THE TABOO OF SIBLING SEXUAL ABUSE: WORKING WITH ADULT SURVIVORS

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Introduction

1. The Nature of Sibling Sexual Abuse
2. Typical versus Atypical Sexual Development
3. The Impact of Sibling Sexual Abuse
4. The Long Term Effects of Sibling Sexual Abuse
5. Working with Adult Survivors of Sibling Sexual Abuse
6. Challenges of Working with Survivors of Sibling Sexual Abuse
7. Working with Families and Minimising the Risk of Sibling Sexual Abuse

Bibliography

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Chapter 6: Working with Adult Survivors of Sibling Sexual Abuse

The complex nature of Sibling Sexual Abuse (SSA) can make it very difficult for survivors to legitimize their abuse and seek help as adults. Due to the confusion around the sexual experiences and shame, many survivors find it difficult to link the SSA to later difficulties in their lives. Repeated and systematic SSA, especially involving young children who are not able to understand or process what is happening, commonly results in dissociation and pushing the abuse elements of the experience out of conscious awareness.

In addition, many survivors minimize the experience and impact of SSA by viewing it as normative sexual experimentation, or a harmless game in which the harming sibling is seen as a child who did not know what they were doing. This reflects what they may have been told when they disclosed the abuse, either by family members or professionals, along with a desire to protect their sibling (Sanderson, 2004).

When working with adult survivors of SSA it is important that professionals and clinicians understand the complex nature of SSA and the difficulties around disclosure and legitimising the abuse. They will need to have an understanding of the nature of SSA, the intrinsic family dynamics and that some siblings who harm may also have been sexually abused. In addition, they will need to have an awareness of the aftermath of SSA in later childhood and adulthood, such as shame, confusion, emotional dysregulation, relationships difficulties, compromised mental health (see chapter 5, pp), and the ripple effect of disclosure.

It is crucial that practitioners pace disclosure and do not force it prematurely. This involves being mindful of the survivor's readiness to talk about shameful experiences that evoke

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confusing and unbearable feelings. When working with trauma it is important to pace exposure to traumatic experiences so as not to re-traumatise the survivor.

Barriers to Disclosure

There are countless barriers to disclosure which are in part due to survivors not being able to link what happened to them in childhood and its later impact. Many survivors of SSA report that in childhood they didn't feel any overt effects of the SSA, and they only realised that it may have had a negative impact when entering intimate or sexual relationships, or when they seek therapy for entirely different presenting symptoms. Due to the confusing nature of SSA, survivors often do not recognise that there may be link between SSA and later mental or physical health difficulties, relationship or sexual difficulties, or substance dependency.

Survivors who dissociated during their abuse will not have access to clear memories of the SSA and fear that their limited verbal recall will result in not being believed. This is compounded if there is a 'trauma bond' (Sanderson, 2019) that binds the siblings together. The switching between abusive and loving behaviour becomes the 'superglue that bonds' the relationship, which is so strong that anything that may threaten that bond will be resisted.

To manage such cognitive dissonance, the survivor is compelled to seal off any negative beliefs about the abuser and to humanise rather than demonise them. In this the child compartmentalises the abuse components within the relationship while focusing on the positive, and caring aspects. This necessitates 'thought blindness' in which reality is distorted to override the true nature of the relationship and normalise the harming sibling's behaviour. In focusing on the loving aspects of the sibling the child begins to see him or her as 'good' and the survivor as 'bad'. Over time the survivor develops an increasingly higher tolerance for abuse, which can become so entrenched that the survivor is unable to admit the abuse to self or others.

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In addition, their crippling sense of shame and inability to trust makes it extremely difficult to explore their abuse experience with professionals until a degree of trust has been established. As a result, SSA may not be disclosed during the early stages of therapy and only emerge when there is a degree of trust. While some survivors do allude to a history of SSA through coded messages, when these are not deciphered by the professional it leaves them voiceless and unheard which impedes further exploration. This hinders the development of a secure and safe relationship in which to break the silence and secrecy.

Shame is a powerful silencer especially if the survivor felt complicit in the abuse, or enjoyed the closeness with their sibling, or became sexually aroused. They typically feel ashamed of what happened and fear being re-shamed and stigmatised if the secret is exposed. Survivors also fear the consequences of disclosure such as the fragmentation of the family or splitting of loyalties, mandatory reporting, or being perceived as at risk of abusing their own children.

In order to facilitate disclosure, practitioners need to be open and engaged in bearing witness. They need to be able to convey empathy and compassion and demonstrate that they genuinely care. This is aided by sensitive pacing of the disclosure and psychological contact, and ensure they do not rush the survivor as this mimics the need to 'rush through' the abuse experience. Being present and in psychological contact with the survivor whether they are talking or silent is critical to demonstrate that they are heard rather than judged, rejected or abandoned. It is also essential that practitioners are able to tolerate and validate the survivor's feelings, no matter how ambivalent, including feelings of love for the sibling who harmed him or her and to normalise these within the context of SSA (Sanderson, 2019).

