SIBLINGS OF INCEST VICTIMS: SIBLING-VICTIM RELATIONSHIPS AND ADJUSTMENT

DISSERTATION

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The non-victimized siblings in incestuous families have often been ignored in research, literature, and treatment. This study explored these siblings' 1) relationship to the victim, 2) attribution of blame, and 3) adjustment. Participants were 30 non-victimized siblings of incest victims, between the ages of 8 and 14. They completed the Sibling Relationship Questionnaire, the Revised Children’s Manifest Anxiety Scale, the Self-perception Profile for Children, the Children’s Depression Inventory, and a questionnaire developed for this research. Participants’ scores were compared with the normative sample scores on several measures.

Siblings perceived little warmth and closeness in their relationships to their victimized sisters. Rivalry and conflict were within normal limits. Siblings blamed victims and other family members less than expected, with the greatest amount of blame attributed to perpetrators. Adjustment was impaired. Males demonstrated less athletic competence, less global self-worth, more worry and oversensitivity than normative samples. Females showed a
tendency toward less global self-worth and heightened general anxiety. Siblings' overall level of emotional distress was higher than most of the normative samples.
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CHAPTER I

INTRODUCTION

Child molestation is a major problem in our society. Mental health professionals, law enforcement agencies, and the general public have serious concerns for the innocent victims of child abuse and their families. Incest is one form of child molestation which may have dramatic effects on all family members. While the victims in these families have received the most amount of public attention, other family members, especially siblings, have often been neglected. The main purpose of the present research was to systematically explore the role siblings play in incestuous families. To begin with, the literature on child sexual abuse was summarized. This included current knowledge of the incidence and etiology of intrafamilial sexual abuse. Descriptions of the personality characteristics of incestuous family members and the interpersonal dynamics involved are discussed. Finally, broad research questions as well as specific hypotheses regarding sibling relationships and sibling adjustment were derived.

Although incest is only one form of childhood sexual abuse it was the focus of this research for a number of reasons. Compared with other forms of sexual abuse, incest
has often been viewed as the most traumatic type for the victims and their families (Finkelhor, 1979). The pathological nature of the relationships within an incestuous family can have dramatic and serious consequences for the future functioning of the family unit. Because the victimization occurs within a caring relationship, the victim is dependent upon the perpetrator for protection and nurturance and cannot easily express hatred toward the parental figure (Herman & Hirschman, 1977). Feelings of ambivalence toward the perpetrator by the victim and other family members hampers any successful resolution. In addition, incest has been less frequently reported than extrafamilial sexual abuse. It may continue unnoticed and/or unreported with multiple episodes not infrequent. Whereas extrafamilial sexual abuse may occur only once in an isolated episode, the progression of intrafamilial sexual abuse has often led to more serious and detrimental long-term effects. All family members, either directly or indirectly, have been affected by the abuse. Primarily, the literature focuses on the victim and the victim's parents. However, adjustment may also be difficult for the siblings of incest victims. Unfortunately, many siblings become victims of incest as well. It is not uncommon to have successive victimization of daughters in an incestuous family (Vander May & Neff, 1982).
Over the past decade, discussions of incest and other forms of child sexual abuse have become more frequent. The public and mental health professionals have become more cognizant of the possible negative impact sexual abuse may have on victims and their families. There have been efforts to protect children. Recent media coverage has served to increase the public's interest and concern. This awareness and the adoption of local legislation mandating the reporting of suspected cases in many states has resulted in an increased number of reports and referrals to child protective service agencies. As more victims and their families enter the mental health and legal systems, the need for effective and timely treatment programs increases. Only through a better understanding of the dynamics of incestuous families can treatment programs improve. Case studies and theoretical monographs on incestuous families abound (Vander May & Neff, 1982). However, in spite of the increased attention, there has been a serious shortage of empirical research on incestuous families.

Many sexual abuse treatment programs in this country have tended to focus on the identified victim, the perpetrator, and the perpetrator's spouse. Few programs involved the victim's siblings in treatment (de Young, 1981). Moreover, while scholarly literature on incestuous
and abusive families has increased in recent years (Lystad, 1982), mention of siblings has been minimal and incidental (Cohen, 1983; Swanson & Biaggio, 1985). Although siblings may not be the direct victims of sexual abuse, they may be victims of pathological family relationships. As such, their psychological well-being should be carefully considered when evaluating the effects of abuse on the family. In addition, siblings’ reactions to the abuse and their possible involvement in the abuse (e.g., through collusion or setting up the victim) may have significant implications for the family’s prognosis. This research attempted to systematically identify some of the dynamics that exist between victim and sibling. Because there is little, if any, published empirical research on the siblings, an exploratory approach was utilized.

There exist a number of problems that impede the progress of research on sexual abuse. These factors include concerns about confidentiality, underreporting, and inconsistencies between theoretical assumptions derived from case material and results of empirical research (Chandler, 1982). Additionally, different definitions of what constitutes incest has led to confusion and misinterpretation of the research. Both psychological usage and legal definitions of the term incest have been imprecise and, at times, conflictual. In some states
incest is defined simply as sexual intercourse between family members. As of 1983, 24 states have extended their legal definition to include stepparents and stepchildren. Only five states considered all forms of sexual contact between family members to fall within their definition of incest (Thorman, 1983). For present purposes, incest includes any form of sexual contact between an adult and a child when the perpetrator has power and authority over the victim. Thus, incest refers to sexual contact that occurs between a child and his or her biological or adoptive parent, stepparent, grandparent, uncle, aunt, or parent's live-in partner.

Incidence and Prevalence

Reported rates of intrafamilial sexual abuse vary greatly in the literature. Reasons for the apparent differences include different definitions of what constitutes sexual abuse or incest, the age range of the samples, and the particular sampling methodology. In spite of such problems, however, it is clear that incest is a widespread problem. Schlesinger (1982) examined the 1982 national statistics and found that approximately 25 percent of all females and 10 percent of all males were victimized. This included incest as well as extrafamilial sexual abuse. Herman (1981) reviewed the data from five surveys taken since 1940 which have gathered information on more than
5,000 women. She found the results to be fairly consistent across time and geographical regions of the United States. One-fifth to one-third of the respondents reported having had a childhood sexual experience with an adult. The perpetrator was a relative in 4 to 12 percent of these reports. Only 1 percent of the women reported having a sexual encounter with their father or stepfather. Russell (1983) took issue with these findings asserting that none of the surveys Herman reviewed used representative samples. Russell's survey examined both extrafamilial and intrafamilial sexual abuse in a random sample of 930 women in the San Francisco area. However, due to a high refusal rate (36%) and an inability to contact many subjects, the respondents represented only 50 percent of the total population sampled. Russell defined sexual abuse as one or more unwanted sexual experiences ranging from petting (touching or attempts at touching breasts or genitals) to forced sexual intercourse before the victim's 14th birthday, and completed or attempted forced intercourse between the ages of 14 and 17. Using these criteria, 16 percent of her sample reported at least one episode of intrafamilial sexual abuse prior to the age of 18, and 12 percent had been abused by a relative before the age of 14. Thirty-one percent reported at least one instance of extrafamilial sexual abuse before age 18, while 20 percent
were abused prior to age 14. Among these respondents, only 2 percent of the intrafamilial and 6 percent of the extrafamilial abuse cases were reported to authorities at the time of the abuse.

In a study on the incidence of childhood sexual abuse in Texas, Kerchner and McShane (1984) sent questionnaires to a representative sample. Of the 2,000 adults who were contacted, 53 percent responded. Childhood sexual victimization was reported by 7.4 percent, 82 percent of whom were female. The definition these authors used was fairly broad, including any contact between a child and another person who is significantly older and/or in a position of authority or control over the child. Additionally, their definition included incest, prostitution, and any obscene or pornographic photographing or filming of children. Unfortunately, due to the low response rate, there is no way of knowing whether and how respondents may have differed from non-respondents.

Childhood intra- and extrafamilial sexual abuse occurs among all socio-economic strata (McFarlane & Waterman, 1986). Studies based on court referrals may give the false impression that it occurs more frequently in the lower classes (Herman & Hirschman, 1977). Newberger, Reed, Daniel, Hyde, and Kotelchuck (1977) pointed out that low income families were overrepresented in official reports.
Giaretto (1976) studied 300 incestuous families. He found that these families were racially and professionally representative of the county’s population. The mean educational level was 12.5 years and the average income was approximately $13,500. Giaretto speculated that lower income groups come to the attention of social service agencies more frequently than other income groups. Therefore, they may be reported more often.

Finkelhor (1979) asserted that the most common type of incest occurs between an adult male and a female child. His estimation was that approximately 1 percent of all female children experience incest. Only two cases of mother-son incest were found using different samples (Justice & Justice, 1979; Weinberg, 1955) of incestuous families ($N = 112$ and $N = 203$, respectively). De Francis (1967) found that 92 percent of the victims in his sample were female and 97 percent of the perpetrators were male. However, his study was not limited to incest. While the percentage of male victims appears quite low, reported rates may actually underestimate the true incidence. Chandler (1982) suggested that more stigma is attached to male child victimization which leads to disproportionate underreporting.

In general, approximately 75 percent of sexual abuse cases involve a perpetrator who was either a relative of the
child or well-known to the child and the child's family (De Francis, 1969; Finkelhor, 1979; Schlesinger, 1982). With regard to incest, father-daughter relationships or stepfather-stepdaughter relationships are the most common forms, occurring in about 70 percent to 80 percent of the cases (Goodwin, 1982).

Etiological Theories

There have been a number of explanations offered for the occurrence of incest despite the strong cross-cultural taboo against intrafamilial sexual behavior. In Western culture, incest may be simply a by-product of patriarchal society (Brownmiller, 1975; Herman & Hirschman, 1977; Lystad, 1982). In the sociological view, patriarchal society fosters an envy and admiration of the masculine image among daughters and mothers are seen as weak and ineffectual (Thorman, 1983). Herman and Hirschman (1977) asserted that women are seen as the possessions of men. Although a young boy yearns for his mother, he learns that when he grows up he, too, will possess women. Daughters, on the other hand, are the property of their fathers, to be given away at marriage. Thus, boys learn to control and dominate while girls learn that they are the less powerful sex. Herman and Hirschman suggested that daughters can only obtain power indirectly by being favored by a powerful male. In addition, it is the traditional superordinate-subordinate
male-female relationship which allows and condones the use of power (Conte, 1982). Brownmiller (1975) stated that although the father enforces the prohibition against mother-son incest, he (by virtue of his power) breaks the rule against father-daughter incest. She believed that this is mainly what accounts for the different rates of father-daughter and mother-son incest.

The sociological perspective may be of particular value because it places the responsibility for incest upon society. In this way, blame shifts from the victim or the victim's mother and potential solutions can be advanced and addressed. However, blaming society does not yield a complete explanation. Some of the insistence that a male dominated society is the main cause of the high prevalence of incest could be a reaction against the outdated view that the mother is the "cornerstone in the pathological family system" as Lustig, Dresser, Spellman, and Murray (1966, p. 39) have stated. While the sociological perspective has merit and contributes to understanding etiology, other views, derived from psychological theory and clinical experience, may lead to a deeper understanding and to more practical solutions to the problem of incest.

Freud, by altering his original theory and disbelieving his female patients' reports of early childhood sexual experiences with their fathers, stifled progress in the
treatment of incest for many years. Believing that these women were only fantasizing, he denied appropriate treatment for those who had actually experienced incest. This made it easier for society to blame the victim. In classical psychoanalytic theory, the children who are unable to resolve normal incestuous feelings of the Oedipal period are likely to develop hysteria and, consequently, may be held responsible for real or imagined early incestuous experiences (Rosenfeld, 1977). Other psychoanalysts disputed Freud's beliefs. Ferenczi (1933) believed that many women had actually been in childhood incestuous relationships. These relationships had deleterious effects upon ego development, making it difficult for them to cope and compromising their ability to interact adaptively with others (Rosenfeld, 1977).

