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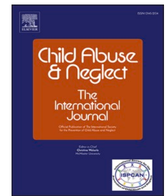

"Just listen to me": Experiences of therapy after childhood sibling sexual abuse

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A R T I C L E I N F O

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A B S T R A C T

Background: Sibling sexual abuse (SSA) is considered to occur more frequently than other types of intrafamilial sexual abuse and is related to numerous detrimental outcomes. Despite this, the literature on SSA is limited, which results in a knowledge gap on the effects of this type of abuse and specifically on survivors' experiences of therapy and challenges for interventions.
Objective: This study extends current knowledge by qualitatively investigating experiences of therapy of adults who experienced childhood SSA, to identify specific challenges and considerations for therapeutic interventions.
Methods: Four small-scale online focus-group meetings were conducted. In total, 12 participants shared and discussed their experiences of therapy for SSA.
Results: Qualitative thematic analyses revealed three central themes and several subthemes that provided important insights. First, many SSA survivors experience difficulties disclosing the abuse and fully engaging in therapy. Second, SSA is embedded within the family and is associated with changes in all family relationships, which needs to be addressed in therapy. Third, trust in and acceptance of the client's narrative are important to provide a secure base. In addition, therapists should acknowledge clients' strengths. Finally, because recovery from trauma is a long process, therapy should be tailored to the specific client and the specific point in their journey of recovery, as several types of therapy are only beneficial under certain conditions.
Conclusions: The findings inform therapists about challenges SSA survivors may experience during therapy, allowing therapists to better finetune their focus in supporting SSA survivors.

1. Introduction

Sibling sexual abuse (SSA) is estimated to be more common than other forms of intrafamilial sexual abuse and is related to numerous detrimental outcomes (Bertele & Talmon, 2021; McCoy et al., 2022). Children who experience SSA show an increased risk of developing various severe psychological and relational problems, such as depression, anxiety, suicidality, low self-esteem, substance abuse, posttraumatic stress, dissociation, relationship and sexual problems, and externalizing behavior (Bertele & Talmon, 2021; Cyr et al., 2002; Morrill, 2014; Rudd & Herzberger, 1999). Despite its frequent occurrence and the large number of possible negative consequences, which are comparable to the consequences of father-child sexual abuse (Cyr et al., 2002; Rudd & Herzberger, 1999), SSA has received less attention in the literature than other forms of sexual abuse (Bertele & Talmon, 2021; McCoy et al., 2022). This

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lack of attention results in a gap in our knowledge on the effects of this type of abuse and on specific challenges and benefits that both the sibling who exhibited the harmful sexual behavior and the survivors may encounter during therapy. The current study aimed to extend current knowledge by investigating experiences with therapy of adults who were sexually abused by a sibling during their childhood, the ultimate aim being to identify possible challenges and considerations for practitioners providing therapeutic interventions.

There are no exact numbers of the prevalence of SSA, partly because of the hidden nature of the abuse and the difficulties in disclosing it, but also because concepts such as 'sexual behaviors between siblings', 'sibling incest', and 'sibling sexual abuse' have erroneously been used interchangeably. Sibling sexual abuse (SSA) is defined, in line with the interpretation of the National Task Force on Juvenile Sexual Offending (Caffaro, 2020; Carlson, 2011; Shaw et al., 2000), as sexual acts initiated by one sibling towards another without the other's consent, by use of force or coercion, or where there is a power difference between the siblings. In contrast, sexual behaviors between siblings and sibling incest may involve mutually enjoyable and consensual sexual activities without the use of coercion.

Thus, though knowledge about the prevalence of SSA is patchy, information is provided by some studies. A large British study, for example, showed in an adult sample that SSA was the most common form of intrafamilial sexual abuse; in 31 % of the intrafamilial cases a sibling was reported as the perpetrator of the sexual abuse (Cawson et al., 2000). Another large study, using a student sample, found that approximately 5 % of participants reported having experienced sibling sexual abuse (Griffee et al., 2016). Based on such results, the general belief among researchers is that SSA is more common than other types of intrafamilial sexual abuse (Bertele & Talmon, 2021; Carlson et al., 2006; McCoy et al., 2022).

Difficulties in estimating prevalence rates arise not only from the use of different definitions but also in part from the tendency of survivors not to disclose SSA. The large majority of SSA cases are never disclosed. Some studies report that only 12–20 % of their sample of SSA survivors ever disclosed the abuse (for a review, see McCoy et al., 2022); this percentage is low, even compared to the low disclosure rates of other forms of sexual abuse (McCoy et al., 2022). These low disclosure rates mean that most SSA cases are not reported to child welfare professionals, leaving the children involved unprotected, unscreened, and without professional support (Stroebel et al., 2013). As a result, most SSA cases endure for several years, and do not end until one of the siblings involved leaves home (for a review, see Bertele & Talmon, 2021; Carlson et al., 2006). There may be several specific challenges for survivors in disclosing sibling sexual abuse. Disclosure is often accompanied by feelings of shame and guilt, the fear of not being believed, feelings of responsibility for damaging family relationships, or feelings of loyalty and protection towards the perpetrating sibling (Ballantine, 2012; McCoy et al., 2022; Rowntree, 2007; Tener et al., 2021). Finally, disclosure is hindered by societal taboos associated with SSA (McCoy et al., 2022; Yates & Allardyce, 2021).

Concerns of the abused sibling about deterioration of family relationships and fears of not being believed or not being understood when disclosing the abuse seem valid, as several studies describe a tendency among parents and professionals to dismiss or minimize SSA. This may be due to a lack of knowledge about what kinds of behaviors can be considered age-appropriate sexual curiosity and exploration as part of normal sexual development (McVeigh, 2003; Tener et al., 2018). When parents, the sibling who exhibited the sexual abuse, and other siblings acknowledge the SSA, they often struggle with reorganizing their perception of their family and find it difficult to provide support to both the sibling who exhibited the abuse and the abused sibling (Tener et al., 2021). Disclosure of SSA often disrupts the family system and complicates relationships between family members.

