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ORIGINAL ARTICLE

Treating Adult Survivors of Sibling Sexual Abuse: A Relational Strengths-Based Approach

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Abstract Sibling sexual abuse is a far more common manifestation of family violence than is often recognized. Researchers agree that it has received less attention than other forms of child abuse trauma despite the fact that good evidence suggests it is no less injurious than child sexual abuse when a parent or other adult is the perpetrator. This paper describes a relational, strengths-based approach to psychotherapy with adult survivors of sibling sexual abuse guided by trauma-informed principles. Cultural considerations are discussed as well as an overview of the clinical research on sibling sexual abuse and its harmful effects. Clinical case material, treatment strategies and a case illustration demonstrate therapeutic principles of the approach in action.

Keywords Adult survivors · Sibling sexual abuse · Relational, strengths-based approach

Sibling sexual abuse may be the most closely kept secret in the field of family violence. More than one in three cases of sexual assault against children in the United States are committed by other minors (Finkelhor et al. 2009). Siblings often are the offenders. The most recent data from a U.S. Department of Health and Human Services child maltreatment report for the year 2014 states that at least 2.3 % of children were sexually victimized by a sibling. By comparison, during this same period 0.12 % were sexually abused by an adult family member. The present article builds on previous clinical and empirical research related to sibling sexual abuse (Caffaro 2014; Carlson et al. 2006; Cyr et al. 2002; Haskins 2003) and focuses on developing a relational, strengths-based approach for psychotherapeutic intervention with adult survivors.

Although accumulating research substantiates the high incidence of sibling sexual abuse (Cawson et al. 2000; Bentovim et al. 1991; Finkelhor 1980; J. Grant et al. 2009, Hardy 2001) and its harmful effects (Haskins 2003; Laviola 1992; Whelan 2003), society still tends to ignore or, at best, to minimize the consequences for children, families, and adult survivors (Caffaro and Conn-Caffaro 2005; Sheinberg and Fraenkel 2001). Sibling sexual abuse results from the convergence of individual, family, and ecological factors; causality is a result of interaction shaped by multiple factors on multiple levels. Clinical experience, empirical research, and self-report by adult survivors suggests that certain family characteristics may be associated with increased risk. For example, parental absence and lack of supervision, attachment difficulties, family sexual environment, differential treatment of siblings by parents or caregivers, rigid gender roles, secrecy, and sibling relationships characterized by power imbalances, coercion, and unclear boundaries have all been associated with sibling sexual abuse (Adler and Schutz 1995; Canavan et al. 1992; Tidefors et al. 2010; and Caffaro 2014). Yet, it is not clear exactly which family dynamics contribute most substantially.

Focusing exclusively on the characteristics of families where sibling sexual abuse occurs, however, risks shifting responsibility away from the sibling offender by suggesting that the abuse is entirely the result of dysfunctional family operations. Although the importance of familial characteristics must not be underestimated, such dynamics usually do not account completely for sibling sexual abuse. Obviously, sibling sexual abuse does not occur in every family with unavailable or ineffective parents. A thorough evaluation entails an

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analysis of the interplay between individual and systemic factors unique to each case (for an expanded discussion of risk and protective factors, see Caffaro 2014, pp. 47–86).

Sibling Sexual Abuse (SSA)

An array of sexual activities is covered by the term sibling sexual abuse including intercourse, attempted intercourse, oral–genital contact, fondling of genitals directly or through clothing, exhibitionism, exposing children to adult sexual activity or pornography, and the use of the child for prostitution or pornography. Adults sexually abused in childhood by a sibling are a heterogeneous group reporting many degrees of abuse, and about whom few generalizations hold. The victim's age and gender, the age and gender of the offending sibling, the nature of the relationship between victim and offender, and the number, frequency, and duration of the abuse experiences all appear to influence outcomes (Stroebel et al. 2013; Cyr et al. 2002; Courtois 2010; Caffaro 2014). The average age of (mostly female) victims at onset of sibling sexual abuse is nine years old (De Jong 1989; Laviola 1992; O'Brien 1991). Sibling offenders (predominantly brothers) are older with peak ages for offending between twelve and fourteen years old (Finkelhor et al. 2009). Age differences should not overshadow other important concerns such as the victim's and offender's gender, physical size and strength, intelligence, and developmental sophistication. Each of these characteristics may create situations of power and dominance between individuals of similar ages. There is often a developmental component to sibling sexual abuse activity. Much of it begins with normative exploration and eventually progresses to abuse with one sibling exerting power or influence over the other with a progression of sexual behaviors over time (Canavan et al. 1992; Carlson et al. 2006). The process by which the sibling offender attains and maintains victim compliance has significance in the subsequent treatment of adult survivors.