It is critical to titrate exposure to the abuse experiences to minimise re-traumatisation. This is best done within a phase-oriented approach (Herman, 2001; Baranowsky, Gentry and Schultz, 2004; Courtois and Ford, 2012, Sanderson, 2013; 2022b; see below, pp). Gentle

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enquiry to encourage initial disclosure is often more helpful than direct questions which can be frightening and intrusive. While some survivors prefer being asked directly, others prefer a gentler approach. If professionals feel uncomfortable about asking direct questions, it can help to develop a range of sensitive questions such as “Has anyone done anything to you that you wish they hadn’t?”, “Were there any things that happened in your childhood that confused or frightened you?”, “Has anyone ever made you feel special and then gone on to hurt you?”, or “Sometimes it is hard to talk about things that are confusing or frightening.
I want you to know that the most important thing is for you to feel safe here, and that I am here for you if you want to talk and if you prefer not to” (Sanderson, 2019).

When the survivor does disclose a history of SSA it is essential to remember to ask questions about how they are now, and not just focus on memories and details of the abuse, as these can lead to numbing rather than making sense of the experiences. It is much more helpful to ask “How do you feel the abuse has affected you?” or “What did you have to do to survive?” or “What sense did you make of the abuse?” and “What would help you the most now?”

Practitioners will need to be respectful of the survivor’s fear around disclosure and pace this sensitively. They will also need to be aware of their own barriers in responding to disclosure of SSA such as disbelief, lack of knowledge or training, not knowing how to respond or facilitate disclosure, opening Pandora’s Box or making it worse for the survivor (Sanderson, 2016). Practitioners may also fear mandatory reporting, or litigation from the survivor’s family or sibling, and feel shame around working with sexual violence (Sanderson, 2019).

It is also prudent for practitioners to be aware of their own attitudes to sex and sexuality (Sanderson, 2013) and to have knowledge about typical and atypical sexual development in children and have an understanding of what is meant by sexually harmful behaviour in children (Sanderson, 2004); 2006; see chapter 2, pp).

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Working with Adult Survivors of Sibling Sexual Abuse

There are a number of therapies that can be used when working with survivors of complex trauma which includes SSA. Current NICE Guidelines advocate Trauma Focused Cognitive Behavioural Therapy (TfCBT) and Eye Movement Desensitisation and Reprocessing (EMDR). While EMDR has many treatment benefits for symptom reduction and the integration of processed traumatic material (Fine, 2009; Gelinas, 2003; Twombly, 2005), it is best used within an overall treatment approach rather than as a standalone treatment. There are however risks of using EMDR with severely traumatised clients as premature exposure can reactivate traumatic memory too quickly (Van der Hart et al., 2013; 2019; Forgash & Knipe, 2008; Gelinas, 2003; Twombly, 2005) and it is now considered to be most effective when employed within a phase-oriented approach to ensure a degree of stabilisation and the acquisition of a range of coping strategies to manage trauma symptoms and emotional self-regulation (Shapiro, 2009).

Cognitive based therapies such as Dialectical Behavioural Therapy (DBT), Cognitive Analytic Therapy (CAT) and Mindfulness-Based Stress Reduction (MBSR) have also been found to be effective, as well as Compassion Focused Therapy (CFT) and Acceptance and Commitment Therapy (ACT) which combines mindfulness with the practice of self acceptance. Schema Therapy can also be beneficial when working with personality adaptations and early schemas that emerge as a result of unmet needs in childhood.

Somatic therapies such as Levine's Somatic Experiencing Therapy (Levine,2012; Payne, Levine, & Crane-Godreau, 2015) aim to modify trauma related stress responses through bottom-up processing that directs attention to internal states through interoception, proprioception and kinaesthesis. While these have considerable benefits when working with survivors of SSA, it

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is important to assess the readiness for these as many survivors find it too traumatizing to be in their bodies (Rothschild, 2017; Sanderson, 2013; 2022).

Some survivors of SSA are unable to speak the unspeakable, and thus benefit more from non-verbal and bottom up processing techniques to bridge the communication gap between what is split off and stored in the right brain. They may find expressive therapies such as any of the art and play therapies or Drama, Dance and Movement therapies more accessible (Sanderson, 2019).

Survivors who are not ready to give voice to their experiences may find that their daily function is improved through alternative therapies such as Animal Assisted Therapy, equine therapy, eco therapy, bibliotherapy, film therapy, or music therapy. Alternatively, they can counterbalance the destructive elements of abuse through engaging in activities that are creative and constructive such as cooking, gardening, knitting, writing, or building.