If survivors of SSA search for therapies that specifically focus on their situation, they may encounter several difficulties. While previous studies have suggested that specific interventions for survivors of SSA are necessary, only a few studies describe specific focus points for such therapeutic interventions (Ballantine, 2012; Caffaro, 2017; McVeigh, 2003; Tener & Silberstein, 2019). Addressing family-relationship issues in therapy is important, whether the therapy occurs during childhood or during adulthood (Ballantine, 2012; Caffaro, 2017; McVeigh, 2003; Tener & Silberstein, 2019), and it may be a good strategy to include parents, the sibling who exhibited the abuse, and other siblings in some form of family-based therapy. However, other studies point out that inclusion of the whole family is not always helpful (Keane et al., 2013; Welfare, 2008). Involvement of family members can only be beneficial if parents acknowledge the sibling sexual abuse and if the sibling who exhibited the abuse takes full responsibility (Ballantine, 2012; Caffaro & Conn-Caffaro, 2005; Welfare, 2008). Moreover, family members need to be available, both emotionally and physically, and willing to participate. If the therapy sessions cannot include family members, family relationships should be taken into account in individual therapy. However, no specific methods are described for addressing and resolving abuse-related family issues in situations where inclusion of family members and family reconciliation is not feasible (Ballantine, 2012; Caffaro & Conn-Caffaro, 2005).

In addition to these areas for attention, which may apply to therapy with adults as well as with minors, some studies describe specific elements for interventions with children who experience SSA. First, of course, therapy should focus on guaranteeing safety by stopping the sexual abuse and preventing further abuse (Ballantine, 2012; McVeigh, 2003; Tener & Silberstein, 2019). Second, parents should receive guidance to help them provide unconditional support both for their abused child and their child who has perpetrated the abuse (Tener et al., 2020). Without such professional guidance, parents may find it easier to ignore that the abuse happened or focus on moving on, thus effectively supporting the abusing instead of the abused sibling (Tener et al., 2018; Welfare, 2008). Finally, it is important to address possible confusion about whether the sexual interactions occurred with mutual consent, and associated feelings of shame and guilt (Ballantine, 2012; Tener & Silberstein, 2019).

Despite an increase in the amount of research on SSA in the past decade (Bertele & Talmon, 2021), and the clear evidence that SSA is related to numerous detrimental long-term psychological consequences (Bertele & Talmon, 2021; Cyr et al., 2002; Morrill, 2014; Rudd & Herzberger, 1999), the literature on the specific challenges and strategies for providing professional support to survivors of SSA is still limited (Tener et al., 2020). To the best of our knowledge, none of the previous studies has directly investigated experiences of therapy of survivors of SSA. In the current exploratory study we aimed to answer the following two research questions: (1) What

elements of therapeutic interventions after SSA are perceived as beneficial by survivors? and (2) What specific challenges and considerations arise in the context of therapeutic interventions after SSA, according to survivors? Given the limited literature on this subject, the exploratory nature of our study, and our focus on the authentic experiences of adults who experienced sibling sexual abuse during their childhood, we used an interpretative qualitative approach: we conducted small focus-group meetings with adults who experienced SSA during childhood to enquire into their experiences of the therapy regarding SSA-related problems.

2. Method

2.1. Sample

Participants were asked to join focus groups of 4 to 6 individuals through calls on the social media accounts (LinkedIn) of the authors and three clinical psychologists familiar to the authors. In addition, the public and private social media cannels (LinkedIn, Facebook) of *Project Speak Now* were used. *Project Speak Now* is an organization that promotes public conversations, and provides education on sexual abuse, as well as guided group conversations among people who experienced sexual abuse and individual coaching for people with traumatic sexual experiences. In all calls, information concerning participation in small focus groups as well as a link to an online registration form was shared.

After completing the online registration form, potential participants were contacted by phone to inform them in more detail on the procedure and content of the online focus groups and to give them the opportunity to ask questions. To ascertain that the SSA was no longer ongoing, participants were included if they were at least 20 years old and had experienced sibling sexual abuse before the age of 18, with the SSA having stopped before they were 18 years old. In addition, individuals could only participate if they had received a therapeutic intervention in the past (at least one year before participation) to ensure that they could elaborate on these experiences. To prevent participation to interfere with any current therapeutic intervention, participants could only join if they were not currently receiving therapy for the sibling sexual abuse.

The online registration form was completed by 18 individuals. Although the number of registrations was limited, in light of the taboo surrounding SSA, we were satisfied with this registration rate. Of the 18 individuals that registered, two did not meet the inclusion criteria (one had no experience of therapeutic interventions and the other experienced sibling sexual abuse in the family but was not abused directly); one did not respond to repeated attempts to make contact; and three refrained from participation in the focus groups after accepting the invitation. This resulted in a final sample of 12 participants (11 females, aged between 20 and 60 years old). The majority of participants ($n = 10$) did not receive any therapeutic intervention for the sibling sexual abuse until they were adults (19 years or older).

2.2. Data collection and procedure

To collect participants' experiences of therapy, we used small focus groups (Nyumba et al., 2018). Our decision to do so was made by carefully balancing arguments for and against this method (e.g. Sim & Waterfield, 2019; Wellings et al., 2000). Two important arguments in favor of this approach were conclusive for our final decision. First, focus groups can provide deeper understanding of the subject than a one-to-one interview. Second, we believed that the presence of others with similar experiences would enhance feelings of safety and increase recognition and support among the participants (Burke et al., 2019; Kitzinger, 1994). From that point of view, focus groups would create a more comfortable and beneficial environment for participants, and might foster rapport among the participants. We chose to organize small focus groups of 4–6 participants, in which all would be able to share their personal experiences and which are considered suitable for sensitive topics (Nyumba et al., 2018). Because participants were from diverse geographical locations, an online environment was chosen. Several researchers have indicated that online focus groups can yield valuable data (e.g. Dos Santos Marques et al., 2021; Lobe & Morgan, 2021). Also, the online environment creates an easier exit route for participants, which may be needed in these meetings about very personal issues.

