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ORIGINAL PAPER

Integrating Internal Family Systems and Solutions Focused Brief Therapy to Treat Survivors of Sexual Trauma

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Abstract

In a recent study 56% of women and 37% of men were survivors of childhood sexual abuse. These individuals who experience sexual trauma may experience depression, anxiety, post-traumatic stress disorder (PTSD) or substance use disorders (Devlin et al., in Fam J 27(4):359–365, 2019). While there are several treatment approaches specifically developed to target trauma and its effects, (e.g., trauma focused cognitive behavioral therapy, and eye movement desensitization and reprocessing) we propose that integrating internal family systems therapy (IFS) and solution focused brief therapy (SFBT) offers a brief, systemic way to improve family relationship patterns in families where one member has experienced sexual trauma. A case vignette is used to show the integration of these two approaches.

Keywords Internal family systems · Solutions focused brief therapy · Sexual trauma

Introduction

In 2012, the Centers for Disease Control, 2012 reported that one in five women, and one in 71 men experience rape in their lifetime. Further, in one year, 5.6% of women and 5.3% of men report experiencing sexual trauma other than rape. It is highly likely that many people will experience a traumatic event in their lifetime, regardless of gender, age, nationality, and socioeconomic status (Devlin et al., 2019; Kilpatrick et al., 2013). Sexual trauma is defined as a sexual act in which the victim is forced, coerced, or groomed to engage in sexual acts against their will (Koss et al., 2007). Sexual trauma is devastating for the individuals who experience it, as well their family members (Devlin et al., 2019). Individuals who experience sexual trauma may experience depression, anxiety, post-traumatic stress disorder (PTSD) or substance use disorders (Devlin et al., 2019) leaving family members concerned and confused about how to support their loved one. The family system is heavily impacted by the occurrence of sexual trauma. Specifically, intrafamilial child sexual abuse accounts for more than 50% of sexual abuse cases involving children, which is highly distressing for children and families to cope with the breach of trust of a family member or friend (National Child Traumatic Stress Network, 2009).

In a sample of 218 adults receiving sex therapy, 56% of women and 37% of men were survivors of childhood sexual abuse (Berthelot et al., 2014). Given the prevalence of sexual trauma, coupled with the resulting mental health and familial difficulty, it is highly likely that marriage and family therapists (MFTs) will treat a client who has experienced a sexual trauma at some point in their careers (Epstein & Baucom, 2002). While there are several treatment approaches specifically developed to target trauma and its effects, (e.g., trauma focused cognitive behavioral therapy, eye movement desensitization and reprocessing (EMDR)) we propose that integrating internal family systems therapy (IFS) and solution focused brief therapy (SFBT) offers a brief, systemic way to improve family relationship patterns in families where one member has experienced sexual trauma.

Background

Sexual Trauma and Sequelae

The severity of the effects of sexual trauma is often dependent on a variety of factors, such as the type of sexual trauma (e.g., forced penetration, rape, fondling, or unwanted touch)

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(Kessler et al., 2017; Watson & Halford, 2010), whether the survivor was physically forced (Roesler & McKenzie, 1994), age at which the trauma occurred (Schoedl et al., 2010), and the relationship to the perpetrator (Watson & Halford, 2010). Most often, perpetrators have a pre-existing relationship with the sexual trauma survivor (STS) (Schaeffer et al., 2011). This is especially true for perpetrators of sexual trauma on child victims (Cantón-Cortés &Cantón, 2010). Survivors of child sexual trauma in which the perpetrator is a family member or trusted adult often leads to increased difficulty making sense of how a previously perceived trustworthy relationship is no longer safe (Courtois, 1988). Along with confusion and distress, STS also often experience guilt and shame, at times blaming themselves for the traumatic experience (Courtois, 1988). The complexity sexual trauma, along with concern for their family members' reactions, also make it difficult for the STS to disclose their sexual trauma (Schaeffer et al., 2011; Schönbucher et al., 2012). These difficult aspects affect the severity of the outcomes experienced by the STS (Cantón-Cortés & Cantón, 2010). The impact of sexual trauma is complex and far reaching (Bonomi et al., 2007; Courtois, 1988; Subica, 2013). Not only is the STS impacted, but their relationships are also affected by the traumatic experiences (Huh et al., 2014; Noll et al., 2003; Staples et al., 2012). Outcomes of sexual trauma impact the individual's mental health (Bonomi et al., 2007; Kessler et al., 2017; Smith et al., 2016), physical health (Kelly et al., 2011; Stein & Barrett-Connor, 2000; Subica, 2013), and relational health that extends to romantic and familial relationships (Godbout et al., 2014).