Whichever approach is used it is important that practitioners are aware that survivors of SSA are not homogenous and there is no 'one cap fits all' approach. Survivors will vary with regard to preferred modalities depending on where they are in their process, their readiness to talk about their experiences and what is most appealing and effective for them. Survivors need to have autonomy and choice to explore what is most helpful for them (Sanderson, 2022a). Applying a Trauma Informed Practice (TIP) and phase-oriented approach is generally considered to be the most effective approach for survivors of complex trauma and SSA (Herman, 2001; Baranowsky, Gentry and Schultz, 2004; Courtois and Ford, 2012, Sanderson, 2013; 2022b; Rothshcild, 2017; van der Kolk, 2015) as it acts as a scaffold to the practitioner's individual preferred modality.

Additionally, it is essential to have an understanding of the pervasive power and control dynamics in all forms of sexual violation including SSA, no matter how subtle or concealed. Survivors of SSA will have experienced a misuse of power and control, fear, excitement and

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confusion which they could not process (Sanderson, 2013; 2022b). To survive, survivors will have learnt to become compliant and submissive, and feel they have little or no choice or self-agency. To minimise the replication of the misuse of power and control, practitioners need to ensure that they provide a secure and safe therapeutic space in which trauma is seen through the eyes of each individual survivor and ensure that power and control is equalised through promoting autonomy and choice. In encouraging survivors to be active agents in their recovery, the practitioner becomes a reliable and faithful companion on their journey to recovery (Sanderson, 2022b).

The Power Threat Meaning Framework

To fully understand the impact of power and control on individuals it is important to view emotional distress and complex behaviours not just as symptoms but within the context of the person's experiences, and their attempts at making sense of these. The Power Threat Meaning Framework (PTMF) proposes an alternative to traditional psychiatric diagnosis and its focus on symptoms (Johnstone and Boyle, 2018; Boyle and Johnstone, 2020). The emphasis in the PTM framework is to understand 'what happened' to the person rather than 'what is wrong with' them. It is a way of understanding how people try to make sense of difficult and confusing experiences in order to gain meaning. Furthermore, it locates the emotional distress and concomitant behaviours as responses, or adaptations, to being controlled and the misuse of power. Practitioners need to ensure that they do not retraumatise survivors by validating their narratives and link their responses to their abuse experiences rather than pathologising or shaming them for their 'symptoms'. By making the link between distress and the abuse of power survivors of SSA can begin to reduce shame and self-blame and reclaim their power and control.

With this in mind practitioners need to structure their approach to encourage survivors to tell their story and focus on asking what has happened to them, how power was used to control

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them, and how this affected them. In addition, it is essential to explore what sense they made of their experiences and the meaning they have ascribed to these (Johnstone and Boyle, 2018; Boyle and Johnstone, 2020). Alongside this, practitioners need to help survivors to identify their threat responses and what they had to do to survive without judgement and recognise which coping strategies are evoked in the present. This includes contextualising and understanding behaviours and responses that appear to be countertherapeutic as protective survival strategies rather than non-compliant, resistant or avoidant. The focus throughout the therapeutic process needs to be on 'what happened to them' rather than what is 'wrong with them'.

Trauma Informed Practice

The PTMF is aligned to the core principles of Trauma Informed Practice (TIP) namely those of safety, trustworthiness, collaboration, choice and empowerment (Quiros & Berger, 2013; Fallot & Harris, 2008; Elliott., Bjelajac, Fallot, Markoff, & Reed, 2005;) Trauma Informed Practice requires the ability to look at trauma through the eyes of each individual. The focus is on creating safety and trust through working collaboratively and promoting choices and respecting autonomy. It also identifies the individual's strengths while emphasising empowerment and that recovery from trauma is possible and that there is hope (Butler, Critelli & Rinfrette, 2011; Quiros & Berger, 2013; 2015; Fallot & Harris, 2008).

Survivors of SSA have learned that relationships are confusing and dangerous rather than a place of safety, and as such will be wary of entering the therapeutic process. It is crucial that practitioners create a secure base in which to foster internal and external safety in order for survivors to feel safe enough to reset their heightened alarm system by reducing subcortical threat activation and bring cortical functions such as cognition back online (Sanderson, 2013; 2022). In developing emotional self-regulation skills survivors will be able to feel more in control over their trauma symptoms.

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In order to manage power dynamics ethically it is essential to reduce the intrinsic structural power in the therapeutic encounter by acknowledging and discussing power dynamics and the rights and responsibilities of both client and practitioner. This needs to be supported by a sharing of power and knowledge through psychoeducation and promoting equality, autonomy, agency and choice. Alongside sharing power, practitioners must be able to modulate control dynamics by encouraging survivors to take control in their lives as well as in the therapeutic space, and be willing to relinquish control by not being too directive or expecting the survivor to work at a pace that is unmanageable for them.