Four online focus-group meetings of 1.5 h each were organized between July and December 2021. The focus-group sizes were smaller than expected because three participants canceled attendance, this resulted in two *mini* focus groups with three participants, one focus group of four participants, and one dyadic interview. The groups were led by the last author, who is experienced in leading online as well as face-to-face focus groups. All participants were encouraged to share their thoughts, opinions, and experiences freely. The discussion was guided to ensure that all participants had enough opportunity to contribute. The meetings were recorded (audio and video) via Microsoft Teams. The video recordings were used to facilitate transcription of the focus groups and the dyadic interview and were deleted after all the transcripts were checked and finalized. Before attending the meeting, participants gave their informed consent and answered a few questions on background characteristics in an online questionnaire. Afterwards, participants received a small gift (worth about 5 euros) to thank them for participation.

The focus-group topic guide, available from the corresponding author upon request, included a number of topics with corresponding questions and prompts. The topics focused on participants' experiences of therapy after SSA and the elements or methods they viewed as helpful or valuable, as well as those they perceived as unconstructive or even harmful. Neither the study nor the analysis plan was preregistered.

2.3. Ethical considerations

Ethical approval for the study was provided by the Research Ethics Committee of the Institute of Education and Child Studies of

Leiden University (registration number ECPW-2021/311). Participants were informed in detail about what to expect from the focus-group meeting: they received both written information and a phone call. During the phone call, participants were informed about the aim of the study, the topics that would and would not be discussed (e.g., that the discussion would focus on treatment experiences and not on the abuse itself), how many other participants would join the meeting, and how confidentiality and traceability would be handled. If they agreed to participate, they signed informed consent before attending a focus-group meeting.

To ensure that participants did not feel pressured to attend the focus-group meetings, it was explicitly stated – both in the written information and the premeeting phone call, and at the beginning of each meeting – that they could withdraw from participation at any time before or during the online focus-group meeting, without having to give any explanation. In addition, they could contact the first author in another online environment during the meetings if they needed to. None of the participants felt the need to take a break or leave the group meeting, nor did any of the participants contact the first author during any of the meetings. Confidentiality was emphasized at the beginning of each meeting: participants were instructed not to share any information about the other participants that they received during the meeting, and were asked to ensure that no other individuals were present or entered the room during their participation. To reduce traceability, participants were asked not to mention names of family members, friends, or therapists, and participants could choose to use a pseudonym instead of their real name. All data gathered in this study were stored and handled confidentially, in line with the European General Data Protection Regulation and University Guidelines for the archiving of academic research.

2.4. Analysis

The video recordings of the focus-group meetings and the dyadic interview were transcribed verbatim by research assistants and entered into the computer-assisted qualitative data analysis software ATLAS.ti (2022, Version 22.1.4.0). Transcripts were pseudonymized by deleting names of individuals, organizations, places, and geographical regions, and were carefully reviewed by the first author. Qualitative thematic analysis was used to analyze the transcripts and generate themes (e.g. Braun & Clarke, 2006; Clarke & Braun, 2017). To ensure the trustworthiness of our results, the data were coded and analyzed in successive stages by two people. First, the first author read the transcripts several times to familiarize themselves with the data. ‘In this stage, a combination of deductive and inductive coding was used. Three general predetermined categories were used: (1) ‘factors related to the therapist’, (2) ‘factors related to the therapy’, and (3) ‘response of parents and other family members'. More substantive, experiential codes within these categories emerged from the transcripts through inductive coding. Following this process, all codes were related to higher substantive, and more abstract categories. In the next stage, codes and categories were carefully reviewed and discussed by the first and the last author. If necessary, codes were merged, relabeled, and broken down into other codes and new categories were created. Based on this new coding system, all transcripts were recoded by the first author, after which the last author reviewed the coding system again. In the event of disagreement, consensus between the researchers was reached by discussion. The two authors' individual interpretations showed conformity with regard to final coding and categorization of the codes. In the final stage, categories were, based on their content, grouped together into themes related to the aim of the study. These themes were iteratively generated based on their comprehensive capturing of experiences.

To indicate quotes and clarify that they came from different participants attending to different focus groups, all quotes from participants, block quotations as well as embedded quotations, are displayed along with a participant number and the number of the meeting they attended, for example code P2F1 refers to participant 2 of focus group 1.

3. Results

The thematic analysis generated three overarching themes regarding challenges and considerations for interventions with survivors of SSA: (1) aspects of sibling sexual abuse that should be addressed in therapy, (2) the role of the therapist, and (3) challenges and benefits of specific types of therapy. Before going into these overarching themes, we give a description of the specific therapeutic interventions and the context of those interventions that participants received.

3.1. Context of treatment experiences

All participants described a long search for a type of intervention or therapist that could help them with the trauma-related problems they struggled with in their adult lives. And all described having had negative, disappointing as well as positive experiences with therapists.

Only two participants received professional help during their teenage years, when they were in secondary school, for the SSA they had experienced. Of the other participants, a few described seeking professional support during their student years, while the majority described seeking help when they were 30 to 40 years old. All of them had extensive experience of treatment, with the majority having received treatment for several years. Moreover, all participants had experience of individual sessions with a therapist such as a psychologist or psychiatrist. Only three participants had also experienced therapy in a group setting, and only one participant had participated in therapy sessions with her parents and all of her siblings. Participants described that it was not always clear to them what type of therapy they had received. However, a large majority reported having received EMDR (Eye Movement Desensitization and Reprocessing) or another type of trauma therapy; a few reported having received schema therapy or some form of body-focused therapy (i.e., haptotherapy or psychomotor therapy). Other types of therapy mentioned included cognitive behavioral therapy and psychoanalytic therapy.