Individual Impact

Mental Health

Individuals who have experienced sexual trauma often report accompanying adverse mental health outcomes including higher rates of depression and other mental health challenges (Bonomi et al., 2007). These effects intensify when the trauma occurred early in life. Specifically, experiencing sexual trauma before the age of twelve years leaves individuals at higher risk than any age group to develop depression (Schoedl et al., 2010). In conjunction with depression, STS are likely to develop and be diagnosed with posttraumatic stress disorder (PTSD) (Cantón-Cortés & Cantón, 2010; Kessler et al., 2017; Subica, 2013). When compared to other traumatic experiences, sexual trauma ranked in the top three of resulting in persistent PTSD symptoms (Kessler et al., 2017), possibly due to the interpersonal nature of sexual trauma (Smith et al., 2016). Symptoms of PTSD for women who have experienced sexual trauma are likely to manifest in the form of avoidance and hyperarousal symptoms (Cantón-Cortés & Cantón, 2010; Smith et al., 2016) whereas for men, symptoms are more likely to manifest as externalized behaviors of acting out in anger and rage, alcohol consumption, involvement in the criminal justice system, and emotional numbness (Sigurdardottir et al., 2014; Turchik, 2012).

Maladaptive Coping

Survivors of sexual trauma often seek therapy treatment to assist them in developing ways to manage the mental health challenges that arise from their experiences (i.e., depression and PTSD). When the family system of the STS is not functioning in a healthful way, the STS may be more likely to rely on maladaptive coping strategies. Due to increased rates of depression, individuals who have experienced sexual trauma, particularly in their youth, engage in more self-harming behaviors and suicidal ideation than their counterparts (Chaplo et al., 2015; Ng et al., 2018; O'Brien & Sher, 2013). They also report more suicide attempts than those who have not experienced sexual abuse (Ng et al., 2018). Suicide and self-harm may be ways that STS attempt to cope with difficult emotions, and further illustrate the importance of emotion-regulation skills in healing from sexual trauma (Chaplo et al., 2015). Additionally, some who experience sexual trauma use substances to cope, leading to possible development of substance use disorders (Ullman et al., 2013). These maladaptive coping methods often exacerbate the mental health issues that so often result from experiences of sexual trauma.

Physical Health

Sexual trauma may carry physical repercussions for those who experience it (Bonomi et al., 2007). Specifically, women who experience sexual trauma report higher rates of chronic pain and physical conditions (Kelly et al., 2011; Subica, 2013). Further, the experience of sexual trauma increases the likelihood of experiencing chronic health conditions (Stein & Barrett-Connor, 2000). Research has shown gender-specific effects associated with men and women who have experienced sexual trauma. Women report negative effects to their reproductive health, as well as chronic pelvic pain and painful menstrual cycles (Dossa et al., 2014; Golding, 1996; Norman et al., 2006; Subica, 2013). Men who have experienced sexual trauma often report physical injury (McLean, 2013) as well as chronic health issues, such as gastrointestinal issues, muscle pain, chronic heart problems, and diabetes (Sigurdardottir et al., 2014). Men's reproductive and sexual health are also impacted by sexual trauma. Male STS often report a greater number of sexual difficulties then those who have not experienced sexual trauma (Turchik, 2012).

Relational Effects of Sexual Trauma

Couple Relationships

The influence of sexual trauma on couple relationships is significant and distressing. Those who enter a romantic relationship post-trauma find that they interact with their partner from a protective mindset that keeps their partner at a distance (Staples et al., 2012). Further, STS report engaging in interpersonal behavior patterns such as overaccommodating, self-sacrificing, and domineering their partner (Huh et al., 2014). These responses create interactions with partners that inhibit emotional intimacy and increased relationship cohesion and closeness (Watson & Halford, 2010), increasing the likelihood that the survivor will experience continued relational distress (Noll et al., 2003; Schloredt & Heiman, 2003). The interpersonal struggles in couple relationships for those with experiences of sexual trauma are even more prevalent for situations in which the perpetrator was a close family member (Noll et al., 2003).