Comparatively little research focuses specifically on sibling sexual abuse. Empirical investigation is scarce; consisting of two major surveys (Finkelhor 1980; Wiehe and Herring 1991), several studies based on small (often clinical) samples (e.g., Caffaro and Conn-Caffaro 2005; Meiselman 1981; Russell 1986; Carlson et al. 2006), and reviews of agency or hospital records (Adler and Schutz 1995; De Jong 1989; Gilbert 1992; Laviola 1992; Meiselman 1981; and Pierce and Pierce 1990), and society's response remains tentative. It is crucial to recognize the wide range of family dynamics and traumatic affects that manifest in each case. The absence of a generational boundary and difficulty in establishing the presence of coercion pose added therapeutic challenges. Also, it may not be easy to establish victim and offender roles. Thus victims may tend to believe that they were active participants in the abuse and could have put a stop to it. Reported cases are still far less common than those of father–daughter incest because many parents who discover sibling sexual abuse are unlikely to deliver a son or daughter to the authorities. Embarrassment, shame, and denial, coupled with entrenched attitudes unfavorable to disclosure such as "We can't break up the family" may be some of the underlying reasons why sibling sexual abuse is reported less often (Caffaro 2014; Carlson et al. 2006; Cyr et al. 2002; Haskins 2003). Of cases that are reported and substantiated, only a small proportion are adjudicated (Adler and Schutz 1995; Ryan 2000; Worling 1995); most are left to the discretion of overburdened child protective services (McVeigh, 2003; Pierce and Pierce 1990). Consequently, advances in evaluating and treating adult survivors of sibling sexual abuse have been delayed.

The majority of boys sexually abused by siblings are victimized by older brothers (Friedrich et al. 1988). Boys and men are less likely to report being victims because of their embarrassment about seeking help and admitting that they have suffered abuse (Duncan 1999; Goodwin and Roscoe 1990). Confusion about the abusive experiences – that is, making sense of the mix of their own positive and negative emotional and physical reactions – may be the most traumatic element for male survivors. A positive physical response such as sexual arousal may encourage a male victim to feel complicit with the abuse and further cloud issues of responsibility and masculinity.

Sibling sexual abuse is also associated with depression, sexual dysfunction in adulthood, and increased risk for further abuse (Haskins 2003; Whelan 2003). The vast majority of abusive sexual contact between siblings includes a misuse of power (Laviola 1992; James and McKinnon 1990; Canavan et al. 1992). Adult survivors of sibling sexual abuse who assume responsibility for their own victimization suffer both short- and long-term consequences. For example, many report difficulties in developing and sustaining intimate relationships (Stroebel et al. 2013; Briere 2002; Courtois 2010; Finkelhor et al. 1989). Indeed, adult survivors frequently find it difficult to trust important individuals in their lives. And, sibling sexual abuse may leave lasting interpersonal effects on the sibling relationship. A significant proportion of adult survivors in several studies (Rudd and Herzberger 1999; Caffaro and Conn-Caffaro 2005; Stroebel et al. 2013) had little or no contact with sibling offenders.