Not all participants described what had prompted them to seek professional support. The reasons mentioned for seeking treatment varied: some participants described seeking help primarily for physical problems and being referred to mental health care; others described memories of the abuse suddenly coming back to them; and three participants mentioned a specific event that triggered trauma symptoms. Other reasons mentioned for seeking professional support included experiencing depressive symptoms or suicidal ideations, encountering problems at school or work, or facing sexual or romantic relationships problems.

3.2. Aspects of sibling sexual abuse that should be addressed in therapy

Participants mentioned several aspects related to the SSA that should be addressed to enhance the impact of the therapy. These specific aspects were: having difficulty disclosing the abuse; having difficulty fully engaging in therapy; and feeling disconnected from their family due to the SSA.

3.2.1. Difficulty disclosing SSA

Several participants indicated that they felt ambivalent about talking about the SSA with a therapist. On the one hand they hoped the therapist would ask "*the right questions and [would] poke through,"* (P1F1) but on the other hand *"you think: phew don't let them go there"*(P1F1). Since sibling sexual abuse is very much embedded within the family system, participants realized that revealing their experiences could have an enormous impact on the family system:

> *... I felt so incredibly responsible for the well-being of my brothers, my parents, my grandfathers and grandmothers. If this got out, then I was the one who held the happiness of the family in my hands. This gave a certain wrong kind of power, like I only have to snap my fingers and I can destroy you all.* (P3F1)

Therefore, some of the participants had never disclosed the abuse to their parents, because they did not want to "*hurt"* them (P2F4) or "*cause misery"* to their family (P2F1).

As a consequence, participants had learned to hide and ignore their traumatic memories and had become accustomed "*to talking about everything except"* the abuse (P2F4). Feelings of family loyalty were an important reason not to disclose the abuse to a therapist, *"I talked about everything except what happened at home. It was true that it had been difficult and that I was having a hard time with myself, but I just didn't dare .. it's still your family"* (P2F1). Some participants described starting with therapy out of a desire to handle current complaints, but feeling anxious about facing the memories of the abuse and related feelings.

> *...one of the questions on the intake form was: have you experienced incest, and it took me a long time to answer that. It was really hard for me to answer that question with 'yes'. I was really so afraid that a cesspool would open up that would never close again and I still thought I had put all that to rest.* (P2F3)

Other participants felt it would not be useful to share their story with their therapist because they expected the therapist not be able to handle their story. *"I realize something else, that I remember I held back on the 'dirty details', because I thought she couldn't handle that"* (P2F4).

According to participants, therapists should be aware of this reluctance to talk about the SSA. They stated that it was essential for therapists to ask their clients whether they had ever experienced sexual abuse and to stay calm if the answer was positive. And if the client denied having experienced sexual abuse, it might be necessary to ask the question again at a later point during therapy: "*if you have any suspicion at all, ask if it happened, because then at least you give the child the opportunity to talk about it."* (P4F2).

3.2.2. Difficulty engaging in therapy

Difficulty fully engaging in therapy could be the result of the participants' struggles with trusting other people and experiences of rejection. Because of their SSA experiences, many participants had developed survival mechanisms such as dissociation in stressful or emotional situations. They described how the effectiveness of therapy could be obstructed by dissociation, if this occurred during sessions that focused on details of the traumatic memories. Also, they described their fear of becoming overwhelmed by emotions and their desire to "*stay in control"* (P4F2). One participant elaborated: "*..it takes a long time before you are able to … make it successfully through trauma therapy without going out [i.e. dissociating] or without thinking: if I do it like this then I'll get through it easily."* (P2F2).

According to several participants, therapists did not always recognize that the participants had not been fully engaged: "[they] *often don't see it either when you 'distance' yourself, when you keep on talking in a socially desirable way*" (P1F2), and as a result therapists erroneously concluded that the therapy had been successful: *"I always got the feedback: 'I think you can do it and that you understand it', I thought: well, I did it again, but basically I was just shooting myself in the foot"* (P2F1).

3.2.3. Feeling disconnected from their family

Participants described that the SSA experiences went beyond the actual sexual acts and involved them feeling unseen by their parents and other family members, which resulted in them feeling disconnected from the family or even actually losing their relationship with their family altogether. Some described a strong sense of "*loneliness"* (P2F1) as a result of not disclosing the abuse and being burdened with a secret. As one participant mentioned: "*you really feel like you have a life sentence"* (P2F1).

However, similar feelings of loneliness and feeling misunderstood were described when participants did disclose the SSA but received no support from their parents or other family members, as it became in some cases "*the elephant in the room"* (P1F4). Parents discounted or minimized the abuse to keep the family together, saying that the survivor should "*get over it"* (P1F1) to make it possible to have family gatherings or "*celebrate public holidays"* (P1F1) together. Some participants described their parents even ignoring the

abuse or excluding the survivor: "*I sort of got kicked out of the family and they all nicely stuck together, and what I said wasn't true and I was crazy and I shouldn't be believed*" (P2F4).

In line with this, participants mentioned that it was important in therapy to pay attention to family-related issues associated with SSA. The therapist should recognize that the consequences of SSA permeated all family relations, and that those problems could still be present in the survivor's adult life.

> *But associated with the abuse, there is also the loss of the bond with your parents. That also changes, at least for me. I mentioned it to my mother and she avoided it. So it's also about loss, I think, of important attachment figures. …, while the focus [in therapy]is very often only on that piece of the abuse and not on the[overarching] problem.* (P2F2)

3.3. The role of the therapist

Participants mentioned several characteristics of the therapist's role and attitude during treatment that they had valued or had experienced as unhelpful or even detrimental. Given these experiences, participants pointed out the importance of therapists showing acceptance and trust, refraining from hierarchy, acknowledging the client's strengths, and being sensitive both to how survivors experienced their relationship with the sibling who had perpetrated the abuse and to the client's stage of trauma-processing.

