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Sibling child sexual abuse: Adult female sibling incest survivors, research and treatment

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Chapter One: Overview and Definitions

Sexual abuse in any form is the ultimate violation of a person's body and psyche since the self, sexuality, and identity are so remarkably intertwined and form the foundation of who we will be in life and how we will be able to experience its peaks and valleys. Sibling abuse is particularly insidious in that the sibling relationship is one that strongly contributes to how we connect with peers throughout our lifetime (Davis & Petretic-Jackson, 2000).

Sibling sexual abuse is not as benign as once believed to be and is actually a widespread and very serious traumatic experience (Phillips-Green, 2002; Worling, 1995; Cole, 1982), especially when the sibling perpetrator is 5 years older or more than the younger sibling (Cole, 1982). It is reported to be the most common form of sexual abuse but the least reported and least written about (Ascherman & Safier, 1990; Finkelhor, 1987; Patton, 1991). It is estimated to occur 3 to 5 times more often than father daughter incest (Smith & Israel 1987; Cole, 1982), but at the same time is minimized (Wiehe, 1990).

SSA typically involves older brothers abusing younger sisters. Pre-pubertal girls are victimized most frequently (Patton, 1991), with the average age of onset for younger sisters beginning around age eight (Cyr, Wright, McDuff, & Perron, 2002). Much less frequently, older brothers have been reported to abuse younger brothers or sometimes older sisters have been reported abusing younger brothers or sisters younger than themselves. This paper focuses on older brothers sexually abusing their younger sisters.

There are many different statistics out there regarding sibling sexual abuse (SSA) and child sexual abuse (CSA) and the two are almost always used within the same study. This can be

confusing but to discuss SSA without CSA is to ignore the larger context. That being said, it is estimated that 25% (Finklehor, 1980; Valentine & Feinauer, 1993), of the female population has had an experience of sexual abuse in their life time. Finklehor, Hotaling, Lewis, & Smith, (1990), found that in a random sample there were 27% of women and 17% of men who reported an experience of child sexual abuse as children. Continuing on, of that amount, it is estimated that 12%-13% or more can be attributed to sibling sexual abuse (Finklehor, 1980; Alpert, 1997). In a different study, Finkelhor (1979), reported that out of his survey of 796 college students, 39% of them reported that they were sibling incest victims, while only 4% reported that they were father-daughter incest victims. Finkelhor in that same study hypothesized that if he were to include non college students in his sample, then perhaps we could project that 40% of all women could have had some type of incestuous experience in their lifetimes by college. Haskins (2003, pg. 339), in a different study reported that “53 out of every 100” children per year are attacked by an older brother or older sister. Most often it is an older brother (ages 13-19), that is the perpetrator against a younger sister of ages 5-11 (Laviola, 1992; Phillips-Green, 2002).

In terms of definition researchers are still in disagreement on how to actually define SSA and how to distinguish it from developmentally appropriate young child sexual exploration. On the whole SSA is still not well represented in the literature compared to research on father/stepfather-daughter incest. One of the reasons for this is because of childhood developmental issues (Laviola, 1992; Cyr, 2002). Many researchers and parents have believed for a long time that SSA is benign and part of normal sibling sexual exploration.

Generally speaking SSA is defined as sexual interaction that occurs between dependent and developmentally immature children-adolescents that also involves elements of coercion, manipulation, and a power differential (Finkelhor, 1979; Gilbert, 1993; Canavan, Meyer, &

Higgs, 1992). What this means is that the victims are unable to fully comprehend and give consent. They usually do not refuse because they are coerced and frightened of retaliation from the older sibling perpetrator. They are afraid of being blamed for the abuse or of not being believed if they do disclose. The fear of being betrayed twice, once by their older brother and then again by their parents, is terrifying. The need to keep the abuse secret is overwhelming (Finkelhor, 1990).

Bank and Kahn (1982) suggest that there are two basic types of sibling incest: power aggression, threat oriented incest, and nurturing, erotic, love based incest. Power based seems to be the most prevalent type in SSA. Sexual activity in these dysfunctional threat based relationships may include behaviors such as: exhibitionism, fondling, voyeurism, oral-genital sex, attempted intercourse, intercourse with or without penetration, and exposing children to pornography, (Salter, 1988; Daie et al., 1989; Wiehe, 1990;1989; Bank & Kahn, 1982). It tends to be a family based phenomenon (Canavan, Meyer, & Higgs, 1992), in terms of how it begins. There are very complex family dynamics, including an absence of healthy boundaries which are needed to set the atmosphere for it to occur (Ascherman & Safier, 1990; Cyr,1992).

Once started, some researchers report that SSA is estimated to last an average of 22 months, or 1-4 years with 40% of the victims suffering effects strong enough to need therapy into adulthood (Daei, Wiltzum, & Eleff, 1989; Browne & Finkelhor, 1986). This abuse has also been reported to continue more than 4 years, sometimes until the older brother moves out of the house at age 18 (Laviola, 1992).

