussions of attempting to create a universal reunification model. This speaks to the uniqueness of each family system and the necessity to provide individualized family treatment and reunification. This also adds to the difficulty of developing models of reunification that can be used as a template, but that can also be customized for each family.

Reunification can be fraught with risk due to team members not having the ability to truly know if a family system will integrate and maintain change to ensure family safety and wellness. Such risks are compounded by the dynamics of abusive families, which often revolve around secrecy. The intergenerational transmission of maltreatment requires multidisciplinary team members to delve into core family values and patterns of behavior and encourage change in family systems. Identifying, examining, and modifying family systems can be an overwhelming and difficult goal. Even when treatment goals are met, team members often rely on each family member to state their desire and readiness for reunification. Due to team members' not having a definitive way to know if a family is ready for reunification, team member ambivalence causes ongoing concern regarding when reunification is truly appropriate and safe. Despite the ongoing controversy regarding family reunification, families continue to reunify. Although reunification

may look different for each family and varying approaches to reunification are utilized, reunification after sibling incest tends to follow the process explained below.

Once the victim, offender, parent and other family members, if needed, have met treatment goals and if the family, in conjunction with the multidisciplinary team, agrees that reunification is the desired goal, the reunification process begins. The victim must express a genuine desire to reunify with the offender in order for the reunification process to begin. The victim's safety is the primary concern during the reunification process and afterward (Cumming & McGrath, 2005).

The reunification process often begins with family therapy facilitated by the victim's therapist and/or the offender's therapist. During the reunification process, the victim may ask the offender clarifying questions about the reasons for the abuse, if the offender will sexually abuse the victim again, what help the offender is receiving and if the treatment is helping the offender (Center for Sex Offender Management, 2005). During family sessions other family members may also ask the offender questions and share their feelings about the sexual abuse. This process is conducted by a therapist to ensure that the session is therapeutic and all members involved feel safe and supported.

While the family is participating in family sessions, there is gradually increasing contact between the victim and the offender that is often monitored by child welfare workers. The type of contact and stipulations regarding this contact is often guided by the wishes of the victim, the parent, and clinical recommendations. The reunification process varies nationally. However, gradual contact between the victim and the offender often begins with supervised visits in a neutral, public setting with a child welfare worker present, and then may transition into visits supervised by the parent. The multidisciplinary team closely monitors family visits with the

safety and needs of the victim as the priority (Center for Sex Offender Management, 2005). If family therapy between the victim, the offender, the primary caregiver and other family members is successful and supervised visitation between the victim and the offender is successful, the offender may be able to return home with a safety plan in place that is created by the family and multidisciplinary team and monitored by the multidisciplinary team.

Uniqueness of reunification after sibling incest

It is imperative for team members to recognize factors unique to family reunification after sibling incest in order to effectively meet the needs of families. There are numerous legal challenges, treatment challenges, and policy challenges due the blanket approach to family reunification. Child abuse policies and procedures primarily focus on adult offenders and more specifically on parents who abuse their children. In cases of child abuse, parents are held responsible and in certain circumstance, parental rights may be terminated. However, in cases of sibling incest, parents are not held criminally liable and are rarely held responsible by child welfare unless they can prove that the parent failed to protect the child from sibling incest. Due to distinct differences between sibling incest and other forms of intrafamilial child abuse, child abuse procedures, policies, and laws that guide child welfare and the criminal justice system are incongruent when the abuse happens at the hands of another child who is a sibling.

How juvenile offenders, victims, and parents are treated in the court system, child welfare system, and mental health system after sibling incest is disjointed and often leaves families feeling further shamed, confused, and hopeless. Giarretto (1977) stated that the child welfare system and criminal justice system that enters a family's life as a result of sibling incest adds to the trauma the family already experienced by focusing on evidence and disclosures. When evidence and/or disclosures are lacking, the child welfare system and criminal justice system step

out of the severely disrupted and traumatized family system and families are left to pick up the pieces. There is a lack of trauma informed team members and as a result families do not receive sufficient supports and services and team members are not able to adequately support one another.

Post Reunification

Once reunification occurs and the family has met all treatment goals and satisfied any legal requirements, the family is often on their own to rebuild and continue to heal. There is little research on family experiences and changes in family dynamics after sibling sexual abuse and even less on the reunification experience of these families. Reunification is a complex process that involves the entire family system, presents numerous risk factors, and multidisciplinary team challenges as discussed in this chapter. Additional issues may arise with siblings who were not involved in the abuse or with a parent who is not as involved in his/her child's treatment as the other parent. Although some family members were not direct victims of the sexual abuse, they were all impacted by its occurrence and are all dealing with their feelings regarding the sexual abuse in their own way.

The Center for Sex Offender Treatment (2005) stated that there is little follow up or monitoring of sex offenders after termination of services. If risk factors arise after reunification, the parent is responsible for addressing them and ensuring family safety. Family risk factors may change over time, so they must be closely and constantly monitored in order to be effectively addressed. The ongoing assessment of families who have experienced sibling incest is crucial for family safety and emotional health.

There is little known about the family's experience with reunification, any issues that may have arisen and how the family dealt with those issues unless the family seeks community support or another abuse allegation is reported to child welfare or law enforcement.

A major concern with reunification after child sexual abuse is the possibility of the offender revictimizing the same sibling or another child. The victim may be vulnerable to revictimization due to his/her sexual abuse history with the offender (Center for Sex Offender Management, 2005). Research indicates that children who have been sexually abused have higher rates of revictimization than children who have not been sexually abused (DePrince, 2005; Finkelhor, 2007). Although research indicates that reported juvenile sex offender recidivism rates are low, there is always a possibility that it may occur (Worling & Curwen, 2000). Recidivism rates are based on reported child sexual abuse cases that are accepted by the child welfare system based on state specific criteria such as the age difference between the offender and victim, whether or not the offender was in a caretaking capacity, and whether the victim and offender reside in the same home (<http://www.acf.hhs.gov/programs/cb/pubs/cm10/cm10.pdf>). What happens to the cases that are not reported and/or not accepted by the child welfare system? How do researchers account for those cases when they are determining recidivism rates? Due to the number of unreported sibling incest cases and the disregarded and/or unsubstantiated sibling incest reports, the actual rate of recidivism of juvenile sex offenders is speculative at best.

Besides revictimization concerns, there are many other issues that families may face after reunification due to the nature of sibling incest. Although issues of betrayal of trust, guilt and shame are addressed in therapy, it is not uncommon for these issues to arise again due to the offender being in the home or in regular contact with the victim. The victim and the offender

have to reconstruct a relationship that allows both of them to feel safe. The parent has to rebuild his/her relationship with both children. Logistics, individual roles, family routines may change to ensure the victim's safety. The parent may struggle with restructuring the family and adhering to the safety plan. Repairing relationships with the offender may be an ongoing issue for all family members. If other risk factors arise such as economic or emotional stressors once a family is reunified, how do families handle those stressors? All these changes impact the dynamics of the family. In order to monitor and address family issues after reunification, the multidisciplinary team must continue to advocate and support children and families who have experienced sibling incest.

Successful reunification requires the multidisciplinary team to ensure that reunification is truly appropriate for the family. Without knowing risks or issues that arise in families after reunification, clinicians do not know how effective their treatment was and what additional supports they may be able to provide to families during the time of transition. Not only is the family reconstructed as the offender re-enters the life of the victim, family dynamics are permanently altered due to the sexual abuse that occurred.

Conclusion and Research Questions

Families who are brought into the child welfare and/or legal system due to sibling incest are provided with numerous, intensive services such as individual and group victim therapy, offender treatment, family therapy, victim advocacy, and various other community services. Families, who are brought to the attention of the child welfare system, receive intensive services from the time that a report of sexual abuse is made until reunification and or treatment discharge occurs. However when the victim and the offender have successfully completed treatment,

families are reunified and sent home with the knowledge and skills they learned in treatment to transition into being a family again.

Once a family has been discharged from treatment, follow up from the multidisciplinary team may include monitoring the family to ensure compliance with the safety plan, continued offender treatment if necessary and compliance with court mandates. If the family follows all treatment recommendations and is in compliance with the directives from the multidisciplinary team, the family's case may be forwarded to ongoing case management that provides periodic check-ins with the family or the family's case may be closed. From that point forward, it is the responsibility of the family to seek support and services to address any family and/or sexual abuse issues that may arise. This major shift from comprehensive and intensive support of the family to limited or no support is a service gap of major concern because multidisciplinary team members have no way to assess family safety and family functioning post reunification.

There are a myriad of issues that families may encounter once they are reunified. Are the tools they learned in treatment enough to sustain them and keep them on a path of recovery despite internal and/or external stressors that the family may experience? This information must be critically assessed throughout the family's treatment and during the reunification process. The needs of the family must be carefully examined to determine what supports are necessary after reunification. Supports may include providing the victim and family with a safe place to share concerns and issues that have arose since the family was reunified and to discuss the safety plan and any modifications that may need to be made to the safety plan (Center for Sex Offender Treatment, 2005).

There are numerous child sexual abuse prevention and intervention programs nationally. However, there is little attention given to ways to create and sustain family cohesion and safety post reunification (Center for Sex Offender Treatment, 2005). This is evident in the lack of services available for families once they have completed treatment and the offender and the victim are reunified. Goals of therapy for families, who desire reunification after sibling incest, include establishing safety and redefining relationships, but that goes farther than helping the family process and cope with the sexual abuse that has affected the family. Families need resources and ongoing community support to continue working towards becoming a healthy family after reunification.

Having perspectives of the multidisciplinary team members about the reunification process will inform all members of the treatment team of ways to enhance services and ensure that families have the support and skills they need to work towards becoming a healthy family free of sexual abuse.

Chapter III: Methods

General Approach

I conducted a qualitative study, using semi-structured intensive interviews to learn about families' experiences with reunification after sibling incest. Qualitative research provides an opportunity to gain insight about intimate human experiences and allows for in-depth exploration of emotionally charged topics (Padgett, 1998; Seidman, 1998). Due to the specialized and unique process of family reunification after sibling incest, and the sensitivity of the topic, a qualitative study provided me with firsthand knowledge and clinical experience from team members who work with such families.

I conducted intensive interviews with multidisciplinary team members. Multidisciplinary team members involved in sibling incest cases typically include child welfare workers, judges, probation officers, victim advocates, offender therapists, and victim therapists. I interviewed offender therapists and victim therapists to obtain in-depth information and exploration of families' experiences including hopes and fears about reunification as well as the actual reunification experience. Intensive interviews provide the opportunity to gain the perspective of multidisciplinary team members who work with families who have been directly impacted by sibling sexual abuse. The questions asked throughout the interview were open-ended to allow for narrative, rich responses. Throughout the interview I monitored the participant's emotional state. Although there was not an instance where a participant became emotionally distressed, if this would have occurred the interview would have returned to a neutral topic and I would have taken appropriate steps to alleviate feelings of distress and connect the participant with appropriate mental health resources. There was no need to provide any participants with mental health resources and phone numbers for follow up support. Interviews were audio-recorded.

Method of Analysis

Modified grounded theory, as proposed by Charmaz (2006), was used to guide the analysis of the interview data. According to Charmaz, grounded theory emphasizes individual story telling or narrative, and is an interpretive approach to data analysis that involves critical analysis of themes that emerge from the interviews. The task of the interviewer is to allow the respondents to tell stories in their own words. From these rich, detailed narrative accounts the research creates meaning through a process of coding and interpretive analysis of themes that arise from the coding.

Sample Size and Recruitment Procedures

Fourteen interviews were conducted with multidisciplinary team members who are involved in the reunification process. The intensive interviews explored perspectives and experiences of family reunification after sibling incest. The interviews inquired about what has gone well within the family as well as any issues that arose throughout and/or after reunification and how the family and multidisciplinary team addressed those issues. I planned to interview 15 team members for my study. I arrived at this number based on the recommendation of my dissertation advisor who stated that a sample of 12-15 is typical for a qualitative study in the DSW program at the University of Pennsylvania.

Purposive, snowball sampling was utilized. I initially contacted the directors of various community mental health agencies, which specialize in working with families that have experienced incest, regarding the study and sent them the study recruitment form. The community treatment providers receive referrals from child welfare, law enforcement, children's hospitals, child advocacy centers, and various community mental health agencies. Study

recruitment forms were disseminated by program directors to multidisciplinary team members. The study recruitment form contained the following information: my doctoral student status, purpose of the study, confidentiality of the study, estimated length of the interview, potential locations of the interview, and compensation information.

All agencies that I contacted expressed interest in the study. However, many of the staff expressed high work demands and difficulty with finding time to be interviewed. I continued to reach out to additional agencies that were involved in family reunification and passed along the study recruitment form. I diligently attempted to make contact with potential research participants via phone and email. Once potential study participants contacted me and expressed interest in participating in the study, a date and time was set for the interview. As I began to conduct interviews, I continued to receive study participants based on word-of-mouth referrals from others who knew about the study. I scheduled interviews with all study participants who expressed interest and met inclusion and exclusion criteria within my recruitment time frame. At that time I had fourteen study participants. As time passed, I received phone calls and emails from other team members who heard about my study and were interested in participating. However, due to dissertation time constraints, I was unable to interview additional people. Initially, I struggled to find participants with the time to take part in the study and by the end of the study I had more interested parties than were needed. It was evident as the interviews were conducted, that study participants were excited to know someone was examining reunification issues and they had a place to express their thoughts and concerns.

Upon initial contact with the potential study volunteer, I reviewed the research subject information sheet along with the inclusion and exclusion criteria. A date, time, and location were arranged for the interview with those who met inclusion and exclusion criteria and verbally

consented to participate in the study. At the interview, the participant again reviewed the research subject information sheet prior to beginning the interview.

Inclusion criteria include the following:

- Multidisciplinary team members who are involved in the reunification process
- Multidisciplinary team members who are available to participate in an intensive interview
- Multidisciplinary team members who speak English

Exclusion criteria include the following:

- Current colleagues of interviewer

To reduce attrition rate, study participants received a reminder call or email prior to the interview. As a token of appreciation, study participants received a ten dollar Starbucks or CVS gift card at the completion of the interview.