3.3.1. Therapist showing acceptance and trust

Participants described the need for a therapist who provided a secure base to prevent them from using avoidance strategies and help them fully engage in therapy. More specifically, participants mentioned that therapists should show "*trust*" (P1F2) and "*unconditional acceptance*" (P2F4) of their client's narrative. Participants often felt ignored:" *... it would be very nice if there was someone sitting across from you who would say I believe you … there has never been anyone; I missed that in mental healthcare.*" (P2F4). They described it as essential that therapists made them feel "*heard and seen*" (P1F2), by truly listening to their story without judgment, or just by providing space to "*cry for an hour*" (P2F3). When a survivor talked about the SSA, it was important that the therapist showed unconditional acceptance and responded in a way that matched with the intensity of the story, without becoming overwhelmed:

> *It is a tough topic. So if it hits them, it wouldn't be a big deal either, because if it didn't hit them, well, you just have a kind of robot sitting in front of you. So that it's intense to hear it that's more than logical and I'd find it rather bizarre if someone wasn't troubled when I told them about the abuse.* (P4F2)

Despite the intensity of the topic, therapists should not be "*afraid to discuss the subject. And then not just once, but several times, because I think that also helps: talking about it helps.*"(P1F4).

Although most of the participants described that it was important for them to feel safe with the therapist, one participant explicitly described that having no security might also be helpful.

> *… what opened my eyes was [the trauma therapy] with different therapists [referring to therapist rotation in intensive trauma therapy] that you really don't know at all, but that makes you talk very freely ... you have no security. You don't know the person in front of you. I had [the trauma therapy] online, so that was also very strange. But it did work just by having to fall back on myself.* (P2F3)

3.3.2. Therapist avoiding hierarchy

The participants had difficulties with therapists who created hierarchy by positioning themselves as the expert and assuming compliance from the client. Such behavior on the part of the therapist was described as triggering difficulties with "*authority and guarding personal boundaries*" (P2F2) and as not contributing to a client feeling recognized. Participants sometimes felt they had little or no say in the procedure of the therapy, which seemed to be designed to follow the protocol instead of being adapted to their problems: "*every time I had to say: I want to work on my trauma, I want to work on my trauma, I want to deal with my trauma. Yes, it will come, it will come, it will come.*" (P2F3).

3.3.3. Therapist acknowledging client's strengths

Participants often mentioned having missed acknowledgment from their therapist for the strength they had demonstrated in coping with the trauma-related issues for most of their lives. They described the fact that the focus was often on the complexity of their trauma, whereas they would have preferred a therapist who expressed "*confidence that I will get there*" (P1F2). Related to this issue, participants expressed their aversion to others expressing pity for them, since pity, unlike sympathy or empathy, "*doesn't do justice to the strength you've displayed to survive and take care of your family. Pity undermines that*" (P3F1).

Some participants did describe positive experiences with therapists recognizing positive aspects of the survival mechanisms they used to cope with the abuse, such as dissociation, even though these same mechanisms might also be related to some of the problems they had experienced.

…at one point my therapist said - that was very nice -: 'You know, it's also a protective shield for you and be glad you have it. You know you have it, so use it when it suits you, if something is painful or confronting. (P2F1).

Participants mentioned further that they valued it when therapists were open about what to expect from the therapy. They stated that it could be helpful to recognize that improvement was possible up to a point, but that it was not possible nor necessary to fix all problems, and that a part of the trauma would stay with you.

> *..look it's not nice to hear that there's nothing more to be done, but it suited me, after everything I had already tried. I was just very far to actually recognize that this was it and that I wanted to make the best of it. That my limitations were okay too, instead of: oh there might still be hope, or this or that. I experienced that as very pleasant.* (P2F1)

3.3.4. Therapist being sensitive to client's feelings regarding the sibling who perpetrated the abuse

Importantly, therapists did not always acknowledge the ambivalent or empathic feelings survivors might have towards the sibling who had exhibited the abuse. Several participants for example did not feel anger towards their brother who had perpetrated the abuse, but felt compassion. Some described seeing their brother as just as much a '*victim*' (P1F2, P2F2, P1F3) of their dysfunctional family as they were. And several participants also mentioned currently having a good relationship with the brother who had perpetrated the abuse. Not addressing or acknowledging this range of various feelings in therapy could cause the survivor to feel misunderstood. *"... I really hated the way my brother – well, the perpetrator, that is – really right from the start of me talking about it, was always portrayed as bad."* (P1F2).

3.3.5. Therapist fine-tuning treatment

All participants described a long process of searching for the right intervention at the right time. *"I have had, well, quite a laundry list of interventions and practitioners – I stopped counting at 37."* (P4F2). Participants pointed out that it was essential for therapists to understand where an individual client currently was in their trauma-processing trajectory, and what type of therapy was appropriate at that particular time. They identified some approaches or elements in therapy as helpful, but also acknowledged that these same elements or therapeutic approaches would not have been beneficial at an earlier stage of their trauma-processing. They described trauma-processing as a trajectory that required an fine-tuned approach that matched with the stage the client was at, emphasizing that it was not possible to compile a "*general* [intervention] *package"* (P1F4).

