Non-abused Siblings of Sexually Abused Youth: Symptom Presentation and Relationship with Victim Distress and Family Functioning

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Introduction

Child sexual abuse (CSA) is a widespread problem, with current self-report research indicating that the lifetime prevalence rate of child sexual abuse by age 17 in the United States is 26.6% for girls and 5.1% for boys (Finkelhor, Shattuck, Turner, & Hamby, 2014). As of the 2010 census, 56% of households with children have two or more children (U.S. Census Bureau, 2010), indicating that more than half of children who experience CSA have at least one sibling living in the home. Victims and siblings display a range of responses to trauma, which may be a result of biological vulnerabilities, neurocognitive processes, and interactions with the environment based on the setting, the relationship to the perpetrator, the severity of CSA, and the disclosure's effects on the sibling's life.

The sibling's environment may have the most impact on the sibling's likelihood of developing secondary trauma following the disclosure of the victim's CSA. Specific social-environmental factors that put a family and a community at risk for a child experiencing CSA could also impact the sibling's reaction to the trauma. Further, families that create an environment that fosters adaptive coping skills and the healthy expression of emotions may impact the sibling's post-abuse functioning.

Individual differences may account for much of the heterogeneity in the response to CSA by victims; however, there is limited research available examining these processes in non-abused siblings. The discrepancy between the family's reports that the siblings can be quite negatively impacted by the disclosure and the measures reporting sub-clinical levels may be due to the use of CSA victim's measures. These measures may not adequately reflect the non-abused sibling's experiences.

The current study examined the impact of CSA disclosure on the siblings of CSA victims and explored the relationships between sibling distress in regard to victim distress and overall family functioning (specifically regarding family cohesion and problem-solving abilities).

Method

Participants

Participants were referred through a multidisciplinary Child Advocacy Center, community mental health agencies, and the Department of Health and Human Services. When multiple siblings or victims participated, only one pair was included for analyses. See Table 1 for more detailed demographic information.

Measures

- *Child Depression Inventory* (CDI; Kovacs, 1992). The CDI is a 27-item measure assessing depression in children and adolescents. This study used the Total Score.
- *Multidimensional Anxiety Scale for Children* (MASC; March, 1998). The MASC is a 39-item measure assessing symptoms of anxiety in children. This study used the Total Score.
- *Family Adaptability and Cohesion Evaluation Scale* (FACES-III; Olson, 1986). The FACES-III is a 40-item self-report form measuring family cohesion, adaptability, and satisfaction. This study included the parent's responses about current cohesiveness.
- *Family Crisis Oriented Personal Evaluation Scales* (F-COPES; McCubbin, Larsen, & Olson, 1982). The F-COPES is a 30-item measure used to assess the family's ability to problem-solve effectively in challenging situations. This study used the Total Score.

Procedures

Project SAFE (Sexual Abuse Family Education) offers a 12-week group treatment for child sexual abuse victims and their non-offending caregivers, and a parallel 6-week group treatment for non-offending siblings (Tavkar & Hansen, 2011).

Participants completed assessments to measure depression, anxiety, the perceived impact of sexual abuse on the family, and family functioning. Data are not available for some variables as this is an archival study.

Children and adolescents were not separated for this analysis because the intent is to understand the relationship between victim distress on sibling distress. The distress scores were created by summing the total score of the Child Depression Inventory (CDI) and the Multidimensional Anxiety Scale for Children (MASC) after having been converted to Z-scores. Pearson's correlations between the sibling's distress scores, the victim's distress scores, and the family's cohesion and problem-solving abilities were examined.