Disclosure by victims of SSA is very difficult because of the youth of the victim and the relationship of the perpetrator as a brother. According to Roesler & Wind (1994), approximately

64% of SSA victims don't disclose until adulthood. Unfortunately, delayed disclosure can bury a victim's childhood with a sense of permeating victimization that results in lifelong pain (Alaggia, 2005). Alternatively, early disclosure can stop the progression or formulation of a victim identity. Many positive outcomes can occur with early disclosure, provided it leads to treatment. Stress and other symptoms can be prevented or corrected. It can also create new opportunities for new insights (Alaggia, 2005). Unfortunately, disclosure can also lead to negative consequences such as the child victim being blamed, accused of lying, or fabricating the story. This then leads the child victim to experience a withdrawal of support and feel abandoned, as well as to experience a whole host of other symptoms resulting in poorer adjustment (Ullman, 2007). The lack of reporting by parents to authorities on the issue is believed to be caused by a variety of reasons including the belief in its' relative normalcy. It is also thought that many families don't want to report the abuse because it would disrupt the family homeostasis and because mothers often feel very protective of their sons, especially if they were themselves victims of paternal child abuse (Laviola, 1992).

SSA often results in the female victim feeling deeply betrayed by her older brother. If she has disclosed to her parents and received negative feedback from them as well, she will feel betrayed again. She often will feel a deep sense of loss of her emotional and psychological well being resulting in feelings of stigmatization, alienation, isolation, and an underlying sense of being "damaged goods" (Finkelhor & Browne, 1985). She will suffer in several crucial emotional areas including: the ability to trust, the loss of control over her bodily integrity, and her connection to her sexuality. Not surprisingly, she also frequently loses the innate capability for fulfilling intimate sexual relationships as an adult. Additionally, she potentially loses the

ability to form deep and meaningful significant relationships within and without the family unit (Finkelhor, 1990; Finkelhor & Browne, 1985; van der Kolk, 1996; (Alaggia,2005).

Chapter Two: Family Context and Characteristics of CSA Sibling Incest

The family environment in which SSA occurs has a variety of dynamics and characteristics which many researchers agree upon (Ascherman & Safier, 1990; Bass, Taylor, Knudson-Martin, & Huenergardt, 2006; Gilbert, 1993; Smith & Israel 1987; Johnston, 1998; Digiorgio-Miller,1998, Cole, 1982; Daie, 1989; Hardy, 2001; Boudewyn, 1995; Canavan, Meyer, & Higgs, 1992; Benedict & Zautra, 1993; Laviola, 1992; Shaw, Lewis, Loeb, Rosado & Rodriguez, 2000; and Canavan, 1992). These environmental characteristics form the foundation of the chaotic family structure and atmosphere in which abuse occurs. Most of these characteristics or dynamics fall into six main themes of study: enforced secrecy, power differentials, the influence on sexual development, dysfunctional family dynamics, relationship styles, and the individual aftereffects of the abuse such as: loss of memory, PTSD, poor choices in marriage, lack of marriage, alienation from the family, sexual dysfunction, confusion between intimacy and sexuality, substance abuse, and depression.

Dysfunctional family dynamics

Dysfunctional families typically have characteristics such as: isolated rigid systems that isolate the family from outsiders and concurrently, diffuse interpersonal boundaries within the family system. Independent thoughts, feelings or actions are seen as destructive to the family system or undifferentiated ego mass. Family members are expected to yield their autonomy in order to belong to the family. Blurred boundaries and blurred roles, or enmeshment is the norm in these families and violations of privacy are the norm. Permitting children and other family members to walk into the bathroom when others are bathing, regardless of age or gender, is seen

as normal. Intergenerational boundaries are not respected (Daie, Whitztum, & Eleff, 1989). This social isolation of the family and their discouragement to be active outside the home handicaps victims so that they are often rejected by other children. Children reject them because of their lack of healthy boundaries. When this happens, the victim withdraws in order to cope. This can also cause them to act out aggressively or to dissociate in some sense (Simon-Roper, 1996).

Dysfunctional families also tend to see anger, aggression, and violence as normal and fighting of siblings and other family members happens frequently. Discipline by verbal or physical abuse in the home is frequent (Laviola, 1992). In fact the SSA perpetrator often uses violence on the sibling victim to express anger and to feel powerful. This power differential and its' abuse is essential to SSA. In terms of parent behaviors and what children may model, one of the chief characteristics of incestual families is that the father is either abusive, detached, or absent. Mothers on the other hand are often dominant and use their sons as husband replacements while concurrently viewing sex as dirty or taboo; sexuality often has a double meaning in the family (Daie, Whitztum, & Eleff, 1989). Mothers who have themselves been sexually abused may often see their children as primary companions and depend on them for emotional support (Burkett, 1991). Unmet needs for nurturance or dependency are often common.

Another aspect or characteristic of dysfunctional families is that parental roles are often weak and “nonexecutive” which in turn can lead to role reversals with children (Wiehe, 1997). Parents are often overwhelmed with life and present a hostile or paranoid attitude to outsiders. Communication is also unusual in that there is a lack of open communication and an avoidance of conflict. Emotional expression is not encouraged and parents tend to view the outside world as hostile.