The view that the early psychoanalytic school perpetuated began to be replaced in the 1950s by a model of family dysfunction (Kaufman, Peck, & Tagiuri, 1954). However, while the focus moved away from the child as the guilty party, the majority of the blame and responsibility for the incest fell upon the mother. Although in many instances she may share some of the responsibility for disturbed or dysfunctional family relationships, the perpetrator is most responsible for the occurrence of incest, and should probably bear the brunt of the blame.
Personality Characteristics and Family Dynamics

The current state of knowledge on the personality characteristics of incestuous family members is incomplete and imprecise. Although detailed descriptions are frequently cited in the literature, they are usually based upon clinical observations. Furthermore, there are few methodologically sound empirical studies that fully support these detailed descriptions. Most personality descriptions or characteristics based upon empirical research are limited due to sampling problems. The most obvious problem results from selection procedures which use only identified victims and perpetrators. Because incest is one of the most infrequently reported forms of child abuse (Schultz & Jones, 1983), only a small percentage of the population of incestuous families is identified. The majority of incestuous families do not get reported to the authorities, do not seek treatment, and, hence, do not become involved in clinical research. Generalization becomes difficult because it is not known how the identified subjects differ from those incestuous family members who are not identified. There is also a more subtle problem which may result from using only identified subjects. It is possible that the process of being identified, in some way, alters the subjects' thoughts, beliefs, feelings, or attitudes about the incest. For
example, identified perpetrators might experience more
guilt than nonidentified offenders, and identified victims
may experience less stress and anxiety than nonidentified
victims. Thus, the following descriptions should be
considered tentative and attempts at generalization should
be made with caution.

Perpetrators

Recent psychological explanations have focused on
individual and family dynamics of the incestuous family. A
number of authors (Groth, 1982; Julian & Mohr, 1979;
Lystad, 1982) have examined personality characteristics of
perpetrators in an effort to better understand the
occurrence of incest. Because most of this work has been
conducted with male perpetrators, the present discussion
will be limited to these offenders.

With regard to demographic variables, the incest
perpetrator cannot be distinguished from those who do not
commit incest. According to Groth (1982) offenders do not
differ from nonoffenders with regard to level of education,
occupation, race, religion, intelligence, or mental status.
However, Julian and Mohr (1979) compared incestuous
families with physically abusive families and found
differences in the age range, ethnicity, income, and
education level of the perpetrators. This national study
compared 102 cases of father-daughter incest with 8,955
cases of physical abuse by fathers. The age of incest perpetrators was older (35 to 49) than the majority of male perpetrators of physical abuse (20 to 34). The ethnicity distribution of incest offenders approximated that of the general population while minority groups appear to be overrepresented among physical abusers. However, lower income and minority groups may be identified more often than other groups. Paradoxically, although incest offenders had higher levels of income than did the abuse perpetrators, they had lower educational levels. Julian and Mohr suggested that the higher ages of incest offenders may be associated with more years of working and higher salaries. While incest offenders may differ on some demographic variables when compared with specific subpopulations, they seem to be indistinguishable from the general population with regard to most demographics. Nevertheless, they may differ in their ability to cope with life stresses and may seek relief from these stresses by engaging in sexual activity with children.

Various researchers have attempted to develop typologies or classifications of the incest perpetrator. Justice and Justice (1979) classified offenders into four groups. The largest group was labeled "symbiotic personalities." These offenders, due to a lack of nurturance, closeness, and attachment in their own
childhood develop a strong need for affection and warmth. Often, they have been unsuccessful meeting these needs in an adaptive manner or have never learned the appropriate skills to meet these needs in a nonsexual way through adult relationships (Cormier, Kennedy, & Langowitz, 1962; Justice & Justice, 1979; Lustig et al., 1966). Instead, they seek to fulfill their longing for closeness through sexual contact with their daughter. Groth's (1982) typology of the "regressed" offender closely resembles the symbiotic personality. Groth sees their primary sexual interest in adult-adult rather than adult-child relationships. However, when their adult relationships become conflictual with responsibilities and demands increasing, these men begin to be sexually attracted to children. They are drawn to children sexually in an attempt to replace their adult relationship and subsequently relate to the child as an adult or surrogate marital partner.

The second type of offender, according to Justice and Justice (1979), was the "psychopathic personality" who seeks excitement, stimulation, and novelty. They are often aggressive and hostile in their quest for stimulation, with sexual activity being only one outlet. These men are often without guilt and are superficial in their expressions of affection. The psychopath who commits incest is often promiscuous and rarely limits his sexual activity to his
daughter. The percentage of incest offenders in the psychopathic personality category is small.

"Pedophiles" or "fixated" offenders in Groth's (1982) terminology constituted the third type of incest offender in Justice and Justice's (1979) classification. This offender has a primary or exclusive sexual attraction to children. Their psychosexual development has prematurely arrested and they are only erotically stimulated by children (Groth, 1982). To Groth, these fixated offenders may often "adapt their behavior and interests to the level of the child in an effort to have the child accept them as an equal" (p. 216). Like the psychopathic personalities these pedophiles make up only a small percentage of incest perpetrators.

Justice and Justice's (1979) final category consisted of all other offenders. The majority of these are psychotics and perpetrators whose culture sanctions incest. Although most incest offenders do not have psychotic tendencies (Sgroi, 1982).

While incest offenders may not possess any specific set of personality traits they do tend to exhibit a number of noticeable characteristics or attributes. Often they relate to others in a passive-dependent submissive style seeing themselves as helpless in the face of external forces and events which exert control (Groth, 1982).
Offenders are often socially withdrawn and isolated, experiencing feelings of emptiness, depression, and fearfulness (Groth, 1982; Panton, 1979). In an empirical study by Panton (1979) male incest offenders (N = 35) obtained MMPI profiles indicative of inhibition, feelings of insecurity, self-alienation, despondency, and fear. These feelings may cause incest offenders to withdraw from conflictual adult relationships and to substitute relationships with a child in order to meet their needs. Alcohol abuse is often a common characteristic of sex offenders and perpetrators of incest (Julian & Mohr, 1979, Justice & Justice, 1979; Lystad, 1982; Maisch, 1972; Sgroi, 1982; Spencer, 1978; Weinberg, 1955).

Although the incest offender may appear as a passive, dependent, helpless victim of circumstance to the outside world, he is often the dominant, powerful, controlling authority in the household. Male incest offenders may be overinvested in their families, and overly controlling of family members (Cohen, 1983; Sgroi, 1982; Weinberg, 1955). Sgroi (1982) described the incest offender as a "me-first" individual. His main goals are to satisfy his own needs first by maintaining control of all family members. His sexual behavior with a child serves to satisfy many nonsexual needs (Groth & Burgess, 1977). The offender can feel safer and less threatened with a child than in an
adult relationship. The child makes fewer demands on him and the relationship is less problematic.

Mothers

Descriptions of non-participant mothers in incestuous families should be considered with caution. Again, a complete and consistent picture may be lacking due to the small percentage of mothers represented in the literature. With large estimates of the incidence of incest and only small numbers of identified mothers in such families, any effort at generalization should be guarded.

Many mothers in incestuous families appear to have a history of rejection and emotional or physical abandonment (Cohen, 1983; de Young, 1981; Finkelhor, 1979; Lustig et al., 1966; Thorman, 1983) often resulting in poor social and parenting skills (Cohen, 1983; Finkelhor, 1979; Sgroi, 1982). These women are frequently reported to be chronically depressed (Browning & Boatman, 1977; Sgroi, 1982), weak, submissive, passive, and dependent (Cohen, 1983; Herman & Hirschman, 1977; Sgroi, 1982). A majority of these mothers are emotionally or physically absent from relationships at home and often have withdrawn sexually from their husbands prior to the incest (Meiselman, 1978; Sgroi, 1982). They may be chronically ill, disabled, or have a number of physical complaints, often with no organic basis (Herman & Hirschman, 1977; Sgroi, 1982). Many of the
mothers in incestuous families are victims of physical abuse by their husbands (Brown, 1979; Finkelhor, 1979; Herman & Hirschman, 1981; Truesdell, McNeil, & Deschner, 1985).

**Parental System**

None of the personality characteristics of incest offenders or mothers of incest victims occur in isolation. Their beliefs, needs, self-concept, temperament, et cetera all interact to set the climate for the occurrence of incest. The common notion in the incest literature is that both parents have experienced severe emotional deprivation at some point in their lives. They have received little nurturance, affection, care and concern and have had difficult and painful experiences with separation and/or rejection. Because of such experiences they feel a need to keep the family together at all costs. In addition, many perpetrators tend to view the outside world as hostile and promote this view within the family, encouraging their children to only trust family members and to curtail all outside relationships. Perpetrators are often the sole authority over all decision making and demand that all social needs be met within the family. Incest serves the function of meeting their needs internally while keeping the family together (Lustig et al., 1966). The elements of secrecy and denial often found in these families reflect the need to protect against the family’s disintegration.
(Cohen, 1983). Family members' collusion, whether overt or covert, conscious or unconscious, similarly helps to protect the family's precarious cohesion while maladaptively meeting some of their needs.

Emotional deprivation in their family of origin may have led these parents to seek a nurturant and caring relationship. However, neither spouse has the ability to satisfactorily meet the needs of the other so both turn to their daughter, albeit in different ways. In the majority of incestuous families, mothers have reversed roles with their daughters which, according to Justice and Justice (1979), "expresses the mother's struggling attempt to get the care and nurturing that she missed in her own childhood" (p. 97). Many mothers are relieved when the daughter becomes the female authority in the household, is responsible for making decisions, taking care of other children, and mothering her mother. The role reversal also enables the daughter to easily slip into the role of surrogate wife to the father. As surrogate wife she fulfills his needs for a nurturant, affectionate, and compliant partner including the sexual needs to which the father feels entitled.

Victims

It is most often the oldest daughter who is placed in the role of adult (Cohen, 1983; Lystad, 1982). This
parental position affords the victim a larger measure of power and importance (Cohen, 1983; de Young, 1981; Herman & Hirschman, 1977). She may recognize her parents' pervasive separation anxiety and is thus implicitly (or even explicitly) given the major responsibility of keeping the family together (de Young, 1981; Thorman, 1983). Because victims are often socially isolated (Cohen, 1983) and frequently have low self-esteem (Herman, 1981), this position of power may be particularly appealing. It may serve to keep them safe from total isolation and abandonment while also meeting their needs for attention and affection. Many victims receive special privileges and gifts from the perpetrator (de Young, 1981). The sexual relationship with their fathers similarly serves to meet their needs for closeness, warmth, and nurturance (Cohen, 1983). Herman and Hirschman (1977) found that victims rarely expressed anger toward their father. Rather, they found that victims often received special treatment from him and felt that they had a special relationship.

The partial fulfillment of the victim's needs for nurturance and affection, may contribute to maintaining the secrecy about the incest and to the low rates of reporting. However, there are a number of more salient reasons which may lead the victim to keep the incest secret. While victims may report incest more frequently than mothers
(Cohen, 1983), they often do not trust their mothers or do not believe that their mothers will do anything about it. Often, their past attempts to report it to others have been unsuccessful (Breines & Gordon, 1983). Victims may be afraid that their mothers and/or relatives will not believe them. Furthermore, they may fear retribution from the perpetrator. Reporting the incest to outside agencies can be very threatening to the victim. This may lead to severe disruption of the family, the offender's incarceration, the parent's divorce, or the victim's own removal from the home.

In addition, the victim may feel a great deal of guilt, blame and responsibility for the abuse and may, therefore, be fearful of disclosing. Children, especially young children, due to their developmental egocentrism, often feel responsible for events that are realistically not under their control (Damon & Waterman, 1986, chap. 3; Wallerstein & Kelly, 1980). Alternatively, some victims, in order to achieve a sense of power and control over a situation of increasing helplessness, may begin to believe that in some way they provoked the abuse (Summitt, 1983). The development of this self-blame may serve to inhibit victim's disclosure of abuse.

Many empirical studies which have attempted to elucidate the effects that intrafamilial sexual abuse has
on victims, suffer from methodological problems. First, when subjects are only selected from reported cases of victimization, results may be difficult to generalize to the larger majority of victims whose abuse has not been reported. Furthermore, since only the most serious cases of abuse may be reported, a sense of the pathology of the victims may be somewhat distorted. Secondly, many studies use adult samples of women who were incest victims during their childhood. These retrospective studies may selectively sample from a small proportion of victims, namely those who are willing to discuss their abuse. Whether these victims are individuals who are least affected or most affected by the abuse is unknown. In addition, the accuracy of the reports may be distorted depending upon the amount of time that has passed since the abuse. This is especially true when studies attempt to assess short-term effects by asking women to recall traumatic events that occurred many years ago. Despite these problems, there is reasonably consistent information on the short and long-term effects that incest victims experience.