Empirical evidence also suggests that harm can occur to male survivors even when a brother believes that he was participating in the sexual abuse voluntarily (O'Keefe et al. 2014; Caffaro 2014). As one example, an individual entered psychotherapy for help in dealing with the harmful effects of having sexual relations with his older sister. She initiated the sexual abuse when he was only eight years old and it represented much of the physical contact with anyone that he remembered from childhood. Although he experienced conflict about it as he matured, they maintained a sexualized sibling relationship

well into adulthood. When the incest began, she taunted my client repeatedly by promising sexual contact only if he begged for it or granted her some favor. Thus he developed a humiliating, low-powered role with his sister. As an adult, however, he achieved an extraordinarily high-powered role in relation to his peers: He became a high-ranking officer in the American Armed Forces and commanded respect and authority wherever he travelled. This did not translate, however, into satisfying adult relationships. He complained bitterly of lifelong difficulties in developing peer relationships; those that existed were primarily hierarchical, and he was always in charge. His marriage was more complex. It contained remnants of the earlier sibling-related powerlessness; he felt that he was controlled and dominated by his wife, and he needed to be in charge. He achieved control by having numerous clandestine affairs throughout their thirty-five year martial union.

Contextual Considerations

Significant contextual concerns also may contribute to sibling sexual abuse. Improved clinical outcomes with a significant number of adult survivors can be achieved by tailoring trauma-informed treatment to a client's symptom constellation, development, context, and background rather than adhering to a single psychotherapeutic approach. Cultural differences between a family's experience of, and response to sibling sexual abuse must also be adequately addressed in designing a collaborative treatment plan (Rapoza et al. 2010). The impact of sibling sexual abuse on an adult survivor's relational script may endure long after the abuse has ended. Different cultural expectations also influence the development of relationships between an adult survivor of sibling sexual abuse and family members. Such abuse often remains unacknowledged by family members. Understanding and recognizing these differences is an essential component of intervention. In effectively addressing the distinctive needs of adult survivors, it is critical to recognize that sibling sexual abuse survivors are not a homogeneous group even within gender, racial, and ethnic classifications. And there is increasing evidence (Grant et al. 2008; Righthand and Welch 2001; Thornton et al. 2008; Tidefors et al. 2010; Worling 1995) that family dysfunction appears to be more evident where sibling sexual abuse has occurred. Some research also reports that an unsupportive family response to the victim upon discovery of sibling sexual abuse is more likely to occur in minority families (Walsh et al. 2012).

A Relational Strengths-Based Approach

Psychotherapy with adult sexual abuse survivors in general, and sibling sexual abuse survivors in particular, must be based on a relational, strengths-based approach that emphasizes and understands the survivor's subjective experience in the context of interactions between the client and psychotherapist (Briere 2002; Courtois 2010; Courtois and Ford 2012; Caffaro 2014). An emphasis on subjective experience minimizes the hierarchical nature of therapy, which assumes that one person (therapist) knows more than another (client) and is able to apply his or her meaning to the client's life events. This is an important component of therapy with adult SSA survivors, given the peer-oriented nature of sibling sexual abuse trauma. A phenomenological orientation is also necessarily empathic because one of the therapist's most powerful tools becomes his or her ability to partially inhabit the survivor's inner world and to perceive indirectly what the survivor perceives (Briere 1992). Fundamental to this relational approach is the notion that therapeutic growth that comes from the trauma therapist taking enough interest in the patient as to be willing both to formulate unmet needs and to proffer that the client deserves to have had these needs met (Chefetz 2015). The approach also directs the therapist to pay far greater attention to precise details of how the person is presently living his life and how unconscious psychological structures and the patterns of daily life reciprocally interact with, and maintain each other (Wachtel 2011).

The ability to view an event from the adult survivor's perspective also diminishes the likelihood that the psychotherapist will form value judgments. Clinicians treating adult survivors of SSA need to be particularly sensitive to questions of mutuality and related issues of shame and guilt, which if left unattended, can cause ongoing emotional problems (Carlson et al. 2006; Courtois 2010). In work with adult survivors when significant family members are unlikely to be available to participate in the therapeutic process, it is important for clinicians to reach for connections between past abuse and current challenges and to work creatively with survivors of sibling sexual abuse to find alternative avenues for resolving abuse-related issues (Haskins 2003).

A strengths-based approach is predicated on the belief that adult survivors already possess the resources necessary to resolve many of their own problems. The trauma therapist's job is to assist in identifying such strengths and facilitate the client's ability to register existing experiences more fully (Tenzer 1984; North and Swann 2009). A significant source of therapeutic leverage is the discovery that people are already doing what they need to for the success of their treatment. Our job is to help them pick up what they have left behind and utilize it in the service of resolving the negative effects of traumatic stress as a result of the sexual abuse.