In addition to the above dynamics discussed, Finkelhor (1985), identified four preconditions which are necessary for SSA to happen in the family. First, the offender must be motivated to sexually abuse; Two, the offender must be able to overcome their internal inhibitions; Three, the offender must overcome external inhibitions (i.e., be alone in house with their younger sibling, babysitting their sister alone at night or after school, or being able to entrap their younger sister somehow); and Four, the offender must be able physically to overcome their younger sister/sibling (i.e., be bigger and/or older), by force, coercion, bribery, threats; or promises of trading affection for sex. The abuse often results in the victim/sibling trying to hide by withdrawing inside of themselves, disassociating from reality, physically hiding somewhere feigning sleep to hide/acquiesce, or screaming and yelling (Herman, 1992).

Chapter Three: Short and Long Term Effects of Abuse

Short Term

Although this paper focuses on adult female survivors of SSA, I want to mention just a few things about the immediate impact on the child victim. Within the first 4 months or so after the abuse, a number of serious effects result. The child may suffer from regression such as bedwetting, poor sleeping, or clinging behavior. He or she might also begin to show delinquency, self-injury, cruelty, aggression, hyperactivity, and somatic complaints. The victim has had their basic assumptions about the world shattered. Their belief in personal invulnerability and magic, perception of the world as meaningful, and self-image of competence and capability has been irreparably harmed (Hoagwood & Stewart, 1990). They may begin to develop emotional, social, and academic problems in school or alternatively they may develop a love of school as it serves as a safe place where they get kind attention.

Their attempt at coping is limited by the age at which they're at. DiPalma, (1994), has listed three coping strategies child victims may use: avoidance, problem solving, and seeking social support. For children, especially under age ten, avoidance is usually the only option. The latter two strategies work better with adults because of cognitive development and feelings of shame and fear at not being believed. Intervention at a younger age is important.

Long Term Effects

If SSA and CSA continues without intervention into adulthood the long term impacts are considerable and are often subsumed under the construct of relational trauma based PTSD. The literature on these effects is extensive (Alaggia, 2005; Herman, 1997; Davis & Petretic-Jackson, 2000; Wiehe, 1997; Jonzon & Lindblad, 2005; Canavan, 1992; Boudewyn, 1995; Carlson, 2006; Deyoung, 1981; Gipple, Lee & Puig, 2006; Davis & Petretic-Jackson, 2000; Phillips & Daniluk, 2004; van den Broucke; Finkelhor & Brown, 1985; Hoagwood, 1990; Kreklewetz, & Piotrowski, 1998; Whiffen, Foot, & Thompson, 2007; DiLillo, 2001; Alexander, Anderson, Brand, Schaeffer, Grelling, & Kretz, 1998; Bartholomew & Horowitz, 1991; Westerlund, 1992; Simon-Roper, 1996; Cicirelli, 1982; Caffaro, 2005; Phillips & Daniluk, 2004).

The themes that these effects can be organized into are: Traumatic loss and grief, betrayal/violation and abandonment, poor self-esteem and identity/self fragmentation, interpersonal relationships and trust, interrupted development, self destructiveness, re-victimization, locus of control, depression, self-blame/shame and guilt, boundary problems, sexual dysfunction, attachment dysfunction, somatic complaints, loneliness/social isolation and withdrawal, stigmatization, learned powerlessness and control needs, substance abuse/addiction and eating disorders.

Traumatic loss and grief

Alaggia, (2005), reports that most survivors must go through some sort of unexplained loss and sadness. After the abuse and later during their life the victim must complete a grieving or mourning process in order to heal. The sense of a lost “normal” childhood and all that comes with that (even though invisible), must be felt and mourned. This can be especially difficult because rituals for mourning a lost life do not exist (Herman, 1987).

Betrayal/violation and abandonment

Herman (1987), and many others believe that it is the betrayal and loss of basic family/kinship roles and the ensuing sense of abandonment that results in emotional devastation for the victim. The victim/survivor may feel anger towards the older sibling and a fear of entrapment may generalize to the rest of her life. She may even feel anger, betrayal and hostility towards her mother for not protecting her (Herman, 1987). Many survivors (38% reported), later in life emotionally cut themselves off from their older sibling permanently. Comparatively, only 3% of siblings reared in healthy families ever do emotional cutoff (Cicirelli, 1982; Caffaro, 2005). Weiner, (1990), reports that emotional cutoffs are connected to depression.

Stigmatization/poor self-esteem and identity/self fragmentation

Many survivors report feeling damaged after the abuse as well as years later as an adult. Phillips & Daniluk, (2004), report that SSA affects the developing sense of self and identity. Poor self esteem results with survivors searching chronically for esteem and identity (Deyoung, 1981). The sense of negative disempowerment from the abuse is linked with self image, so that the victim grows up feeling helpless and without a sense of agency. One of the ways in which this low self-esteem is maintained is also through social isolation and withdrawal which leads to loneliness which leads to the next category of interpersonal relationships.