Setting

In person interviews were conducted in either my office or in a private room at the community mental health agency where the interviewee worked. Phone interviews were conducted in my office. The location ensured privacy and minimized the opportunity for distraction and disruption during the interview.

Analysis

I analyzed the following sources of data: verbatim transcript of the interview, and the researcher's notes from each interview. I used open, axial, and selective coding throughout the analysis (Corbin & Strauss, 2008). Open coding is line-by-line coding used initially to develop a

list of codes. As codes are added, merged, and/or deleted, provisional categories and subcategories emerge from the interview transcripts. Axial coding included a comparative analysis of differences within categories and between categories. Selective coding included further examination and enhancement of concepts and themes to develop a framework for understanding the thematic process contained in the data. I used memo-writing throughout the analysis to help clarify and create categories, subcategories and themes (Charmaz, 2006).

I coded the initial eight interviews line by line and then coded the rest of the interviews sentence by sentence. Charmaz (2006) stated that line by line coding should be used for initial interviews then larger pieces of data can be coded. After all interviews were initially coded, I began to create provisional categories based on similar codes. Once initial categories were established, I went through each category to see if they could be further collapsed. Some categories were merged based on similar themes. I used axial coding to further analyze the dataset. Subcategories were developed within certain initial categories that illustrated categorical differences. Some subcategories became provisional categories as a result of having numerous similar codes within them. As I developed a list of codes to be discarded, I made sure there were not any additional codes that could be grouped together. Finally, I identified seven major categories along with several subcategories.

Context of Interviews

The interviews were conducted in person or via phone. The in person interviews were conducted in an office at the study participant's place of employment or the researcher's office. The setting was private and free from distraction. The study participants appeared comfortable and were forthcoming with their thoughts and feelings about family reunification. I conducted all

phone interviews in the privacy of my office. Two phone interviews were disrupted by someone knocking on the participant's office door or the participant receiving a phone call on another line. However, we were able to reengage in the interview after the short disruptions. Each interview lasted approximately 45 minutes. All interviews were recorded on a hand-held recording device that remained in my office in a locked drawer throughout the course of the study. I transcribed interviews directly from the recorder. Once interviews were transcribed, the interview was deleted from the hand held recorder. The transcripts will be destroyed by the interviewer at the termination of the study.

Critique of my performance as interviewer

I was able to stick to the interview guide and bring study participants back to the original question if they digressed. The structure of the interview allowed participants to have a clear understanding of the questions that were being asked and there was a logical flow to the questions. There were times that a study participant asked for clarification of a question, which caused me to realize that some questions may be worded too broadly.

At the beginning of the first few interviews I told the participants that I also worked in the field. I initially brought myself into the introduction of the interview guide because I thought it helped explain my interest in family reunification after sibling sexual abuse and the reason for my study. However, in thinking about it later, I realized my disclosure regarding my role may have impacted their responses to my questions. After those initial interviews I no longer disclosed information to the participants regarding my professional role in family reunification.

My clinical experience allowed me to sit with the silence in between questions in case the study participants had more to add. I think it was easy to stay in my interviewer role and not slide

into my therapeutic role because I was interviewing mental health professionals as opposed to clients. Due to mental health professionals talking about child sexual abuse as part of their job allowed for open, honest conversation without the emotional distress that may be present if I were interviewing clients.

Although most interviews contained an ongoing narrative, there were a couple of interviews that elicited short answers. In those instances I could have probed a bit more in order to encourage the participants to further share their experiences. Interestingly, the interviews that elicited the least amount of narrative were conducted with clinicians who are new to reunification work. Their lack of experience may have impacted their ability to comprehensively answer specific questions regarding the reunification process.

I did recognize that I was more engaged in the interviews that reflected some of my own clinical beliefs about working with families where sibling incest occurs. Memo writing helped me to identify and think about times that this occurred and the implications of this. As a result of reflecting on this issue, I was mindful of this in subsequent interviews.

Protection of Human Subjects

I obtained IRB approval prior to beginning the study. I took numerous steps to ensure study participant confidentiality and anonymity. Signed consent forms were not utilized in order to protect study participant privacy. Personal identification information was not used in the study. Any potentially identifying participant information that came up in the course of the interview, such as place of employment, was omitted from the transcripts. Interviews were assigned a number to ensure anonymity. Interviews were recorded on an audio recorder that was password protected and stored in a locked desk in the researcher's locked office. Paper records

were stored in the locked desk and all files stored on the researcher's computer were password protected. Each written transcript was assigned a numerical code to ensure confidentiality.

Participant Profiles

Study participants included four male and ten female clinicians who work with children and adolescents who have experienced sibling incest either as a victim or offender, or in some cases both. Twelve clinicians worked in agency-based settings and two worked in private practice settings. Out of the fourteen clinicians, seven worked with the offending child and eight worked with the victim child. Out of the twelve clinicians that worked in agency settings, four worked in outpatient offender programs, five worked in outpatient victim programs, and three worked in a residential offender program. Both private practice clinicians worked primarily with victims. Two study participants held Doctoral Degrees in Psychology and twelve study participants held Masters Degrees in social work, psychology, or counseling. The length of time in the field of child sexual abuse varied from two years to twenty-six years. The study participants were appropriate for the study and provided varied experiences as a result of differences in educational backgrounds, clinical training backgrounds, clinical settings, and length of time in the field. Although these factors were not specifically asked about in the interviews, this information came up throughout the course of interviews. Additionally, as a result of varied educational and clinical backgrounds, therapeutic approaches and beliefs differed.

The characteristics that made study participants appropriate informants were their first-hand clinical experience with sibling incest and its impact on their clients. The interviewees had professional experience to draw from and provided a front line perspective regarding issues that

arise throughout the reunification process and supports that may benefit families who have reunified following sibling incest.

Reflexivity Statement

In addition to the clinical bias that was evident in some interviewees, I became aware of my own clinical bias throughout the interviewing process. I realized that I am part of the “us and them” mentality. I am guilty of focusing primarily on the victim’s needs and neglecting the offending child’s needs. Although this has changed as my clinical expertise has grown, there is still a belief inside of me that the victim’s feelings trump the offender’s feelings. I realize as a result of the interviews that this is a common and widely held belief based on which “side” you are on. This clinical issue raises questions around the impact of clinicians’ bias on treatment.

Study participants educated me and helped challenge my own thinking and biases regarding family reunification after sibling incest. I found myself bringing some of their suggestions into my own work. I felt a sense of refreshment and excitement in my work. This was an unexpected result of my research study. I did not previously consider the ways my clinical work may be enhanced by the clinical perspectives of the study participants. I welcomed this into my work because I realized that my belief in my own clinical expertise sometimes causes me to disregard what other good work is being done in the field. This was a reminder of the power of peer collaboration. This was even more evident as study participants voiced concerns with the reunification process that mirrored my own. Beginning these conversations is an opportunity for clinical growth and support which can lead to more effective and comprehensive services for families who reunify after sibling incest.

Chapter IV: Findings

Thematic Analysis

Through coding and analysis of fourteen interviews, seven themes emerged. These themes included: role of therapist, process of reunification, challenges of multidisciplinary team member collaboration, challenges of ensuring family safety, challenges of determining family readiness, clinical concerns, and lack of a road map. Within some provisional categories subcategories were developed. The categories and subcategories were reflective of the nuanced responses of the study participants to questions regarding family reunification after sibling sexual abuse.

Who's the Client and What's My Role?

Family reunification after sibling incest is fraught with difficulties due to team members having to continually assess and address the needs of the family system. This ongoing dynamic challenges team members to determine their role and responsibility, not only to their individual client, but also to their client's family. An additional element present in working with families, who have experienced incest, is a clear differentiation between victim treatment and offender treatment. Due to this dichotomy, team members often have strong personal and professional beliefs about victims and perpetrators of incest. This emotional and value laden aspect of working with incestuous families impacts clinical perceptions, team collaboration, and the therapeutic process.

When asked about their role in the reunification process, all study participants directly referenced or eluded to their allegiance to their individual client. Although most respondents also

discussed the importance of the family system, it was often clear based on their statements that their primary concern was for their client. This theme is illustrated below.

The overall goal is the health of my client, for the child I'm seeing.

I always take the client as my primary client, his needs are most important.

My goal is to make sure my client is ready.

I am the victim therapist so everything I do comes from the victim's perspective.

When asked about meeting the needs of the family system, respondents spoke about the difficulty in doing this. Although most respondents stated that the incorporation of the family system is critical in successful reunification, they shared their struggles with meeting this need. The following quotes highlight this difficulty.

Whenever I start working with a family I share with them, I am your child's therapist but you are not alone in this process.

I really hope for healing, mainly for my client, but also for the family.

My role is to help the victim, make sure that the victim's voice is heard, that the victim has a safe person to continue to help them, carry them through the process, it also is to help the family system support the victim as well.

I kind of encourage families to remember that they need to look at what the victim needs.

Some respondents discussed the role conflict they experience when they attempt to meet the needs of the family unit. This ongoing issue is evident in the excerpts below.

I have to first be aware of my bias towards my client and really wanting what's in their best interest but then at the same time really being aware of the multiple parties.

I think that each therapist, we all advocate for our own client and see things from our own client's point of view so I think sometimes there is tension between the therapists around what their client needs.

The multiple aspects of this theme illustrate the complexity of the therapeutic role and the ongoing challenges clinicians face. Issues regarding clinical responsibility to the individual and the family were present in all interviews. Many respondents referred back to this difficulty when responding to other questions regarding the reunification process. This illustrates that this issue is present in all aspects of the reunification process and the way it is handled directly impacts the clinician, the identified client, the client's family, and other multidisciplinary team members involved in the process.

Navigating the Reunification Process

When asked what the reunification process looks like, what the goals of reunification are, and what their experiences have been with family reunification after sibling incest, respondents discussed many factors that impact family reunification such as how it is defined, determining when it is appropriate, and their approach and beliefs about it. Within this theme, two subcategories became salient: the importance of clarification and varying definitions of reunification. Clarification is a term used in sex offender treatment to describe a process where the offender admits to the victim and pertinent family members to sexually abusing the victim, accurately describes the sexual abuse, takes responsibility for it, apologizes for it, and demonstrates empathy for the victim. Additionally, the victim has the opportunity to ask the offender questions about the sexual abuse and express his/her thoughts and feelings about it. This process often begins with letter writing that is monitored by the victim therapist and the offender therapist and may lead to face to face sessions, when appropriate. Clarification is facilitated and monitored by a therapist (Schwartz, 2011).

The Necessity of Clarification

All study participants referenced the critical importance and therapeutic power of clarification. Various components of clarification were emphasized as is reflected in the following quotes.

I think there also needs to be a process of clarification before reunification can happen as well, and that is a process, that is not an event, it includes many different layers from individual to family and the correspondence obviously starts out in the way that is going to be least, or that will initiate the least amount of emotional distress on the victim, it might be by writing, I've had some that will actually occur by Skype, some that have been video recorded, there is a lot of different ways based off the victim's needs.

So I always start with the clarification process first before we even get into actually doing reunification. And part of the clarification is to insure that all of that ownership is taken by the offender and also to look at restitution. And I firmly believe in doing restitution as part of the therapeutic process for offenders. They have to realize what they have to give up something or pay back for what they have taken away. And that's just part of the approach that I use. And so the kid, that's especially difficult because child and adolescents, they are not taught about restitution and about giving up something that means a great deal to them because they have taken away.

Safety was identified as an integral piece of clarification.

In those family sessions through that clarification component that happen are really critical because it's a reinforcement of, you know, mom and dad are going to be sure that these rules are going to be adhered to so I can continue to maintain a sense of safety as well.

Some respondents stressed the importance of differentiating between apologizing and asking for forgiveness.

So once we reach that, where all therapists agree that all core treatment themes have been addressed from the victim's perspective, the offender's perspective, and the parents' perspective there is usually a clarification letter that the adolescent has written basically taking full responsibility for the abuse, identifying the grieving strategies, and apologizing, that does not mean asking for forgiveness but apologizing. That usually comes to me at the victim therapist and I might say you know she's too young to understand this sentence, this whole issue over here needs to be rewritten so a five year old understands it. You know he keeps saying don't be scared of me, don't be scared of me but she was never scared of him because he was very nurturing and nice to her so that grooming piece needs to be better addressed. So they're working on that piece and

simultaneously I'm working with the victim on what do you want to say to your brother about what he did to you and what questions do you want to ask him? So with that piece of work I've got a letter with statements and questions and I give that to the offenders therapist and the offender's therapist makes sure that the adolescent, because they go over this, this is what your sister is saying, this is the impact and how do you feel and how are you going to respond and here are the questions that she has. Truly, 95% of the time the number one question is why did you do it to me? So anyways we go back and forth. I'm looking at the offender's clarification letter, the offender and their therapist are looking at my client's questions and when we feel like we have those two pieces together then we schedule our clarification, reparation sessions where the offender takes responsibility and offers up how he is going to repay her and the victim can ask questions.

Another concern that often comes up is clarification at its onset of reunifying the family, you know, it's not about an apology and it puts kids who have been victimized in a very difficult position when a sibling looks at them and says "I'm sorry," because the natural response would be "I forgive you" and so that's something that we address and we are preparing for those sessions that forgiveness is something they can or don't have to give if they aren't ready to do that and you know I've had a kid who I did clarification with two weeks ago and the initial face to face he said he was sorry and she just looked at me and smiled and that processing afterward, she said I wanted to say it was okay but it wasn't so I chose to say nothing, and that's a sign of a very empowered victim, and that's the ultimate goal, is for the victim to feel very empowered through the process.

Although respondents focused on various aspects of clarification, the agreement on the importance of clarification was obvious. Respondents discussed clarification as a precursor to reunification and a tool to assess family readiness for reunification. Additionally, respondents shared multiple reasons that clarification is an essential component of the reunification process. Respondents' responses captured the complexity of the clarification process and the implications for family reunification.