Researchers have identified gender-specific effects of sexual trauma on couple relationships. Specifically, female STS report increased difficulty forming and maintaining healthy interpersonal relationships (Huh et al., 2014; Noll et al., 2003). Male STS report similar difficulties in maintaining romantic relationships. However, the struggles experienced by men have been found to be more related to the emotional dysregulation that results from ST (Kia-Keating et al., 2010). Anger is a common outcome of ST and can inhibit the closeness and intimacy needed to have healthy romantic relationships. Other male STS feel the need to keep themselves emotionally protected, leading to a lack of availability to their partner (Kia-Keating et al., 2010).

In addition to relationship quality, trauma responses resulting from experiencing sexual trauma affect the sexual relationship between STS and their romantic partner (Haase et al., 2009; Schloredt & Heiman, 2003). Women with experiences of sexual trauma report having sexual desire, (Dossa et al., 2014; Rellini & Meston, 2007) more negative affect during sexual intercourse, (Meston et al., 2006; Schloredt & Heiman, 2003) more pain during sexual intercourse, (Golding, 1996) and more difficulties achieving sexual arousal (Rellini & Meston, 2007). STS may also avoid sexual encounters and sexuality as a means of coping with negative emotions, and trying to forget their victimization (Maltz, 2012; Staples et al., 2012). However, this process also negatively impacts their romantic relationships and negatively impacts the sexual relationship between partners (Staples et al., 2012). While these outcomes have been found for female STS, there is little to no literature that discusses male sexuality and romantic relationship functioning post-ST.

Despite the challenges that STS may experience, romantic relationships may also serve as a protective factor against the negative outcomes of sexual trauma (Whiffen et al., 1999). STS who perceived their romantic relationship was of high quality were less likely to experience persistent depressive symptoms (Whiffen et al., 1999). Romantic partners who are calm, patient, understanding, and accepting often allow the STS to experience a sense of security and safety in the relationship for both male and female STS (Fassler et al., 2005; Kia-Keating et al., 2010; MacIntosh et al., 2016). Partners that are sensitive to the needs and are supportive of the STS helps to decrease the sense of shame and guilt that often accompanies sexual trauma victimization (MacIntosh et al., 2016). The stability and safety that can come from a healthy romantic relationship may provide the STS with the space to process the trauma and begin to connect with their partner, which in turn helps decrease mental health symptoms as well as feelings of guilt and shame that may exist for the STS (MacIntosh et al., 2016).

Family Relationships

Families in which sexual trauma occurs are commonly a context for other forms of abuse and violence (Turner et al., 2012). For STS, relationships with parents may be further strained if the sexual trauma occurred in childhood and if the victim feels the parent did not protect them or take appropriate actions to stop the abuse from occurring. These experiences lead the STS to feel a sense of betrayal from their parents, especially if the perpetrator was a family member, friend, or even the parent themselves (Cantón-Cortés & Cantón, 2010; Edwards et al., 2012). In cases where the perpetrator was a parent or parent-figure, survivors often experience confusion as they attempt to make meaning of the trauma (Courtois, 1988). They often combat conflicting feelings of loyalty and devastation, thus further complicating the relationship with their parents and family members (Courtois, 1988; Edwards et al., 2012). These feelings can be exacerbated if there is lack of support upon disclosure of the trauma (Godbout et al., 2014).

The family of origin has the potential to not only exacerbate the sequelae of sexual trauma, but to be a powerful protective factor against further distress. Families that provide the victim with a sense of security, safety, empathy, and empowerment paired with positive experiences of touch and close relationships can lead to a decrease in the severity of symptoms that come post-trauma (Zoldbrod, 2015). Parents who are supportive upon disclosure of the sexual abuse can help mitigate insecure attachment in later life for their child (Godbout et al., 2014). Additionally, families that are more cohesive and expressive support the healing process (Fassler et al., 2005).