Interpersonal relationships and trust

By far, interpersonal relationships, especially sexual ones, are massively affected by SSA. The shattering of trust is crucial. Russell (1986) reports that 47% of the female/brother sibling abuse survivors in his sample never married. Feinhauer, Callahan, & Hilton (1996), reports that victims are afraid to feel closeness because it reminds them of the original trauma and thereby retraumatizes them. These residual effects prevent healthy relationships as the adult relationships they try to form are over burdened with feelings and memories from the past. Gross betrayal of trust committed by family members contributes to lasting difficulties in interpersonal relationships (Finkelhor & Browne, 1985), as well as “rejected disclosures” also do (Jonzon & Lindblad, 2005). Variability in adjustment exists based on the original closeness within the family relationships (Ullman, 2007). Other possible effects on relationships include failure in social and workplace settings, dissatisfaction on life, social isolation, and alienation from humanity. It is also interesting that female SSA victims show more dysfunction from sibling abuse with their brothers than CSA do from their fathers (Westerlund, 1992)

Interrupted development

It is the interference with development that provides some of the most powerful effects on the victim/survivor of SSA. Since SSA typically lasts for many years it impacts 2-3 developmental periods of a child’s life when the schema/template for how to perceive life is being set up (Phillips-Green, 2002). Developmentally delayed, or emotionally stunted, the victim develops identity issues. These are well established in the field of trauma research (Phillips & Daniluk, 2004). Sexual abuse effects a child’s developing sense of self. The energy usually used for development is instead used for survival and coping with the abuse (Canavan, 1992). The victim develops a maladapted template for understanding and forming relationships which

involve guilt, secrecy, revictimization, and powerlessness. The victims' sense of self gets distorted so that love, pain, pleasure, and fear have been linked in ways that prevent her from making sense of emotions or developing trust in herself. I personally suspect that a large piece of this entrenched phenomenon is due to learned emotional responses that are hidden in the brain's limbic system.

Self destructiveness

Victims of SSA tend toward self-destructive behavior such as failure at self-care, risk taking behavior, accident proneness, self defeating behaviors, and re-victimization. Survivors have a tendency to repeat the victim role in other relationships. This repetition is almost a compulsion in the continuous search for the ideal relationship that will be redeeming (Finkelhor & Browne, 1985). Related to this, Thomas & Hall, (2008), report that 1st marriages for SSA survivors which are intended for escape from the abuser, often end up in divorce at a rate of 68%.

Locus of control & depression, anger/hostility

Jack & Dill, (1992) report that CSA often leads to an externalized locus of control which undermines self-esteem leading to resentment and the silencing of anger. This in turn leads to a divided self where the victim/survivor secures relationships by putting the needs of others first (Whiffen, Foot, & Thompson, 2007). Over time such self-silencing and feeling outside of oneself can lead to depression.

Depression is endemic to CSA and SSA. In addition to that, Feinauer (1989), reports that women with the highest rates of depression are those with physical contact during the sex abuse. It is thought that depression is linked with other effects such as suicidal ideation, lack of spontaneity, passivity, emotional numbness, self silencing of anger, hiding conflict, being

compliant, and putting the needs of others before the self (Whiffen, Foot, & Thompson, 2007; Herman, 1997). These are all behaviors learned by SSA victims within the complex dynamics within their families of origin.

Self-blame/shame and guilt

SSA victims are typically overly sensitive to the comments of others since they have often experienced ridicule by their brother perpetrators or families. They learn to be always over concerned about what others think about them as well as what others are feeling (Wiehe, 1997). They blame themselves for the abuse which leads to social isolation. Ironically, they blame themselves as a way to have a sense of psychic control which helps them survive but later works against them (Hoagwood & Stewart, 1990). As young children this egocentric stage of childhood limits perception and interpretation of reality so that the young victims blame themselves rather than allow in the reality that life is capricious and that they are vulnerable.

Boundary problems

Perhaps one of the most central components of understanding SSA would be boundary issues. The diffuse boundaries and violations learned in victim's dysfunctional families lead to boundary violations later as an adult. Survivors tend to confuse the boundaries that delineate affection, sex, and abuse just as they experienced in childhood; that is the template they learned. They have a tendency to sexualize relationships that are not sexual. This is called "Traumatic Sexualization" and refers to the process of shaping a child's sexuality in developmentally inappropriate and interpersonally dysfunctional ways (Finkelhor, 1990). As adult parents these survivors often are more "self focused" as they experience fear at being consumed or violated by another person whether that be a friend or sexual partner (DiLillo, 2001). Kreklewetz, &

Piotrowski, (1998) have observed that because of this boundary concern, many SSA survivors are often over vigilant with their own daughters being left alone with their brothers.

Sexual dysfunction

Issues concerning sexuality and relationships for CSA and SSA survivors are well studied. Post assault sexual dysfunction is common. Becker, Skinner, Abel, & Cichon, (1986), and Davis & Petretic-Jackson (2000), identify the driving forces behind sexual dysfunction as alienation, mistrust, powerlessness, betrayal, low self-esteem, preoccupation w/safety in relationships, a tendency to conceal feelings, a longing for dependency, difficulty with self-protection, and a confusion regarding limits and boundaries.