Table 1. *Univariate Statistics for Siblings, Victims, and Caregivers*

Variables	Univariate Statistics		
Non-Abused Siblings			
Age	*M* = 10.47	*SD* = 2.75	*N* = 62
Gender	Male		34 (54.8%)
	Female		28 (45.2%)
Ethnicity	European-American		43 (70.5%)
	Asian American		3 (4.8%)
	Hispanic American		5 (8.1%)
	Native American		3 (4.8%)
	Biracial		2 (3.2%)
Relationship to Victim	Biological Siblings		44 (71%)
	Step or Half Siblings		6 (9.6%)
	Adoptive Siblings		3 (4.8%)
Sexual Abuse Victims			
Age	*M* = 11.42	*SD* = 3.45	*N* = 45
Gender	Male		4 (9.8%)
	Female		37 (90.2%)
Ethnicity	European-American		30 (66.7%)
	African American		1 (2.6%)
	Hispanic American		5 (12.8%)
	Native American		2 (5.1%)
	Biracial		1 (2.6%)
Non-Offending Caregivers			
Age	*M* = 37.42	*SD* = 9.13	*N* = 36
Gender	Male		3 (7.9%)
	Female		35 (92.1%)
Ethnicity	European-American		31 (86%)
	Hispanic American		4 (11.1%)
	Native American		1 (2.8%)
Relationship to Victim	Biological mother		29 (72.5%)
	Biological father		2 (5%)
	Step or adoptive mother		3 (7.5%)
	Grandmother		1 (2.5%)
Highest Grade Completed	High School Level		7 (17.5%)
	College Level		21 (52.5%)
	Graduate Level		2 (5%)
Number of children in home	*M* = 3.89	*SD* = 1.21	*N* = 35

Results

Table 2. *Univariate Statistics of Sibling Distress, Victim Distress, and Family Functioning*

Variables	*M (SD)*	*N*
Sibling Distress		
CDI	45.65 (11.66)	48
MASC	52.41 (16.50)	39
Victim Distress		
CDI	54.77 (12.69)	30
MASC	57.52 (15.13)	25
FACES	36.84 (6.59)	32
F-COPES	104.75 (13.10)	32

Results supported the hypothesis that siblings do experience distress that is significantly associated with the level of the victim's distress. Bivariate correlations indicated that increased victim's distress is related to increased sibling's distress ($r = 0.551$, $p = 0.008$).

Family measures suggested that less cohesiveness in the family is significantly associated with increased sibling distress ($r = -0.460$, $p = 0.027$). The perceived problem-solving ability of the family is also negatively correlated with sibling distress ($r = -0.487$, $p = 0.018$). Families who reported less cohesion also tended to report fewer family problem-solving skills ($r = 0.481$, $p = 0.005$).

Table 3. *Bivariate Correlations of Sibling Distress, Victim Distress, and Family Functioning*

Variables	1	2	3	4
1. Sibling distress	-			
2. Victim distress	.551**	-		
3. Family cohesion	-.460*	-.310	-	
4. Family problem-solving ability	-.487*	-.439*	.481**	-

*$p < 0.05$, **$p < 0.01$.

Discussion

Sexual abuse has wide-reaching effects and non-abused siblings merit attention (Baker, Tanis, & Rice, 2001). Non-abused siblings present to treatment below clinical levels (Schreier et al., 2011) but these results indicated that they experience distress that is associated with the victim's distress and with the family's cohesiveness and problem-solving abilities. Impaired family functioning may be a risk factor for abuse or it could be a result of the changes that occur following disclosure, particularly if the perpetrator was a member of the household or a close friend. It is important that non-abused siblings of CSA victims receive support as well.

While currently being refined and evaluated, the Project SAFE sibling treatment includes the identification of emotions and healthy coping skills, recognition of "good vs. bad" touches, discussion of the impact of sexual abuse on the family, age-appropriate sexual education, information about why offenders offend, and skills for keeping themselves safe in the future.

Project SAFE caregivers have provided the feedback that both parents and siblings find group to be beneficial (Schreier et al., 2011). According to parent report, their children feel supported by the opportunity to discuss their experiences. It is noteworthy that victims have reported valuing their sibling's participation. Treatment gives siblings the opportunity to better understand what has happened in their family and to discuss their experiences with others who may be experiencing similar changes in their family structure. Including the entire family in concurrent treatment may improve family functioning and reduce risk for future victimization.