Due to the sense of betrayal by people who appear to be trustworthy, it is critical that practitioners are experienced as trustworthy, and that this is conveyed to, as well as felt by the survivor. Survivors of SSA commonly find it difficult to trust, and practitioners need to consistently demonstrate their trustworthiness through honesty and authenticity. This is best facilitated by being explicit in terms of boundaries, managing expectations, articulating therapist and client responsibilities and respecting clients' emotional limits and not judging them when they feel overwhelmed, stuck or unable to fully engage in the work. They need to ensure that they do not shame survivors by interpreting their behaviour as resistant when in essence these are protective survival strategies that have been activated as a result of fear or shame (Sanderson, 2013; 2022b).

Practitioners will need to be patient as it takes time to build trust, with some survivors never able to trust fully. It is advisable not to force or push trust but allow it to evolve over time. Survivors often search for evidence of trustworthiness through testing behaviours and therapists need to understand these as survival strategies to regulate closeness rather non-compliance. The building of trust is aided when the practitioner is able to be present and engaged and able to provide non-biased information about trauma symptoms, how these impact and the dynamics of the therapeutic process. This psychoeducation and openness to

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talk about the nature of the therapeutic relationship, including traumatic transference, and counter transference, is crucial to develop trust in the therapeutic alliance. Therapists will need to be honest and authentic as they demonstrate their capacity to bear witness without judgment and show fortitude in the presence of unspeakable experiences, wordless terror and unbearable feelings.

To ensure that survivors feel safe, practitioners need to promote choices especially when working with survivors of SSA who were not given choices during their abuse or were blamed for their participation. It is essential to provide as much choice as possible in the therapeutic setting such as where to sit, the positioning of the chairs, and the proximity and physical space between practitioner and client. Survivors need to be able to see the door and feel that they have a choice in how closely the chairs are positioned, and at which angle.

Many survivors feel uncomfortable sitting directly opposite the practitioner as this elicits shame and feel more comfortable if the chairs are placed at an angle, or side by side, at least initially. This also helps to regulate eye contact as it is often under gaze of others that shame is induced and trauma wise practitioners (TWP) need to be mindful that the intensity of eye gaze, and eye contact can be triggering and lead to dissociation (Sanderson, 2013;2015). Practitioners are encouraged to share the regulation of eye gaze and proximity with each individual client to find the optimal distance that feels safe for them. It is helpful at the beginning of each session to check with the client how comfortable they feel and to spend a few minutes settling into the therapeutic space through breathing and grounding exercises.

In addition, survivors need to feel that they have a choice in whether to talk or not to talk, and to regulate silence. While therapeutic silences can be fruitful opportunities to reflect and access feelings, for many survivors silence is experienced as punitive and is reminiscent of the abuse. It is essential that practitioners regulate the silence appropriately, and that prolonged

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silences do not trigger, or activate shame or dissociative states. The shame associated with SSA is easily evoked in prolonged silence and can feel re-traumatising.

Throughout the therapeutic process and journey to recovery survivors must be encouraged to make autonomous choices and have these respected and supported by the practitioner. To equalise power it is helpful for practitioners to adopt a collaborative and non-hierarchical approach in which survivors are encouraged to take an active role in their healing and empowerment. To facilitate this therapists need to ensure that the therapeutic relationship is co-created and based on mutuality (Jordan, 2017; Miller, 2015). In being explicit and transparent therapists reduce the need of the survivor's need to 'mind read' and promote self-agency in a safe way.

Alongside collaboration, TWPs need to ensure they respect the survivors right to make autonomous choices such as the chosen treatment modality, case formulation, intervention, planning and the evaluation of treatment. This will enable them to restore control and build trust in their self-agency as well as making life choices post therapy.

Equalising and sharing of power is crucial to facilitate empowerment in which the survivor is accorded respect and seen as expert in their own life and experiences. Most importantly practitioners need to recognise and validate the resources and skills that the survivor already has which have enabled them to survive such as courage and resilience. In focusing on their strengths, survivors will feel empowered rather than rendered helpless. This can lay the foundation for further empowerment through the cultivation and acquisition of more skills and reclaiming control over their bodies and restoring reality.