Almost all survivors have problems with relationships with the opposite sex. They link intimacy with the vulnerability that they will be hurt again and feel humiliated. One of the results from this is that they frequently display promiscuity or aversion to sexual relationships; they tend to see sex as a commodity to give to someone in order to get love and affection (Laviola, 1992; Jehu, 1988; Wiehs, 1990). Sex is linked with coercion, sadness, fear, shame, self loathing, and exploitation (Butenheim-Levendosky, 1994; Jehu, 1988). Survivors also tend to prefer emotional distance, and report their marital satisfaction lower (Whisman, 2006; Whiffen and Oliver, 2004; Dennerstein, Guthrie, & Alford, 2004). It is reported that 58% of sexually abused women are dissatisfied with sex. Women experience intensely ambivalent feelings with an intimate partner such as mistrust, disillusionment, and devaluation (DiLillo, 2001). Part of the rationale for this constellation of effects is that sexual contact is associated in the child's mind with fear, revulsion, boundary violation, and powerlessness. These effects contaminate their future adult sexual experiences (Finkelhor & Brown, 1985). The reason for this is because all of the above

negative effects are also linked with intimacy and sexuality, closeness, interdependence, and self-disclosure at the same time (Perlman & Fehr, 1987).

Survivors tend to pick partners that are less well adjusted, overly dependent, insecure, immature, exploitative, have high control needs, and provide low care (Jehu, 1988; Mullen et al., 1994). DiLillo, (2001), reports that the major impact of CSA is on the quality of the relationship w/partner. Bittenheim & Levendosky (1994), say that sexual activity tends to be viewed not as “coming together with a cherished other” but as an opportunity for coercion, exploitation, and shame.

Another area that is studied related to CSA and SSA is that of sexual dysfunction and its sub-themes such as: desire, arousal inhibition/anxiety, lack of pleasure, orgasmic difficulty, lubrication difficulty, and pain. According to Rosen, Taylor, Leiblum & Bachmann (1993) for survivor women percentages tend to be 38.1% inhibition/anxiety, 16.3% lack of pleasure, 15.4% orgasmic difficulty, 13.6% lubrication difficulty, and 11.3% pain. Sexually abused women have arousal problems with 56% of women reporting low sex desire, passive/active avoidance of sexual intimacy, emotional detachment, and flashbacks with adverse feeling states (Becker, 1986; Dennerstein, Guthrie, & Alford, 2004). Many women also report feeling a lot of anxiety so they avoid sex. Kaplan cited in Beck (1995), also reports that women who feel anger and fear suppress or block sexual desire since having desire meant that they wanted the incest.

Arousal dysfunction may also be associated with lack of control and disassociation (Jehu, 1988; Briere, 1992). Many survivor women (Westerlund, 1992), can be physically aroused but not emotionally. Other sexual dysfunctions arising from SSA include phobias, vaginismus, dyspareunia, and orgasmic dysfunction (Daie, 1989). Disassociation can also lead to dysfunction in that it provides a barrier between the victim/survivors sense of self and the full impact of the

abuse. It provides a false sense of control beginning as a conscious effort to block out the pain of the abuse but through repetition becomes an unconscious and automatic response to any stimuli that are associated with abuse (Collins & French, 1998; Haskins, 2003).

Attachment dysfunction

According to Alexander, Anderson, Brand, Schaeffer, Grelling, & Kretz (1998), and Bartholomew & Horowitz, (1991), incest survivors are linked to insecure attachment and fearful avoidant attachment and are less likely to be in a committed relationship and more likely to be in a relationship that reinforces negative views of themselves. The study showed a larger amount of incest survivors having insecure attachment which means it is very important in trying to understand SSA survivors not to take the subject out of the context of their family.

Chapter Four: Theory and models and Child sexual Abuse

There are a variety of models or theories that can be used to help us understand how SSA and child sexual abuse (CSA), in general impacts the mental health of victims. Many of these seem to all focus on the interpersonal relationship aspect of CSA in terms of how the victim learns to cope with life, relate to others, and feel about themselves. In the simplest perspective, CSA and the later problems that surface in relationships can be viewed from a classical conditioning perspective. CSA, or SSA is the unconditioned stimulus that becomes conditioned to evoke a negative response such as the fear, revulsion, powerlessness, anger, shame, and anxiety learned in the abuse that then generalizes to other situations involving sex and intimacy.

Victim-Response Cycle

Simon-Roper (1996), present another model called the victim-response cycle which allows us to understand and treat child sexual abuse (CSA). The basic idea is that the relationship

that the victim has with the perpetrator becomes a model that informs other adult relationships in the future. This model becomes a “blueprint” for the victim’s survival or functioning to be used in their life. The victim expects their future relationships to include aspects of their original trauma as well as their attachment style and coping response style. This learned relational framework (Bass, Taylor, & Huenergardt, 2006; Sheinberg & Fraenkel, 2001), learned through the trauma of incest disrupts the young victim’s developmental sense of trustworthiness, openness, loyalty, etc.