> *I don't think there is one right way, because it very much depends on each situation, but also where you are in your life at that moment.... So every practitioner also has, well, a part in it in which they can help. But you can't – I don't think you can heal completely with one practitioner. .. [a practitioner] can contribute to this part and then you move on to the next part that you are ready for at that moment."* (P2F2)

Participants observed that such fine-tuning demanded flexibility, a balance between patience and acting at the right time; it was important for therapists to tailor therapy to the needs of the individual instead of administering protocolized care '*..as a therapist, [you should] also see that okay, this isn't working. So I must choose a different route.'*(P3F3). This individual tailoring also called for a focus on the needs of the "*specific person and less on the diagnosed disorder"* (P2F3). SSA could have enduring consequences for individuals, and survivors could need different approaches in different stages of life. One participant advised therapists: *"...make sure you are informed as a therapist and give people space, listen and don't keep thinking in boxes, but apply what is needed at that moment."* (P2F3).

3.4. Challenges and benefits of specific types of therapy

Finally, participants mentioned challenges and benefits of specific types of therapy and discussed under what conditions or in what contexts these types of therapy or methods might or might not be beneficial. Within this theme, participants discussed the subthemes of family involvement in therapy, body-focused therapy, and support from others with lived experiences.

3.4.1. Family involvement in therapy

Given that SSA has consequences for the total family system and is related to problems in the relationships between all family members, it may be valuable to include family members of the survivor in therapy. Several participants missed the involvement of their family members in therapy. For example, a participant found it striking "*...that nobody ever asked: take a family member with you* [to therapy] *or how do you talk about this at home....I think: they really slipped up there."* (P2F2). In fact, only one participant had had therapy sessions with all family members (siblings and parents); she described this as helpful for her as well as for the whole family. Not all participants believed that involvement of family members would be helpful. For some participants, letting family members join therapy sessions was not feasible since they did not want to disclose the abuse to their parents, and others did not want to confront their brother who had perpetrated the abuse. In other cases therapy with all family members was unfeasible because the brother denied the abuse, or showed no remorse: "[my brother] *told me outright that what I remembered was just the tip of the iceberg – that I actually knew very little and much worse things had happened*" (P3F3). Also, family sessions were sometimes perceived as impossible given the dysfunctional family relations that already existed before the abuse took place and/or was disclosed, "*I don't want to think about being in the same house with my family, because the house would blow apart"*(P2F1).

3.4.2. Body-focused therapy

Most participants acknowledged that it was important to pay attention to trauma responses of the body in therapy. They described difficulties with being aware of their own physical sensations and responses, difficulties with being touched, or feelings of "*disgust"* (P2F4) with their own body. They had often learned to shut down their body in order to cope with the abuse: "*Because you've learned that trick, to just endure something without feeling."* (P2F2). Some participants had found body-focused therapy helpful and mentioned how valuable it was for them to pay attention to their physical body in therapy –"*That was actually the missing link for me.*" (P1F3). However, the timing of such body-focused therapy is apparently key, as other participants described how they "*couldn't do much with it*

at that time" (P1F2) or *"it didn't work"* (P1F4) for them, because it "*didn't feel safe"* (P1F4). They mentioned how anxious they felt when focusing on their body, *"it [body-oriented therapy] would really be step 20 in therapy for me, because I still find that the most difficult part"* (P2F4). This emphasizes the importance of providing body-oriented therapy when the client is ready for it, in a way that is attuned to the client. This can be illustrated by the description of a participant's experiences with a hapto-therapist:

> *When she touched me it was like a bridge too far. So for six months it was first about [literally how close to the client the therapist can sit]: if I'm sitting here, how much tension will that create? And if I sit there, does that change anything? Because it's such finetuning because the body responds so quickly to things* (P2F2)

3.4.3. *Support from others with lived experiences*

During all four meetings participants mentioned that they had missed contact with fellow sufferers. This contact can make survivors feel understood. Because the impact of SSA goes far beyond the sexual acts itself, contact with an experience expert or a peer group of survivors may be a potential valuable treatment component. Several participants mentioned that it might be impossible for someone without lived experiences of SSA to provide genuine understanding and recognition of SSA-related feelings and thoughts: *"Because, [when] they have such a good brother or sister relationship, it is almost unbelievable..."* (P1F4).

In line with this, participants mentioned the importance of having contact with other survivors of SSA specifically, as it affected the whole family, which, as the participants stated, made it "*very different"* (P1F1, P2F2, P1F3, P2F3, P3F3) from other types of sexual abuse. Participants' experience was that survivors of other types of sexual abuse often received support from their families, while the participants themselves had experienced a lack or even complete absence of support from family members: "…*but when [the abuse] took place outside the family, the family was often very supportive…while for me it's actually the family…*". (P1F1). Related to this, participants who had participated in peer support groups or group therapy with survivors of other types of sexual abuse had not felt understood: on the contrary, participants had felt "*alone"*(P1F1) or that they "*again didn't fit in"* (P1F4).

Speaking with others with similar lived experiences gave them a sense of recognition and understanding. This also became clear during the focus-group meetings, as for many participants this was the first time they had come into contact with someone else who had experienced SSA: "*I think it's horrible what you've been through, but I enjoy feeling understood."* (P2F1).

4. Discussion

The current qualitative study explored central issues in therapeutic interventions for survivors of sibling sexual abuse, by investigating these survivors' experiences of therapy. The three central themes that emerged from the qualitative analysis of the focus-group data –(1) aspects of sibling sexual abuse that should be addressed in therapy, (2) the role of the therapist, and (3) challenges and benefits of specific types of therapy– all related to challenges that survivors of SSA may experience during therapeutic interventions, and provided valuable information on what aspects of therapies and attitudes should be taken into account by therapists.