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The Three Phased Approach to Working with Trauma

Whichever type of treatment option is accessed, it is important that it is regulated and sensitively paced so that the survivor is not retraumatised. This is best achieved through a phased-oriented model using the principles of TIP which can either be used as a single specialist approach or be incorporated into an existing or preferred treatment approach (Herman, 2001; Baranowsky, Gentry and Schultz, 2004; Courtois and Ford, 2012, Sanderson, 2013; 2022b). The advantage of a phased approach is that it is flexible and survivors can go at their own pace to build the necessary resources to enable them to explore the trauma without becoming retraumatised, and acquire skills that will promote resilience and post-traumatic growth (Courtois and Ford, 2012; van der Kolk, 2015; Rothschild, 2017; Sanderson, 2022a).

While the model consists of three distinct phases - **Stabilisation, Processing and Integration** - practitioners need to be aware that the phases are dynamic and not linear, and that there is considerable fluidity and oscillation between phases. All three phases are inter-related and inter dependent and equally important as each phase builds on the gains and skills mastered in previous phases. It is worth noting that severely traumatised survivors may not be able to progress beyond phase one. This should not be interpreted as failure as recovery is not dependent on remembering. What is essential is to be emotionally regulated and be able to live in the present rather than be catapulted back into the past (van der Kolk, 2015).

The length of time for each phase is not measured in terms of time, but rather in the mastery of skills acquired and cultivated at each phase. Rather than focus on the SSA prematurely, the aim is to create a safe and secure base in which to build internal and external safety and enable the survivor to restore control over trauma symptoms through affect regulation using grounding skills to build distress tolerance before remembering and processing SSA experiences.

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This is accompanied by psychoeducation in order to understand the impact of SSA and to normalise trauma symptoms as adaptations and reactions to threat which enabled them to survive. Psychoeducation enables survivors to recognise that trauma resets the emotional alarm system on either high alert resulting in hyperarousal and hypervigilance or shut down as seen in hypo-arousal (Sanderson, 2022a; 2016). When hyperaroused, subcortical areas of the brain such as the amygdala predominate, or come online, while the cortical areas of the brain involved with cognition, thinking, and decision making, are reduced, and go offline. In hypoarousal all systems shut down.

In order to process the SSA and concomitant overwhelming feelings, survivors need to feel safe to acquire the requisite skills to gain mastery of over trauma symptoms and to mute or deactivate the subcortical areas of the brain involved in threat responses, so that the cortical areas of the brain can come back on online.

As the phases are not measured in time but on the acquisition and mastery of skills, it is critical that practitioners assess readiness to move on to the next phase, and be prepared to move back and forth fluidly (Courtois and Ford, 2012; Cloitre, M., Courtois, C. A., Ford, J. D., Green, B. L., Alexander, P., Briere, J., & Van der Hart, O. (2012).). It is essential to remember that oscillation between phases are not an indicator of failure, but rather an opportunity to reinforce skills and consolidate gains made. Newly acquired skills and strategies may need to be repeated numerous times before they are fully consolidated to enable emotions and cognitions to be processed and integrated.

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Phase One: Stabilisation

In Phase One the focus is on creating safety, promoting self-care, improving daily life, identifying the survivor's strengths and coping strategies, and assessing their current needs. This needs to include a risk assessment if the harming sibling still exerts power and control over the survivor. During this phase emphasis is placed on developing stabilisation skills such as grounding and emotional self-regulation in order to manage overwhelming trauma reactions, and building a personalised recovery toolkit (Sanderson, 2019; 202a).

In order to restore control over trauma reactions and reset the alarm system, it is important to identify the range of triggers that lead to emotional dysregulation. Initially, this involves recognising and identifying emotions, and developing grounding techniques such as breathing, mindfulness and self-soothing skills that increase distress tolerance and widen the Window of Tolerance (Ogden, Minton & Pain, 2006) by regulating overwhelming trauma reactions. These techniques can include regular exercise to discharge trapped energy, adrenaline and distress hormones (Levine, 1997; Payne, Levine & Crane-Godreau, 2015) or relaxation and mindfulness skills that pay attention to body sensations and increase physical awareness (Rothchild, 2017; van der Kolk, 2015)

Rather than meditation or relaxation techniques that involve closing of the eyes, which is likely to trigger the alarm system and activate dissociation, it is better to start off with Progressive Muscular Relaxation (PMR). This involves the tensing and relaxing of various muscle groups to allow the survivor to feel more in control over their body rather than entering a dissociative state. Similarly, mindfulness can impact negatively on some survivors and needs to incorporate trauma safe adjustments such as shorter exposure, open eyes and combining interoception with proprioception (Rothschild, 2017; van der Hart et al, 2019; Sanderson, 2022a).

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Learning new skills for emotional self-regulation to help the survivor stay in their window of tolerance is best achieved through consistent practice. It is helpful to build relaxation and distress tolerance techniques into every session especially at the beginning and before leaving. The most important thing is to help the survivor experiment with a mixture of techniques rather than prescribing a single one. This will allow them to discover the techniques that work best for them, so that they are more able to regulate their emotions.