The focus with this relational approach is on what is *actually and presently happening* in therapy between the client and clinician. Building safety and providing support are, of course, paramount. And much has been written about viewing a sexual abuse survivor's "resistance" as a mechanism of communication or feedback to the therapist (Claiborn and Goodyear

2005; Briere 1992; Herman 1992). Enabling the client to recognize the active role they play in their difficulties is often hampered by the burden of guilt and self-blame that such recognition can generate. However, through understanding of how they consistently bring about certain consequences not intended, the adult survivor can be empowered to initiate changes without being simultaneously immobilized by guilt and self-reproach (Wachtel 2011). All of this is more likely to occur in the contextual of a safe and reliable therapeutic relationship.

Attachment and Self-Regulation

An important influence on conducting psychotherapy with adult SSA survivors is the attachment paradigm that states that the real relationships of early childhood—not our internally driven fantasies about them—fundamentally shape us (Wallin 2007). Attachment theory lends itself to this notion by stating that the parent–child relationship is as important to the child as eating and sleeping. Bowlby (1973/1982) recognized a long time ago that attachment is a biological imperative rooted in evolutionary necessity: The attachment relationship to the caregiver is critical to the infant's physical and emotional survival and development. Although mothers (as caregivers) have traditionally fulfilled this role, there is evidence that infants can be attached to a hierarchy of figures, including fathers, and siblings (Charles 1999; Teti and Ablard 1989).

Incorporating an attachment perspective helps increase the survivor's flexibility in interpersonal relationships beyond seminal family-of-origin patterns (Alexander and Anderson 1994; Morrow and Sorell 1989). This is especially useful with adult survivors of sibling sexual abuse because so much negative interaction and blaming typically takes place in such families. An attachment perspective aids in the exploration of the sibling sexual abuse by examining aspects such as frequency of the abuse, degree of self-blame, and family disruption, in relation to how the victim currently manifests their self-concept (Morrow and Sorell 1989). How the sibling sexual abuse survivor views themself is seen as a social construct, developed in large part, by social interactions around that individual. Obviously, family factors loom large in terms of their explanatory and etiological significance. But the attachment framework reaches beyond to include other important social interactions, such as friends, intimates, etc. Examining the social constructs present in the adult survivor's life can create a better understanding of what needs to be addressed and recognized for effective treatment to occur.

For example, one's relationship with a sibling can offer a valuable avenue by which the processes of early bonding can be developed, established, and maintained. Secure sibling attachments act as buffers to the effects of insecure attachments with parental caregivers. Conversely, insecure or abusive sibling attachments can serve as traumatic templates for dysfunctional intimate relationships in adulthood. These co-created relationships, much like those reenacted in psychotherapy, provide a key context for the development and transformation of self (Norcross 2002; Safran and Muran 2000; Mallinckrodt 2010). Sibling sexual abuse survivors may feel empowered by the normalization of their subjective experience in treatment. Because adults sexually abused as children sometimes depend heavily on their therapists, clinicians must respond to these needs in order to facilitate self-responsibility (Briere 1996). The therapeutic attachment provides clients with an opportunity to experiment with new ways of experiencing themselves, which may be generalized to other relationships.

An important aspect of addressing self-regulation in treatment emphasizes boundary confusion and relationship dynamics. The absence of a generational boundary violation in sibling sexual abuse poses additional therapeutic challenges (Caffaro 2008). For example, siblings may believe more readily that they were active participants in the abuse and could have put a stop to it. Adult survivors may be even more ambivalent about responsibility for the abuse when adopted or stepsiblings are involved. Furthermore, they may blame themselves for traumatic attachments to their childhood sibling offender, which were formed as a result of parental abuse or neglect (Katz and Hamama 2015).

A therapeutic climate offering support and risk in the proper balance must exist if adult survivors of sibling sexual abuse are to achieve and maintain treatment gains (Courtois 2010). Although elusive, this attachment template in therapy facilitates the development of self-support for new experiences and increases a client's regulatory capacity.