The first theme identified specific aspects of SSA that are important to address in therapy. Participants mentioned several reasons why engaging in therapy is challenging for SSA survivors. While adult survivors of SSA may actively seek professional support, they may experience barriers to disclosing or discussing the SSA they experienced or to fully engaging emotionally during therapy. These barriers may originate from a tendency for traumatized individuals to avoid exposure to traumatic memories and trauma-related triggers (Knight, 2015; Lawson et al., 2020). SSA involves an early-life violation of trust, security, and protection from harm within the sibling relationship and the relationship with parents/primary caregivers. These disruptions during childhood are associated, both during childhood and later in life, with more hostility towards others, and difficulties in trusting others and in forming positive interpersonal relationships (Ballantine, 2012; Caffaro, 2017; Carlson, 2011). Several participants mentioned that these difficulties in trusting others might be associated with the dismissive or negative responses of family members or friends when the participants disclosed the SSA. There is some literature suggesting that SSA survivors may experience such negative responses more often than survivors of other types of sexual abuse (McCoy et al., 2022), which may make it more difficult for SSA survivors to trust that a therapist will accept their narrative. Furthermore, SSA survivors may have learned to ignore or dissociate from intense emotions as a coping mechanism that provides them with a sense of control and safety, which is necessary if no safety can be expected from their home environment (Pearlman & Courtois, 2005). The combination of having difficulties with trusting others and with forming positive interpersonal relationships, and the tendency to dissociate from strong negative emotions, especially when these are related to the traumatic experience, poses a challenge for SSA survivors as well as for the therapist when it comes to establishing a working alliance, which is essential for therapy to be effective (Levenson, 2020; Pearlman & Courtois, 2005).

Another aspect that is clearly related to SSA and that needs to be addressed in therapy is the distortions in family relationships. In line with previous research, participants described that the SSA affected not only the individual functioning of themselves and their family members, but also the relationship between them and their family members (Ballantine, 2012; Caffaro, 2017; McVeigh, 2003; Tener & Silberstein, 2019). These relational problems with family members were sometimes more prominent than the trauma related to the sexual abuse acts itself. This family-wide impact and relational trauma differentiates SSA from other forms of sexual abuse, especially extrafamilial sexual abuse (Westergren et al., 2023). Some of the damage to the family dynamics following the disclosure of SSA is similar to the changes described following the disclosure of child sexual abuse by a parent (McElvaney et al., 2022; Van Toledo & Seymour, 2013). For example, the non-abusive parent may not (or not consistently) believe the child, as a result of loyalty to the other parent, and parental support towards the survivor may be compromised by the parent's distress and feelings of guilt and self-blame (Bolen & Lamb, 2004; Van Toledo & Seymour, 2013). In addition, previous studies have reported changes in the relationship between survivors of intrafamilial sexual abuse and their siblings, sometimes resulting in closer relationships and sometimes in more

difficult relationships (Crabtree et al., 2021; McElvaney et al., 2022). What differentiates SSA from parental sexual abuse is that both the survivor and the individual who exhibited the abuse have a similar position in the family. Parents probably experience similar feelings of loyalty, responsibility, and unconditional love towards each of their children, which may make it more difficult for them to support both siblings after the disclosure of SSA (Tener et al., 2018).

It is important for therapists to acknowledge that the trauma of SSA does not only encompass the abuse experienced but also includes associated feelings of betrayal, misunderstanding, lack of support, and potential feelings of grief over the loss of the relationship with parents and other family members. Involving family members in therapy could be beneficial. If inclusion of family members is not possible or not endorsed by the adult survivor, the therapist should at least inquire into the potential impact of the SSA on family relationships and examine how disrupted family relationships may play a role in the survivor's life. Based on the participants' experiences, it can be expected that without this broader focus standard individual trauma therapy will only have limited effect.

In addition to aspects that therapy should address, other important factors identified for the experienced effectiveness of the therapeutic intervention included the role and attitude of the therapist. The participants stated, for instance, that to help survivors of SSA to fully engage in therapy, the therapist should show unconditional acceptance of their client's narrative, make the client feel seen and heard, and show that they can handle the client's story. Earlier research has also emphasized the importance of focusing on the traumatic SSA experience in a safe, trusting environment (Caffaro, 2017). This may be of importance, since the abuse often occurs in a family situation in which survivors were not seen by their parents. In line with the descriptions of our participants, previous research suggests that to establish a safe relationship, the therapist should show authentic emotions without becoming overwhelmed; should listen and communicate without judgment; and should show genuine attention and interest in the client's experiences and perspective (Levenson, 2020; Palmer et al., 2001).

As part of a safe environment, several participants indicated that a therapist should invite clients (maybe more than once) to talk about possible experiences of sexual abuse, in this way showing that the client is welcome to discuss their experiences with SSA. It is clear both from the participants' stories and from the literature that a therapist should not expect clients to tell them about SSA experiences without being asked; nor should they expect SSA survivors to tell them about the abuse the first time they are asked about these experiences (Knight, 2015; Levenson, 2020). Barriers to discussing the abuse may arise due to a tendency among survivors to prioritize the emotions of others and feel responsible for others' emotions. This tendency was mentioned by several participants and is consistent with the existing literature describing this propensity to attend to other people's emotions in individuals who have experienced interpersonal trauma (Levenson, 2020). Survivors may therefore not feel safe to share their traumatic experiences if they sense that a therapist is overwhelmed by their story.

Negative experiences of previous therapy can also form an extra challenge for creating a safe working relationship. These negative experiences are not uncommon in clients who suffer from interpersonal trauma (Knight, 2015; Palmer et al., 2001), which is in line with the experiences described by the participants in the current study. In addition, continuity and stability in the therapeutic relationship is described in the literature as important to create safety, which is thought to be important for effective intervention (Knight, 2015). As expected, this strategy will not work always and for everybody. In our study, one participant for example emphasized that discontinuity in therapists actually made it possible for her to concentrate on herself and her own emotions.