Psychoeducation is crucial in understanding how the body reacts to distress and to make sense of how trauma impacts on the mind and body. It also helps the survivor to make the link between SSA, trauma symptoms and emotional dysregulation. This, alongside the stabilisation skills, will enable them to learn more adaptive skills to regulate their emotional reactions and tolerate distress when exploring memories of SSA.

Reframing symptoms as adaptations to threat and confusion, or as survival strategies, allows the survivor to have a better understanding of their behaviours. Psychoeducation also empowers the survivor to regain a sense of control and reduce shame and self-blame thereby allowing them to develop compassion for the self and what has happened to them.

Some of the components in the stabilisation phase, such as psychoeducation and grounding skills, can be delivered as group workshops, from which survivors can progress into one-to-one sessions. Many survivors report that group work which emphasises raising awareness and understanding SSA is an invaluable source of support that helps them make sense of their abuse experiences (Sanderson, 2019).

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Phase Two: Processing

Once the survivor has mastered stabilisation skills and widened their window of tolerance, they can enter phase two which focuses on processing the SSA experiences, flashbacks and intrusive memories. In processing their experiences, survivors can come to realise the harm done and become aware of distorted perceptions of self, others and the world which can be challenged to restore reality and belief in themselves. In addition, survivors can begin to reallocate shame and responsibility, and grieve the many losses associated with SSA. In releasing the pain and sorrow, they can begin to feel empathy and self-compassion for the child that was hurt and betrayed.

Remembering and realisation can be excruciatingly painful, especially if the survivor has dissociated from the experiences, or buried them. Practitioners must make sure that this exploration is appropriately paced so that the survivor is neither rushed nor becomes too focused on recovering memories and details of the abuse, as these may lead to desensitisation and numbing rather than integration. As feelings and memories are revived it is important to help the survivor to grieve their losses and begin to make meaning of their SSA.

Phase Three: Integration

The final phase aims to integrate the abuse experiences and create meaning. This paves the way for post-traumatic growth, in which the survivor is able to reconnect to the self, others and the world. As their view of themselves and others change, they can form healthy attachments to others without fear or shame, and begin to live in the present (Sanderson, 2019; 2022a). In essence, post-traumatic growth allows for renewed purpose and meaning, a greater appreciation of life, vitality as well as feeling more alive.

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The Therapeutic Relationship

The therapeutic relationship is fundamental to restore relational worth and aid recovery. It is also an opportunity for the survivor to experience new ways of relating and develop relationship skills which they can use to build, or rebuild relationships with others, including family members. To undo the effects of SSA, it is crucial that practitioners are able to offer a genuinely warm, human relationship in which the survivor is valued and respected. To achieve this it is crucial to adopt a collaborative and non-hierarchical approach in which the survivor is able to take equal control of their healing rather than being controlled and directed by the therapist and their therapeutic modality (Sanderson, 2013). Trauma wise practitioners need to be able to be non-coercive, flexible and pace the work within limits that are manageable for the survivor (Sanderson, 2019). This necessitates establishing a supportive, non- judgemental, non-shaming and sensitively attuned therapeutic relationship in which the survivor feels safe.

In addition, it is vital to create a collaborative working alliance in which shared agreements are made about expectations of both parties, and how these can be managed, along with relational safety, especially as the therapeutic relationship unfolds and grows. In order for the therapeutic process to be truly empowering, agreements need to be bidirectional rather than imposed and controlled by either party, and be open to negotiation as the therapeutic relationship evolves. To facilitate this it is prudent to have regular reviews of how the survivor feels about the therapeutic process, the regulation of connection, the therapeutic goals, and to what extent these are being achieved. Through such open discussion both the survivor and practitioner can stay on track and revise and re-negotiate as necessary (Sanderson, 2022b) to more effectively manage both client and practitioner expectations, and retain a realistic, positive and hopeful outcome.

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Bearing in mind that survivors tend to experience relationships as sources of danger rather than comfort, TWP's need to be mindful when building the therapeutic relationship that the attachment system will be activated which, rather than induce a sense of comfort and safety, can engender anxiety, fear and dissociation. As proximity and intimacy can lead to the hyperactivation of the attachment system it has the potential to trigger frightening material, flashbacks and intrusive memories. The concomitant emotional dysregulation in turn significantly reduces the capacity to mentalise and can lead to further distress in the therapeutic relationship (Fonagy and Adshead, 2012). It is crucial to balance working on relational fears and the capacity to mentalise in order to fortify the therapeutic relationship. This needs to be sensitively paced and TWP's need to be mindful of not making unrealistic demands for trust or being overly reassuring as this can increase distress and anxiety and replicate abuse dynamics, leading to further disorganisation of the attachment system which can undermine the healing process and may cause harm.