As an adult according to Simon-Roper, (1996), there is a “trigger” event either internal or external to the victim which activates the cycle learned early in life, so to speak. This trigger is often in the form of a future/current abusive relationship. Friedrich, (1990), suggests that patterns of behavior learned in a traumatic relationship early in life often generalize to other relationships in the future whether they’re traumatic or not. This activation is fueled by the victim’s low self-esteem and other abuse effects such as shame and guilt for the abuse. Many CSA victims fail to develop an integrated sense of self due to their abuse. They are exposed to many confusing messages about themselves, messages which can include role confusion, diffuse boundaries, guilt and shame for the abuse, and lack of concern for their needs yet overprotection at the same time. These mixed messages disrupt the child victim’s mastery of developmental tasks and creates a painful conflicted self-view. They try to compartmentalize these memories and messages in order to function and to decrease pain. Social withdrawal is common which encourages particular coping behaviors which feed into anticipation of certain perpetrator behaviors that come just before the abuse. This then cycles into more post abuse more guilt and shame, then efforts to alleviate the guilt, leading back into the victim’s fragmented view of themselves, boundary confusion, etc. (Simon-Roper, 1996). What makes this victim-response

cycle so insidious and difficult to alter is that a trigger can occur at any point on the cycle. A trigger can be sex by itself, or feelings of guilt or shame in general for anything, or an encounter of certain behaviors with someone that the perpetrator used to perform prior to abuse (these could be anything), or an experience of rejection by someone, boundary confusion, or social withdrawal, or a re-experience of low self-esteem from a new situation not involving sexual abuse.

Attachment Theory

Attachment is central to how individuals understand life and connect in intimate relationships with others; the attachment dynamic is believed to continue influencing a victim's self-esteem for life (Bowlby, 1988). It interacts with context and CSA to form sibling relationships which in turn informs the development of empathy, and identity (White, 2001; Bass, Taylor, & Huenergardt, 2006). In fact, attachment style (secure), is one of the suggested modifiers of CSA which allow a victim to develop a secure sense of self and identity that contribute to the victim being less susceptible to the shame and other effects of abuse (Simon-Rope, 1996). Bowlby (1988), indicates that there are three basic attachment styles: secure attachment, anxious/resistant attachment, and anxious avoidant. The first represents a style where the child is confident that his or her needs will be met. The second represents a style where the child is uncertain of the caregiver's responsiveness/availability. The third represents a style where the child expects rejection and does not expect their needs to be met. From these attachment styles, a child develops an "internal working model" of him or herself as deserving or undeserving of attention, trustworthy or responsive, etc. (Bowlby, 1988). Children that are raised in abusive homes tend to have the second and third type of attachment styles. The reason for this is that secure attachment cannot develop without being allowed to communicate openly with

caregivers about one's feelings (Bowlby, 1988). Incestuous families do not encourage open communication but rather secrecy. This combination according to Alexander et al. (1998), results in CSA victims with insecure attachment styles (especially fearful avoidant), being less likely to be in a committed relationship, more likely to experience depression, self-defeating behaviors, dismissing behaviors, and less likely to acknowledge distress.

Family Systems Theory

Understanding family context is crucial to understanding CSA and SSA (Bank & Kahn, 1982). Context makes a major difference in why one person will seem to show more resiliency in life over another. Family Systems theory is ideal for understanding context and the complex, interdependent network in CSA and SSA (Haskins, 2003). Patterns of behavior, coercive control, boundaries, triangulations, low cohesiveness, and parental unavailability are all aspects of SSA and family systems theory (Alexander & Warner, 2005). There are an infinite number of trajectories that a victim's life can take depending on context and many other variables. The challenge of theory and research is to find some kind of common ground or rules that are predicting of a victim's long term life trajectory (Thomas & Hall, 2008). Mayer, (1994), indicates that incestuous families are often enmeshed, secretive, and socially isolated; incest is actually a symptom of family dysfunction. Haskins (2003, pg. 341), reports that "individuals in families that physically and sexually abuse tend to have low self esteem, high impulsivity, low frustration tolerance, an inability to identify or meet needs, a lack of problem solving skills, affective and expressive problems, communication deficits, feelings of helplessness and futility, frequent and unresolved losses, and isolation." One of the factors crucial to understanding SSA within the context of families as well as interpersonal relationships is the concept of betrayal (Freyd, DePrince, & Gleaves, 2007).

Another possibility based on psychoanalytic thought and Erickson's stages of development might be that CSA and SSA prevents or interferes with fundamental drives within the child and the developmental periods they move through such as security/safety/trust/mistrust, autonomy/freedom, identity/role confusion, and intimacy/isolation, etc. These stages or perhaps drives are thwarted, or permanently altered by the sexual abuse. The visual image comes to mind of ancient Chinese women who at a very young age had their feet bound so that they would not grow normally. The result seen in photos being a deformed foot that had grown back in on itself curled under. The drive in this case to "grow" continued but in a much altered direction. Perhaps the analogous psychological image here is that of the "self" and it's "drive to develop and grow." Perhaps CSA combined with insecure attachment permanently shatters or divides the self into pieces.