Currently, there is disagreement regarding the effects of incest depending upon the age of the victim. Cohen (1983) believed that the younger the child the more serious the consequences will be on their personality development.
However, this hypothesis has not been supported by research. One methodologically sound study which found significant differences between age groups, used measures of overt behavior, somatisized reaction, internalized emotional stress, and self-esteem (Tufts, 1984). The 7 to 13-year-old age group exhibited the highest rate of pathology. Forty percent of the victims studied scored in the seriously disturbed range based upon multiple criteria. Only 17 percent of the 4 to 6-year-olds met the criteria for the category of "clinically significant pathology."

In a recent and comprehensive review of the literature on the impact of child sexual abuse, Browne and Finkelhor (1986) indicated that the most commonly reported initial effect is fear. Other short-term emotional effects include anger, hostility, (Browne & Finkelhor, 1986), depression and shame (Deaton & Sandlin, 1980). Empirical studies have demonstrated that victims have a high degree of self-blame or guilt (DeFrancis, 1969) and that victims of sexual abuse, (as compared to other types of abuse), "...always blame themselves, regardless of the severity or frequency" (Ney, Moore, McPhee, & Trought, 1986, p. 517).

Behavioral disturbance may be characterized by defiance, frequent fighting with siblings or peers (DeFrancis, 1969), truancy, running away, drug and alcohol abuse, suicidal acts, and inappropriate sexual behavior
Friedrich, Urguiza, and Berlke (1986) looked at behavioral disturbance in children who had been sexually abused within the past two years. Using the Child Behavior Checklist (Achenbach & Edelbrock, 1983) they found that 46 percent of their sample had significantly elevated scores on the Externalizing scale suggesting many undercontrolled behaviors. In addition, 39 percent of their sample showed elevated Internalizing scale scores, suggesting patterns of depressed, inhibited, and anxious behaviors.

Depression is the most frequently reported symptom among women who were molested as children (Browne & Finkelhor, 1986). Self-destructive behavior may also be common. Briere (1984) using a sample of 153 counseling center clients, found that 54 percent of sexual abuse victims versus 34 percent of nonabused clients, had a history of suicide attempts. Anxiety, tension, feelings of isolation, and low self-worth are also supported by empirical research (Browne & Finkelhor, 1986).

Incest may have long-term effects on interpersonal relationships. Many women report feelings of rage and hostility towards their mothers and fathers (de Young, 1982; Herman, 1981). In a study by de Young (1982) 79 percent of her sample reported feelings of hostility toward their mothers, while only 52 percent reported predominant
feelings of hostility toward the perpetrator. Similarly, Meiselman (1978) reported that 60 percent of incest victims in her sample disliked their mothers while 40 percent demonstrated strong negative feelings toward their fathers. Women who have been victimized as children also appear to demonstrate long-term problems with sexual functioning. Both Herman (1981) and Meiselman (1978) reported high rates of sexual dysfunction among victims of incest. Other long-term effects that have been noted are prostitution (James & Meyerding, 1977) and substance abuse (Peters, 1984).

Siblings

Although siblings of incest victims are often ignored in the literature, knowledge of the dynamics of incestuous families is not complete without discussion of the part played by siblings. Furthermore, one can no longer ignore the serious effects that incest and the disclosure of the incest can have on siblings of the victims. What we know about siblings in incestuous families is at best tentative, even more so than what is known about perpetrators, mothers, and victims. Few articles and monographs have dealt with the role siblings play in these families. Furthermore, few research articles have addressed the effects that incest, or the disclosure of the incest, may have on siblings (Swanson & Biaggio, 1985).
This inattention to siblings in the literature may parallel the inattention siblings receive in incestuous families. They seek nurturance and affection that is often lacking (de Young, 1981). They may often feel rejected by both parents because many of these siblings have highly authoritarian fathers, and mothers who have eschewed parental functions (Berry, 1975). These feelings of rejection may be compounded further when siblings recognize the special privileges and attention often received by the victim (Sgroi, 1982). Feelings of worthlessness and rejection may be complicated with intense feelings of resentment, jealousy, and rivalry toward the victim (Berry, 1975; de Young, 1981). As mentioned above, the victims in these families often assume the role of surrogate parent and are given control and authority over their siblings. This may lead to increased resentment, discipline problems, and much confusion over appropriate family roles (de Young, 1981).

Some siblings may, unconsciously or consciously, act to set up their brother or sister for further victimization (de Young, 1981; Sgroi, 1982). This collusion occurs most often when there has been some threat of harm to the victim and the incest is being kept secret by coercion (de Young, 1981). In this case, collusion serves to protect the sibling from becoming the next victim. As with mothers,
severe separation anxiety and a fear of the dissolution of the family may also motivate siblings to collude in the incestuous relationship (de Young, 1981; Kibbie, 1984; Swanson & Biaggio, 1985). Collusion may also occur when victims wish to set up a younger sibling so that they will no longer be victimized (Sgroi, 1982).

Behavioral problems may not be uncommon among siblings of incest victims. According to de Young (1981), efforts to gain needed attention may result in compulsive or self-destructive tendencies such as truancy, running away, or other behaviors. With female victims, siblings may also try to emulate her sister’s pseudomature sophistication and sexuality in an attempt to gain attention. However, this may increase their chances of being sexually victimized by someone outside of the home (de Young, 1981).

As addressed previously, the actual incestuous experience can have dramatic effects upon the victim. In contrast, the trauma for siblings may not be a result of the incest per se, but could be more closely related to events surrounding the disclosure of the abuse. The quality of familial relationships may be a major consideration in mediating the effects of disclosure. Perhaps a sibling’s resentment toward the victim would increase dramatically if a well-liked perpetrator was removed from the home. The sibling may blame the victim
for subsequent problems (e.g., financial difficulties, displacement of family members, loss of friends or outside activities). The sibling as well as the victim may be removed from the home and placed in foster care or with relatives. Alternatively, a sibling may be glad the perpetrator was removed from the home.

Siblings have been observed to react to the disclosure in a number of different ways. They may be angry, depressed, fearful, resentful, and confused (Deaton & Sandlin, 1980) or have strong feelings of guilt, especially if they colluded in some way (de Young, 1981). Male siblings may wonder if they will grow up and become abusive of their own children (Deaton & Sandlin, 1980). While some siblings will react with resentment toward the victim, perhaps because of the dissolution of the family, others may react protectively and with concern (Sgroi, 1982).

Kibbie (1984) explored the behavioral and emotional reactions of siblings in incestuous families. Using a comprehensive questionnaire, much data was gathered from clinicians working with these families. Demographic data and reactions and responses of siblings to the disclosure of the abuse were collected and analyzed. Kibbie found that the most typical response by the siblings (N = 39) to the disclosure of their sister's molestation was to blame the father. This occurred in 30.6 percent of her sample.
The Child Behavior Checklist (Achenbach & Edelbrock, 1983) was also used to assess siblings' behavioral reactions before and after disclosure. Prior to disclosure, siblings were seen to exhibit school problems, oppositional behaviors, truancy, and fear of loss or change. After disclosure, "53 percent developed feelings of shame, 51 percent felt depressed, 74.2 percent feared desertion, 71.9 percent feared removal from home, and 51.7 percent were concerned about (the) breakup of family" (p. 63).

These observations suggest that it may be the disruption of the somewhat stable, but pathological, family system that causes the most distress for siblings. Other potential problems of siblings need exploration as well. For example, very little is known about sibling-victim relationships in incestuous families. Whether a sibling is supportive or resentful and hostile toward the victim may have important implications for intervention. How a sibling views their own, as well as, others' responsibility and blame for the abuse may affect their treatment prognosis.

The present research focuses on two relatively unexplored areas of concern: sibling-victim relationships and siblings' adjustment. First, a systematic exploration into the relationships of victims and their siblings was made. This included an assessment of the sibling's
attitudes toward the victim as well as toward other family members with regard to responsibility and blame for the abuse. Informal observations suggest that sibling-victim relationships, for the most part, are not characterized by nurturance and caring, but by jealousy, rivalry, and conflict. Additionally, siblings appear to have a tendency to blame the victim, the victim’s mother, and the incest perpetrator, in that order. These observations were directly assessed in the present study.

Sibling-victim relationships and siblings’ attribution of blame appear to be mediated by a number of factors including, the sex of sibling and victim, their relative ages, the quality of relationships among other family members, and by the impact of the events following disclosure of the abuse. It was predicted that siblings who were closer in age to the victim would tend to blame the victim more for their abuse than those who were further apart in age. With regard to sex, it was hypothesized that male siblings would tend to blame female victims more than would female siblings. In addition, when siblings’ relationships with perpetrators were reported as highly positive, it was predicted that their relationship with the victim would be less positive, characterized by more conflict and rivalry, and that these siblings would tend to blame the victim and their mothers to a greater extent.
The second area of study analyzed siblings' adjustment. Siblings' adjustment was predicted to be poorer than that of the normative population. Levels of anxiety and depression were also predicted to be high, especially when high levels of family disruption has occurred since disclosure. Siblings were predicted to show relatively low levels of perceived competence in general. Moreover, due to the physical nature of sexual abuse, it was hypothesized that siblings would show low levels of perceived competence in the physical domain.
CHAPTER II

METHOD

Participants

There were several requirements for participation in this study. Participants were the male (n = 18, 60%) and female (n = 12, 40%) non-victimized siblings of incest victims. Each participant had one or more sisters between the ages of 6 and 16 who were victims of intrafamilial sexual abuse. Intrafamilial sexual abuse was defined as exploitative acts involving physical touching between a parental figure (father, step-father, long-term partner of mother, uncle or grandfather) and a female child.

Participants ranged in age from 8 to 14 (M = 11.43 years) (see Table A-1). Children within this age range possess the social, emotional, and intellectual development necessary for accurate assessment of the variables under study. The age range for participants' sisters was limited so that the relative age of sibling to victim would allow for a meaningful sibling relationship to exist with regard to the areas studied, and still be within the school-aged years. The siblings of the participants ranged in age from 6 to 16 (M = 11.36 years).
All mothers reported that each participant was aware of his or her sister's abuse. Some participants did not know the exact details of the molestation. However, all children were aware that their sisters were inappropriately touched and by whom they were molested.

Table A-2 lists the participants by ethnicity. Twenty-one of the participants were Anglo (70%), six (20%) were Hispanic, two (6.7%) were Black and one (3.3%) was of mixed Hispanic and Anglo descent.

Children were selected from child abuse programs within two major metropolitan areas in Texas and California. Participants were drawn from the San Fernando Valley Child Guidance Clinic in Los Angeles County (n = 16, 53.3%), the Dallas Child Guidance Clinic (n = 5, 16.7%), and the Department of Human Resources in Dallas (n = 4, 13.3%). The remaining five participants (16.7%) were obtained from a variety of clinics in the Los Angeles area.

The families of participants were either currently in treatment or entering the treatment process. All victims (i.e., participants' sisters) had at least two weeks of treatment with a mean length of 34 weeks. The length of treatment for the sibling sample ranged from no treatment to two years with a mean length of 14 weeks. The mean time between disclosure and entrance into treatment was 24 weeks ranging from families that entered treatment within one
week of disclosure to 163 weeks (approximately three years). Families had disclosed the abuse from 6 to 288 weeks prior to the actual testing date, with a mean time of 56 weeks.

Of the 45 families contacted, 35 (77.7%) agreed to participate. The response rate may be artificially high due to therapists' prior screening out some of the families. It was not possible to complete interviews with five (14.2%) of the children. Some potential respondents were excluded because their therapist suspected that they were victims of sexual molestation.

**Materials**

Demographic data were gathered from case records and from mothers of participants (see Appendix B). Data included the number and age of family members and their relationship to the sibling and victim (e.g., biological father, adoptive father, or step-father). Parents' ages, occupations, education level, and ethnicity were also obtained. Any changes in family constellation and living arrangements since the disclosure of abuse was noted. Additional information included the date of the family's initial evaluation, treatment history, and length and type of abuse. When this information was lacking or unclear in case records, parents were asked for clarification.
A total of five self-report questionnaires were given to each participant. The Sibling Relationship Questionnaire (Furman & Buhrmester, 1985) was used to assess sibling-victim dynamics. The Family Attitude Questionnaire primarily addressed participants’ attributions of blame, relationship to other family members, and level of family disruption. Siblings’ adjustment was assessed by three separate measures. The Self-Perception Profile for Children (Harter, 1985) measured participants’ self-concept. The Revised Children’s Manifest Anxiety Scale (Reynolds and Richmond, 1978) was used to measure the child’s anxiety. The Children’s Depression Inventory (Kovacs, 1982) assessed the amount of general emotional distress that these siblings were currently experiencing.