Practitioners need to be aware of their own attachment histories and attachment style as their attachment system can become hyperactivated when working with survivors or when experiencing relational difficulties in their personal life. This can equally lead to a loss of mentalising function, lack of mirroring and attunement, and impaired reflective functioning. If left unchecked, these can increase the survivor's anxiety and evoke traumatic re-enactments, or elicit practitioner defences or acting out (Sanderson, 2013).

Rather than stress the need for trust, the central focus needs to be on building a connection to counteract the disconnection and betrayal of trust inherent in SSA. It is essential that practitioners promote mutually empowering ways of engaging in relationships and embrace the restorative healing of power-in-connection (Jordan, 201; Miller, 2015). Such connection has to be offered and not be seen as the sole responsibility of the survivor. In offering a genuinely human relationship based on mutuality, empathy and compassion, survivors can experience relational worth and begin to connect to the self and others (Jordan, 2017; Miller, 2015). To facilitate this, TWP's need to ensure that that they are authentic, visible and fully engaged in

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the therapeutic process. It is helpful to regularly monitor and check with the survivor to what extent they feel connected and to be aware of signs of disconnection and withdrawal, and address these. They will need to understand that disconnection can occur for a variety of reasons, not least when the intensity of intimacy and connection becomes unbearable necessitating the need to withdraw. Survivors commonly oscillate between wanting to be connected and fearing connection, which leads to approach-avoid behaviours which need to be recognised as protective strategies (Sanderson, 2022a).

Practitioners need ensure that they remain present and attuned despite such testing behaviours and are able to track what is felt in the moment and be reflective rather than reactive. As the therapeutic relationship is integral to healing and recovery it needs to be tended with care and sensitivity, with practitioners remaining consistent and predictable especially when survivors present with disorganised attachment style or whose lives are in a constant state of flux or chaos. Practitioners will need to guard against their own destabilisation and ensure that they are able to tolerate uncertainty and unpredictability (Sanderson, 2013, 2022b). In order to manage any fluctuations, impasse and ruptures in the therapeutic relationship TWPs need to demonstrate their constancy and consistency in their support of the survivor. In addition, it is essential that when there are ruptures that these are explored and the relative contribution of both parties is discussed. If some of the responsibility for the rupture lies with the practitioner it is imperative that he or she apologise. This is particularly important as survivors rarely receive apologies for the SSA or harm done to them. Receiving a genuine apology can be very healing as it reduces the tendency to blame and shame the self or taking responsibility for other people's actions and behaviour (Sanderson, 2019). It also provides an opportunity for the practitioner to model human frailty in making errors or mistakes, and the power of apology and willingness to repair any harm done. Invariably it is the repair of the rupture that is more meaningful and healing than the actual rupture.

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To ensure mutuality in the therapeutic relationship it is important for practitioners to take the initiative when a rupture occurs and to apologise for their part in this rather than wait for the rupture to metastasise or for the survivor to challenge them. Such openness and honesty is integral to feeling safe in relationships as it reduces the need to mind read. Mind reading is an indispensable skill which enables people to survive dangerous and frightening experiences as it helps them to pre-empt danger and put protective strategies in place (Sanderson, 2013; 2022a). The need to mind read invariably indicates fear, confusion or lack of safety, and necessitates the survivor exiting their frame of reference by coming out of their mind in order to enter the mind of the practitioner, and thereby losing contact with their sense of self. To avoid replicating the need to mind read, TWPs need to be explicit in their communication and encourage clarification of understanding and meaning (Sanderson, 2022b).

In essence TW's need to promote mutuality and equality in the therapeutic relationship in order to truly empower the survivor to restore relational worth and to feel safe in relationships. This needs to be accompanied with a shared understanding of the human condition and a sense of humility. Practitioners need to avoid what Maltsberger and Buie (1974) call the three narcissistic snares faced by clinicians which are 'to know all, to heal all and to love all'. Moreover, it is when survivors feel safe in relationships that spontaneity and positive affect is restored which allows them to experience pleasure and joy in connection and intimacy rather than fear. It will also enable them to set boundaries without fear or shame so that they can flourish and grow.

To facilitate mutuality in the therapeutic relationship, practitioners need to be emotionally well regulated, somatically aware, embodied and be able to mentalise. Through being embodied they can use their body as a tuning fork to resonate with the survivors inner experiencing, and be aware of their own somatic reactions. It is however important not to assume anything and check any perceptions, feelings or thoughts with the survivor. Practitioners need to be able to track client's somatic responses and be aware of any emotional dysregulation in order to know

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when to brake or accelerate exploration of distressing or shaming material (Rothschild, 2000; 2017). If the survivor becomes overwhelmed with unbearable emotions or begins to shut down, or dissociate they will not be able to mentalise or process their experiences. Rather than interpret this as resistance or non-compliance, it is crucial to see this within the context of hyper or hypo-aroused states and the concomitant reduction in cognitive processing. This indicates the need to slow down and re-regulate before continuing further exploration. It is helpful to adopt a dyadic, or co-regulation approach in which both parties demonstrate emotional self-regulation skills in order to remain present and embodied (Sanderson, 2015).