Experiential Focus

The advantages of an experiential approach in therapy addressing sibling sexual abuse can be illuminated by three key principles of neuroanatomy: 1) the brain changes in response to experience in a 'use-dependent' fashion; 2) the brain internalizes and stores information from any experience in a 'state-dependent' fashion, and 3) the brain retrieves stored information in a state dependent fashion (Perry 2001). No part of the brain can change without being activated – you can't teach someone how to play basketball while they are asleep or teach a child to ride a bike by talking with them.

Understanding that *experience,* rather than simply *insight*, leads to enduring change for adult survivors is central to this framework. Co-created enactments between therapist and client, when processed appropriately, frequently lead to key moments of change. Expressing genuine interest in a client's narrative also facilitates exposure and change, (Pascual-Leone and Greenberg 2007) and contributes to the over-

coming of anxiety by rendering the "unspeakable" spoken about. Clinical experience and a preponderance of evidence (Bachelor 1988; Castonguay and Goldfried 1994; Diamond et al. 1999; Tryon and Kane 1993) suggests that the therapist's ability to convey understanding and appreciation of the client's phenomenological perspective in the *here and now* is central to building a strong therapeutic alliance. This approach has ramifications for psychotherapy by shedding light on the varying processes that therapeutic orientations target in an effort to help clients create lasting, positive change (Pascual-Leone and Greenberg 2007). Significant experiential events are important markers for positive overall outcomes in therapy, something that is well supported by the literature on the relationship between client experiencing and outcome (Greenberg and Malcolm 2002; Greenberg and Pascual-Leone 2006).

For example, Piaget's insights about an individual's tendency to integrate his psychological structures into coherent systems and thereby, adapt to his environment, are fundamental to understanding how experiential learning and change occurs in psychotherapy. According to Piaget, adaptation takes place through the complementary processes of *assimilation* and *accommodation* (Piaget et al. 2007). Assimilation is the process by which we make the unfamiliar familiar, enabling us to approach new situations in a way that allows us to bring to bear what we have learned from our previous encounters with the world. The representative quality of the transference relationship can be understood as product of cognitive schemas in which assimilation predominates over accommodation (Wachtel 1981). The adult survivor, in a sense, transforms the novel therapist into someone that they are familiar with; namely, another significant person in their life. They assimilate certain qualities of the therapist and their interaction into a pre-existing framework and under certain circumstances, responds "as if" the therapist were that person. The therapist, of course, is similarly susceptible to reacting to their client in a manner rich with representation. These co-constructed relational events, adequately processed, can lead to insights for both client and therapist. However, for change to be effective and enduring, therapeutic interaction must also function as a catalyst for adult survivors taking action in the context of their lives (Wachtel 2011). Therefore, therapy must include attention to the various contexts in which a survivor lives and how they are changing outside of therapy. Agency and self-determination are of utmost importance as an antidote to the helplessness likely experienced at the time of sibling sexual abuse trauma. A great deal of evidence suggests that one of the most powerful correctives for trauma survivors is exposure to what has been fearfully avoided (e.g., Foa and Kozak 1986; Foa et al. 2006; Deacon and Abramowitz 2004). However, experts (Briere 1996; Courtois 2010) wisely counsel about the importance of titrated exposure to manageable quantities of trauma-related distress. Mastery, and the experience of safety is crucial. Exposing adult survivors of sibling sexual abuse to disturbing material gradually, at their own pace, contributes significantly to the client's experience of competence.