IFS and Trauma/Sexual Trauma

Internal Family Systems (IFS) therapy focuses on three levels of a client's well-being; the intrapsychic, family, and societal levels (Miller et al., 2007). Influenced by models of therapy that rely on systems theory, IFS focus beyond the external system that affects the client to examine the internal system. IFS combine two theoretical paradigms from the world of psychology and family therapy: systems theory and the multiplicity of the mind (Schwartz, 1995; Smith et al., 2019). With a focus on the internal structure and external structure, an IFS therapist can connect and understand clients at every systemic level (Smith et al., 2019) and free the oppressive beliefs that exacerbate the pain of sexual trauma (Wilkins, 2007).

IFS is recognized by the National Registry of Evidence-based Programs and Practices (NREPP) as an evidence-based treatment for various mental health disorders such as generalized anxiety disorder and depression. While IFS has been endorsed as an effective treatment for trauma (Schwartz et al., 2009; Twornbly & Schwartz, 2008), there have been no effectiveness studies (Lucero et al., 2018). When working with trauma, an IFS therapist's goals are to unburden the extreme parts to allow harmony, restore trust in Self-leadership, and relate from Self to the outside world (Schwartz et al., 2009, p. 361).

SFBT and Trauma/Sexual Trauma

Solution-focused brief therapy (SFBT) assumes that change occurs when clients can access resources and identify solutions to their problems (de Shazer, 1985). In SFBT, clients are viewed as the experts of their problems and subsequently the expert at identifying the best solutions (de Shazer, 1985). The therapist's role is to help clients access these solutions and integrate them into their daily lives (Tambling, 2012).

SFBT can be particularly effective for clients who have experienced trauma (Kim, 2008). The client-centered and strength-based assumptions of SFBT provide clients with unique opportunities for empowerment and healing. SFBT therapists believe that clients are the experts on potential solutions and can therefore choose the most effective ways to cope with and move past their trauma (Sharry et al., 2001). This type of ownership over their therapeutic process, particularly in the goal-setting stage, enables clients to reclaim a sense of control, an especially powerful and important moment for clients who have felt robbed of their sense of control due to trauma (Tambling, 2012). A common critique of SFBT as a treatment modality for sexual trauma is the model's brevity (O'Connell & Palmer, 2003). Critics have proposed that sexual trauma is most effectively treated in long-term therapy settings, arguing that brief models of therapy would not provide as comprehensive of care. Proponents of SFBT suggest, however, that long-term therapy is only effective for clients who find it helpful (O'Connell & Palmer, 2003). Therefore, SFBT would be the better option for clients who prefer short-term therapy as opposed to more long-term modalities, especially given the risk that clients may not seek services at all if opposed to long-term care (O'Connell & Palmer, 2003). Furthermore, when integrated with IFS, SFBT can be utilized as a more long-term modality. Given its strength-based, client-centered approach, SFBT can provide clients with a unique sense of agency and empowerment in their trauma recovery process. This agency and empowerment provide clients with an important framework of resilience when working through the more emotionally intensive aspects of IFS.

Integration IFS and SFBT for the Treatment of Sexual Trauma

IFS and SFBT each contribute unique theoretical aspects that enrich the integration of the two models in ST treatment. Therapists may find it helpful to conceptualize treatment through phases.

Beginning

When treating STS clients, it is important to build on their current strengths while prioritizing their immediate needs (Courtois & Ford, 2009). Clients attending therapy to process sexually traumatic experiences may not be in a position right away to process the traumatic experience, because they are unaware of the intensive nature of the ST treatment and then realize after assessment that it may not be the best time in their life to seek healing due to external circumstances that drain necessary resources for treatment. In this integrative model, the therapist might begin with a miracle question such as "If you were to go home tonight, wake up in the morning, and recognize that a miracle happened in the night that solved your problems, what would you notice throughout the day that would prove a miracle happened? As the therapist and client progress through the miracle scenario the therapist can listen for risk issues that may need to be addressed (such as, immediate danger, insufficient resources, etc. (Maslow, 1943)) first. If present, therapists should address these needs before moving into more intensive ST treatment to maximize effectiveness of therapy.

During the assessment process, the therapist is attuned to the clients use of language. Questions the therapist might ask themselves is, "Am I hearing any parts language, are there times when my client does not talk about the problem, are there moments that the client feels rather in control of their circumstances, can my client identify strengths in their lives, etc."