Defining Reunification

Study participants discussed the reunification process in various ways based on clinical setting, clinical role, and clinical training. The differences amongst respondents demonstrated the multiple approaches and understanding of family reunification after sibling incest. The

respondents spoke of the difficulty in defining family reunification due to the uniqueness of each case. These differing views and definitions of reunification are reflected in the following comments.

Some respondents defined reunification as emotional healing and reestablishing relationships.

You know over the years I've often thought that we should call it re-engagement rather than reunification because often the goal isn't for the family to live together, because that's often not feasible and not even really appropriate or healthy, but to me the goal is recovery, is healing, it's emotional healing, and repairing to redefine the relationships in a way that feels comfortable and safe.

It depends on the family system, it depends on whether or not when you say reunification, are we talking about just living together or are we talking about just having contact with each other, because you know a lot of the kids that I work with here, you know are estranged to some of their family members where they haven't had contact with them so we have to first define what reunification means, is it actually, like I said, living under the same roof or is it just establishing a relationship with someone that they haven't spoken to in quite some time.

I think another issue is also getting on the same page about what reunification looks like and about what healing from this experience looks like. It's not about punishing and it's not about forgetting and moving on, it's about you know talking really openly about this and using it as an opportunity to have some really open communication about what's going on in this family.

Respondents shared logistical variations in defining reunification.

We see how the community visits go, we rework safety plans if needed, we put more supports in place if needed then we talk about an in home visit, maybe he comes over for dinner. Then we talk about overnight visits, weekend visits and then ultimately to moving back in.

...Contact can start with letters being written to one another expressing the acknowledgment of how difficult the situation is. We can start with supervised visits or giving joint therapeutic sessions with the victim, the victim's therapist, the family members, myself and the offender. And we take it little by little by little.

Some respondents shared that reunification may only be clarification.

It could start out as that kid going home and living at home you know until he is 18 or reunification just may be clarification, doing that apology accepting, everyone accepting the trauma that everyone has encountered and then possibly either the kid living with another family member with visitation

I also think there is quite a difference between this clarification, the clarification sessions and then actual reunification because you can start the process and know that kids never going to go home, not going to go home, not going to live at home, but you still want to do reunification and clarification because that can be successful without the kids going home which may encompass visits or that kid going to residential living and still getting the visits. So ultimately reunification can look different for different children and does not always mean ending up back home.

The above quotes demonstrate the multiple ways reunification can be examined and defined. Respondents spoke of the intricacies of the reunification process that result in difficulties in developing a set standard of practice. The participants' responses exemplify the enormous challenges of family reunification after sibling incest.

Challenges of Team Work

When asked about their experiences with family reunification after sibling incest, issues that arise throughout the reunification process, and recommendations to improve the reunification process, respondents spoke about the lack of communication and support amongst team members. Multiple concerns were raised in every interview regarding the fragmented child welfare system and the negative impact on practice. Specific issues arose including: professional collaboration, differing agendas, power of judicial system, and professional competency.

Professional Collaboration

Respondents stated that collaboration between agencies involved in the reunification process was often problematic. Some respondents identified communication problems between the larger multidisciplinary team such as department of human services, the court system, and probation, while other identified lack of contact between individuals, specifically therapists, as a

primary concern. All respondents, victim therapists and offender therapists, referred to the lack of communication between therapists as an issue that needs to be addressed. Communication barriers amongst clinicians are demonstrated in the following quotes.

We don't often know what treatment the other child has engaged in, we struggle sometimes with coordinating care, we attempt to work with the other agency which sometimes goes smoothly and sometimes does not.

I think it would be good if there was some type of way that the therapists of the victim were to communicate more regularly with the therapist of the offender and instead of doing it with phone calls where we have to go back and forth because we do enough of that as it is, it would be great if there was some type of reporting module that could happen so that it's structured.

Really having some kind of contact with each agency because a lot of times it starts with one therapist going on the report of a parent, maybe knowing what the other therapist's name is, then calling the main receptionist and hopefully trying to find a way to that therapist, who might be a master's level person who's there all the time, it might be a practicum student, a doctoral student that's there part of the week, a fee for service person who's there once in a while.

It's very hard usually to get any information. I don't find other therapists as cooperative as I would be or hope to be you know. So there's a big disconnection.

A respondent referred to turf wars that inhibit collaboration.

It can be hard to find a good collaborative team I think among the offender's therapist and victim therapist, people can get very territorial.

Respondents shared multidisciplinary team collaboration issues.

I actually lie to a lot of my workers and I'll say hey listen we have a meeting, I need you to be present because that's the only way I can get transportation for my clients, you know make up a meeting and say oh by the way, can I meet with the parent real quickly, so I'll do that, that's typically the only way I get most of my parents to come up here.

More systematic, clear communication and facilitation between different parties would absolutely make this job easier.

Some respondents discussed treatment difficulties due to the victim and offender receiving therapy at different times.

Just getting all parties involved. It's difficult because sometimes the victim had therapy three years ago by the time we see the kid and that agency is either shut down or the therapist is gone and they can't find the files and then we have the judge saying we're going to discharge this kid and we're saying we can't make that recommendation because we don't know if the victim's ready. We don't want to pull out and it all ends so then we have to play victim's therapist as well.

It's really nice when the victim is in therapy at the same time. That's beautiful but it rarely works that way.

Respondents discussed the necessity of team communication.

I think everything about this process needs to be shared and I think that's where the collaboration comes into play. I think that you have to reach out to the other providers in the area and talk about what worked for you and what hasn't worked for you and this is something that I'm struggling with and what are your thoughts about it? I don't think that this is a population that you should keep to yourself or that work that we do we should keep to our self because it is such a very difficult population and specialized population to work with.

I think it's really important to have colleagues who are familiar with this work, who do this work, that you can really talk to about how it's going, what some of the frustrations are, you can brainstorm with around barriers or issues that come up, you know, not to be doing this in a vacuum.

Collaboration challenges were brought up by respondents throughout their interviews.

This illustrates a common and serious problem that impacts the comprehensiveness of service delivery. Respondents spoke about this issue at the micro and macro level and these were shared concerns amongst all study participants. Suggestions to resolve this issue included establishing systemic structure, shared agency policies, clinician buy in to the importance of collaboration, and a more streamlined process of communicating with one another.

Differing Agendas

When asked about service delivery and issues that arise throughout the reunification process, respondents identified varied agency roles and goals as a contributing factor to lack of

team collaboration. Study participants shared their frustration with this issue due to the impact it has on the therapeutic process. The following statements from respondents illustrate this point.

There are so many people involved including DHS, often times as the puppeteer in the middle, pulling the strings, you know, you go here, you go there, and not having the right educational background, the people who do this. A social worker is a social worker, a therapist is a therapist. Everybody has their role but when in the bureaucracy of it all somebody decides what to do next and then I don't think their qualified or they haven't spent time enough with this creature, like really in depth time to listen to them, really know, that bothers me.

I think it's hard when DHS wants to put a number to it. Can we finish this case now? Can we do this? Can we do that? It's like you know, tell me how many times they have to come.

I don't mean to take their qualifications away but sometimes I wonder why I am talking to you because this child has these needs and you are not meeting these needs. You're meeting your needs; you are just there to make sure everything is bureaucratic, checked off on a piece of paper so you don't have any responsibilities. So that means to me you are not the right person for the job.

The function and goals of the agencies involved in family reunification often contradict one another. This lack of a shared, trauma informed approach to family reunification provides families with mixed messages and ultimately does not provide families with consistent support throughout the reunification process. Additionally, these communication issues directly impact the information shared between team members. Respondents were in agreement regarding the need for a common agenda developed by multidisciplinary team members specially trained in family reunification and the particular issues that must be considered after sibling incest has occurred.

Power of the Judicial System

When asked about issues that arise throughout the reunification process and recommendations to enhance the reunification process, respondents shared their lack of power in the court and probation process as a stressor. Respondents discussed various reasons for this lack

of power such as the bureaucracy and politics involved in family reunification. Additionally, funding issues often dictate decisions regarding treatment and family reunification. Illustrations of judicial power are provided below.

This field is very political and it's this constant back and forth between what is clinically recommended and what does the court want. So I worry that the court is going to cut things off before I get to finish.

Recently I had an experience where the judge was really calling for reunification... Ultimately I recommended to the court that they needed to fully go through the reunification process. I needed time to ascertain the victim's readiness. She wasn't currently in treatment. I stated my concerns in regards to reducing risk but regardless the judge ended up recommending reunification from the bar of the court despite my concerns.

The judicial system as well is a huge barrier because sometimes judges will just let kids off probation or they'll keep them on unnecessarily.

The consequences of judicial power as discussed by respondents included premature treatment termination and premature family reunification. These issues complicate treatment when therapists are attempting to maintain parental commitment to treatment and the reunification process while the family is being told by another entity that they can reunify. All the factors respondents mentioned represent the larger theme of the challenging and overwhelming goal of systemic team support.

Professional Competency

In identifying reunification issues, respondents shared their concerns with the lack of adequate training of multidisciplinary team members. The issue of professional competency was viewed as a contributing factor to poor collaboration, differing agendas, and disjointed service delivery. Respondents shared the critical impact training has on treatment and the reunification process as demonstrated below.

Well the main thing is qualified providers and I don't know if that's a nationwide problem but it sure is a problem in the community that I work in. We don't have providers that have the required training to do this work. I had an intake today with a 4 year old girl and the adolescent is already back in the home, she hasn't received treatment and I'm like how did this happen. Who approved this? They had another provider that said it was okay and told probation it was okay. There has been no clarification; he hasn't made a full disclosure of what he's done. The mom said he hasn't actually taken responsibility for what he's done and he's living in the home with the victim. So really if there's a needed service, it's training for providers.

One of the problems that can come up is sometimes before, let's say before a victim gets into treatment, there's already contact happening, and let's say there's been an admission of what happened or a finding by DHS and there's, the team, the service team feels like there can be supervised contact, so this has been a huge barrier when I work in these cases, because then the child referred into treatment, you know we'll say, no that has to stop, because we feel strongly that it's very confusing to a victim to have this sexual abuse either disclosed or discovered and then not have the repair apology work before there is contact, so ideally there should be no contact while everybody's working on their pieces, and the first contact should be through therapy in a very planned way but often, you know, service providers, DHS, family members are not trauma informed and then you have to really be in that bad guy position.

Some things that I worry about are what's going on with the offender's side therapist, you know if there is a therapist who, maybe isn't, I feel like especially when children are court ordered to attend treatment and to move through treatment, like offender treatment, how mechanized things can become, I think also sometimes I have a real distrust of the system around me because it is so chaotic and you know between writing notes and you know meeting the demands of CBH and all this other stuff, I don't think a lot of clinicians that work in community mental health settings are necessarily very clinically on the ball.

Other respondents spoke about the danger and ethical concerns of general mental health practitioners taking on specialized clinical issues such as sexual abuse and family reunification.

Your average therapist doesn't have a working knowledge as far as how to work with law enforcement and probation and the process of clarification and reunification, all the dynamics that go on.

It is such a specialized area of treatment and you need to go through specialized training after your general mental health training in order to know how to work with this populace and all of the intricacies that this population brings.

Make sure you have appropriate, ongoing training specific to sexual abuse treatment, adolescents with illegal sexual behavior and the family reunification piece. If you do not have current training and you aren't part of professional organizations like APSAC like APSA, you're not getting journals, you're not getting continuing eds specific to this type of work, you are operating outside your scope of practice and you can and probably will do more harm than good.

Respondents raised individual and agency competency issues and the negative impact these have on family reunification after sibling incest. The ramifications of inadequate training were a central concern of respondents. This issue is exacerbated when there is a lack of communication amongst team members and individuals do not know what services families have previously received or the quality of those services. Additionally, respondents' expressed lack of faith in team member competence is a roadblock to collaboration.

The Challenge of Ensuring Family Safety

An ongoing theme that emerged throughout interviews was the necessity and difficulty of safety planning. When participants were asked about strengthening family protective factors, goals of the reunification process, and their hopes and worries about family reunification, safety was the most common response. Twelve of fourteen study participants emphasized the central importance of family safety, which encompassed emotional, physical, and sexual safety of all members. Safety was referenced repeatedly throughout interviews as a therapeutic factor that required constant monitoring prior to, and throughout, the reunification process.

Some respondents focused on their own client's safety as priority.

It is part of my responsibility to make sure that every decision that is made during reunification is done with the victim's best interest at heart and their welfare and safety being paramount.

To ensure victim safety, you know, and it's not about repairing the old relationship between the offender and the victim, it's about building a new safe relationship between victim and offender, it's not a lot of "remember when," in fact I discourage that part to

happen, it's a lot more about this is going to be about a new relationship where the victim will be very safe.

Constantly working through safety contracts and supervised contracts about what that contact looks like to ensure that visits are safe and secure for the victim.

Other respondents emphasized safety within the family unit.

I think the paramount goal is that everyone is safe, emotionally, physically...

I think that the answer is going to be different depending on each clinician that you speak to. But ultimately for me reunification can't happen unless we can insure that safety is going to be present. And, you know, I mean that in some different ways. Not just sexual safety, in that we don't want another sexual offense to occur, but physical safety, emotional safety, mental safety. The purpose of reunification is to bring a family back together. But we can't bring a family back together if safety cannot be insured. And so while we want families to be whole again, we want them to heal, but I think healing cannot occur unless there's safety.

A respondent stressed the importance of offender safety.

...5 years ago the research was very focused on the victim which obviously you are very focused on the victim but the emotional safety of the offender is extremely important as well. Because they are the ones that are usually pulled from the home, pulled from their families and yes they hurt somebody and that's not discounted but there are a lot of emotional safety issues and often what we do find is that the offenders are having a much harder time reintegrating than even the victim because the victim has gone through their therapy and a lot of times there is still a lot of shame and guilt that you hope you've worked through.

The challenge of changing family functioning was brought up by several respondents.

This challenge included the difficulty in feeling confident that parents will adhere to safety plans.