To illustrate, Zoe, a survivor of sibling sexual abuse, phoned my office up to 6 times weekly, usually in crisis. The phone calls often began on Friday evening and continued throughout the weekend. When I returned her calls, Zoe would not answer her telephone and call back within a few minutes. At subsequent appointments, she would be remorseful and guilt-ridden. That Zoe felt angry and helpless was obvious. While I observed that she appeared less anxious after the weekend phone calls, Zoe remained convinced that I would eventually abandon her for the trouble she had created. This pattern persisted over several months, despite my efforts to set limits and discuss her feelings related to the calls. I began to be aware of my growing wish to control Zoe's behavior. Issues of control are central to treatment of sibling sexual abuse; the survivor is controlled through power and sex and consequently has difficulty collaborating in relationships (Price 1993). At a subsequent meeting, Zoe once again began to express her anger at me for not returning her calls to her satisfaction. I reflected back to her how frustrating it must be to wait by the phone, sometimes for hours: she agreed. I suggested that any one might feel frustrated, waiting by the phone with a strong desire to talk to another about so many important things. Zoe looked sad and our conversation began to change. She reported how, as a child, she would often phone home to remind her father to come and pick her up after school. Zoe's father, however, was frequently unavailable. He could be found drinking and gambling in afternoon casinos, often forgetting to retrieve his daughter. One time when her father failed to pick her up, Zoe had to walk home alone from school. When she arrived her older brother was waiting. The first time she remembered being sexually abused by her brother was after school while they were alone in the empty house. Clients abused by siblings may bring to the therapy all of their unresolved feelings related to caretakers who failed to protect them. Zoe was capable of idealizing me when she felt supported and devaluing me when disappointed.

Trusting me with her secret was a critical juncture in Zoe's treatment and in our therapeutic relationship. She filled in details of her traumatic childhood in steady increments. She also reviewed and recast her personal narrative from varied perspectives. For example, I asked Zoe to share with me how I was both like, and unlike her father. She provided a list of ways in which we did not resemble each other, and gradually teased out qualities that her father and I shared. Her recognition that I was frequently unavailable on weekends, much like her father was not there for her after school provided the foundation for subsequent disclosure. This assimilative insight, coupled with Zoe's growing acknowledgment of my consistent support during our struggles, deepened our therapeutic relationship and provided her with a more secure relational

script for how to work through co-created difficulties–in contrast to the attachment template derived from her traumatic experience in her family of origin.

Our co-created therapeutic experience also influenced her behavior outside the therapy office in a somewhat paradoxical fashion. As Zoe began to experience more intense feelings toward me, she began to reach out to others more and her calls to my office gradually diminished. Her ability to change in response to environmental demands: reaching out to others and decreasing phone contact with me, represented the complementary process of accommodative learning. Assimilation and accommodation are invariants. The two processes are simultaneously present in every act. The balance between them varies but both are required for learning and change. Additionally, understanding that it is experience, rather than simply insight that leads to enduring change for adult survivors is central to this framework. Enactments between psychotherapist and client such as the one described here are fundamental to change. A considerable body of evidence exists to support such an approach (Elliott and Greenberg 2007; Greenberg and Pascual-Leone 2006; Orlinsky et al. 2003; Bohart et al. 2002).

Affect and Cognition

A relational strengths-based approach also includes challenging the adult survivor's abuse-related cognitive appraisals about themself and the world. This point is especially relevant in light of the frozen images (of self and offenders) often maintained rigidly by sibling sexual abuse survivors, which may serve as templates for other intimate adult relationships (Caffaro 2014). Cognitively oriented interventions can help the survivor to develop a more accurate self-image and a more realistic view of relationships with others. Therapy also must focus on helping the adult survivor to identify and express their feelings. Finally, skills and behaviors needed for competent, effective day-to-day living are frequently an important component of treatment. Therapeutic models of trauma treatment such as contextual therapy (Gold 2009) emphasize the importance of remediating affect regulation and interpersonal skill deficits stemming from dysfunctional relationships in the family of origin. Psychotherapy frequently can provide opportunities for experimentation with a variety of behaviors that one may not yet be ready to practice in everyday life. The following sibling sexual abuse case illustrates several therapeutic elements intrinsic to a relational strengths-based approach.

Clinical Application in Practice

Gabriella, thirty-one years old, requested therapy for difficulties that were beginning to surface in a long-distance intimate relationship. She and her boyfriend were fighting a great deal and Gabby recognized a pattern of not standing up for herself. She often went along with her boyfriend's direction, even though she inwardly objected. Her boyfriend's authoritative style made it more difficult for her to assert herself. In our initial meetings, Gabby dutifully recounted her childhood history. One of my early therapeutic tasks was making sure she did not disclose more information than she was able to process in each session. She was raised in a family of some prominence; her father was a respected physician, and her mother was a socially conscious volunteer for those less fortunate. Gabby was born twelve years after her only brother, Gene. By the time she turned six, he had already left home for college. Shortly after Gene's departure, Gabby's parents adopted two children. One day, as Gabby remembers it, two siblings, Jeffrey, age 12 and Monica, age 10, began living with her family.