Other aspects of the therapist's role include refraining from hierarchy, acknowledging the client's strengths, and fine-tuning the treatment. These aspects require the therapist to stand beside their client and to be aware of the needs and circumstances of each specific client at that specific moment, as well as of the client's personal strengths. Sensitivity to a SSA survivor's stage of trauma-processing is essential. Therapists should be aware that processing SSA-related trauma takes time, which may be a challenge since most therapies are time-restricted (Palmer et al., 2001). If extension of therapy is not possible, therapists should be clear that they can only help the SSA survivor in part. In our study, several participants indicated that they realized that they needed more than one therapist to treat their SSA-related trauma. A therapist is not a magician that can solve all issues. However, ideally therapists will monitor and support their clients over an extensive period, as the impact of SSA can persist throughout the person's life. And if the therapist is not able to help the SSA-survivor effectively (or is no longer able to do so), they should be honest and suggest a different form of therapy. Thus, it is very important for the therapist to be flexible regarding the approach and duration of the therapy. Furthermore, it is essential that the therapist is aware that the impact of this type of abuse continues throughout an individual's life, even if trauma symptoms can be treated. To provide tailored support, therapists should take into account not only the client's current problems, but also the client's abilities and strengths.

The importance of fine-tuning was also evident in the final theme, which related to the challenges and benefits of specific types or methods of therapy. It emerged that the involvement of family members in therapy, body-focused therapy, and group therapy or support groups could all be beneficial, but only under certain conditions. For instance, if family relationships were too disrupted, possibly already before the SSA started, a therapeutic intervention involving the whole family would not be feasible, let alone valuable. Previous studies also mention that it is only if parents acknowledge the SSA and perpetrating siblings recognize their role in the abuse that inclusion of these family members in therapy may be helpful for the survivor (Keane et al., 2013; Welfare, 2008). The benefit of therapy with a focus on the physical body was also subject to the right conditions. It can be very valuable for SSA survivors, as many have learned to ignore or dissociate from physical sensations and responses as a coping mechanism (Pearlman & Courtois, 2005). However, this body-focused therapy is only valuable if the amount of tension and distress is manageable for the SSA survivor at that point of trauma-processing. The beneficial effects of support groups, finally, also depended on certain conditions being met: In line with previous research (Van de Ven et al., 2021), contact with peers allowed participants to experience genuine recognition of their feelings, genuine understanding, and reassurance that they were not alone in their struggle with SSA trauma-related problems. However, if a peer support group was composed of survivors of other types of sexual abuse with different experiences, particularly in terms of family relationships and family support, participation to such a group could actually create or exacerbate feelings of

loneliness.

This study has several important strengths. First, it is only the second study in the Netherlands to investigate sibling sexual abuse (Simons et al., 2022), and one of the first worldwide to investigate challenges in therapeutic interventions with survivors of SSA from the survivor's perspective. We focused on the participants' point of view by using a flexible topic guide and by creating space for participants' stories and interactions. A limitation, however, is that we had a small, and not representative sample. It could be that survivors who are willing to talk about their experiences with therapy are different from survivors who are not willing to participate. Our participants may have had more experience with talking about their trauma, or may have had (more) pronounced experiences with therapeutic interventions.

The small sample size also resulted in mini focus groups with fewer participants than is usually believed to be ideal for this method, and in one dyadic interview. This may have limited the range of different perspectives and the number of opportunities to respond to and build upon experiences of others. However, due to the sensitive nature of the topic and the taboo surrounding SSA, low participation rates were to be expected. Despite their small size, the mini focus groups provided unique information on survivors' experiences of therapy. We consider the participation of every individual as valuable. As was expected, the sample consisted predominantly of females. This is in line with other studies investigating experiences of survivors of SSA (for a review see: Bertele & Talmon, 2021), and with evidence suggesting that the majority of SSA survivors are female (Thomsen et al., 2023). However, the predominance of female participants in our sample limits the transferability of our results to the male perspective and prevents us from giving a rich description of gender-specific experiences. It is important to note that, since almost all participants only had experience of therapy during adulthood, specific recommendations for therapeutic interventions during childhood cannot be directly derived from our study. It seems evident, given the long-term family-wide problems that result from SSA, that it is disirable to provide therapy to the complete family system, including the survivor, the sibling who exhibited the abuse, parents, and other siblings. Further research may focus on early therapeutic interventions for families that have experienced SSA, and also explicitly on children who exhibit SSA, to prevent the occurrence of further abuse also in the next generation.

The current exploratory qualitative study revealed several challenges that survivors of SSA had experienced during therapeutic interventions. A recurring topic was that therapy should be tailored to the specific situation of each individual client. For example, the collapse of family relationships following disclosure of SSA calls for the involvement in therapy of parents, the sibling who perpetrated the sexual abuse, and other siblings. However, there are several conditions that need to be met for inclusion of the family in therapy to be valuable. Whether a certain approach in therapy is experienced as beneficial depends in part on the stage of recovery of the client. In addition, peer support groups can be supportive, but it seems important that participants in these groups experienced similar changes in family relationships or rejection by family members. In addition, the therapist should find a balance between providing safety and confronting their client by not avoiding discussing SSA and focusing on the related traumas.

Another important conclusion that can be drawn from our results is that therapists as well as other professionals should not be hesitant about asking whether their client has experienced any form of sexual abuse. Our results suggests that therapists working with SSA survivors may need specific knowledge and practices to build a successful working alliance with their client and to provide tailored support during therapy.

Ultimately, the present study provides an important first insight into the challenges faced by survivors of SSA and offers some preliminary recommendations for therapists to consider during therapeutic interventions for SSA survivors. Further research is needed to determine whether therapeutic interventions can be adapted to the specific needs and challenges of SSA survivors and to provide therapists with the specific training and skills required.

CRediT authorship contribution statement

Sheila R. van Berkel: Writing – original draft, Visualization, Project administration, Methodology, Investigation, Funding acquisition, Formal analysis, Data curation, Conceptualization. **Iva A.E. Bicanic:** Writing – review & editing. **Anja van der Voort:** Writing – review & editing, Methodology.

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Data availability

The data that has been used is confidential.

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