To answer these questions, therapists can utilize principles from SFBT and IFS to find the strengths of the clients and identify moments in their lives where they live contrary to their narrative. The therapist searches for exceptions to the concerns that bring the client into therapy, as well as integrating scaling questions to build a more complete picture of the client's life context. It is also important for the therapist during this beginning phase of therapy to identify how the different parts (i.e., managers, fighters, and exiles) are interacting with one another and the ST. This information can and will be used during the middle phase of treatment.

Middle

Provided that safety and immediate needs have been addressed, the client and therapist then discuss the necessity of processing prior sexually traumatic experiences. The therapist and client begin identifying the client's parts, exploring their roles, motivations, and patterns of interaction. Using techniques from IFS such as the room technique to first explore different parts of themselves can help them experience compassion, curiosity, or acceptance of those different parts (Schwartz et al., 2009). Through this process, therapists help clients validate and acknowledge each part, encouraging them to challenge any inclinations to silence, avoid, or dismiss their own experience (Green, 2008).

At this phase, the therapist takes a collaborative stance, allowing the client to progress at their own pace to minimize anxiety. When exploring these different parts, therapists can integrate SFBT language and questions to empower the client and emphasize strengths. Therapists might ask "How does this part of yourself respond to/view the sexual trauma you have experienced?" or "Have there been times in your life that you have been able to collaborate with this part of yourself and been able to stay in control when you relive a traumatic sexual experience?" These questions help to better understand the context of each part of the individual while maintaining a focus on the solutions and times that they have been able to maintain self-leadership.

Termination

In the termination phase of treatment, the focus shifts to maintaining self-leadership over the different parts of that individual as well as reflecting on the solutions and strengths that the client identified throughout treatment. The client and therapist revisit times during treatment that the client was able to live their preferred way of living (i.e., recognizing the exceptions) as well as times when the client experienced less anxiety when encountering a trigger. In IFS terms, this intervention assures the parts, specifically the managers and firefighters that it is safe for them to step back and allow the self to lead. During this phase of treatment, the therapist can use direct access in speaking with the different parts identified and discuss progress made and scale that progress from 1 to 10 to help them feel secure in allowing the self to lead. The therapist can also allow the different parts to further discuss their preferred realities and what miracles they would like to see and whether those align with the individual's self. The termination phase of treatment is a time for the client to solidify confidence in their ability to govern their different parts, shifting control more permanently to the balanced self. This enables clients to interact with their ST from a solution-focused and strength-based mindset as they move forward from therapy.

Case Vignette

The following is a case study used to demonstrate the integration of IFS and SFBT to treat STS. This case vignette is based on an actual clinical case, with some details changed to protect client confidentiality. Actual details are shared with the permission of the clients our vignette follows a couple where the female partner is an STS. Although ST impacts both men and women, the following case study focuses on a female victim in part, because literature shows that men are less likely to disclose their experiences of ST (Gagnier & Collin-Vézina, 2016), leading to less experiences treating male victims. This discrepancy is a gap in literature and treatment which needs to be addressed in future research and theoretical papers.

Background

Janet is a 39 year-old, Caucasian American, cisgender, female, an STS, she reports engaging in sexual relationships with multiple partners. Janet's partner, Steve is a 44 year-old Caucasian American, cisgender, male, diagnosed with diabetes who currently relies on government assistance for income. They have one son, David, who recently turned 20 years-old and has lived with many medical conditions his whole life. Janet made the initial phone call for therapy stating that "life is becoming too much to handle and I need help."

Early Phase of Treatment

In their first session Janet and Steve describe their concerns that Janet is engaging in extra marital sexual relationships without the knowledge of Steve. These sexual relationships have put tremendous strain on their relationship because Janet feels guilty for seeking out these relationships and Steve feels underappreciated and neglected. The therapist asks a miracle question to begin identifying potential solutions to their problems as well as attune to the language of