Gabby tried her best to adapt to her new situation, but it was difficult from the start. She felt abandoned by her brother Gene and her parents, who now had three children to care for. To make matters worse, she was unable to form a strong alliance with either of her new siblings. Gabby had only limited contact with other children until her adopted siblings arrived; her world had consisted largely of adults. She was eager to please her new brother and sister, identifying with her parents' wish that they care for those less fortunate and become one happy family. The result was devastating; from ages seven to eleven, Gabby was sadistically abused by her adopted siblings. Her parents, blinded by the image of the picture-perfect family, offered no protection. Gabby's perception of her parents was stewed in contradiction; prominent and seemingly civic minded on the one hand and yet, emotionally absent and thus, unable to protect their only daughter.

Early stages of therapy focused on providing Gabby with empowering and context-appropriate support, and building safety and trust. For example, her anger at her mother's nonprotective stance was framed as courageous given Gabby's experience that support from her mother was not forthcoming whenever she was vulnerable. I also began inviting her to pay closer attention to the ways she avoided feelings (other than anger) that arose during the therapy or between sessions, but without any requirement to change or to disclose details of her traumatic childhood. During one session, while Gabby was sharing how her mother did not provide much nurturing but how her adoptive sister did, she became quiet. I wondered aloud what was going on, but Gabby appeared not to hear my question. I noticed that she was repeatedly looking up and to the right toward a wall hanging in the office, and asked her about this. She replied that she just enjoyed looking at the decoration, and denied that there was any significance to her behavior. I suggested that she continue to look toward the wall and focus in on her present experience of looking away. Suddenly she acknowledged that she felt like she was

disappearing in the room, and realized that the distraction was a way to avoid her feelings. This simple awareness had genuine value. She recognized the meaning of her behavior in treatment, and of the way she typically regulated painful feelings by keeping busy and distracting herself whenever possible. She stated, "If I am looking at you, it's harder for me to talk about this. It's like… as you become more real to me, I have to block you out; otherwise it's not safe." I asked if she could say more about not feeling safe. Gabby replied, "It sounds kind of silly, but my fear is that you could hurt me in some way." Gabby further revealed that it actually felt more as if she could not trust herself to express strong feelings in therapy. She began to cry. Aware of her increased vulnerability in the session, I normalized her reaction and supported her growing strength.

Several sessions later, Gabby arrived appearing a bit agitated; she had spent the weekend with her boyfriend. During an intimate exchange, he had asked Gabby to touch him. Gabby became very anxious. I asked, "What happened next?" While being intimate with her boyfriend, she recalled visualizing her adopted brother making her touch his penis. The next thing she remembered was the sight of her boyfriend's penis after making love. It looked small—about the same size as her offender's, she speculated. This was all she could recall about the sexual experience over the weekend. Gabby was beginning to look and feel uncomfortable. I acknowledged her discomfort and gently guided her to orient herself to familiar surroundings in the office. She sat with her feet planted on the floor, took a few deep breaths, and repeated positive, soothing self-talk. Now more effectively grounded, while I remained affectively present and available, Gabby signaled her readiness to continue. She said that her siblings would take her down into a crawlspace under the house, tie her up, and blindfold her. They would place various objects in her hands and made her guess what they were. Once Jeffrey had placed one of her hands in iced cold water, and forced the other around his penis. Another time they forced Gabby to suck her sister's nipples while Jeffrey made humiliating comments. Gabby looked anxious and began to breathe more rapidly. I intervened and led her through another previously rehearsed grounding exercise. I reminded her that she was free to end our current discussion or take a break whenever she chose; she wanted to continue.