A person comes in with a model that they were taught and it doesn't fit the client so there are certain things that I think are important that kind of need to be in place such as supervision, line of site supervision, safety planning on what to do with touch, what to do with conflict, things like restriction of certain media that are problematic for the offender but I also find that sometimes safety planning can be superficial unless we really take time to address what the parent is comfortable with facilitating and what the offender thinks actually will help them.

A respondent discussed the importance of normalcy in family interaction while also maintaining family safety.

You've got two goals, to make sure the family is safe, that the victim and offender are safe together but also to help the family get to a place where they are able to interact freely and comfortably with each other in the most normal way possible for them.

Respondents stressed the importance of establishing safety from the beginning of treatment and continually addressing safety concerns throughout treatment.

You know I think that has to start at the onset of individual treatment, there needs to be a very clear understanding with the families on what to expect through the process and that you know, I kind of make very clear in regards to what clarification looks like and that it is a victim-driven response and that it needs to be in support of what the victim needs in order to establish internal and external safety.

I think from an individual therapeutic perspective, safety planning is one of the key parts, or components that are emphasized in every therapeutic session, a family session that safety component is also reinforced.

The last sessions are typically family based and again it is very much reinforcement of safety and prevention and for the most part the kids, the questions they will ask are, are you safe yet? How will I know? Those are typically what come out which gives us a good place to continue to reinforce that concept of safety within the home and what that's going to look like.

Although there were a variety of responses regarding assessing and developing family safety, respondents shared common concerns. At the core of these concerns, was the inability to absolutely know if their clients and the client's family truly felt safe. This uneasiness is felt throughout the reunification process and presents many challenges for team members when assessing family readiness for reunification after sibling incest.

The Challenge of Determining when Families are Ready

Due to the complex dynamics inherent in incestuous families, team members have a difficult task in helping families work through individual and collective feelings, processing the trauma that disrupted the family system, and redefining the family system. Additionally, if

families have other stressors associated with employment, substance use, domestic violence, personal trauma histories, or other chronic stress, team members must be able to determine the impacts of these stressors on a family's ability to support one another and reunify after sibling incest. This daunting task was brought up repeatedly by respondents when asked about their concerns throughout the reunification process. Family readiness for reunification was a primary factor of ongoing assessment and worry for all study participants. Family readiness included subcategories of pressure, denial, and parental ambivalence.

Pressure

Study participants shared common concerns regarding external pressure on the client to hurry through the treatment process and express readiness to reunify. There was a shared feeling among respondents that pressure often exists for the victim, the offender, and the family. Respondents stated that the pressure comes from parents, other family members, and child welfare agencies. Additionally, some respondents spoke about the internal pressure that some clients put on themselves.

Many respondents shared their concerns about family pressure placed on the victim.

I worry about the victim feeling a sense of pressure from the family system to move through the process faster than they necessarily are ready.

I've worked with families where the caregiver and the offender are really ready, oh he's worked so hard, he's admitted it, the victim's not quite ready and they need a lot of help and support to understand, everything hinges on victim readiness, so it's great that the offenders done his work and he's ready to apologize and he's ready to do this letter, he's going to have to be patient because the victim isn't ready yet and everything is focused at that point around what's best for the victim.

I worry that perhaps the victim is getting pressure to want to reunify even when the bottom line is they don't want to.

It's absolutely a given that reunification can never even be considered unless the victim wants it to occur and that the desire has not been induced by the offender's parents or extended family members. That they're not coercing the victim to say, "Yes, I want this person back in my life."

Respondents discussed the impact of family pressure on the victim.

I worry that the victim may not be voicing everything that they are concerned about. A lot of times there is a lot of blame and outside forces in the family are influencing the children to say things they may not fully feel. So I worry about the genuineness of it.

I worry about the victim, pressure on the victim to make it all okay for everybody else, to act like everything is fine.

I hope that the victim has had enough time throughout their own services to heal and that they haven't rushed the process so that we can actually achieve a sense of stability and happiness within the family again.

Others spoke about pressure on both the offender and the victim.

There can definitely be pressure on the offender to admit, to be ready, there is often pressure on the victim to be ready to forgive, to be ready to begin reunification.

I worry that the family can make the perpetrator or the victim feel guilty and lead them to develop more unhealthy, secretive relationships.

A respondent discussed parental pressure placed on the victim and offender.

Often times you'll have a concerned parent that definitely wants reunification to happen so kind of making sure that it's all individual parties that want it and not just one person that's kind of pushing it for everyone else.

A respondent expressed concern about systemic pressure placed on the family.

There can also be a lot of pressure, although I've usually seen this with the victim child more than with the offending child, pressure on the victim child to like speed it along, and I think a lot of the reason why that is a factor is because of most family's involvement with DHS and involvement with these systems that are just so slow moving, and sometimes the tendency to view therapy or treatment as just another FSP objective or something that needs to be ticked off, come on, come on, come on, we need to do this, pressure you know for kids to say things and to disclose things and to talk really openly about sexual abuse, I think that parents don't necessarily have a lot of patience for indulging rapport building and talking about feelings.

Personal pressure that clients sometimes put on themselves was also discussed.

Often everybody is not ready at the same time, often the offender is ready before the victim is ready, sometimes the victim is ready, really misses the person, wants to see them, but the offender is minimizing or denying and that's not okay and so, the child sometimes has to understand that just like you need time to talk about what happened and understand it and get your feelings out, so does he, he needs to really look at this touching problem, understand what happened, why it happened, because he has a really bad touching problem and he might need some more time, doesn't mean he doesn't care about you but he needs more time to know about why this happened and know how to be safe, so the victim and the offender have to be ready.

Pressure placed on individuals and families was a major concern expressed by study participants. This pressure makes it difficult for team members to accurately assess family readiness for reunification. Clients may be pulled in various directions and their words and behavior may be incongruent with their thoughts and feelings about reunification. These issues often leave team members with lingering concerns.

Denial

Denial is a common response to a traumatic event. Victims and offenders of sibling incest often express denial and minimization of the sexual abuse in order to cope and attempt to decrease the shared guilt and shame associated with sexual abuse. These feelings underlying denial are often felt by parents and family members of the victim and offender. Respondents shared the prevalence of denial amongst parents and the affect it has on the reunification process.

You know I think initially parents will go through that denial stage where they don't see why they can't be back together immediately, then you see the healing process kind of take, some parents will be very adamant that there will not be contact, either because they can't support it or they got their own stuff that they have to work through, so there are some families who I've had over the years that it's very clear in the beginning that clarification will not be supported, I always leave that open ended because things may change later in life.

A parent who may have lingering feelings of unsureness of what the pathway was to the offense can complicate it because parents sometimes, like kids, will present like everything is okay but then you see them sort of shutting off when certain topics come up or glazing over things.

Don't play the elephant in the room...Let's not act like sexual abuse didn't happen. You're not doing any good for anybody because that's what they did before they came in here.

Respondents shared examples of parental minimizing after sibling incest and the impact it has on parental commitment to treatment.

The caregiver has to believe that the offense has happened, believe and support, I've worked with families when even when the offender is admitting the caregiver will deny or minimize, well he only did that because...

Denial is obviously a huge factor, family's denial, and then pulling in the external, outer layer of the family also who don't see it as either, they see it as I don't ever want to see this kid again or it's not a big deal and it just happened once.

You have some parents who don't really follow up with treatment for the victim and really want the perpetrator home and their family just to go back to normal because they think the perpetrator got treatment; everything is going to be fine.

The consequences of denial often include the parent's inability to emotionally support the child's treatment and recovery.

Oftentimes we encourage students to say okay if you are having bad thoughts, if you are having bad feelings, I need you to speak to your parents, kind of let them know that you need some kind of support, but parents are like no, I don't want to know that, you should not have those thoughts, so a lot of denial continues to exist.

Respondents shared the potential for safety to be compromised when parents are in denial of the incest.

You find it quite ironic you want your family back together but you aren't willing to do the work to make the environment safe because I think there's still some denial going on around did it really happen.

Parents feel like well, you should be able to watch your sister while I'm at work, you're her brother and what you did when you were five years ago, four years ago, three years ago, that should be over because you already know you can do time for it.

If a parent is in denial, you know, if the parent is minimizing the impact of the offense on the victim, typically I don't find it to be very, I really haven't had a parent that's been like I'm holding this kid accountable for everything and I'm going to make sure he follows the safety plan, and typically one of the issues with these kids, is their parents, they've been able to kind of get their parents to be on their side or just dismiss these things, like I have a student now that, did his victim clarification with this mom and then mom was like, well now they should be able to live together.

The impact of guilt on denial is described by a respondent.

Also trying to take away any guilt they may have themselves because usually that is the underlying part of the denial is that of course this didn't happen because if it happened it makes be a bad parent. However it's really hard to deny when the offender is saying it.

The multifaceted ways that denial impacts the family reunification process are evident in the respondents' accounts. Denial is a common and critical factor present in incestuous families and it contributes to the vast challenges associated with family reunification after sibling incest. Denial impacts many aspects of family readiness for reunification and must be appropriately addressed in order for successful family reunification to occur.

Parental Ambivalence

Closely associated with denial and parental commitment to family reunification is parental ambivalence. Respondents discussed common experiences with parental ambivalence and contributing factors to parental ambivalence. Respondents shared that a primary reason for parental ambivalence is parents' not fully understanding the extent of the time and emotional commitment that is required for family reunification to occur.

The call for reunification is often initiated by the parents... when they become aware of everything that's involved, sometimes that can waiver a little bit.

My only real concern is let's say a parent makes a commitment to one of the kids and the parent decides to step out or back out or whatever you know kids are back and forth with

it and I expect that with kids but if the adult and the kids alike are saying, yes I want to make this commitment, then make the commitment, don't just say it and not do it.

Another contributing factor to parental ambivalence is a parent's mixed feelings towards the victim and offender and the responsibility of supporting both their children.

Sometimes you get families that don't want the other child to come home. They think they do but when they are actually faced with it they may say, "No, this is not something we want to follow through with."

I think that it is extremely important for the offender to be able to hear the family share with them what this is like for them and how difficult the restrictions are and balancing still caring for the offender and showing them love and support while showing support and love for the victim. And that's really difficult because parents feel split.

It's a lot of high emotions that are natural and to be expected, anger, sadness, shame, guilt, embarrassment that the family's experiencing. And that brings up issues because there is a struggle between, you know, I naturally feel angry and disgusted that my child has done this but love my child and how do I balance those conflicting emotions?

A respondent discussed how parental resentment that can develop as a result of the immense restrictions often placed on the offending child.

I think that ultimately the greatest issue is just confusion or lack of wanting to follow through with what is recommended to them because the parent doesn't fully understand some of the rationale that we have as therapists. And I think that that gets strengthened when a parent starts to feel like they're being punished. And then trying to separate the emotions of well my child needs to be punished or the offender needs to be punished. Not me. Why am I the one that has to deal with all of these restrictions as well? And a lot of my clients tell me, you know, I feel like I'm on probation. I know my child is on probation but I feel like I am too. And that's not fair to me. And so that brings up negative emotions that they have to work through.

Parental ambivalence is an important factor that respondents identified as an ongoing clinical concern and frequent barrier to the reunification process. Interestingly, ambivalence associated with meeting the needs of the family system was a mirrored concern of both parents and respondents. Respondents acknowledged the immense difficulties that they experience as team members and that families face throughout the reunification process. The multiple

challenges of helping families prepare for reunification in the midst of their fluctuating feelings creates many obstacles for team members and families to overcome.

Other Clinical Concerns and Challenges

Respondents raised many clinical concerns and challenges throughout their interviews when answering questions regarding the appropriateness of family reunification, the process of family reunification, and issues that arise in family reunification after sibling incest. Many of their concerns were connected to other themes. However, a few that emerged as subcategories include parental mental health, parental commitment, and revictimization.

Parental Mental Health

Considerable attention was given to parental mental health issues by study participants. Family systems theory provides a lens for understanding the development and maintenance of family dysfunction and the intergenerational patterns that exist. Respondents acknowledged the impact of family trauma histories and family stressors on parental mental health.

...parents and their own mental health. Obviously these kids didn't just wake up and do this on their own. They weren't born to do this so yeah I think every parent should be required.

So many times the parents are just unhealthy, for lack of a better word, in some cases the kids are healthier than the parents are.

For multi problem families where let's say it's not just the adolescent that perpetrated sexual abuse but mom has substance abuse and there's domestic violence, there's long standing, chronic multi problems in the family, in those situations the parents need to be in their own therapy.

Respondents discussed the importance of parents being involved in individual therapy in addition to the joint sessions that they participate in with the victim and offender.

Once I build a trusting therapeutic relationship with the parents, to perhaps suggest individual work for themselves with a professional that can help them through all of this and that way I know they're at a place where they have mental stability and they can show insight and self-awareness to the effect that this has had on them.

So it's just as much instilling that sense of self-worth and worthiness to that parent that we try to do for the kids we're working with.

There is always a part of me that wishes it's mandatory of the parent to go through individual counseling themselves because it is such a traumatic experience for the parents.

I have come across a lot of families where it takes a tremendous amount of time for them to heal themselves and to understand their child's specialized triggers.

A respondent acknowledged the difficulty in finding appropriate treatment options for parents whose children were involved in sibling incest.

I think it can be hard to find a component of treatment for caregivers, I think they get support and involvement through the victim therapist, the offender therapist, and through the role that they need to have through most therapies but I really think they need their own therapy with someone who is also experienced in working with caregivers who are in a care-giving role with victim or offender... especially when mom had her own sexual abuse history.

Respondents highlighted the many reasons that parental mental health is often a concern during family reunification. Parental mental health issues contribute to various obstacles that can arise in the reunification process such as denial, ambivalence, and ability to ensure family safety. Additionally, mental health issues amongst parents impact parental commitment to ongoing family healing.

Parental Commitment

Parental commitment to the reunification process was discussed by study participants as a continual challenge. This subcategory relates to parental ambivalence and the difficulties parents face. Respondents discussed that parents wavering feelings towards the victim, the offender, the child welfare system, and the court system impact their motivation and ability to fully commit to

the requirements necessary for successful family reunification. The multiple factors that contribute to parental resistance and decrease parental commitment are evident in the following quotes.