Sibling Relationship Questionnaire (SRQ). The Sibling Relationship Questionnaire (Furman & Buhrmester, 1985) is a 51 item self-report measure designed to assess the quality of the child’s relationship with her or his sister. This instrument has been primarily used with fifth and sixth grade children, but is reported to be appropriate for use with children between the ages of 6 and 16.

Furman and Buhrmester (1985) used several steps to develop the SRQ. First, children described their relationship with a sibling. The most common descriptive
phrases were incorporated into the SRQ. To decrease the tendency to respond in a socially desirable way, every fifth item began with a short statement designed to make each alternative appear equally desirable.

The SRQ is composed of 17 domains of sibling relationships, each addressed by three items. The domains assessed are Affection, Quarreling, Nurturance of Sibling, Nurturance by Sibling, Antagonism, Similarity, Intimacy, Dominance over Sibling, Dominance by Sibling, Competition, Admiration of Sibling, Admiration by Sibling, Satisfaction, Companionship, Parental Partiality, Importance, and Prosocial Behavior. Each item is rated on five-point scale. For example, in response to the question "How much do you and your sister insult and call each other names?," participants would circle "Hardly at all," "Not too much," "Somewhat," "Very much," or "Extremely much." Scores were derived by averaging the responses to the three relevant items. The Importance subscale was not applicable to this study because its primary use is for making distinctions between siblings when a child is rating more than one sibling.

Furman and Buhrmester (1985) performed a principal components analysis of the 17 domains. Four higher-order factors were revealed: Warmth/Closeness, Relative Status/Power, Conflict, and Rivalry. These factors appeared to be relatively independent of each other, with low non-
significant correlations between the four dimensions. However, the Conflict and Rivalry scales showed a moderate correlation ($r = .35$). Nevertheless, Buhrmester (personal communication, July 20, 1989) found that using the derived higher-order factor scores was less useful and reliable than analyzing the individual domain scores. Therefore, the domain scores in this study have been analyzed individually but organized for theoretical purposes under their relevant factor headings.

The Relative Power/Status scales included the Nurturance by Sibling, Nurturance toward Sibling, Dominance by Sibling, and Dominance toward Sibling domains. The Warmth/Closeness scales included the Intimacy, Affection, Prosocial Behavior, Companionship, Similarity, Admiration by Sibling, and Admiration toward Sibling domains. The third dimension, Conflict, included the Quarreling, Antagonism, Competition, and Parental Partiality domains. Although a fourth dimension was initially revealed, that of Rivalry, only one domain (Parental Partiality) loaded on this dimension. Furthermore, since this dimension was moderately correlated with the Conflict dimension, Buhrmester and Furman (1989), abandoned use of it and instead included the Parental Partiality scale in the grouping with the Conflict scales.
Furman and Buhrmester (1985) reported reliability data for the SRQ. The internal consistencies (Cronbach’s alpha) of the SRQ domain scales exceeded .70, except the Competition subscale which attained a coefficient of .63. Test-retest reliability for the subscales was calculated over a 10 day interval, using a sample of 94 fifth and sixth grade children from public and parochial schools. These reliability coefficients ranged from .58 to .86 with a mean of .71. No reliability data were reported for the four major dimensions. While meaningful validity data do not yet exist, this measure appears to assess some important aspects of sibling dynamics.

Normative data was provided by Buhrmester and Furman (1989) on third (n = 106), sixth (n = 112), ninth (n = 85), and twelfth (n = 60) grade children from suburban public schools in the Denver, Colorado area. They found that the relative age of subjects had significant effects on perceived relationship qualities for 12 out of the 15 scales. As one might expect, most marked was the main effect of relative age on the Power/Status scales which is reflected in their normative data. Not only are the norms separated by grade, but they are further broken down for subjects rating older siblings and those rating younger siblings. In order to make adequate comparisons between participant’s scores and the normative data, participants
in the present study were divided into groups approximating these normative categories. The third grade norms were used for participants ages 8 and 9 (n = 10), sixth grade norms were used for participants ages 10, 11, and some 12-year-olds, and ninth grade norms were used for participants ages 12, 13, and 14.

**Family Attitude Questionnaire (FAQ).** Before beginning the FAQ, children were asked to list up to three major problems for which their families were coming to the clinic. The Family Attitude Questionnaire consisted of a 15 item self-report measure devised specifically for this study (see Appendix C). The questionnaire was primarily designed to address issues of blame and responsibility within the child's family, level of family disruption, and general attitudes toward family members. More specifically, questions addressed how family members got along, who the children felt most comfortable with, how much time they spent with others, how much attention they received from family members, as well as other salient issues. A 5-point rating scale ranging from "Hardly at all" to "Extremely much" was used to record the participants' responses.

One objective of this questionnaire was to assess how much children blamed family members (i.e., mother, father, sister, and self) for their sister's molestation. While a
direct inquiry would yield the most accurate and
generalizable results, the intrusiveness of such a question
could be anxiety provoking or psychologically damaging. In
order to reduce the likelihood of anxiety, no direct
questions having to do with sexual molestation were asked.
Instead, the attribution of blame questions were more
general: "How much do you blame (mother, father, sister,
self) for problems in your family?" The untested assumption
was that children would associate the phrase "problems in
your family" with their reason for being in treatment, that
is, the incest.

The FAQ was also used to assess the nature of the
participants' relationship with the perpetrator. This
question was not asked directly. Participants were asked,
"How much time would you like to spend with your father?".
("Father" was changed in some instances so that the word
used indicated the perpetrator.) Wording the question in
this way seemed to be less intrusive while giving a general
indication of their relationship. The assumption was that
children would want to spend more time with the perpetrator
when the relationship was good than when it was poor.

In addition, three separate estimates of the level of
family disruption were utilized. The first two were
derived from scores on the FAQ while the third was
formulated from the demographic data.
The first measure of disruption (DIS 1) was derived from responses on the Family Attitude Questionnaire. Question 2 asked participants to indicate how much time they spent with various other people before coming into the clinic for the first time. Question 3 asked how much time they spent with each person after their families began coming to the clinic (i.e., after entering treatment). One assumption was that any change, whether positive or negative, can be considered disruptive. Therefore, the absolute value of the difference between time spent with each person (family, friends and perpetrator) before and after entering treatment, was used as the first gauge of disruption.

The second measure of disruption (DIS 2) was also a derived score. It was the absolute difference between how much participants liked the way things were before they first came to the clinic (question 14) and how much they like things now (question 9).

The third and least subjective estimate of family disruption (DIS 3) was the actual change(s) in family constellation and living arrangements as reported by the participants' parent. Responses to the question "Has the placement of any family members changed since the abuse was disclosed?" were sorted into four categories from least to most disruption. In the first category (n = 9), were
situations where the perpetrator was out of the home prior to the disclosure. For example, abuse by a non-custodial parent would fall into this category. Level 2 included situations in which the perpetrator moved out of the home immediately after the disclosure (n = 7). Judged as more disruptive (level 3) were situations in which the mother, victim and sibling(s) moved away from the perpetrator (n = 5). Disclosures in these families often resulted in multiple moves to a relative's home, an apartment, and/or back into their original home once the perpetrator moved out. Finally, the most disruptive situation (level 4) involved the victim and/or her sibling(s) being placed into foster care for three or more days (n = 6). There were 3 families for whom there was insufficient data to make any determination.

The Self-Perception Profile for Children (SPPC). The Self-Perception Profile for Children (Harter, 1985), is a revision of the Perceived Competence Scale for Children (Harter, 1979). This instrument is a 36 item self-report measure which assesses intrinsic motivation and perceived competence in various areas. The SPPC measures general feelings of self-worth, and separately taps a child's self-evaluations in cognitive, social, athletic, physical, and behavioral domains. This is an improvement over other self-concept instruments (Coopersmith, 1967; Piers, 1969)
which sum responses across a diverse range of content to obtain a global rating of self-esteem. Harter (1982) argued that children can and do differentiate their competence within various skill domains and that this information can be informative.

The six subscales appear to be stable (Harter, 1985). There are five specific domains (Scholastic Competence, Social Acceptance, Athletic Competence, Physical Appearance, and Behavioral Conduct), as well as a more general scale that measures Global Self-Worth. Internal consistency coefficients for a combined sample of 748 sixth and seventh grade pupils from Colorado were .80, .80, .84, .81, .75, and .84, respectively. Scores for each subscale were derived by summing the weights of six items. Weights range from one to four (least to greatest perceived competence). Test-retest reliabilities were not presented for this revision.

Evidence for the SPPC’s validity must be inferred from studies which compared scores on the subscales of Harter’s (1982) earlier version of this test (PCSC) with alternate forms of this measure and with other existing measures. On each subscale, correlations were calculated between a child’s self-rating and the ratings of others. There appeared to be a definite age trend on the cognitive subscale. Using a sample of 746 participants from third
through ninth grades, correlations between self and teacher reports steadily increased with each grade level from .28 to .73. Only the seventh graders did not fit the general pattern ($r = .31$). For the physical competence subscale (currently labeled physical appearance), a correlation of .62 was found between gym teachers' ratings and children's ratings using 209 third through sixth graders. To assess the social competence subscale, children's self-report scores were compared with a sociometric standing derived from the Roster and Rating Scale (Roitascher, 1974). A correlation of .59 was found using a sample of 85 fourth, fifth, and sixth graders. Evidence for the SPPC's construct validity derives from moderate to high correlations between cognitive competence scores on the PCSC and measures of preference for challenge ($r = .57$), independent mastery ($r = .54$), and curiosity ($r = .33$) on Harter's (1981) measure of intrinsic versus extrinsic orientation.

One methodological problem with many self-concept scales for children has been a susceptibility to socially desirable responses. To minimize this tendency Harter (1979) devised a "structured alternative format." Figure 1 shows the way in which items were presented to the child.
The child must first decide which alternative is most similar to herself or himself. The child then decides whether this characteristic is "sort of true" or "really true." Harter argued that either choice is legitimized by this type of format. Thus, the child is presented with a broader range of possible responses than just "true" or "false." A profile of the six subscale scores can be constructed by plotting the scale scores for each participant. Normative scores are available for children in the third through eighth grades (Harter, 1985).

The Revised Children's Manifest Anxiety Scale (RCMAS). The Revised Children's Manifest Anxiety Scale (Reynolds & Richmond, 1978) is a 37 item self-report measure of anxiety used with children from kindergarten through high school. Three subscales assess physiological anxiety, worry and oversensitivity, and concentration. The remaining 9 items form a Lie scale. High Lie scale scores do not necessarily invalidate the child's performance, but rather may be indicative of a personality characteristic, that is,
defensiveness (Reynolds & Richmond, 1978). High lie scale scores among younger children may be indicative of social desirability (Reynolds & Paget, 1983).

The RCMAS is based upon several earlier scales beginning with Taylor's (1951) Manifest Anxiety Scale for adults. The earliest adaptation for children, the Children's Manifest Anxiety Scale (Casteneda, McCandless, & Palermo, 1956), has been used in more than 100 studies. The most recent revision improved upon previous versions in a number of ways. First, items have been deleted, added, and reordered. In addition, norms for children in grades 1 through 12 have been reported and the reading level of the items has been lowered. Finally, the title has been changed to "What I Think and Feel."

Internal consistency estimates of the RCMAS for the development sample as well as a cross-validation sample, showed correlations above .80 (Reynolds & Richmond, 1978). Test-retest reliabilities over a three week period or longer have consistently been above .90 for both males and females (Reynolds & Paget, 1983). For a large sample of elementary school children retested after nine months, Reynolds (1981) reported a moderate reliability coefficient of .68.