The capacity for dual awareness along with the ability to mentalise enables practitioners to be alert and sensitive to their own as well as their client's moment-by-moment experiencing as well as modelling requisite mentalisation skills (Fonagy and Adshead, 2012). Practitioners need to facilitate mentalisation in survivors so that they are more able to understand their own mental state and the mental state of others. This is best effected through the use of reflection and the modelling of mentalisation skills that enable them to see and hear self and others. In addition, TWPs need to convey to the survivor that they have them in mind, both during and outside of the session, as the sense of someone having them in mind builds a bridge between sessions and reduces the sense of aloneness in the world. To ensure that the survivor is able to acquire the requisite skills to mentalise, TWPs need to make sure that they have mastered a degree of affect regulation as the capacity to mentalise is significantly weakened by intense emotions (Fonagy and Adshead, 2012).

Trauma wise practitioners also need to be open minded and be able to demonstrate flexibility and fluidity of thinking, and avoid reductionist formulations or simple solutions, and be able to tolerate complexity and uncertainty. This is crucial given that many survivors tend to engage in rigid, dichotomous thinking (Sanderson, 2019) and find it hard to employ more nuanced thinking. It is important not to shame survivors for their lack of flexibility in thinking as this has been a necessary strategy that has aided their survival.

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A corollary to this is inflexible behaviours and boundaries. Many survivors try to obtain an illusion of control by engaging in obsessive compulsive types of behaviour that have afforded them a semblance of safety in the past, or by trying to control their environment or others. It is essential that practitioners negotiate and model healthy boundaries which are firm without being punitive, and set appropriate limits (Sanderson, 2022b). These need to be consensually agreed, explicitly stated, and revised as necessary. This is particularly the case with boundaries outside of session contact around touch which need to be explicitly stated at the beginning of the therapeutic contract.

In order to establish an optimal therapeutic relationship despite the myriad fears around connection and intimacy, TWPs need to possess a range of relational skills that demonstrate their trustworthiness and capacity to be present. They need to be attuned, responsive and be able to offer genuine relational warmth (Jordan, 2017; Miller, 2015). In addition, they must be able to sustain connection and remain engaged and avoid being too abstinent as this is reminiscent of the abuse. The focus needs to be on 'being with' rather than 'doing to' and being comfortable with bearing witness to suffering, extreme, terror, rage, shame and chronic loneliness without retreating, or dissociating (Sanderson, 2013; 2022b). Practitioners need to be able to sustain connection and hold the unbearable pain that is too overwhelming for the survivor until they are able to do so. Rather than caretaking, TWPs need to work towards empowering the survivor to reclaim their autonomous self and restore self-agency.

In the presence of a warm, compassionate and genuinely caring relationship survivors can learn new ways of relating to others through setting healthy boundaries, developing more-effective communication skill, reflective functioning and mentalisation. It also helps them to build mutual respect and develop relationship skills. This is a powerful antidote to their experience of relationships as a source of confusion or danger rather than a source of security, warmth and growth. Through this, the survivor can begin to enjoy their relationships rather than fearing shame, rejection or abandonment. This can transform their view of

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themselves and what it means to be connected and thereby lead to empowerment and post traumatic growth (Sanderson, 2022b).

Challenges for Practitioners

Working with survivors of SSA raises a number of challenges such as assessment and safeguarding issues, as well as a fear of re-traumatisation. In addition, some practitioners find it hard to believe some of the abuse experiences and find it difficult to bear witness to the survivors lived experience. A further challenge is becoming aroused when listening to the survivor's experiences. Practitioners need to be mindful that such arousal is not necessarily sexual, but may represent fear and alarm which has been eroticised, and mirrors the survivor's experience (Sanderson, 2019). It is crucial that practitioners are able to take this to supervision, preferably with a trauma trained supervisor, to get the requisite support.

Listening to and supporting survivors can be extremely harrowing and challenging, and professionals must ensure that they are supported in their work with appropriate training, supervision and mentoring. Research has shown that frontline professionals are impacted when working with people who experience trauma or SSA through vicarious traumatisation. It is crucial that practitioners engage in self-care to minimise the risk of burnout or Secondary Traumatic Stress (Sanderson, 2013; 2022) and ensure that they are able to be bear witness and fully support survivors of SSA in their journey to recovery and healing.

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