We often have kids ready to be done with our program and reunification hasn't started because we can't get the family members to be consistent.

I guess really the only one is that if the family has verbalized that they want to make a commitment to the reunification that that in fact is what they are going to do, that they are going to commit to it, you know and not just say it and not do anything about it, because I don't want to set anybody up or start the process if you know this party is going to drop out, or this one is going to say, forget it I don't really want to do this kind of thing.

The influence of the child welfare system and the criminal justice system was also seen as a factor impacting parental commitment to reunification.

I don't know if it's truly because they really are interested in it or is it because they want to get DHS out of their hair.

I worry that the family is going through the motions, like we know what we need to do to reunify and get you people out of our lives and after that we're going back to our old ways. So I worry about that. I worry that there aren't going to be long term changes to support successful reunification.

I worry about families showing me what they think I want to see but then acting a different way when they're outside of my office. I worry that they are compliant only because it's forced through the court system instead of them buying into how amazingly powerful therapy can actually be. I worry that it's not a true investment for them in that they're just simply going along with whatever is being asked of them.

There are some of those cases where you just know in your gut that the family system just really isn't going to follow through on all of the components that are part of terms or assisting the offender getting off probation and there's concerns that there may be a lack of follow through with some of those and you know it helps when probation is involved because they can help facilitate the importance of that.

A lack of parental commitment often results in premature termination from treatment and/or the reunification process.

I find that the parents prematurely stop the process. Once the child is home they think everything is done and then that's a loss.

The impact of differing views within the child welfare system impacts parental buy in to the reunification process.

For parents, not to take the child out the minute, not to assume that everything is great the minute it's a done deal with the court, allow the child to grow in and out of therapy.

Respondents referred to the stressful expectations placed upon parents.

It's a lot too for parents thinking about their commitment, their one child may be the offender and then the victim and just the appointments, just the simple pragmatics of the situation.

People say this is what they want but when it actually comes down to doing the work, are they willing to commit to working through the difficulties, it is not abandoning each other at the first sign of a problem, and not willing to throw the towel in because things didn't go the way they should go, that families need to understand you know you're going to have difficulties, you are going to have struggling, you are going to have conflicts and the things that you used to do before that separated the family obviously can't be repeated.

You have to have a caregiver who believes the victim, who can be firm and supportive of the offender but also hold them accountable and can be part of their support around their recovery and their safety planning, and will be absolutely vigilant around supervision and be really clear about expectations, boundaries, you know, no alone time between victim and offender ever, and then the victim has to feel emotionally and physically supported.

Differing ideas about the importance of the therapeutic process and the need for parental involvement were discussed by study participants.

For myself as the clinician, it would be easier if all of the families bought into the therapeutic process and we didn't as clinicians, you know, try to explain to them just how important resolving all of these issues are.

I try to include everybody's sentiments but oftentimes the family has a whole different perspective on what treatment should look like, because they feel like, well I know this child, he knows that if he does this again I'm kicking him out, you know, they think that consequences are going to serve as a treatment modality.

Treatment problems, not denial in that the event occurred but denial that it can continue to occur, oftentimes parents are like, well no, you already had that, you should have gotten over that already, that happened years ago.

Parental commitment to the reunification process is effected by many internal and external factors. Often the combination of personal ambivalence and inability to process their feelings regarding the sibling incest causes parents commitment to ebb and flow. Respondents identified this issue as an integral piece of family reunification that must be present.

Revictimization

A shared concern amongst the majority of respondents, regardless if they worked with the offender or the victim, was the potential for revictimization. These concerns stemmed from the challenges of assessing family readiness for reunification and the pressure often placed on the family system to move the process along. This concern is evident in the following respondent quotes.

If the offender will repeat. That's the main concern.

We want to reduce the likelihood that sexual victimization happens again.

I hope reunification is successful i.e. no further sexual revictimization.

I find that so often incest and sexual abuse, they are just these systemic issues that can pervade generation after generation and am I returning this child to a system, like a larger system that has not healed and they are being exposed and reintroduced.

One respondent shared her feeling that revictimization is not as prevalent as people believe.

I also think we make it a little more scary than it is because we know juveniles once caught, their recidivism rates go extremely down, down to low percentages and if they've completed treatment, we're talking 0-13% recidivism.

Recidivism rates are difficult to assess due to low disclosure rates. However, the potential for recidivism was present in the concerns of study participants. Recidivism is closely tied to family safety and when speaking about safety concerns and family readiness, the fear of recidivism was brought up.

Lack of a Road Map

Interwoven throughout the interviews were prevalent concerns about the lack of research and lack of clinical literature regarding family reunification after sibling incest. When asked what the reunification process looks like, when they enter and exit the reunification process, family follow up after reunification, and ways to enhance the reunification process, 13 out of 14 study participants referred to the lack of research, training, clinical direction, and a sense of having to make their own way. Respondents shared the numerous clinical challenges these issues bring.

Respondents referred to the lack of specialized training available to team members.

Ongoing training is good but there's not a whole lot of training in the clarification or reunification piece, so that's a little bit hard.

The need for a clear process was emphasized by study participants.

I think it would make it easier if it was a more defined process. Like if I had you know, this is a process, this is where you start at, it's just more so doing it as we go I feel like.

...manualizing it would be important, having that kind of set template that everyone can kind of refer to, customizing it appropriately for each client but more streamlined more universal.

Respondents shared how they navigate the reunification process with limited tools.

Lack of literature, I'm one for trying to tailor things to the client but it is also extremely useful to have certain therapeutic models to go off of and I only found one kind of just published journal writing that I use now in my work that provides guidelines but it's great to have more than one. There's not a real over abundance of structures for clinicians to follow in this process. So it involves a lot of thought on the part of the clinician and supervision with the clinician's supervisor to map out something that is

more streamlined. In other areas of treatment, processes are often more streamlined and the roads are more well paved.

Supervision is really crucial, especially in issues like this that are not well charted in literature and therapeutic manuals.

...You know for me I can consult research, look at what are some things to keep in mind, and again, I'm just starting back up here so I don't know if there's some kind of reunification manual here. I'm more going off of my past experience.

Try to seek out as much literature and speak to clinicians about their experiences because it's an area that requires you to do more leg work to find out what has been done before.

I've reached out to the different agencies that provide this work in order to insure that I'm doing everything that I possibly can to be ethical and to stay up to par with, you know, current research and what other providers are doing and to hear from them what their approach is in regards to reunification. And that's something that I will continue to do because I don't believe that within this population you can be successful on your own. I think it takes a tremendous amount of support and collaboration and just being able to talk with other providers about this work because it is so specialized.

These critical missing elements put team members in a precarious position where they are forced to make decisions based on clinical experience and intuition. This has many repercussions and raises concerns around best practice. Additionally if there is a lack of support and resources for team members, the ability to collaborate effectively is compromised.

All the themes that emerged throughout the interviews speak to the overwhelming challenges faced by both families and team members involved in reunification after sibling incest. Just as the dynamics of incest are multilayered and enmeshed, so are the treatment implications and the reunification process. These themes provide a starting point to establish evidence based research and clinical guidance that will enhance service delivery.

Chapter V: Discussion

This study sought to examine the experience of family reunification after sibling incest from the perspective of members of the treatment team who provide services to families. The primary research questions were: What are family experiences of reunification after sibling incest? How can protective factors be increased after sibling incest? How can family experiences promote continued healing and improve service delivery?

I approached this study with the hope that multidisciplinary team members would be able to shed light on what the process of reunification is like for the families going through family reunification after sibling sexual abuse. However, when questions were asked regarding family experiences, study participants understandably veered towards talking about their own experiences and challenges working with families. Perhaps I was naïve in assuming that I would be able to gain insight into family experiences through the eyes of the clinicians. What I found during the interviews is that clinicians who do this work are in need of their own support. My study was so focused on client needs that I failed to acknowledge the possibility that clinicians may lack support as well. The overriding message from clinicians is that this is emotionally tough work to do and there is no framework to follow. As a result they often rely on self education and clinical intuition to guide their work.

There was a common answer to the question of increasing protective factors after sibling incest and it was focused around victim safety, offender safety, and overall family safety. I found that there was not a clear delineation between strengthening protective factors, treatment goals, and the overall reunification process. Study participants stated that strengthening protective factors encompassed decreasing risk of revictimization, implementing wellness plans and safety plans. This makes sense due to the emphasis on emotional and physical safety in all aspect of

family reunification work. One study participant spoke of strengthening protective factors in the following way.

I think that that comes from a strength based approach in referencing what the strengths that the offender has, what the strengths that the victim has and what the strengths that the parents have and pulling from that and saying, you know, you have this incredible sense of devotion to your children and I can see that each and every time that we get together. And that sense of devotion and compassion will help you throughout this process.

One research question that was answered is ways to improve service delivery. Study participants had varied ideas on ways to improve the process of family reunification after sibling sexual abuse. Although some suggestions were directed towards larger, macro social issues, many were realistic ideas that could be implemented at the agency level. A primary problem with comprehensive service delivery is funding. However, the ideas that the study participants' presented were modifications to systems that are already in place.

The fourteen interviews provided insight into the enormous challenges that families and clinicians face throughout the reunification process. The overarching themes that consistently emerged throughout the interviews were therapist role, process of reunification, multidisciplinary team collaboration, family safety, family readiness, clinical concerns, and lack of road map. The following section will conceptualize the results of the study and examine implications for theory, practice, and policy.

Therapist Role

Therapists' perceptions of their role in the reunification process spoke to the impact of various educational backgrounds and theoretical orientations on treatment. It was helpful to interview clinicians who work with both the offending child and the victim child. The diversity and similarities in their clinical experiences were interesting and many issues were raised. A dynamic that was evident throughout the interview process was an "us and them" mentality. Each clinician had similar concerns about the "other" therapist. There was a clear distinction of which side the clinician was on and although he/she spoke of the importance of family needs and family safety, there was an allegiance to their client that sometimes presented as a clinical bias. One study participant referred to the offender's therapist as "*the opposing side.*" Other evidence of clinical bias was in the language used to describe the other child's behaviors. For example when discussing the offending child, terms were used such as the child with "*illegal sexual behavior*" or the child "*who caused harm*" or "*the horrible thing that you did.*" Although these terms may be accurate, they denote a judgment and a label that can impact therapy and equal treatment of all family members. One study participant referred to the stigma that is placed on and internalized by the offending child.

A lot of the guys I worked with, in terms of offenders, the stigma, really internalizing the stigma of everything they have been through, what they've done.

Some participants spoke about the importance of compassion and empathy for both the victim child and the offending child. Although there were varying beliefs verbalized, the passion and commitment to healing was evident in all interviews. These issues highlight the importance of ongoing supervision and self monitoring. Because therapists who do reunification work often develop an expertise in either victim or offender work, it is easy to solely focus on victim or offender treatment issues, develop bias' and potentially discount the importance of understanding the other side. Gil (2006) discussed the power of countertransference and "the tendency to over-

or-underprotect the family system” (p.127) when working with incestuous families. Gil stated that this can cause clinicians to provide unbalanced support to the family system. One study participant spoke about her commitment to staying abreast of current offender research as a victim therapist.

Working with sexual abuse victims in general, it is key to have a network of care supervision and to continue to utilize that when you got tough cases, I continue to be very involved in the provider meetings which typically is with probation and juvenile sex offender treatment providers. I'm the only victim therapist that ever goes, I go for a reason, it helps me be better at what I do from that perspective and then I have ongoing care supervision with colleagues that you know if you got a rough case it is important to be able to talk about that but that peer piece I guess what I'm saying, extends to the offender providers.

Process of reunification

Multiple definitions and issues were identified regarding the reunification process and a central reason is because of the uniqueness of each family system and process. Study participants discussed similar tenets of the reunification process such as clarification. However, all other aspects of the process vary based on what reunification will look like for each family. The tremendous diversity requires flexibility within the process and within the treatment model. Family uniqueness and variations in the definition and implementation of reunification present many challenges for research and manualizing treatment approaches. There are family reunification models and there are research-based treatment models for children who have been victims or offenders of sexual abuse. However, the missing piece is a merged, evidence-based model that encompasses the dynamics of incestuous families, the impact of sibling incest on family systems, and all facets of treatment that are unique to families who reunify after sibling incest.

Multidisciplinary team collaboration

There was overwhelming support for team collaboration voiced in the interviews. However, most study participants spoke of the lack of collaboration due to multiple factors such as differing goals, differing timelines, lack of communication, and lack of training. It is important to note that respondents do not work in child advocacy centers which enhance team collaboration by housing many multidisciplinary team members (i.e. child welfare, law enforcement, victim therapists, victim advocates, forensic interviewers, medical staff) under one roof or near one another, allowing for communication and ongoing team collaboration during child abuse investigations and case staffing (www.nationalcac.org/history/history.html). Additionally, child advocacy centers are staffed by specially trained professionals and provide training opportunities for multidisciplinary team members. Study participants may have a different experience with team collaboration and appropriately trained team members if they were part of a child advocacy center. Although, offender services are not part of child advocacy centers, so respondents may still experience collaboration and communication challenges with team members.

Study participants stated that another difficulty regarding team collaboration is the number of parties involved in the reunification process such as victim therapist, offender therapist, the court system, probation, child welfare, and various other entities, ongoing collaborative communication is difficult to facilitate. Some study participants spoke about feeling rushed due to pressure placed on them by other agencies.

If you feel rushed in the process it's not a good thing. With anything around sexual abuse, with any kind of abuse, if it's ever a last minute decision just don't make it.

DHS, I don't think they ever take enough time.

Don't get pushed by those that call you and say I need an answer; I need a report; what's the progress; where does the kid stand?

It is important to consider how high caseloads and short time frames impact multidisciplinary team members' ability to collaborate with one another. Although caseload size and time were issues raised by clinicians this is an ongoing systemic issue. The economic climate causes team members to have less time to do more work. One study participant shared the impact the issue has on his work.