A factor-analytic study by Reynolds and Richmond (1979) lends support to this scale's construct validity. Their results suggest the existence of three factors
representing physiological manifestations of anxiety, worry and oversensitivity, and fear/concentration. The Kuder-Richardson reliability estimates were .65, .64, and .60, respectively. The three factors appear to be stable with regard to males and females as well as for blacks and whites (Reynolds & Paget, 1981). These factors support the multidimensional nature of anxiety reported in the literature (Finch, Kendall, & Montgomery, 1974).

Concurrent validity of the RCMAS as a measure of trait anxiety was demonstrated by its high correlation with the State-Trait Anxiety Inventory for Children (STAIC) trait scale (r = .85, p < .001) and its low correlation with the STAIC state scale (r = .24, n.s.; Reynolds, 1980).

The Children’s Depression Inventory (CDI). The Children’s Depression Inventory (Kovacs, 1982) is a 27 item self-report measure used to assess general emotional distress. The CDI is an extension of the Beck Depression Inventory (Beck & Beamesderfer, 1974) for use with children between the ages of 8 and 13. Children indicate which of three alternative descriptions is most representative of his or her feelings or attitudes during the past two weeks. Items are scored on a scale from zero to two with zero representing the absence of a depressive symptom and two representing the strongest form of that symptom.
The CDI is one of the most widely used self-report depression scales for children (Kazdin, 1981). A number of studies have addressed its reliability and validity. Saylor, Finch, Spiroto, and Bennett (1984) examined the CDI's internal consistency, test-retest, and split-half reliability with samples of normal and emotionally disturbed children. Internal consistency, using the Kuder-Richardson formula, was .94 for a sample of 72 normal children and .80 among 105 disturbed children. Test-retest reliabilities, after a one week interval were .38 and .87, respectively. An additional sample of emotionally disturbed children were retested after six weeks. The reliability coefficient for this sample was .59. Split-half reliabilities (both even-odd and first half-second half) for both samples, ranged from .57 to .74. All of the correlations were significant.

Saylor et al. (1984) found the CDI to differentially distinguish between normal children and those with broadly defined emotional distress. However, although inpatients displaying depressive symptomology scored higher on the CDI than inpatients not displaying such symptoms, the differences were not significant. Saylor et al. (1984) pointed out that small sample sizes, high variability in the scores, and lack of well-defined criteria for childhood depression, may have contributed to the non-significant
results. In contrast, Kovacs (1982) demonstrated the CDI's ability to discriminate 27 children with major depression from 12 children in partial remission and from normal school children.

Construct validation studies (Saylor et al., 1984; Saylor, Finch, Baskin, Furey, & Kelly, 1984) suggest that the Children's Depression Inventory may measure a construct that overlaps with self-concept and anxiety. These authors report that high CDI scores consistently correlate with self-reports of low self-concept. Kovacs (1982) and Saylor et al. (1984) also found consistent relationships between CDI scores of depression and scores of anxiety measured by the RCMAS (Reynolds & Richmond, 1978).

While no definitive normative data are available for this instrument, Kovacs (1980/81) reported a mean of 11.33 for a large sample of school children from the metropolitan Toronto area. In a later evaluative study of the CDI by Saylor et al. (1984), mean scores for a number of normative samples ranged from 6.29 to 8.54. The most conservative mean score (M = 8.54) cited in this study came from a sample of 175 public school children in a study by Kline, Hodges, Siegel, Mullins, and Griffin (1982).

Procedure

A cover letter explaining the study was presented to parents and guardians by their therapist or by the
investigator. The investigator then made further arrangements for testing with those families who were willing to participate. Prior to participation, the investigator gave a brief overview of the project and answered questions and concerns of the parent and child. The issues of informed consent, confidentiality, and the voluntary nature of the research were explained. Both the parent and child then signed their respective consent forms (see Appendices D and E). The investigator began by gathering demographic data from the parent, after which he met with the child alone. During that meeting the child completed the Sibling Relationship Questionnaire, the Family Attitude Questionnaire, the Self-Perception Profile for Children, the Revised Children’s Manifest Anxiety Scale ("What I Think and Feel"), and the Children’s Depression Inventory in that order.
CHAPTER III

RESULTS

Demographic Data

Demographic data on the respondents and their families were gathered in order to better characterize this sample and to help specify the generalizability of this study with increased accuracy. The sexual abuse experienced by the participants' sisters ranged from fondling and masturbation to sodomy and sexual intercourse. Many of the sisters were victims of more than one episode of abuse and more than one type of abusive act. The molestation experiences were classified into one of four categories based upon the intrusiveness of the most serious act: fondling, masturbation, oral copulation, and intercourse. These categories are similar to the those used by Faller (1988). Ten victims (33.3%) had been fondled by a family member, three (10%) victims were made to masturbate the perpetrator, four (13.3%) victims were made to engage in oral copulation, either fellatio or cunnilingus, and 13 (43.3%) victims' molestation included either attempted or actual sexual intercourse or sodomy. For one victim, the intercourse led to pregnancy. A non-significant correlation was found between the age of the victim and the
severity (intrusiveness) of abuse ($r = .23$). However, for victims 11 years and over there was a significant correlation between their own age and the severity of abuse ($r = .54, p < .04$). Furthermore, the severity of abuse was significantly related to the length of abuse ($r = .40, p < .03$).

Generally, the perpetrator was the biological father of both the respondent and the victim (57%; $n = 17$). One perpetrator was step-father to both respondent and victim. In four cases (13.3%) the mother’s live-in partner was the perpetrator. In three cases the perpetrator was a grandparent and in two cases he was an uncle. In two cases the perpetrators were step-fathers to the victim and biological fathers to the respondents. In one case the perpetrator was the biological father to the victim and step-father to the respondent. Thus, the perpetrator was the father ($n = 19$) or in the father role ($n = 6$) for most (83.3%) of the participants.

The perpetrators ranged from 20 to 72 years of age ($M = 39$). Seventeen (57%) were employed in skilled or unskilled blue-collar jobs while six (20%) were in white-collar positions. Of the remaining perpetrators, three were incarcerated and four had unknown occupations. Their education ranged from fourth grade to four years of post-graduate work ($M = 11.72$ years). Eighteen perpetrators had
completed high school while only one had graduated from college.

Almost all (n = 27, 90%) of the respondents' mothers were the biological parent of both the respondent and victim. In one case the respondent and her sister were adopted at birth. Mothers ranged in age from 28 to 44 years (M = 34). Half of the mothers (n = 15) were employed in white-collar positions and 20% (n = 6) were employed in blue-collar jobs. Eight mothers were unemployed and one mother's occupation was unknown. The education level of mothers ranged from 8th grade to three years of college (M = 12.2 years). Twenty-one mothers were high school graduates (see Table A-3).

Sibling Relationships

Student's t tests comparing participants' scores on the 15 scales with scores from the normative sample were performed. However, since the number of participants within each group is so small (less than 10) the results of these analyses should be evaluated with much caution. Furthermore, even though statistical significance was reached in some cases, the small sample size could lead to spurious and highly indiosyncratic findings. Student's t tests on groups with less than 5 participants were not calculated.
For participants comprising the third grade group who had an older victimized sister ($n = 8$) a number of differences were found. They perceived less nurturance, $t(7) = -2.96$, $p < .05$ and admiration, $t(7) = -2.55$, $p < .05$ by their sister, less intimacy, $t(7) = -3.21$, $p < .05$, and prosocial behavior, $t(7) = -2.35$, $p < .06$ between them. There were only two participants in this grade category who had rated younger sisters. 

Comparisons were not made with sixth grade level participants having older sisters ($n = 2$). However, sixth grade participants with younger sisters ($n = 8$), perceived less admiration by their sisters, $t(7) = -3.29$, $p < .05$ and less prosocial behavior, $t(7) = -2.50$, $p < .05$ between them. Also, these participants perceived more quarreling, $t(7) = -2.55$, $p < .05$ and competition, $t(7) = 3.07$, $p < .05$ in their relationships with their sisters.

Participants in the ninth grade group having younger sisters ($n = 6$) showed lower Companionship scale scores than the normative sample, $t(5) = -3.16$, $p < .05$ and higher Parental Partiality scores than the normative sample, $t(5) = 2.96$, $p < .05$. There were too few participants with older sisters in this group to perform any meaningful comparisons. 

**Attribution of Blame**

One of the main issues explored in this research involved the participants' attribution of blame for their
sisters' abuse. When participants listed three major problems in their family 13 (43.3%) listed the abuse as one of the major reasons for coming to therapy. Eleven children (36.7%) gave a variety of responses, but did not list their sisters' abuse as a problem. Six children either gave no response or stated that they did not know what problems their family had. All problems described by the participants are listed in Appendix F.

Participants who indicated that their sisters' molestation was a reason for coming into treatment (n = 13) were compared to all other participants to determine whether there were any differences in their attribution of blame. The results are reported in Table A-4. Students' t tests were non-significant. Participants for whom the incest was salient did not differ from those not listing the abuse as a problem in the amount of blame that they attributed to mothers, victims, perpetrators, or themselves for problems in their families.

It was predicted that participants who were closer in age to their sisters (victims) would tend to blame them more than those who were farther apart in age. This was not supported by the results. A non-significant correlation was found between the absolute age difference and the amount of blame attributed to the victim (r = .11, n.s.). Relative age of the participants was also
correlated with the amount of blame attributed to the victims. It was found that participants who were older than the victims blamed their sisters no more nor less than siblings who were younger, ($r = .03$, n.s.).

The prediction that male siblings would tend to blame the victim more than female siblings was not supported. Table A-5 reports the results of $t$ tests between males and females. There were no significant differences on attribution of blame to any of the family members or perpetrator.

Siblings who had more positive relationships with the perpetrators were expected to attribute more blame to their sisters and mothers than those having poor relations with the perpetrators. Siblings were separated into two groups based upon wanting to spend "very much" or "extremely much" time with the perpetrator ($n = 16$) and those who desired less time with him ($n = 12$; "hardly at all" and "not too much"). The results of these $t$ tests are listed in Table A-6. Two siblings were not used in this analysis because they gave a rating in the midrange. Four Student's $t$ tests were performed using these two groups. The difference on amount of blame associated with the mothers approached significance, but the means were in the direction opposite to the prediction. That is, siblings with poor relationships with the perpetrator tended to blame mothers
more than those whose relationships were better. No
difference was found for blaming the victim. As expected,
siblings who had less positive relationships with
perpetrators blamed them to a significantly greater degree
than those with more positive relationships.

The investigator hypothesized that participants who
had a positive relationship with the perpetrator would have
conflict and rivalry in their relationship with the victim.
Therefore, a negative relationship between the amount of
time a participant would like to spend with the perpetrator
and the amount of time they would want to spend with their
sister was expected. However, no relationship was found ($r = -.03$, n.s.). The amount of time participants wanted to
spend with the perpetrator showed no relationship to
participants' scores on the Conflict scales from the SRQ
(Quarreling, $r = -.10$; Antagonism, $r = .15$; Competition, $r = .18$; and Parental Partiality, $r = .26$). Thus, a positive
attitude toward the perpetrator was not related to a
negative attitude toward the victim.

Finally, a comparison was performed in order to
determine whether siblings differentially attributed blame
to any of their family members. The Friedman Test was used
for this purpose. The Friedman Test is a two-way analysis
of variance by ranks for matched subjects. However, it can
be used with equal precision in cases where the same
subjects are observed more than once (Kerlinger, 1963) as in the present study. Siblings' ratings on the attribution of blame questions were considered to be rankings (allowing for ties between family members), so that this non-parametric statistic could be used. Results suggest that perpetrators were blamed to a much greater degree than were victims, mothers, or the siblings themselves, $\chi^2(3, N = 30) = 24.09, p < .01$).

In order to test whether siblings who had been in treatment longer than others blamed perpetrators more than mothers, sisters, or themselves, a second Friedman test was performed using only siblings who had received more than the median amount of treatment (8 weeks). The result of this second analysis was non-significant, $\chi^2(3, n = 13) = 5.72, \text{n.s.}$.

**Adjustment**

It was hypothesized that participants' adjustment would be poorer than that of their same aged peers, due to the upheaval and stress caused by disclosure and because their families were likely to be dysfunctional. In order to test this hypothesis siblings' mean scores on the SPPC, RCMAS, and CDI were compared to the means for the normative samples.