Chapter Five: Recovery: Surviving vs. Thriving

An important aspect of SSA to be aware of is that there are many individual differences. How do some women create narratives that somehow redefine and interpret their adversity and misfortune in a constructive manner with a positive meaning to life (Valentine & Feinauer, 1993)? Is the ability to thrive after trauma innate or taught (Walsh, 2007)? What are the modifiers of SSA effects that encourage resiliency (Valentine & Feinauer, 1993; Thomas and Hall, 2008)?

SSA Effects Modifiers

The first modifier suggested is courage, resolute determinism/ and the ability to deliberately embrace turning points in life surrounding role changes thereby creating growth as opposed to depression and the sense that everything is ruined (McAdams & Bowman, 2001).

Another modifier that can lead to thriving is the ability to find supportive relationships outside the family through school, church, clubs, etc. this allows the survivor to surround themselves with people who believe in them (Valentine & Feinauer, 1993). The ability to set limits on intrusive and exploitative family members (Thomas & Hall, 2008), is also a related modifier.

Self strengthening measures such as using metaphors of strength in describing oneself can serve as a modifier, as well as being able to externalize attributions for blame. This prevents shame/blame of oneself for the abuse. Victims who are able to externalize blame are reported to have higher self concepts and less depression (Hoagwood, 1990). Self-regard or the ability to think well of oneself (Valentine & Feinauer, 1993), and religion or spirituality or recognizing a personal power can also modify the effects of SSA.

Most important though could be the ability to feel an inner sense of self in spite of hardship and the ability to seize critical turning points/opportunities for change in life as opposed to rejecting them in favor of the security for staying the same. Key to this ability is an inner locus of control and the ability to recognize a personal sense of power/efficacy which gives a person the ability to reframe their reality. How a person interprets or narrates their experience is very important (Valentine & Feinhauer, 1993). Children who have suffered abuse are more likely to have an externalized locus of control than an internal locus of control (Simmons & Weiman, 1991); low locus of control is linked strongly with low positive coping skills and coerced victimization experiences (Walsh, 2007).

Two last adult modifiers in particular are a good marriage and generativity, or the ability to parent well, establish a stable career, and help other victims (Feinauer, Callahan, & Hilton, 1996).

Trajectories

Thompson & Hall, (2008) discuss three patterns of life trajectories that SSA victim/survivors typically follow: A steady upward progression in life toward wholeness; a lengthy roller coaster pattern (crisis to crisis), until assuming upward pattern; or a struggling pattern with stagnation or a downward pattern (depression, unresolved issues with family, lack of supportive intimate relationship, serious after affects of abuse, being stuck in the past). What seems to be essential to eventual healing and positive upward movement is being able to embrace thematic narratives of redemption and liberation. This can happen by therapy, by god, by a loving relationship with another, or in some cases, self redemption. A survivor needs to resolve the fundamental questions of: to tell or not tell; to remember or not remember; to forgive or not to forgive. Successfully navigating these questions can change the trajectory of the survivor's life from surviving to thriving (Thompson & Hall, 2008).

Chapter Six: Treatment and Interventions

Recovery stages

Phillips & Daniluk (2004) suggest that recovery or healing happens when the client is able to replace their victim identity with a survivor identity, and then a post survivor identity. They suggest that this happens by disengaging the client's identity with their experience of the incest. They then help the client shift their worldview from the world being a dangerous place to a place of possibilities and safety. They turn regret and loss of what could have been into resiliency and growth and replace the client's false self which feels primarily shame and loathing, with their true self. They do this by expanding the boundaries of the self to give space to the disowned parts of the self that they somehow walled off years ago.

Simon-Roper, (1996) suggest that the therapist and client work through the victim response cycle. This allows the therapist to focus on attachment and the fragmented sense of self rather than just the symptom of low self esteem. They explore the client's feelings of responsibility for the abuse, their sense of shame, their need for predictability, and their feelings of being used by people.

Sgroi (1989) uses four stages of healing therapy: acknowledging the reality of the abuse; overcoming secondary responses to the abuse; forgiving oneself (ending self-blame and punishment); adopting positive coping behaviors; and relinquishing the survivor identity.

Bass & Davis, (1987) discuss how in the early stages of recovery the victim's sexual abuse experience often dominates their life; the world is seen through the lens of a victimized child. As a woman begins to externalize the experience of the abuse and disown her responsibility for what was done to her, she starts to admit to the personal strengths that were required of her child self in coping and surviving the trauma. At that point a very significant shift occurs in her identity which moves her from a victim identity to an agentic identity. She may go on for months or years as she works through the multiple layers of pain, grief and loss trying to find her true self and place in the world. As she leaves the stigma of the abuse behind she encounters an increasing sense of visibility, congruence and connection, or an emerging sense of self definition and self acceptance. She shifts her worldview, experiences a sense of regret over what has been lost, and then a sense of resiliency and growth.