I think the thing is if your masters level therapist in a community behavioral health setting, you tend to load your day up with a lot of stuff, so you end up with full days where you're trying to maximize your time, your efficiency and your income as well...I mean my day is scheduled down to the minute.

Another concern raised was the lack of training and understanding about family reunification and sibling incest. Study participants expressed their frustration with attempting to meet their client's needs when members of the multidisciplinary team do not have a working knowledge of the multilayered trauma issues that must be identified and addressed in order for successful family reunification to occur. The lack of training and understanding also arises from differing roles of team members in the reunification process and some roles do not require team members to be trained in issues such as trauma informed care, family systems, and child sexual abuse. The lack of training also stems back to time and money. Agency-based settings are often limited in the trainings available and the funds available to workers. Additionally, specialized training in reunification with incestuous families is scarce. The Child Welfare and Information Gateway (2011) stated that child welfare workers involved in family reunification are more successful when they have a social work degree, specialized reunification training, and clinical experience. This seems obvious, however the reality in the field is that many multidisciplinary team members lack adequate training and professional experience and therefore struggle to understand and meet the needs of their clients.

Family safety

Family safety encompasses many factors such as emotional safety, physical safety, wellness planning, risk reduction, boundary setting, and open communication. The importance of family safety was evident in this study and supports evidence-based treatment models for victims and offenders of child sexual abuse as well as child welfare guidelines, which describe family safety as a primary goal. Finkelhor (2007) stated that children who have a history of trauma are at higher risk of experiencing additional trauma than children without trauma histories. If families are being reunified and there is an absence of family safety factors or a gradual decrease in family safety, children's risk for experiencing additional trauma increases dramatically.

Family readiness

Closely tied to issues of family safety is family readiness for reunification. Family readiness is a critical factor in the outcome of family reunification. van der Kolk (2005) indicated that the most critical factor in a child's successful recovery from sexual abuse is the support of a caregiver. The same pressure that multidisciplinary team members feel is often felt by families; the time constraints that are placed on them to meet child welfare goals, treatment goals, probation goals, etc. are often overwhelming. Additionally families often put pressure on one another to finish treatment in an effort to move on from the trauma that has permeated so many aspects of their life.

Denial is a common barrier to family readiness for reunification. Study participants provided numerous examples of parental denial, rationalization and minimization of the sibling incest. Hindman (1989) stated that denial, rationalization, and minimization are common victim responses to incest so it is important to understand the shared and often similar psychological impact that sibling incest has on the family system.

An important contributing factor to family readiness is parental ambivalence. Ambivalence often stems from feelings of betrayal by the offender, uncertainty if the offender will be able to change and not reoffend, and divided loyalty. These ambivalent feelings are another example of parallel emotional experiences of both victims and parents following sibling incest. Freyd (1996) spoke about the impact of betrayal trauma on victims of sexual abuse and their need to hold onto their perceived relationship with the offender. Betrayal trauma is a dilemma for parents of the offending child as well. Divided loyalty often contributes to parental ambivalence and denial. Courtois (2009) discussed the struggle for families to demonstrate love and loyalty to both the victim and offender. In a study of thirty incestuous families, Bolen & Lamb (2004) found one third of parents expressed ambivalence that caused wavering in emotional support of both the victim and the offender. Bolen & Lamb stated that ambivalence should not be interpreted as an inability to support the victim, but understood as an expected result of attempting to maintain loyalty to the victim and the offender.

Knowing the multifaceted issues that arise and cause ambivalence, the various systems involved in the families lives need to develop additional avenues of support. By providing ongoing family support and services throughout the reunification process, families will be better prepared to meet one another's needs and decrease the chance of experiencing additional trauma, returning to treatment or reentering the child welfare system.

Clinical concerns

A multitude of clinical concerns were discussed by study participants. Many of the concerns are interwoven with other major themes. Clinical concerns demonstrate the difficulty for clinicians in separating treatment and reunification issues arising from trauma histories, family dynamics, and other environmental and psychological factors. Of primary concern for the

majority of study participants was the possibility of revictimization. Although research indicates that revictimization rates are relatively low (Worling & Curwen, 2000), revictimization was still a primary concern for clinicians. Risk factors for reoffending escalate when other clinical concerns are present such as unresolved parental mental health issues and wavering parental commitment to adhering to and maintaining family safety plans. When parental mental health is not addressed and parental commitment is not in place, the risk of revictimization increases. Additionally clinicians who work in sexual abuse understand the intense secrecy and shame that surrounds sexual abuse and often leads to a lack of disclosure. Knowing the impact of secrecy and shame on disclosure, it is unclear if incident rates of revictimization are truly low or if a lack of disclosure and reporting contributes to an inaccurate prevalence rate.

It is evident based on the accounts of study participants that working in a very specialized area can be overwhelming and emotionally depleting. Some study participants discussed the emotional toll this work has on them.

This is a difficult population to work with, it's very emotionally charged and I need to be aware of my own emotions and my own reactions and take care of myself.

After 15 years with this population I've found it much easier not to take things home but I can say that I can remember my first reunification case. It was actually a kid who had been in this locked facility for quite some time and had abused 3 of his siblings. This kid at a young age was sexually abused horrifically and all of the kids in the family had a lot of incestual acts going on. We actually did a very smooth reunification in terms of just them visiting our facility. None of the siblings would ever live together and that was clear cut but that worked out real well. But that was very emotional for me and just the first case.

You have to insure self care so that you don't burn out so that you don't take on the fatigue and the trauma of your patients. That included, placing the boundaries of once you step outside of the office you're no longer at the office. You're into the other parts of your life. And to try to isolate those different areas of your life so that you're not bringing work home and you're not treating your family differently or you're not viewing your family in the ways that you view your patients.

It affects my personal life, in that, I've become a little bit paranoid, you kind of overanalyze certain things sometimes, especially people's behaviors and their motives, you always kind of question family's interactions with children.

You have to really have good self care outside of the work because it can stay with you, it's very intense.

It's just that general anxiety we have because we are in the field.

Lack of a road map

The lack of research and clinical literature in this area is a critical missing piece. As has been illustrated in the accounts of the study participants, many factors must be addressed and in place for successful family reunification to occur. Without a streamlined process, reunification training specific to sibling incest, or research to refer to, multidisciplinary team members are forced to use clinical judgment based on their experience. Making decisions based on clinical intuition is a vulnerable place to be. Additionally, systems are not in place that track families post reunification. Study participants discussed reasons for the difficulty in following up with families once they have been discharged from treatment and/or probation.

It's very difficult because many of our kids are off probation and they are already 18 so yes follow up is difficult. However, what we have proposed in our new RFP that we just sent to CBH and we just met with them yesterday is a case manager position that would actually do a 6 month follow up. Obviously the families don't have to comply if they are off probation but that's what we are really striving for in our agency so we can do that follow up. And we are now, actually just before you came in I compiled a 3 year sample of all the kids we have discharged successfully and we are going to give that information to CBH and they are going to do a track on those kids if they can find them. Some of them are 21 years old. So we are trying to do more outcome data for sure but it is very difficult to follow our kids because usually when they are released from us they are released from probation. We don't always recommend that and that doesn't always happen but the majority of the time it does. So they would have to be willing to let us check in on them. You would hope if they were successfully discharged they had the buy in and you would hope if they went through the reunification process the family is invested but right now the follow up is minimal but we are working on making that stronger. That needs to happen.

Once the reunification process is complete, we no longer are a part of their life. We discharge them. So the times that that remains open is dependent upon the family and how successful the reunification process has been. After that point in time that reunification is okay, we step away and I'm not sure what services are available at that point. And that's actually a really great question. I don't know.

It's usually a phone call or if I don't reach the family because they moved, their phone number changed or whatever, then going through the vehicle of the social worker in charge... I mean there would probably be an attempt.

A lot of times reunification ends up being the last goal of therapy and I wish I could say that aftercare happens all the time. In my experience, a lot of agencies aren't built to have that aftercare piece. I think it comes down to just a pure financial bind. I think everyone agrees that there should be some kind of aftercare but funding that can sometimes be problematic.

Traditionally once the kid leaves the program, yeah that's it, you know the kids might call me a couple of weeks in a row to just let me know how they're doing or whatever, and you know that's fine, but I don't continue do any kind of therapy or anything like that once they're discharged, you know it's unethical at that point so once they leave here from a therapeutic stand point, I'm finished.

This is another critical gap in family reunification after sibling incest. Without follow up, multidisciplinary team members have no way of knowing if reunification has been successful or what issues have arose for families. Terling (1999) stated that professionals involved in reunification must recognize reunification as an adjustment period for families and a potentially fragile time for the family system. Any additional stressors that families face may impact the families' ability to focus on their safety plan. This is another important reason that follow up post reunification needs to occur. There is no way of knowing how families are doing or stressors they are facing if follow up is not built into family reunification after sibling incest. The Child Welfare Information Gateway (2011) conducted a review of child welfare reunification processes in nineteen states and found that the key to reducing risk of revictimization and return to the child welfare system was post-reunification services. Issues that were identified as family risk factors included lack of service availability, lack of intensive and long term services,

disrupted services, and funding issues. These findings are consistent with the findings of this study. One study participant spoke of the lack of follow up.

I wish there was more research, longitudinal, like several years later after families have done the re-engagement and healing pieces. How is it going? What is happening? Was it effective? What do they think? What would have been helpful? What do they need?

These numerous reunification issues illuminate the need for comprehensive support for multidisciplinary team members who work in family reunification after sibling incest. Support includes, but is not limited to, collaborative team processes, adequate training, and the availability of evidence-based research, comprehensive service availability, and implementation of self care.

Implications for Theory

The findings of this study address and support major tenets of trauma theory and family systems theory. The findings underscore the multifaceted impact sibling incest has on the family system and the family's ability to cope with the trauma. Trauma theory discusses the diverse responses that individuals can have to trauma and as a result, the multiple ways they cope with trauma (Courtois & Ford, 2009; Gil, 2006; Berzoff, 2009). The study identified and discussed how the diversity in response and coping with sibling incest is seen and addressed in treatment and throughout the reunification process. Additionally, the study highlighted the parallel emotional process that often occurs between victim, offender, and parent and the shared *traumagenic dynamics* that include feelings of guilt, shame, and responsibility (Finkelhor, 1985).

This study supported concepts of family systems theory such as understanding the impact of trauma on the entire family system and being cognizant of the difficulties families face in changing individual and systemic beliefs and behavior. Courtois (1999) and Gil & Cavanaugh

Johnson (1993) stated that incest often arises out of a dysfunctional family system. Participant spoke of this family dysfunction and the importance of addressing systemic change in the family.

A huge component too is that family system because sexual abuse happens in a system, it's not in a vacuum so there can be family and environmental factors that were not in place, that in some ways, I guess maybe enable is too strong a word but maybe created an environment where it's easy for something like this to happen so that is a whole piece that needs to be looked at, what are the dynamics, what are the caregiver's beliefs.

Sometimes families just want everything to kind of go back to normal, we have to help caregivers understand that going back is not where you want to go because that's what wasn't working, that was an environment where this happened, we need to create and define a whole new environment that's much more open, clear, safe, with specific boundaries.

McNevin (2010) discussed the importance of recognizing the often overwhelming process of change that families are faced with and expected to make. This process requires a balance between respecting and validating the family system and holding individuals accountable for their actions. Sibling incest often adds significant stress to an already weakened or unhealthy family system. Massat & Lundy (1998) discussed that parents commonly experience relationship stress and financial stress as a result of sexual abuse. This family stress may be exacerbated when issues of poverty are added. If a family system is overloaded, goals and expectations of family reunification may not be a priority. A study participant speaks to this issue.

Families might go into crisis, they might not be able to pay the heating bill, you know, you really have to reduce the chaos that very well might have been part of that family's life for a long time.

McNevin (2010) stated that “families are often in the midst of chaos, separation, crisis and shock” (p.63) due to the sibling incest so these family system issues must be acknowledged,

addressed, and monitored. These are all issues that multidisciplinary team members need to take into consideration when assessing the needs of families.

Implications for Practice

Gelles (2001) stated that child welfare professionals need to be able to identify family risk factors and assess parental commitment to change. This needs to be a collaborative effort amongst all multidisciplinary team members. The issue of risk and family readiness are often difficult to assess and this makes team communication and collaboration of utter importance. The Child Information Gateway (2011) found that states that conducted ongoing risk assessments were able to make reunification decisions that were in the best interest of the child and sometimes that included the decision not to reunify the family.

Warsh, Maluccio, & Pine (1994) stated that there must be collaborative planning from early on and this planning must be comprehensive and examine many factors such as family history, parental mental health, and community support. Additionally, reunification planning from beginning to end must be developed based on individual family needs rather than agency timelines. All these factors were brought up in this study as well and need to be at the forefront of reunification discussions amongst professionals in the field.

Implications for Policy

Many policy issues need to be addressed regarding family reunification. There is overlap between practice and policy issues since policy impacts and often dictates service delivery. Gelles (2001) stated that in order for family reunification to truly be tailored to the needs of the family, the field of child welfare should replace the words “reunification and preservation with child safety and the best interests of the child” (p.12).

Wulczyn (2004) stated that twenty-five percent of children who are reunified and move back in with their family will reenter the child welfare system. This finding requires policy makers to examine the process of family reunification to target areas that need to be strengthened or redeveloped in order to decrease recidivism rates. Knowing that child welfare advocates for family reunification it is imperative to utilize the findings of this study to educate multidisciplinary team members about the family dynamics of incestuous families, treatment needs, community support needs and the critical necessity of team collaboration. Additionally, policy makers need to recognize child sexual abuse as a public health problem and allocate funds to developing comprehensive services for families and specialized training for team members. The Children's Bureau (2010b) stated that child welfare needs to offer more flexible funding in order to increase the availability of community resources for families. It is crucial to understand the unique needs of this population in order to provide effective treatment.