Due to gender differences on four of the six SPPC subscales (Harter, 1985), male and female participants'
mean scores were compared to the norms by gender on athletic competence, physical appearance, behavioral conduct and global self-worth. All participants were combined and their scores compared to the norms on the scholastic competence and the social acceptance scales. The results of these analyses are shown in Table A-7. Male siblings of incest victims rated themselves as significantly less athletically competent than the normative group and had significantly lower global self-worth ratings. Female siblings' global self-worth ratings, in general, were lower than the normative sample, but the differences only approached significance. Participants did not differ significantly from the normative group in their self-ratings of scholastic competence, social acceptance, physical appearance, or behavioral conduct.

On the RCMAS, Reynolds and Paget (1983) reported norms for Black and White males and females. Due to the small number of minority children in the present research, all participants were grouped by gender only and compared to the normative data reported for the White samples. Results of the t test comparisons are listed in Table A-8. A significant difference was found for females, who reported substantially more anxiety than the normative group. Although the mean total anxiety score for male participants was higher than the mean for the normative sample, this
difference was not significant. Males scored significantly higher than the normative sample on the worry/oversensitivity scale.

Finally, siblings' scores on the Children's Depression Inventory were compared with normative data from two major studies. The first study (Kovacs, 1980/81) used a large sample of school children from the metropolitan Toronto area. CDI scores for participants (M = 9.28) did not differ significantly from Kovacs' normative sample (M = 11.33), t(29) = 1.53, n.s. However, in a more recent study, Kline et al. (1984) reported a mean score for their normative sample of 8.54. When this score was used a significant difference was found with participants reporting significantly more distress than Kline et al's sample, t(29) = 2.09, p < .05.

Family Disruption and Adjustment

In order to test the hypothesis that the greater the amount of disruption the poorer the participants' adjustment would be, three measures of family disruption were correlated with three measures of adjustment.

Results yielded non-significant correlations between absolute change in amount of time spent with family members and anxiety (r = .04), depression (r = -.08), and global self-worth (r = .24) scores. The second measure of disruption (the difference between how siblings liked
things before and after coming to the clinic) also yielded non-significant correlations with anxiety ($r = .29$), depression ($r = .07$), and global self-worth ($r = -.11$) scores. Finally, correlations between the parental report of disruption and participants' anxiety scores ($r = .10$), depression ($r = .20$), and global self-worth scores ($r = -.15$), were non-significant.
Support for the various hypotheses under study was mixed. Results suggest that while sibling relationships in incestuous families cannot be characterized by rivalry and conflict, there is clear evidence that closeness and warmth are lacking in these relationships. Furthermore, siblings' perceptions of their relationship to the victim appear to be influenced by age and relative sibling position.

In general, siblings appeared to attribute less blame to family members than expected. They did not blame the victims more than others. In fact, they attributed the most blame to the perpetrators. Sex and age did not seem to influence the amount of blame siblings had toward family members. Furthermore, contrary to what was expected, siblings' relationship to the perpetrator (whether positive or negative) had little impact upon siblings' relationship to the victims.

Siblings' adjustment appeared to be impaired in a variety of areas. Males demonstrated less perceived athletic competence and global self-worth, but more worry and oversensitivity than normative samples. Females showed a tendency toward less global self-worth and heightened
general anxiety. Finally, siblings' level of emotional distress appeared higher than that of some of the normative comparative samples.

Before describing these findings in more detail, some general comments about the nature of the present research are necessary. Few studies have systematically explored siblings in incestuous families. Furthermore, no empirical studies have explored siblings' adjustment using self-report data. One reason for this omission may be due to the recency of interest in sexual abuse and the predominant focus on the mother-father-daughter triad in systemic theories of incest. Given the lack of empirical research and theory about siblings in these families, an explorative study should serve two functions. It should begin to clarify and expand upon the issues and dynamics that have previously been suggested and it should give direction to future research.

Therefore, in order to gain useful information, the scope of an exploratory study must be limited. For this study, a number of restrictions were necessary. First, the age range of the siblings was limited so that results would be most applicable to the families typically seeking treatment. The majority of the siblings were latency-aged with a few in pre-adolescence. While younger victims and their families are being seen with increased frequency
(MacFarlane & Waterman, 1986), these children are not developmentally able to understand the areas explored in this study. Most importantly, the measures given to the siblings required a certain level of cognitive development that younger children may lack. In fact, this did become an issue with some of the younger participants who had difficulty making fine distinctions in self-concept. On the other hand, children who are significantly into their adolescence begin to develop a qualitatively different understanding of their self-concept (Harter, 1985), and, therefore, may differ from latency aged children in significant ways.

Second, the definition of intrafamilial sexual abuse has been limited to exploitive acts involving actual physical touching between a parental figure (father, stepfather, long-term partner of mother, uncle, or grandfather) and child. As discussed earlier, there is much variability in the use of the terms child sexual abuse, incest, and molestation in the literature. Often studies do not operationally define abuse which makes comparisons among different studies exceedingly difficult. Limiting the abuse to only acts of father-daughter incest may have lead to more precision. However, the relationship of a trusted male adult having a position of authority and dominance over a child, seemed to be a more important dynamic than the biological tie between the child and the perpetrator.
Finally, the age of the victims was limited to those between 6 and 16 years of age. This was necessary to adequately address sibling relationship variables that may otherwise not be applicable. For example, a 12-year-old sibling’s relationship to and attribution of blame for a 3- or 4-year-old victim would most likely be qualitatively as well as quantitatively different from a sibling pair closer in age and cognitive/social development.

These parameters, (age of siblings, age of victims, and definition of intrafamilial sexual abuse) served to focus the breadth of this study and lead to more accuracy in the possible application of the results. However, the restrictions limited the number of siblings who could participate in a timely fashion. Therefore, it is important to interpret the results cautiously and draw conclusions tentatively. The results should be a starting point for hypothesis generation and further scientific exploration.

Another important and unexpected factor affecting sample size was the wide variability in the willingness of therapists within child abuse agencies to refer participants to this project. As in all research where participation is voluntary, some refusal to participate was expected. In fact, the response rate for this particular population seemed high (77.7%) and may have been artificially elevated due to prior screening of the families by their therapists.
What was alarming, however, was the resistance encountered from therapists within agencies that had officially approved the study. Many therapists would not allow their clients the opportunity to participate. On the one hand this is admirable, showing a desire to protect their clients from harm and to protect their identity. On the other hand, however, it is important to conduct research such as this to learn more about the effects of incest. Every effort was made to minimize the risk to the participants and to limit the amount of work the therapists would have to do. Therapists had only to make a referral and obtain permission for the experimenter to contact the family. Many therapists, even some within the agencies where the experimenter was employed, were reluctant to make referrals despite having clients that met the criteria for inclusion. Most agencies and therapists that declined to participate did not offer reasons. Among those that did offer explanations, most suggested that their clients had expressed feelings about being "abused by the system" (i.e., Child Protective Services) and the therapists saw the research as further abuse or manipulation.

While it is clear that many families who have recently disclosed child abuse are under much emotional stress, it is curious that the response rate for the therapists was much lower than that of the potential participants who were
contacted. Out of 20 agencies contacted, half agreed to participate. However, only 7 of these 10 referred any potential participants despite frequent contacts. Three of these seven referred only one child over a period of more than one year.

It is possible that the therapists' decision not to refer clients was less based on their own resistance to research and more on a judgement that these families would be negatively affected by additional intervention. Clearly, there are families who enter treatment angry at the disruption and dissolution of their families and resentful of the social service system. Such reactions may be particularly likely for families referred by the Department of Children's Services. Many of these families may be unlikely to participate. On the other end of the continuum are those who may be in need of more nurturance and support during this difficult time. Such families may be more eager to participate in research or any additional intervention that they perceive as supportive or potentially helpful. Therapists may be prone to seeing these families as somewhat helpless and vulnerable and make the decision to not subject them to anything that may increase demands made upon them, despite the potential for future benefit. Further research might help to clarify therapists' perceptions of their clients and how these
perceptions impact therapists’ decision to suggest a family consider participation in research.

**Demographic Data**

One of the major suppositions for this research was that siblings are often the ignored members of the incestuous family and that this lack of attention may be paralleled in the family’s treatment. The large percentage of siblings in this study who were in treatment (93%), suggests that this assumption should be questioned. However, this high percentage may be an artifact rather than an accurate representation of siblings whose sisters are in treatment for incest. The clinics from which the participants were drawn were specifically selected because they had programs for sexually abused children and often included siblings in some form of treatment. Many other clinics that were contacted indicated that while they did treat sexually abused children, they did not have organized groups or programs and thought that they would not be able to access siblings who met the criteria. Through personal communications with clinicians and agencies, it was noted that there is a growing trend toward including the siblings in treatment. Most often siblings are included in individual therapy or within the context of family treatment. However, it seems that the focus of treatment is still on the victims and parents and that the non-victimized siblings are often ignored.
One issue that is problematic throughout most of the research on child abuse concerns gathering data from a clinic population rather than from a random sample of the population. All participants came from families in which the sexual abuse had already been disclosed and at least one family member was in treatment. Furthermore, almost all of the participants (90%) were engaged in some type of psychotherapeutic or psychoeducational treatment. Widom (1988) has suggested that there are a number of disadvantages to using a clinical population in research, including the propensity for subjects to give more socially desirable responses, the demand characteristics of the setting, and the volunteer status of the participants. While these biases may be very difficult to minimize, due to the secrecy of the problem and possible ethical and legal complications of obtaining participants from the general population, it nonetheless, can affect the results. Families in which incest has been disclosed who are in treatment are likely to represent only a small fraction of the families in which intrafamilial sexual abuse has occurred.

It is difficult to know in what ways families who have disclosed abuse and sought treatment differ from those who have avoided disclosure. On the one hand, families in which the abuse has not been disclosed may be more isolated and
disturbed than those families that have sought treatment. Alternatively, these same families may be seen as having more resources at their disposal and may be better able to avoid disclosure and intervention by the police or social services department. Both these explanations may be plausible and result in keeping some families from disclosure and subsequent treatment. One variable that should be examined in future research would be whether the family was in treatment voluntarily or by court order. It is possible that those families in treatment by court order may be more representative of the families who have resisted treatment and have kept the incest a secret. Still, only tentative conclusions can be made when generalizing the results of this study to families who have not entered treatment for whatever reason.

It is widely believed that intrafamilial sexual abuse occurs in all strata of society. It crosses racial boundaries, educational levels, and socio-economic status. The fact that most of the participants came from Anglo families in the middle to low end of socio-economic status (as based upon mothers' and perpetrators' occupations) may be a function of the types of agencies from which the families were drawn and their locations. All participants were referred from non-profit community-based agencies either public or private. Most centers were in urban areas
where Anglo and Hispanic populations predominate. Many of these families entered treatment programs recommended by the Department of Children’s Services. These families may have had fewer resources and could not afford private practitioners. Thus, characteristics associated with the sample may have affected the results.

The abusive acts that victims were subjected to ranged from fondling and masturbation to sexual intercourse and sodomy. A non-significant correlation was found between age of the victim and the severity (intrusiveness) of the abuse. However, when this analysis was limited to children over the age of 10 a significant relationship was found. Looking at the data more closely revealed that 8 of the 10 victims over the age of 11 had engaged in intercourse. Thus older children may be more at risk for the most intrusive forms of incest.

Perhaps more revealing was the fact that the severity of abuse was positively correlated with the length of abuse. There is support for this in the literature (Gelinas, 1983). It is clear that a progression of sexual abuse, from mild forms to more intrusive and potentially harmful forms seems to occur. Age itself was not related to severity, at least among younger children. This points to the possibility that as a girl approaches puberty the probability that the perpetrator will try to engage in
sexual intercourse with her increases, especially if the abuse has been chronic.

Sibling relationships

In interpreting the results, some caution is necessary. A number of the comparisons were made using t tests. When multiple t tests are used, the chances of obtaining some spurious positive results are increased. However, in order to decrease this possibility, all t tests were two-tailed, even for those analyses where predictions were made in a specific direction. This more conservative approach helps to mitigate the potential hazard of using multiple t tests. Since this was an exploratory study, the findings, although tentative, should be considered carefully, and may point to relationships that should be explored further.