the client. Janet starts by saying she would not have nightmares about a previous relationship. As an adolescent and into her teenage years Janet was groomed and forced to perform sexual acts with an older man and his wife. Janet recalls that this went on for more than 5 years and when she tried to talk to her mother her mother did not believe her. In these nightmares she finds herself back in the man's home and then jumps to her own home where she pleads with her mother to believe her. Janet says that if those nightmares were to stop, she would wake up more relaxed and in control. The therapist takes note of the language Janet used, specifically, that Janet does not talk about a deficit, but rather an addition to her life if changes were made. Janet continues by saying that because she feels out of control, she seeks to gain control by finding sexual partners that allow her to control the sexual relationship. She states that with Steve's medical condition it is difficult for them to have a consistent sex schedule and so it is easier for her to find those outside the relationship. She mentions in the moment that there is a part of her that feels guilty, but that is overwhelmed by a part of her that is seeking stability and control. After the act that part that feels guilty surges forward and Janet leaves feeling "dirty and used." Steve agrees with Janet and adds that for him the main thing would be a sense of control. He expounds to say that he cannot control his wife's dreams, her mood, or the actions she makes and because of that he feels he cannot control any part of his life.

As the therapist gathers this information, they consider the clients' basic needs. The therapist asks an additional probing question, "What else would be different?" Steve and Janet in unison say, "Ends would meet." For Janet and Steve, they have been living paycheck to paycheck for many years and find themselves in significant debt due to their own medical conditions, and their son's. As part of treatment the therapist explores provides space for the couple to discuss their financial situation. The therapist encourages the couple to continue to identify solutions, and further explores each person's self-parts that become activated when thinking about their financial situation. Though the therapist conceptualizes the sexual trauma as the primary problem, in this model, it is important to hold space for topics that are of importance to the client.

Throughout treatment, Janet, and Steve mention that there are times they are living a life that is more congruent with the miracle scenario they described early in treatment. The therapist is exploring these moments by asking, "You have mentioned before that there are times where you do not seek out those sexual partners, and times Steve where you do feel more in control, what about those time made it easier for you to live the way you want to live?" Janet starts by saying that at times the guilty voice in her head is louder than the out-of-control voice. That guilty voice is loudest when she is living congruent to her beliefs. If she is not living according to the beliefs and morals that she has the out-of-control voice is much louder and more difficult to ignore. As the therapist continues to follow this path, they attend to strengths Janet exhibits and to build on those strengths. For example, "I heard you say that during one particularly stressful time that you didn't turn to your destructive behaviors. It must have taken a lot of strength to not give in, what did you do in that instance instead?" Another question that could be asked to help Janet step into a different frame of thought would be, "When would your partner, son, or friend say that you are in your most congruent state? What about these times makes them say something like this? In those moments what would you say you are doing differently that contributes to what others are seeing? This question illuminates the strengths that Janet has and further seeks for exceptions to the problem. It also allows room for other voices to enter therapy and for Janet to view her situation differently and making space for different explanations to the same situation.

Middle Phase of Treatment

At this point Janet has been able to identify several parts of herself, two firefighters that she calls "firefighter" and "self–sabatoger", a manager she has named "mamma bear", and several exiled parts that coordinate with time points in her life. For example, mid-20's Janet, teenage Janet, young Janet. As these parts are identified, the therapist might ask, "How would those around you describe these different parts? Would they add or take away anything? How do they know when these parts of yourself show themselves? These questions serve to expand Janet's frame of mind and give more depth to the different parts of herself.

As Janet continued to reflect on these different parts, she began to appreciate certain aspects of them such as the love that mamma bear can have for others and the protective nature of her firefighter and her self-sabotaging part. She also was able to identify areas that she wanted to change like her teenage and mid-20's self that sought out the destructive behaviors, because that is what they felt they deserved. Further reflection revealed that it was during this phase of her life that she was first groomed by an older man and introduced to harmful substances that initiated years of sexual abuse. The therapist took note of the word choice Janet used in saying that parts of herself felt that she deserved to live such a lifestyle. Here the therapist questioned that language and asked for times when Janet did not feel that she deserved to live in such a way. In addition to Janet's reports the therapist asked for the input of those who live around her and asked, "What would those around you say about you deserving the "negativity" that you talk about?" These questions helped Janet find exceptions to the reality that she created and gave her space to accept other explanations for what she was experiencing.