Implications for Future Research

This study was a first step in understanding familial and clinical experiences of reunification after sibling incest. Themes that arose should be further researched to gain more detailed understanding of the issues that impact treatment. Additionally, other multidisciplinary team members' voices need to be heard in order to understand their struggles and to see if they mirror those of the clinicians or if they are different. This is important for both practice and policy.

Although it can be difficult to access parents and children involved in the reunification process, it is important to know about their experiences in order to ascertain if their needs are being met and if not what micro and/or macro changes need to occur in order to meet their needs. Research needs to be conducted that includes the perspectives of child victims, child offenders,

and their family in order to truly understand the family experience of sibling incest. Furthermore, cultural influences must be examined to determine how a family perceives and copes with sibling incest. This knowledge will help clinicians appropriately tailor treatment to meet the needs of the family and will provide guidance for other team members in regards to how to most effectively support families throughout and after reunification.

Strengths

The study identified a significant gap in research and provided insight into a highly complex, specialized intervention and treatment process. The study participants provided a collective voice that offered front line clinical perspectives of family reunification after sibling incest. In addition to highlighting systemic struggles, the study also identified individual clinical challenges. Additionally, study participants were diverse in educational backgrounds and clinical training. This allowed for different clinical perspectives.

Limitations

Small sample size was a limitation of this study. Qualitative studies have potential for researcher and participant biases. (Primeau, 2003) Although qualitative studies are not meant to be generalizable, they allow entrance into an uncharted area of research. The study participants were all clinicians and although they had varying experiences, they represented only one piece of the multidisciplinary team.

In retrospect, I would modify some of my research questions because I made the assumption that multidisciplinary team members would have insight into client experiences and that was not the case. My own commitment to wanting to hear the voice of the family caused me to disregard the potential contribution that team members' insight may have. I would modify the questions to specifically focus on team member's experiences with family reunification after

sibling sexual abuse. Additionally I would add questions that specifically examined the needs of team members. In the development of the research questions, I placed team members' needs second to family needs and that was a mistake. I now recognize the overwhelming need for support of the team members who are on the front lines doing this work. The experiences of the study participants changed the focus of this study and highlighted important areas that I overlooked when designing the study. This study provided me with more self reflection than I anticipated and required me to examine my thoughts and values that I have developed as a clinician.

Although I thought I was being objective when developing the interview guide, my questions were developed based on my own experience in the field and the clinical and macro issues that have arose in my work. Although many of these concerns were voiced by the study participants as well, I could have added some broader questions that allowed for more open exploration of issues and successes experienced by team members. In retrospect, I realize that many of the questions asked were problem based not strength based. This may have limited the study participants' ability to discuss success and positive aspects of their work.

Conclusion and Recommendations

This study set out to shed light onto the relatively unexamined process of family reunification after sibling incest. This study elicited rich narratives of clinicians immersed in this work. Their experiences identified practice and policy issues that need to be addressed. A primary concern that must be addressed is the lack of evidence based best practices and collaborative clinical models for family reunification after sibling incest. Team members cannot meet the needs of the families they are working with in the absence of a reunification template that captures the complexity of sibling incest. As respondents mentioned, this is a highly

specialized area that requires collaboration, education, and training and team members must come together to share knowledge, conduct research, and develop a better way of supporting children and families.

Child welfare must re-examine the inadequate, universal family reunification model that is currently used because it does not meet the unique needs of reunifying siblings, as it was created for reunifying parents and children. Policy makers and team members must be trained in the nuances of incest in order to truly understand the challenges of treatment and reunification and to fix the current one-size-fits-all approach to family reunification. Through training and education, professionals involved in child welfare will gain an in depth understanding of the uniqueness of sibling incest and be able to address the fault lines between the various systems involved.

Additionally, since juvenile sex offenders are not typically incarcerated for sexual abuse, child welfare and the criminal justice system must develop a realistic intervention, treatment, and reunification plan for families rather than making arbitrary and sometimes rash decisions, regarding when families can reunite. The reality is that families will find a way to reconnect despite the efforts of the multidisciplinary team to keep them apart for however long they deem appropriate. Knowing this, policy makers and team members involved in family reunification must develop a lasting reunification model that ensures family safety and is congruent with sibling incest.

Team members agree that safety is a priority in order for family reunification to occur but there is not currently a standard or effective way to assess family safety. Safety is typically addressed simply by developing a written safety plan in conjunction with the family and then hoping it is being followed. There has to be a better way to ensure that children's' safety is being

monitored. And safety monitoring should not end when a case is discharged by the courts or child welfare. When child welfare determines that a child is not safe, they take immediate and sometimes extreme measures to ensure that child's safety. However, when child welfare has completed their checklist for the case or need to meet a deadline, the overwhelming concern that was initially there for the child is no longer present and the case is closed or passed on to an ongoing child welfare worker who will sporadically check in on the child.

Another area that must be examined is the state determined protocol for accepting reports of child sexual abuse. Reporting guidelines are developed in conjunction with child abuse laws and as a result if a case cannot be prosecuted because it does not meet the state definition of sexual abuse, it is often dismissed. If a child is being sexually abused it should not matter what the age difference is between the offending child and the victim child or if they live together. Incest is incest and there should not be predetermined definitions of which children receive intervention and support. This selective process also impacts the ability to determine actual prevalence rates of child sexual abuse because if an allegation or disclosure is rejected by the child welfare system, that case is not included in research. This results in skewed prevalence and revictimization rates and also effects societal views of the urgency of this public health problem.

It is evident based on this study that there are many facets of family reunification after sibling incest that must be understood and considered in order to develop effective reunification models, ensure family safety, and support multidisciplinary team members who are involved in this challenging work. Ongoing research is vital to gain understanding of family and team member experiences of reunification after sibling incest and the intricate dynamics and challenges they face. With continued research, revamping of current reporting and reunification

protocols, team member collaboration and training, professionals and families will have the support and guidance needed to successfully navigate the reunification process.

Appendix A

Research Subject Information Sheet

University of Pennsylvania Research Subject Information Sheet

**Title of Research Study: Moving Families to Future Health: Reunification Experiences
After Sibling Incest**

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You are being asked to participate in a research study. This is not a form of therapy or treatment. You can choose whether or not you want to participate. Below is a detailed description of the study. The researcher will review the research subject information sheet with you. If you have any questions about the research subject information sheet, please ask the researcher. If you decide to participate in the study you will be asked to provide verbal consent. As a mandated reporter, if further sexual abuse is reported during the interview, the researcher is required by law to notify the department of human services.

What is the purpose of the study?

The purpose of this study is to understand reunification experiences after sibling sexual abuse. The researcher is a doctoral student in the DSW program at the School of Social Policy and Practice at the University of Pennsylvania. I am conducting this study for my dissertation.

Why was I asked to participate in the study?

You are being asked to participate in the study because you identified yourself as a multidisciplinary team member involved in the reunification process.

What is involved?

The interview will last approximately one hour. The researcher will make an audio recording of the interview and may take written notes. The researcher will ask you questions about your professional experience with reunification after sibling sexual abuse. The researcher will ask questions about strengths and stressors in your clients' families and your hopes and fears about your clients' families after reunification. The researcher will also ask you questions regarding services that may be helpful to other families who are going through a similar experience.

How will confidentiality be maintained and my privacy protected?

The information you share will be kept strictly confidential. The researcher will not share information about whether or not you participate in this study with anyone. The researcher will never use your name or any personally identifying information in the write-up of the interview. A master list linking participant identifiers with identification numbers will not be maintained. Subject identification numbers and the date of the interview will be included in the audio recording. Your name will not be on the research subject information sheet or used in the interview. Only the researcher will be able to listen to the audio recording. Once the researcher has analyzed the interview and completed the dissertation, the researcher will destroy the audio recording, interview notes, and interview transcript. The researcher will remove anything that might serve to identify you, including geographic locations and names of particular individuals you might mention in the interview. The research subject information sheet will not be signed. You will be given a copy of the research subject information sheet. The researcher will make every effort to keep all information you tell her confidential, as required by law. The Institutional Review Board (IRB) at the University of Pennsylvania is responsible for protecting the rights and welfare of research volunteers like you.

What are the risks?

The ways that confidentiality will be protected have already been described. The risks of participating include the possibility that you may become upset due to talking about a difficult experience in your clients' lives. In the unlikely event that you find that what you discussed in the interview is upsetting to you after the interview is over, please be in touch with me. I will provide you with names and numbers of individuals or agencies that can provide further assistance.

How will I benefit from the study?

The interview will not have a direct benefit for you. However, you will aid the researcher in gathering information that may be helpful to families and other professionals who are involved in reunification after sibling sexual abuse.

What choices do I have?

You have the choice not to participate in the study. There will be no negative consequences if you decide not to participate. Any program or agency that you work with will not know whether you participate or not.

If you do decide to be interviewed today, you can stop the interview at any time. You can also refuse to answer any questions that you don't want to answer.

When is the study over?

The study is expected to end after all participants have completed their interviews and all the necessary information has been collected. The study may be stopped without your consent for the following reasons:

- The interviewer feels it is best for your safety and/or health
- The interviewer, the sponsor or the Office of Regulatory Affairs at the University of Pennsylvania can stop the study anytime.

Can I leave the study before it ends?

You have the right to drop out of the research study at anytime during your participation.

Will I have to pay anything?

There is no cost to participate in this study.

Will I be paid for being in the study?

If you decide to participate you will be given a \$10 gift card when the interview is completed.

Who can I call with questions, concerns or complaints about my rights as a research participant?

If you have questions, concerns, or complaints regarding your participation in this research study or if you have any questions about your rights as a research participant, you should speak to the Principal Investigator listed on page one of this form. If a member of the research team cannot be reached or you want to talk with someone other than those working on the study, you may contact the Office of Regulatory Affairs at the University of Pennsylvania by calling (215) 898-2614.

Appendix B

Interview Guide

I am interested in family reunification after sibling sexual abuse. Having a family separated then brought back together can be difficult. Since most families are eventually reunified I want to learn about the reunification process. I would like to know what it is like for you to go through this process with your clients and their family. This information will help me to better understand the way reunification is handled in various environments and will help me identify effective strategies used throughout the reunification process as well as areas that can be improved to better meet the needs of families.

1. When is reunification appropriate?
2. How do you determine when your client and their family are ready for reunification?
3. What does the reunification process look like?
4. What is your role in the reunification process?
5. How do you balance the needs of all family members involved in the reunification process?
6. Do you attempt to strengthen protective factors in the client's home? If so, how?
7. What issues arise during and/or after the reunification process?

Probe: How do you handle those issues?

8. Question: How does the reunification process affect your clients and their family?

Probe: What do you hope for?

Probe: What do you worry about?

Probe: Do you talk to anyone about your hopes and worries? If so, who?

Probe: How do you take care of yourself?

9. Question: Do parents want their children to live together again?

Probe: How do you know when your clients are ready to live together again?

Probe: Do you have any worries about your clients living together again? If so, what do you worry about?

10. Question: What services do families receive during the reunification process?

Probe: Are they helpful?

11. Question: Do families receive any services after reunification? If so, what?

Probe: Are the services helpful?

Probe: Are there any services that clients' are not receiving now that would be helpful?

12. Question: When do you stop working with families who reunify?

13. Question: Is there anything that would make this process easier for you or the families you work with?

14. Question: Is there anything you would tell families or other professionals who are involved in this process?
15. Debriefing Question: Is there anything that I did not ask you that I should have asked to help me understand what this experience was like for you?
16. Debriefing Question: What was it like to talk about this today

References

- Acierno, R., Kilpatrick, D. G., Resnick, H. S., Saunders, B., de Arellano, M. & Best, C. (2000). Assault, PTSD, family substance, and depression as risk factors for cigarette use in youth: Findings from the national survey of adolescents. *Journal of Traumatic Stress*, 13, 381-396.
- Berzoff, J., Flanagan, L. M., & Hertz, P. (2008). *Inside out and outside in: Psychodynamic clinical theory and psychopathology in contemporary multicultural contexts*. United Kingdom: Aronson.
- Bolen, R.M., & Lamb, J.L. (2004). Ambivalence of nonoffending guardians after child sexual abuse disclosure. *Journal of Interpersonal Violence*, 19, 185-213.
- Briere, J. & Scott, C. (2006). *Principles of trauma therapy*. Thousand Oaks, CA: Sage Publishing.
- Caffaro, J. V., & Conn-Cafarro, A. (1998). *Sibling abuse trauma: Assessment and intervention strategies for children, families and adults*. New York, NY: Haworth.
- Carlson, B. E., Maciol, K., Schneider, J. (2006). Sibling incest: Reports from forty-one survivors. *Journal of Child Sexual Abuse*, 15(4), 19-33.
- Canavan, M. M., Meyer, W. J., & Higgs, D. C. (1992). The female experiences of sibling incest. *Journal of Marriage and Family Therapy*, 18, 129-142.
- Cavanaugh, T. J. (2009) *Understanding children's sexual behaviors*. Tcvajohn.com.

Celbis, O., Ozcan, M. E., & Ozdemir, B. (2005). Paternal and sibling incest: A case report.

Journal of Clinical Forensic Medicine, 13, 37-40.

Center for Disease Control (2010). Prevalence of Individual Adverse Childhood Experiences.

Retrieved from website: <http://www.cdc.gov/nccdphp/ace/prevalence.htm>

Center for Sex Offender Management (2005). *Key considerations for reunifying adult sex offenders and their families*. Silver Springs, MD: Author.

Charmaz, K. (2006). *Constructing grounded theory: A practical guide through qualitative analysis*. Thousand Oaks, CA: Sage.

Child Welfare Information Gateway. (2011). *Family reunification: What the evidence shows*.

Washington, DC: U.S. Department of Health and Human Services, Children's Bureau.

Children's Bureau. (2010b). *Summary of the Title IV-E child welfare waiver demonstrations*.

Washington, DC: U.S. Department of Health and Human Services, Administration for Children and Families. Retrieved January 2012 from

www.acf.hhs.gov/programs/cb/programs_fund/cwwaiver/2010/summary_demo2010.htm

Cohen, J. A., Mannarino, A. P., & Deblinger, E. (2006). *Treating trauma and traumatic grief in children and adults*. New York, NY: Guilford Press.