Another problem encountered, specifically with the SRQ, was small sample sizes. In order to make use of the normative data, it was necessary to divide the participants into groups that matched the normative sample groups. However, this greatly limited the number of participants in each group making statistical analysis suspect. With this in mind, only very tentative conclusions should be made. Rather than discarding this information altogether, it might be more useful to consider the following discussion as providing some direction for future research and hypothesis generation.
While rivalry and conflict among sibling and victim in incestuous families appeared to be elevated, the differences were not seen across the entire participant sample. On the other hand, participants, clearly, did not perceive their relationship to their sisters as characterized by aspects of warmth and closeness. In fact, in some instances, scores on the Warmth/Closeness scales appeared to be significantly lower than that of the normative sample.

These differences between participants' and normative sample's scores seemed to depend upon the age/grade category into which participants fell. For those participants in the lowest grade category (Grade 3), three of the four significant differences between their perceptions and that of the normative sample were on dimensions characterizing warmth and closeness. More specifically, they demonstrated less perceived intimacy, admiration by their sisters and less prosocial behavior between them. Participants in the sixth grade category also perceived less prosocial behavior and less admiration by their sisters than did the normative sample. Ninth grade participants having younger sisters perceived less companionship than the normative group. This seems to suggest that some aspects of warmth and closeness between participant and victim are impaired, at least when compared to the normative samples' relationships.
Rivalry and conflict seemed to characterize only a small proportion of the participants. Only Grade 6 participants who had younger sisters perceived greater Quarreling and Competition in their sibling relationship than did the normative sample. Ninth grade participants with younger sisters perceived greater parental partiality (favoritism) than the comparative normative sample.

On the Relative Status/Power scales only one significant difference was found. Third grade participants who had older sisters perceived less nurturance by their sisters than did the normative sample.

While it appears hopeful that rivalry and conflict do not seem to predominate sibling’s relationships in incestuous families, as suggested here, positive qualities in their relationships seem to be lacking. This is somewhat disheartening, and suggests that these children have already begun to develop patterns of relating that reflect their parents often pathological relationships. Distorted notions of intimacy, nurturance, and sexuality often exist in the parental relationship and serve as a precursor to incest (Groth, 1982). Children in these families, both siblings as well as victims, are exposed to these distortions which form the basis for their future relationships.
Attribution of Blame

One of the central themes in the treatment of children who have been sexually victimized, is the responsibility and blame they feel for the abuse. The current literature suggests that it is common for victims to feel much guilt, self-blame, and responsibility for the abuse (Damon & Watermamn, 1986; Summitt, 1982). When intrafamilial abuse involves some sort of role reversal, victims are made to feel even more responsible for the stability of the family, whether real or imagined. Once the abuse is disclosed, dissolution of the family may follow and the victims may feel blame for this as well. This self-blame often affects their self-esteem and possibly contributes to a wide variety of behavioral and emotional problems.

Siblings, too, may feel partly responsible for the abuse and subsequent breakup of their family, especially if they colluded in some way or suspected the problem (de Young, 1981; Kibbie, 1984; Swanson & Biaggio, 1985). If siblings were jealous and rivalrous of their sister’s relationship with the perpetrator, then when the abuse is disclosed they may feel that their conscious or unconscious wishes influenced the events that followed. This may evoke feelings of omnipotence and guilt. During this study one sibling was removed from the final sample due to his later
disclosure that he, too, had been molested by his father. After months of treatment, this child explained that he knew his sister was being molested but would turn his back or walk out of the room so that he would not see what was happening. He went on to say that he felt very guilty not only for his own abuse, but for knowing that his older sister was being molested and not doing anything about it. Clearly, the amount of guilt, responsibility, and blame that each family member holds, can impact the family’s post-disclosure psychological functioning.

One reason for not asking siblings about the abuse directly, was the assumption that some of these children would not know about their sister’s molestation. In fact, this was not the case. Parents reported that all of the siblings knew that their sisters had been molested and by whom they were molested. It is likely that many of the siblings learned of their sister’s molestation after disclosure and through therapy. In her study, Kibbie (1984) found that only 40.5 percent of her sample of siblings of incest victims were reported to know of their sister’s molestation prior to public disclosure. In the present research it is not known how many children knew of their sister’s abuse prior to disclosure. As the previous case example illustrates, even if one were to directly ask a child if he or she knew of their sister’s abuse prior to
disclosure, this would likely be significantly underreported. Nevertheless, prior screening of the participant’s knowledge of the abuse (both before and after disclosure) would allow for more direct questioning if done cautiously and possibly by the child’s therapist. This would certainly lead to more accurate results. It would also be valuable to compare those siblings who knew of the abuse prior to disclosure to those who did not.

A number of assumptions were made which attempted to allow siblings’ attribution of blame for problems in their family to be used somewhat synonymously with their attribution of blame for the incest. First, is that the families had come to the clinic for treatment directly related to the sexual molestation. It seems plausible that the victims’ molestation was a major focus of treatment because participants were recruited from programs that specifically treated victims of abuse. Second, it would be important that the siblings consider the abuse as a major problem in their family. Only 43.3 percent of the siblings listed their sister’s molestation as a major problem. Many others may have considered this to be a major problem, but were reluctant to indicate it directly due to feelings of shame, embarrassment, fear, or other motives. This makes it difficult to know whether or not a sibling is attributing blame to a specific family
member for the incest, thereby accounting for the lack of support for some of the hypotheses. Nevertheless, the relative level of blame attributed to various family members is, in and of itself, valuable information.

One hypothesis was that male siblings would blame their sisters more than female siblings. This was based upon the assumption that the abuse would be an assault to males’ need for masculine identification. In order to defend against this assault to one’s self-esteem and self-concept, children would project blame onto their sisters. Theories addressing victims’ (especially male victims) tendency to identify with the aggressor would lend support to this prediction (Herman, 1981). However, this hypothesis was not supported. Male and female siblings did not differ in the amount of blame they attributed to their sisters. One problem with the identification with the aggressor theory is that these siblings were not themselves abused. Therefore, they may have less need to defend against feelings of helplessness and vulnerability and take on the powerful attributes of the perpetrator (or, at least, to side with him) to the degree that many male abuse victims do. While most would agree that incest perpetrated by one’s primary male role model impacts the identification process for children, the need to identify with the aggressor in order to adequately cope with one’s feelings, does not appear to be applicable.
In a broader sense, the notion of blaming the victim, while often observed in the public at large, may not hold much credence for family members of a sexually victimized child, aside from the perpetrator. At least from the perspective of the sibling, victims and their mothers were not blamed more than the perpetrators. In fact, the opposite was found (i.e., children blamed the perpetrators to a significantly greater degree). This was in line with Kibbie's (1984) finding that sibling's most typical response to the disclosure of incest was to blame the father. A possible explanation for this could be that it is much safer (i.e., less threatening) to blame a person/parent who is out of the home and upon whom the child is less dependent. In addition, these children generally lived with their mothers, and therefore may be prone to expressing their mother's view of blame.

Another possible explanation for the siblings' low attribution of blame to the mother and victim, may be related to the treatment they have received. Often, one major goal of treatment is to reduce feelings of guilt, blame, and responsibility, especially for the abuse and breakup of the family. This may have led to siblings' comparatively low amounts of blame attributed to victims, mothers and themselves, and higher amounts of blame to the perpetrators. This may also account for the finding that
the amount of blame was distributed more equally among family members for those siblings who were in treatment longer. Given that siblings' understanding of the dynamics of sexual abuse increases through treatment, then one would expect less blame for all members of their family, including the perpetrator.

Another hypothesis, that siblings who are closer in age to the victims would blame them more than farther spaced siblings, was not supported. It was believed that siblings closer in age to the victims would have more difficulty believing that their sisters did not hold any responsibility for the abuse because the siblings themselves, for whatever reason were able to "avoid" abuse. However, this was not the case.

One of the variables that was thought to mediate blame was the quality of siblings' relationship to the perpetrator. Participants who were more attached to the perpetrator, received more nurturance from him, and who liked the perpetrator better, might have much more difficulty blaming him than children who felt distant, neglected, or jealous of the special attention the perpetrator paid to their sister. While no direct assessment of siblings' attachment to or nurturance from perpetrators was made, a general scale of "liking" for the perpetrator was derived from the Family Attitude
Questionnaire. Specifically, the amount of time that the sibling would like to spend with the perpetrator was used as a measure of liking for the perpetrator.

In discussing this analysis, some question arises as to the merit of using all perpetrators versus using only those who were fathers of the participants. One might assume that the biological tie of a father with his children would be more influential than that of another relative or adult partner of the child’s mother. While this may be a valid argument in some circumstances, the salient factor here is the quality of sibling-perpetrator relationship not the biological connection. When the perpetrator functions in a parental role, that is, being in a position of trust and authority over the child, then the degree of liking for the perpetrator should influence the child’s ability and willingness to blame him regardless of the actual biological relationship.

The results suggested, however, that those children who wished to spend time with the perpetrators did not blame their sisters or mothers any more than did siblings who did not wish to spend much time with the perpetrators. Additional analyses showed that the degree of liking for the perpetrator was similarly unrelated to the degree of conflict and rivalry among siblings and victims. These results suggest that the quality of siblings’
relationships to the perpetrators may be less influential upon sibling-victim dynamics than expected.

While the sibling-victim relationship did not seemed to be related to the degree of liking for the perpetrator, siblings did show variability in the amount of blame they attributed to him. Children who wished to spend little time with the perpetrators blamed them significantly more than did children who wished to spend more time with them. At this point it is impossible to know whether these children did not want to spend time with the perpetrators because they blamed them, or, if the amount of blame they had toward perpetrators was a function of the degree of emotional connection (i.e., liking) to them. Perhaps this question can be more adequately answered in future studies using more rigorous methods.

Adjustment

There were a number of areas in which siblings' adjustment appeared to be poorer than that of normals. Male siblings rated themselves as less athletically competent than normals and showed a tendency to rate themselves lower on physical appearance. Males showed significantly lower ratings of self-worth than the normative sample. Females, too, rated themselves as having less self-worth than normals, although the differences only approached significance. Most scores,
for both male and female siblings were lower than the normative means.

Without comparing siblings of incest victims to other treatment and control groups it is difficult to know the source of their lowered self-concept. Having a close family member perpetrate sexual abuse on one’s sister could easily be seen to impact one’s self-esteem. Studies that look at self-concept in children who have mentally or physically ill brother or sisters could help to illuminate the present findings. In a study by Tritt and Esses (1988) children who had siblings with a chronic physical illness were found to be no different in self-concept than children with healthy siblings.

The level of anxiety reported by participants was generally higher than that reported by the normative sample. Males scored significantly higher on the worry/oversensitivity scale. Female siblings reported significantly higher levels of overall anxiety. The fact that male participants did not show the same level of overall anxiety as the female participants has interesting implications. Females may perceive more threat and vulnerability growing up in a family where a same sex sibling has been sexually molested, fearing the possibility of their own victimization. Females appeared to have experienced more chronic heightened levels of anxiety.
across the various domains (i.e., physiological anxiety, worry/oversensitivity, and fear/concentration), rather than in one specific area. Males tended to report heightened anxiety within a restricted range, manifested by worry and hypersensitivity.

Children who have been diagnosed as anxious have been shown to display deficits in social competence and social skills (Strauss, Kease, Kazdin, Dulcan, & Last, 1989). However, participants in this study did not show major deficits in their social competence as measured by the SPPC, despite having elevated levels of anxiety. One explanation for this may be that the level of anxiety experienced by the siblings was not sufficient to disrupt their social functioning to the point at which their esteem or competence in the social realm suffered. In fact, it may be that siblings' level of social competence and social skills were adequate enough to prevent themselves from victimization similar to that of their sisters.

A note of caution is in order. The normative data on the RCMAS was separated by sex, age, and race and were available for Anglo and Black children between the ages of 6 and 18. Since there were only a few minority children in the present sample (two Blacks and six Hispanics), it was not feasible to make separate comparisons using the minority normative data. However, upon close examination,
the minority siblings' scores did not seem to differ significantly from the that of the Anglo majority. Therefore, to aid in the comparisons, all participants' scores were collapsed across race and only the normative data for the Anglo sample was used in the comparisons. Another justification for using only the Anglo norms was that their scores tended to be lower than the norms for other ethnic groups (Reynolds & Paget, 1983), leading to a more conservative analysis. On the other hand, the inclusion of the minority scores might lead to some inflation of the total sample's means. In any case, these results should be interpreted with caution.