Together, the therapist and Janet decide it is time for Janet to interact with teenage and mid-20's Janet, separately. This will allow Janet to listen to their concerns and get to know them better and find value in their existence (Green, 2008). The therapist initiates this activity by saying, "Janet, I want you to image that you are looking into a room with teenage Janet sitting in a chair, what does she look like? When you are comfortable go ahead and open the door and step into the room with her. How does she react? How do you react to her? What sort of things is she saying? Is there anything that you would like to share with her?" These questions allow Janet to explore this part of herself in a curious way so that the other part of her does not become defensive and make it difficult to connect with. The therapist can continue to coach Janet and have her ask questions of her 20-something part such as, "When was the last time you felt in control? What do you do to feel in control? If the things concerning you were gone, what would you be doing instead?" These questions help you find the exceptions to Janet's story, but also help Janet begin to think in a way that is focused on solutions rather than on the problem. As she comes to a stopping point in the conversation with her younger selves, this is a good place to return to the present and process what happened. Invite Janet to think about what went well, what was unexpected, and what concerns her. The therapist can praise Janet for her ability to be in the room with those vulnerable parts of herself and not become defensive or dismissive of their concerns. This process continues for several session with both teenage and mid-20′s Janet providing Janet with valuable information about her past and how that past influences her today.

Termination Phase of Treatment

Scaling questions can be used throughout the treatment process to help Janet visualize the progress she has made. "On a scale from 0 to 10, 10 being exactly where you want to be, 0 being the most painful moments of your past, where do you see yourself right now?" Another question could be, "How would your son, friend, or roommate, rate you on this scale?" These questions continue to encourage Janet to think about the growth that she has experienced over the therapeutic process. As therapy moves to the final phase of treatment the focus should shift to self-leadership. Throughout the bulk of treatment in the interactions that Janet had with the different parts of herself you were teaching her, and she was teaching her parts that she has the capability to be in control, that she is no longer in danger, and that she wants to live differently than she has before. As the therapist begins to discuss termination, they become more and more interested in Janet's ability to keep her "self" in the center and in control. The therapist can ask questions like, "What was a time this week where you expected another part to take over, but your "self" was able to maintain control?" To further process this moment, "What was it like for that part of yourself to be asked to take a step back? Were they hurt? Did they feel heard?" Also, "in what ways would your friends and family say that you are in more control?" These questions allow for further dialog between Janet's parts in case there continue to be unsaid concerns. An indicator for appropriately timed termination is when Janet reports satisfaction with the amount of time she is in control of her situation. This will be evident by the report, but also by her ability to identify the solutions of the week and focus on the strengths that she possesses rather than the weaknesses.

Discussion

The case vignette presented illustrates the integration of IFS and SFBT for the treatment of sexual trauma. While this case example illustrates one possible course of therapy treatment, each client presents with unique concerns and unique needs. This vignette illustrated one way that IFS and SFBT can be integrated when working with an STS. A limitation of the case vignette presented is the lack of discussion of diversity. Clients present with diverse identities including their unique intersections of marginalization and privilege. When using a humanistic approach such as IFS, (Gehart, 2015) it is of the utmost importance for the therapist to clarify meaning and understand the meaning the client is using. Failing to do this could lead to incorrectly interpreting the client's experience and not providing the proper care. Similarly, allowing clients the space to be the expert in their lives requires the therapist to step into a client's culture and make sense of their preferred reality in a way that would be beneficial for the client. Both elements require a therapist to recognize the cultural differences between client and therapist and then doing all they can to minimize miscommunication.

Limitations and Directions for Future Research

Though the present conceptual paper makes a substantive contribution to the literature on systemic ways of treating sexual trauma in a systemic way, it is not without limitations. This is a conceptual paper that did not include empirical data. Future research should aim to obtain outcome data from client s of therapists who have utilized this approach to begin to establish its efficacy. Though IFS and SFBT have been empirically validated for certain presenting problems depression (Sundstrom, 1993), parenting concerns (Zimmerman et al., 1996), antisocial behaviors (Seagram, 1997). There has yet to be empirically driven research within a sexual trauma survivor population. Future research would benefit from testing the effectiveness of IFS and SFBT in treating sexual trauma, in addition to testing the proposed

integration. With empirical evidence therapist can progress knowing this procedure has been shown to work.

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Declarations

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