Gabby related most of her remaining memories as if the abuse were somehow her fault. She stated, "I don't remember liking it, but I must have." I suggested that Gabby say more about the part of her that "must have liked it." I told her that I knew that it was an unusual thing to ask, but thought she might feel differently after obtaining a full hearing from both sides of her internalized conflict. Gabby began hesitantly, "I have mixed feelings about all of this. Maybe I'm making too much of a few incidents. After all, I never told them to stop when they did all these mean things to me." I suggested that she switch gears and speak about the part that did not like being hurt by them. Gabby continued, "Well, the things they did to me did hurt. Besides, I couldn't tell them to stop… I was just a kid, and I wanted them to like me so much… and I still have trouble with saying no to this day, but that doesn't mean I like the things to happen that I can't say no to." I directed her to respond from the other part. She replied, "You are just playing the victim, wanting people to feel sorry for you. I wish you would just grow up and get over it already." I motioned for her to continue. Gabby looked uneasy. I asked her to pay attention to what she had just said. She stated that this was what she had heard all of her life—from her parents, her boyfriends, everyone. The lack of support from others made it difficult for her to dismiss these thoughts and feelings. Her abusers' sadistic nature added to her confusion: Gabby recalled that her adopted siblings did not look angry while they did cruel things to her. I asked, could she focus on the part of her that "wished she would just get over it," and respond? She took a deep breath and replied, "I want to get over it, too. But I know now that in order to do that I have to face what happened, not pretend it was OK, or my fault."

Suddenly, she paused and cried, "I wasn't too small!" "What do you mean?" I asked. She continued, "Jeffrey used to tease me by saying that I was too small for him to, you know… Then he would regularly attempt to enter me with his fingers to see if I was big enough for him. For years, I thought there was something wrong with me. Now, I realize, believing that only caused me to feel responsible for the abuse. I grew up believing that he kept hurting me because I was too small, not because he was sick. For the first time ever, I'm starting to believe that I'm fine the way I am." I acknowledged Gabby's budding positive self-appraisal and affirmed the strength and courage it took for her face these feelings in my presence. There continued to be therapeutic challenges ahead but Gabby made steady progress from this point forward.

A central therapeutic issue for Gabby was her realization that the sibling sexual abuse was not her fault. Arriving at this awareness involved experientially examining some of her long-standing beliefs about responsibility for the abuse in a manner focused on her strengths, respectful of her pace, and processed in the context of a strong therapeutic relationship. Gabby was gradually empowered by her growing capacity to manage and regulate feelings associated with her abuse. She had also challenged a powerful negative cognition related to her victimization. She could now begin the process of discriminating between offender-based frozen images and her current perceptions. Shame-based views of herself as "too small", or that she "must have liked" the abuse were central features of Gabby's self-perception and the sibling-derived traumatic events. These were eventually traced to the lethal combination of self-blame for the sexual abuse and faulty attachment ties to her parents. Her deep-seated shame served to maintain the sibling sexual abuse secret until her intimate relationship with

a current boyfriend activated her memory of the victimization. When Gabby experienced adequate safety and connection in the therapeutic relationship, she was able to process details of the sexual abuse secret. A relational strengths-based approach helped to dislodge aspects of her negative self-regard and begin her journey forward towards recovery. Present-focused relational experiences in therapy were instrumental in supporting change in Gabby's intimate behavior with her boyfriend. Her earlier relational script, shaped by the sibling sexual abuse, no longer served her and became easier for her to successfully challenge.

Conclusion

Sibling sexual abuse is a form of family violence whose widespread prevalence has been known for some time, but which has generated surprisingly little specific scholarly and clinical attention. Future studies of sibling sexual abuse must address both qualitative and quantitative measures of family and adult functioning in addition to the retrospective data usually reported on adult victims recalling childhood sexual experiences. Routine screenings of adults about adverse childhood experiences (including sibling sexual abuse) should be part of every health care visit. The long-term effects of intervention with adult survivors are also understudied.

It is also important to determine what treatment models work best with clients. The current paper provides preliminary information on a relational strengths-based approach for counseling adult survivors of sibling sexual abuse. In many ways, trauma-informed psychotherapy has answered questions of general effectiveness and now is focusing on more prescriptive treatment that might answer the challenge to find what treatment delivered by whom is most effective with a specific problem under which set of circumstances. There is also need for a specialized clinical focus on sexually abusive sibling relationships. In such families it is often parents who, either physically or psychologically abandon their children. Under these conditions a child may depend on an older sibling even when that dependency is fraught with pain, anxiety and further maltreatment; the long-term effects on adult survivors can be profound.

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