Cole, M.C., & Putnam, F.W. (1992). Effect of incest on self and social functioning: A developmental psychopathology perspective. *Journal of Consulting and Clinical Psychology*, 60 (2), 174-184.

Courtois, C. (1999). *Recollections of Sexual Abuse*. New York, NY: Norton.

- Courtois, C. & Ford, J. D. (2009) *Treating complex traumatic stress disorders*. New York, NY: Guilford Press.
- Courtois, C. (2010). *Healing the Incest Wound* (2nd Ed.). New York, NY: Norton.
- Corbin, J. & Strauss, A. (2008). *Basics of qualitative research* (3rd Ed.). Los Angeles, CA: Sage.
- Cramer, P. (1991). *The development of defense mechanisms: Theory, research, and assessment*. New York, NY: Springer-Verlag.
- Cumming, G. & McGrath, R. (2005). *Supervision of the sex offender*. (2nd Ed.). Brandon, VT: Safer Society Press.
- Cyr, M., Wright, J., McDuff, P., & Perron, A. (2002). Intrafamilial sexual abuse: brother-sister incest does not differ from father-daughter and stepfather-stepdaughter incest. *Child Abuse & Neglect*, 26, 957-973.
- Darkness to Light (2010). The issue of child sexual abuse. Retrieved from website: <http://www.d2l.org/site/pp.aspx?c=4dICIJOkGcISE&b=6069255>
- DePrince, A. P. & Freyd, J. J. (2002a). The harm of trauma: Pathological fear, shattered assumptions, or betrayal? In J. Kauffman (ed.) *Loss of the Assumptive World: A theory of traumatic loss*. New York, NY: Brunner Routledge.
- De Young, M. & Lowry, J. A. (1992). Traumatic bonding: Clinical implications in incest. *Child Welfare*, 71, 165-175.
- DiGiorgio-Miller, J. (1998). Sibling incest: Treatment of the family and the offender. *Child Welfare*, 77(3), 335-347.

- Elliott, M., Brown, K., & Kilcoyne, J. (1995). Child sexual abuse prevention: What offenders tell us. *Child Abuse & Neglect, 5*, 579-594.
- Finkelhor, D. H. (1980). Sex among siblings: A survey of prevalence, variety, and effects. *Archives of Sexual Behavior, 9*(3), 171-193.
- Finkelhor, D., & Browne, A. (1985). The traumatic impact of child sexual abuse: A conceptualization. *American Journal of Orthopsychiatry, 55*, 530-541.
- Finkelhor, D., Ormrod, R. K., & Turner, H. A. (2007). Re-victimization patterns in a national longitudinal sample of children and youth. *Child Abuse & Neglect, 31*, 479-502.
- Ford, J. D., & Russo, E. (2006). Trauma-focused, present-centered, emotional self-regulation approach to integrated treatment for posttraumatic stress and addiction: Trauma adaptive recovery group education and therapy (TARGET). *American Journal of Psychotherapy, 60*, 335-355.
- Frazier, K. N., West-Olatunji, C., St. Juste, S. and Goodman, R. (2009). Transgenerational trauma and child sexual abuse: Reconceptualizing cases involving young survivors of CSA. *Journal of Mental Health Counseling, 31*, (1), 22-33.
- Freyd, J. J. (1996). *Betrayal trauma: The logic of forgetting childhood abuse*. Cambridge, MA: Harvard University Press.
- Friedrich, W. N. & Sim, L. (2006). Attachment styles and sexual abuse. In R. E. Longo & D. S. Prescott (Ed). *Current perspectives: Working with sexually aggressive youth and youth with sexual behavior problems*. Holyoke, MA: NEARI Press.

- Gelles, R. J. (2001). Family preservation and reunification. In E. White (Ed). *Handbook of Youth and Justice*. New York, NY: Kluwer Academic/Plenum Publishers.
- Giarretto, H. (1977). Humanistic treatment of father-daughter incest. *Child Abuse & Neglect, 1*, 411-426.
- Giarretto, H. (1982a). A comprehensive child sexual abuse treatment program. *Child Abuse & Neglect, 6*, 263-278.
- Gil, E., & Cavanagh Johnson, T. (1993). *Sexualized children: Assessment and treatment of sexualized children and children who molest*. United States: Launch Press.
- Gil, E., and Roizner-Hayes, M. (1996). Assessing family readiness for reunification. In E. Gil (Ed.) *Systemic treatment of families who abuse*. San Francisco, CA: Jossey-Bass Publishers.
- Gil, E. (2006). *Helping abused and traumatized children: Integrating directive and nondirective approaches*. New York, NY: Guilford Press.
- Hanson, R. K., & Bussiere, M. T. (1996). *Predictors of sexual offender recidivism: A meta-analysis*. Ottawa: Department of the solicitor general of Canada.
- Haskins, C. (2003). Treating sibling incest using a family systems approach. *Journal of Mental Health Counseling, 25*, 337-350.
- Herman, J. (1992). *Trauma and recovery*. New York, NY: Basic Books.
- Hindman, J. (1989). *Just before dawn*. La Grande, Oregon: Alexandria Associates.

- Kendler, K., Bulik, C., Silberg, J., Hettema, J., Myers, J., & Prescott, C. (2000). Childhood sexual abuse and adult psychiatric and substance use disorders in women: An epidemiological and cotwin control analysis. *Archives of General Psychiatry*, *57*, 953-959.
- Kilpatrick, D. G., Ruggiero, K. J., Acierno, R., Saunders, B. E., Resnick, H. S., & Best, C. L. (2003). Violence and risk of PTSD, major depression, substance abuse/dependence, and comorbidity: Results from the National Survey of Adolescents. *Journal of Consulting and Clinical Psychology*, *71*, 692-700.
- Kilpatrick, D. G., Saunders, B. E. and Smith, D. W. (2003). *Youth victimization: Prevalence and implications*. Washington, DC: U.S. Department of Justice, Office of Justice Programs, National Institute of Justice.
- Kinniburgh, K., Blaustein, M., Spinazzola, J. & van der Kolk, B. (2005). Attachment, self-regulation, and competency. *Psychiatric Annals*, 424-430.
- Kira, I. A. (2010). Etiology and treatment of post-cumulative traumatic stress disorders in different cultures, *Traumatology*, 1-14.
- Laviola, M. (1992). Effects of older brother-younger sister incest: A study of the dynamics of 17 cases. *Child Abuse and Neglect*, *16*, 409-421.
- Levine, P. (1992). *Waking the tiger*. Berkely, CA: North Atlantic Books.
- Madanes, C. (1990). *Sex, love, and violence: Strategies for transformation*. New York, NY: Norton.

- Mash, E., & Barkley, R. A. (2007). *Assessment of Childhood Disorders*, New York, NY: Guilford Press.
- Massat, C., & Lundy, M. (1998). "Reporting costs" to nonoffending parents in cases of intrafamilial child sexual abuse. *Child Welfare, 77*, 371-388.
- McLeer, S., Deblinger, E., Atkins, M., Foa, E., & Ralphe, D. (1988). Post-traumatic stress disorder in sexually abused children. *Journal of American Academy of Child Adolescent Psychiatry, 27*, 650-654.
- McLeer, S. V., Dixon, J. F., Henry, D., Ruggiero, K., Escovitz, K., Niedda, T., & Scholle, R. (1998). Psychopathology in non-clinically referred sexually abused children. *Journal of the American Academy of Child and Adolescent Psychiatry, 37*, 1326-1333.
- McVeigh, M. J. (2003). 'But she didn't say no': An exploration of sibling sexual abuse. *Australian Social Work, 52*, 116-126.
- Minuchin, S., Montalvo, B., Guerney, B., Rosman, B., & Schumer, F. (1967). *Families of the slums*. New York, NY: Basic Books.
- Minuchin, S. (1985). Families and individual development: Provocative from the field of family therapy. *Child Development, 56*, 289-302.
- Molner, B. V., Buka, S. L. & Kessler, R. C. (2001). Child sexual abuse and subsequent psychopathology: Results from the national comorbidity study. *American Journal of Public Health, 9*, 753-760.
- Monahan, K. (1997). Crocodile talk: Attributions of incestuously abused and nonabused sisters. *Child Abuse and Neglect, 21*, 19-34.

- Monahan, K. (2010). Themes of adult sibling sexual abuse survivors in later life: An initial exploration. *Clinical Social Work Journal*, 38, 361-369.
- National Task Force on Juvenile Sex Offending (1993). National Adolescent Perpetrator Network Revised Report. *Juvenile & Family Court Journal*, 44, 3-108.
- Nisbet, I. A., & Seidler, K. (2001). Characteristics of adolescent sex offenders in New South Wales. *The Australian Educational and Developmental Psychologist*, 18, 71-83.
- McNevin, E. (2010). Applied restorative justice as a complement to systemic family therapy: Theory and practice implications for families experiencing intra-familial adolescent sibling incest. *The Australian and New Zealand Journal of Family Therapy*, 31, 60-72.
- Noll, J. G., Shenk, C. E., & Putnam, K. T. (2009). Childhood sexual abuse and adolescent pregnancy: A meta-analytic update. *Journal of Pediatric Psychology*, 34, 366-378.
- O'Brien, M. (1991). Taking sibling incest seriously. In M. Q. Patton (Ed.), *Family sexual abuse* Newbury Park, CA: Sage Publications.
- Office of Juvenile Justice and Delinquency Prevention. (2009). Juveniles who commit sex offenses against minors. *Juvenile Justice Bulletin*, 1-11.
- Phillips-Green, M. J. (2002). Sibling Incest. *The Family Journal: Counseling and therapy for couples and families*, 10(2). 195-202.
- Prevent Child Abuse America (2007). Total Estimated Cost of Child Abuse and Neglect in the United States Retrieved from website:

http://www.preventchildabuse.org/about_us/media_releases/pcaa_pew_economic_impact_study_final.pdf

- Primeau, L. (2003). Reflections on self in qualitative research: Stories of family. *The American Journal of Occupational Therapy*, 57, 9-16.
- Putnam, F. W. (2003). Ten-year research update review: Child sexual abuse. *Journal of the American Academy of Child and Adolescent Psychiatry*, 42, 1-14.
- Ryan, G., Miyoshi, T. J., Metzner, J. L., Krugman, R. D., & Fryer, G. E. (1996). Trends in a national sample of sexually abusive youths. *Journal of the American Academy of Child and Adolescent Psychiatry*, 35, 17-25.
- Rudd, J. M., & Herzberger, S. D. (1999). Brother-sister incest-father-daughter incest: A comparison of characteristics and consequences. *Child Abuse & Neglect*, 23(9), 915-928.
- Saunders, B. E., Kilpatrick, D. G., Hanson, R. F., Resnick, H. S., & Walker, M. E. (1999). Prevalence, case characteristics, and long term psychological correlates of child rape among women: A national survey. *Child Maltreatment*, 4, 187-200.
- Schwartz, B. K., (2011) *Handbook of sex offender treatment*. Kingston, NJ: Civic Research Institute.
- Seidman, I. E. (1998). *Interviewing as qualitative research: A guide for researchers in education and the social sciences* (2nd ed.). New York, NY: Teachers College Press.
- Shaw, J. A., Lewis, J. E., Loeb, A., Rosado, J., & Rodriguez, R. A. (2000). Child on child sexual abuse: Psychological perspectives. *Child Abuse & Neglect*, 24, 1591-1600.

Smith, H., & Israel, E. (1987). Sibling incest: A study of the dynamics of 25 cases. *Child Abuse & Neglect, 11*, 101-108.

Snyder, H. N. (2000). *Sexual assault of young children as reported to law enforcement: Victim, incident, and offender characteristics*. National Center for Juvenile Justice, U.S. Department of Justice.

Terling, T. (1999). The efficacy of family reunification practices: Reentry rates and correlates of reentry for abused and neglected children reunited with their families. *Child Abuse & Neglect, 23*(12), 1359–1370.

Terr, L. (1999). Childhood trauma: An outline and overview. *American Journal of Orthopsychiatry, 148*, 10-20.

The National Children's Advocacy Center (2012). History. Retrieved from website:

<http://www.nationalcac.org/history/history.html>

United States Department of Health and Human Services Children's Bureau (2009). Child Maltreatment. Retrieved from website:

<http://www.acf.hhs.gov/programs/cb/pubs/cm09/cm09.pdf>

United States Department of Health and Human Services (2010). Family Preservation Policy Implications. Retrieved from website:

<http://www.childwelfare.gov/supporting/preservation/policy.cfm>

United States Department of Justice (1996). The extent and costs of crime victimization: A new look. Retrieved from website: <http://www.ncjrs.org/pdffiles/victcost.pdf>

- van der Kolk, B. A. (1987). *Psychological trauma*. Washington, DC: American Psychiatric Press.
- van der Kolk, B. A. (2005). Developmental trauma disorder: Towards a rational diagnosis for children with complex trauma histories. *Psychiatric Annals*, 35(5). 410-408.
- Venziano, C. (2000). The relationship between adolescent sex offender behaviors and victim characteristics with prior victimization. *Journal of Interpersonal Violence*, 15 (4), 363-375.
- Warsh, R., Maluccio, A. N., & Pine, B. A. (1994). *Teaching family reunification: A sourcebook*. Washington, DC: Child Welfare League of America.
- Welfare, A. (2008). How qualitative research can inform clinical interventions in families recovering from sibling sexual abuse. *Australian and New Zealand Journal of Family Therapy*, 29(3),139-143.
- Wiehle, V. R. (1990). *Sibling abuse: Hidden physical, emotional, and sexual trauma*. Lexington, MA: Lexington Books.
- Worling, J.R. & Curwen, T., (2000). Adolescent sexual offender recidivism: Success of specialized treatment and implications for risk prediction. *Child Abuse & Neglect*, 24(7), 965-982.
- Wulczyn, F. (2004). Family reunification. *The Future of Children*, 14(1), 95–113.