Emotionally Focused Therapy (EFT)

EFT is ideal for SSA treatment. It focuses on emotions of shame, disgust, fear, anger, and helplessness. It is an attempt to integrate structural family therapy and experiential psychotherapy. It is anchored in attachment theory (Simon, 2004) and looks at human behavior

as being driven from the inside out (Elliott, Watson, Goldman, & Greenberg, 2003). It sees human interactional behavior as biologically driven to attachment. The idea is that how we attach ourselves is influenced by cognitive affective schema which includes our belief about our self-lovability and the availability of significant others (Bartholomew & Horowitz, 1991). Low self-esteem is seen as being at the core of our fear of revealing our self to others. Relationships are seen as valuable for what they can provide our self (i.e., a safe haven and base for exploration of the world) (Pistole & Arricale, 2003).

Existential Psychotherapy

Existential Psychotherapy (Fisher, 2005) is perhaps ideal for treating and understanding CSA and SSA. The theory is focused on “being” in the world. It looks at three critical elements in a relationship: trust and betrayal, protective internal structures, and dissociative patterns. The theory and therapy emphasizes presence, authenticity, and awareness; therapists use tools like awaring, focusing, bracketing, and tagging. Part of what makes it powerful for survivors is that it focuses them on their sense of shame. Survivors find it very hard to access the vulnerability necessary to actualize their lives in the present, because they were trapped in a childhood fog of terror and secrecy as children. Existential therapists believe that healing comes from the journey into a client’s subjective experience; by journeying into the client’s true self. By engaging in intimacy with the therapist, old fears can surface and can be dealt with in the present. Because trauma attacks a child’s sense of security, the child growing up in a home with sexual abuse has had the world turned inside out before they were able to develop self-reliance. In a sense, what was true became hidden and a lie became a reality when they were a child. This effectively served to split the self and it is that which must be healed. The intuitive self has been “subjugated and has had to navigate life without an internal compass.” This resulted in a loss of internal

locus of control and the self became a shadow. This means that as the child withdrew from herself and her sense of the world, she accepted the family myth and therefore could no longer trust herself. This disconnect results in chronic unbearable anxiety and a double self (Fischer, 2005).

Three adaptive techniques help the survivor to reach adulthood: the elaboration of dissociative defenses, development of a fragmented identity (walls off painful feelings), and a pathological regulation of emotional states (Herman, 1992). Eventually the façade breaks down and the fragmented self becomes conscious and the fear and anxiety surface. This then opens the therapeutic process by stimulating projective identification, identity issues, nightmares, heightened startle responses, flashbacks, etc.

Family Systems

A family systems approach to treatment (Haskins, 2003), focuses on relationships and the interdependent network within the family of origin. Intimacy is a core focus since when intimacy fails in a family, violence typically replaces it. Sibling abuse is seen as a manifestation of family dysfunction (Mayer, 94). Often the perception in the family is that “everyone hurts,” no one cares, and no one listens. Everyone in the family suffers in a different way. Older siblings become parentified, and triangulation, scapegoating and emotional deprivation occurs with parents often needing support from their children (Haskins, 2003). Unfortunately by the time adult survivors frequently enter therapy for SSA, family therapy per se is no longer practical or often even possible. Systems theory can however be used as a model in which to explore the lessons learned from the family that are still motivating the client’s behavior. Whenever possible however, it is often helpful in detoxifying shame and fear to have the client confront their abuser.

Chapter Seven: Conclusion and Future Directions

Sibling sexual abuse is a complex and pervasive social problem which goes to the heart of family life. It not only impacts the victim and everyone else in the family, it also impacts society in the very real loss of potential through many victims' stunted development.

Several theories seem to overlap in their treatment of the issue that if integrated into a new theory might be able to provide the theory driven treatment that researchers like Davis & Petretic-Jackson (2000), would like to see. A unified theory would allow a theory based protocol of treatment not just an illness and symptoms protocol. This could in turn then provide us with a sense of predictability as well. For example we might try to find the common ground involved with attachment theory, family systems theory, stage and drive theory, identity and locus of control, existential theory, classical conditioning theory, and the victim response cycle. Theories are like different lenses that allow us to see different pieces of a problem; all of the pieces are real and have truth. The goal is to see them all, collect them, and then put the puzzle together. Questions we might ask and investigate include: How does attachment, the "self," and locus of control interact in its effect on resiliency in SSA survivors? Is this the determining factor in why some victims manage to thrive and some only "survive?" How does this connect with trust and betrayal and shame? How does the victim internalize betrayal? Does the victim interpret her inability to stop the abuse as a betrayal somehow of her "self?" Is that what causes the self to split or fragment leading to an external locus of control?

Beyond theory, there are several more concrete concerns that could be investigated such as addressing research itself and how it is done. How can we make the research of such a nebulous area more quantified and measurable? Knowing that disclosure is essential to healing, how can we change public policy to take the taboo and stigma out of the discussion of incest?

What kind of programs can we develop that make it easy and socially acceptable to discuss incest at any age, including and especially for children? These are questions that need answers.

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