Siblings' emotional distress as measured by the CDI appeared to be somewhat higher than most of the "normal" samples used for comparison. In fact, for a number of studies in which the CDI was used, the siblings' mean CDI score exceeded published means, except for one group of diagnosed depressed inpatients (Saylor et al., 1984; Kline et al., 1982; and Kovacs, 1982).

While it is important to recognize that victims of intrafamilial sexual abuse and their siblings demonstrate deficits in adjustment, knowledge of the specific individual and contextual factors that lead to poor adjustment would be of great value in formulating treatment goals and tailoring interventions. The individual's coping
skills, intellectual functioning, and the family's stability and social supports, are just a few of the possible factors which mediate adjustment.

While the validation and elucidation of these factors must be left for future research, one such contextual factor was explored in this study: the degree of family disruption or change. In attempting to separate the effects of disclosure from the influences of the abuse itself on sibling adjustment, measures of family disruption were assessed and then correlated with adjustment scores. Surprisingly, no relationships were found. Since it is likely that children's adjustment is multidetermined, it may be that level of disruption, taken alone, does not account for much of the variance in adjustment. In addition, incest itself may just be one of many problems in a highly dysfunctional family. As such, these families may have a history of previous family disruptions, (i.e., marital conflict, separations, divorce, etc.), which might mitigate the impact of the disruption associated with the abuse. Given the amount of trauma, confusion, and turmoil that families are observed to demonstrate at the time of disclosure, it seems unlikely that this is a completely plausible explanation.

Another more likely explanation for the apparent lack of relationship between disruption and adjustment may be
related to the types of measures used. Each measure of disruption was correlated with three measures of adjustment; the total anxiety score from the RCMAS, the global self-worth scale from the SPPC, and the total depression score from the CDI. The first two adjustment scales may be less sensitive to situational variables, such as the disruption following disclosure. They tend to measure more stable personality characteristics or traits rather than transient states of adjustment (Harter, 1985; Reynolds, 1980). The depression scale, on the other hand, was designed to assess more transient and recent symptoms. While this measure may be more sensitive to situational variables, siblings may have had ample time to revert to their characteristic coping strategies after the disclosure since most families had disclosed more than two weeks prior to the actual testing time. In fact, the median time between disclosure and testing was 29 weeks. It is possible that had the CDI been given to each child at intake or soon after disclosure, the relationship between disruption and emotional distress would have been more apparent.

The fact that the majority of siblings participating in this study were engaged in some form of treatment and came from a clinical population was already discussed in reference to its impact on the generalizability of the
results. Consideration also needs to be given to the impact of treatment upon the siblings' adjustment. If treatment itself was influential in participants' adjustment, one would predict that the length of treatment would be positively related to adjustment. However, non-significant correlations were found. This is not surprising given the variability in the type and scope of the treatment received. Furthermore, some mothers stated that their families had received therapy elsewhere prior to entering their current treatment. It was not known whether this previous treatment was directly related to the sexual abuse or even whether the siblings themselves had been treated. Nevertheless, most families had entered treatment within 8 weeks after disclosure, minimizing the possibility that participants would have received previous treatment related to the incest.

Until these and other individual and contextual factors influencing siblings' adjustment are illuminated, it may be difficult to know whether the differences found in adjustment are due to the sequelae of intrafamilial abuse and/or to the fact that this sample was gathered from a clinic population.

One major consequence of doing research with a clinical population such as this, where participants and their therapists may be highly resistant to participation,
and where the criteria for inclusion are so stringent, is that the number of participants is limited. There is little doubt that the small number of participants in this study severely attenuates the practical significance of some of the results. However, these tentative findings are still superior to clinical articles based upon the casual observations of clients and case studies because the results are obtained from standardized measures and systematic questioning.

This study’s aim was not to determine the potential efficacy of treatment with victims or their siblings. However, it has illuminated some foci for treatment with the siblings that may have significant impact upon their future functioning. One such focus should be on the relationship between the sibling and victim.

The interactional patterns between sibling and victim can be seen as a testing ground for the development of behaviors, thoughts, and attitudes about social functioning that will carry on into adulthood. In other words, the qualitative aspects of their current relationships may be precursors to their adult interpersonal relationships. With this in mind, it appears necessary to foster more nurturance and empathy among siblings because these attributes seem to be especially lacking. Developing appropriate attitudes toward intimacy, warmth, and closeness would also appear to
be very important in working with these siblings. This may help to prevent children from adopting distorted and/or pathological ways of relating to others which has often led to the perpetuation of incest to succeeding generations.

One way to achieve these goals would be to see all the siblings in an incestuous family in treatment together. Schibuk (1989, p. 226) argues that "sibling therapy...is particularly appropriate in situations that require a deliberate focus on the unit of continuity, or the subsystem that remains intact during a process of family reorganization." While she advocates sibling therapy for children of divorce, her logic could equally apply to situations where families must reorganize after the disclosure of incest. Other important areas of focus in the treatment of siblings include lessening sibling’s anxiety and distress, and fostering increased self-esteem and self-competence.

Future Research

There is much reason to be concerned not only for the victim but for the sibling in incestuous families. This research only just begins to explore the impact intrafamilial sexual abuse has on the non-victimized siblings and the dynamics that exist between siblings in these families. While siblings are gradually being included more often in treatment programs, much more attention in research and practice is necessary.
Future research might focus on treatment process and outcome. As a follow-up to this study, one might explore if and how attributions of blame and adjustment change through the course of treatment. Other research might consider the efficacy of different treatment modalities with siblings. Differences in adjustment between siblings of victims of intrafamilial versus extrafamilial sexual abuse could be explored.

Regardless of the direction taken, careful consideration of mediating variables should be made. Time between disclosure and treatment, number of abusive incidents, the use of threat or force during the molestation, sibling's knowledge of the abuse prior to disclosure, how they learned of abuse, and history of physical and/or sexual abuse in the extended family are just a few of the variables that might be considered to influence the impact of the abuse on victims and their non-victimized siblings.

Future research will not only add to the growing body of knowledge on intrafamilial sexual abuse but may help to illuminate the needs of siblings and prevent them from being the neglected and often overlooked member of these families.
Table A-1

**Age of Participants**

<table>
<thead>
<tr>
<th>Age</th>
<th>Male</th>
<th>Female</th>
<th>Mean</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>8</td>
<td>0</td>
<td>3</td>
<td></td>
<td>18 (60%)</td>
</tr>
<tr>
<td>9</td>
<td>2</td>
<td>2</td>
<td></td>
<td>12 (40%)</td>
</tr>
<tr>
<td>10</td>
<td>4</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>11</td>
<td>1</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>12</td>
<td>2</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>13</td>
<td>6</td>
<td>3</td>
<td>11.8</td>
<td>18 (60%)</td>
</tr>
<tr>
<td>14</td>
<td>3</td>
<td>3</td>
<td>10.8</td>
<td>12 (40%)</td>
</tr>
</tbody>
</table>

Table A-2

**Ethnicity of Participants**

<table>
<thead>
<tr>
<th>Ethnicity</th>
<th>Male</th>
<th>Female</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Anglo</td>
<td>12</td>
<td>9</td>
<td>21</td>
</tr>
<tr>
<td>Hispanic</td>
<td>4</td>
<td>2</td>
<td>6</td>
</tr>
<tr>
<td>Black</td>
<td>2</td>
<td>0</td>
<td>2</td>
</tr>
<tr>
<td>Other</td>
<td>0</td>
<td>1</td>
<td>1</td>
</tr>
</tbody>
</table>

Table A-3

**Occupational Category**

<table>
<thead>
<tr>
<th>Category</th>
<th>Blue Collar</th>
<th>White Collar</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Unskilled</td>
<td>Skilled</td>
</tr>
<tr>
<td>Perpetrator</td>
<td>6</td>
<td>11</td>
</tr>
<tr>
<td>Mother</td>
<td>4</td>
<td>2</td>
</tr>
</tbody>
</table>

^Unemployed
Table A-4

**Grouping by Admission of Incest on Attributions of Blame**

<table>
<thead>
<tr>
<th>Group</th>
<th>Mean</th>
<th>SD</th>
<th>t value</th>
<th>p</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Blame of Mother</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Yes(^a)</td>
<td>1.692</td>
<td>1.182</td>
<td>-0.172</td>
<td>&lt; .10</td>
</tr>
<tr>
<td>No(^b)</td>
<td>2.529</td>
<td>1.419</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Blame of Perpetrator</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Yes</td>
<td>4.077</td>
<td>1.32</td>
<td>1.74</td>
<td>&lt; .09</td>
</tr>
<tr>
<td>No</td>
<td>3.235</td>
<td>1.30</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Blame of Victim</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Yes</td>
<td>1.846</td>
<td>0.987</td>
<td>0.40</td>
<td>n.s.</td>
</tr>
<tr>
<td>No</td>
<td>1.706</td>
<td>0.920</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Blame of Self</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Yes</td>
<td>1.923</td>
<td>1.115</td>
<td>0.43</td>
<td>n.s.</td>
</tr>
<tr>
<td>No</td>
<td>1.765</td>
<td>0.903</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

\(^a\)These were the respondents who listed their sister’s molestation as one of the problems in their families.

\(^b\)These were respondents who did not list their sister’s molestation as a problem.
Table A-5

**Gender Differences in Attributions of Blame**

<table>
<thead>
<tr>
<th>Group</th>
<th>Mean</th>
<th>SD</th>
<th>t value</th>
<th>p</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Blame of Mother</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Male</td>
<td>2.11</td>
<td>1.278</td>
<td>-0.27</td>
<td>n.s.</td>
</tr>
<tr>
<td>Female</td>
<td>2.25</td>
<td>1.545</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Blame of Perpetrator</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Male</td>
<td>3.67</td>
<td>1.283</td>
<td>0.32</td>
<td>n.s.</td>
</tr>
<tr>
<td>Female</td>
<td>3.50</td>
<td>1.508</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Blame of Victim</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Male</td>
<td>1.667</td>
<td>0.907</td>
<td>-0.71</td>
<td>n.s.</td>
</tr>
<tr>
<td>Female</td>
<td>1.917</td>
<td>0.996</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Blame of Self</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Male</td>
<td>1.778</td>
<td>1.003</td>
<td>-0.37</td>
<td>n.s.</td>
</tr>
<tr>
<td>Female</td>
<td>1.917</td>
<td>0.996</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Table A-6
Liking for Perpetrator on Attributions of Blame

<table>
<thead>
<tr>
<th>Group</th>
<th>Mean</th>
<th>SD</th>
<th>t value</th>
<th>p</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Blame of Mother</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>High</td>
<td>1.75</td>
<td>1.238</td>
<td>-1.98</td>
<td>&lt; .06</td>
</tr>
<tr>
<td>Low</td>
<td>2.75</td>
<td>1.422</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Blame of Perpetrator</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>High</td>
<td>2.938</td>
<td>1.289</td>
<td>-2.87</td>
<td>&lt; .008</td>
</tr>
<tr>
<td>Low</td>
<td>4.250</td>
<td>1.055</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Blame of Victim</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>High</td>
<td>1.750</td>
<td>1.065</td>
<td>-0.22</td>
<td>n.s.</td>
</tr>
<tr>
<td>Low</td>
<td>1.833</td>
<td>0.835</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Blame of Self</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>High</td>
<td>1.750</td>
<td>1.00</td>
<td>-0.23</td>
<td>n.s.</td>
</tr>
<tr>
<td>Low</td>
<td>1.833</td>
<td>0.835</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Table A-7

Sample Self-concept Scores Compared to Norms of the SPPC

<table>
<thead>
<tr>
<th>Scholastic Competence</th>
<th>Social Acceptance</th>
<th>Athletic Competence</th>
<th>Physical Appearance</th>
<th>Behavioral Conduct</th>
<th>Global Self-Worth</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>MALES</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Sample</td>
<td>2.73&lt;sup&gt;a&lt;/sup&gt;</td>
<td>2.60&lt;sup&gt;b&lt;/sup&gt;</td>
<td>2.62</td>
<td>2.75&lt;sup&gt;c&lt;/sup&gt;</td>
<td></td>
</tr>
<tr>
<td>Norm</td>
<td>3.11</td>
<td>2.96</td>
<td>2.87</td>
<td>3.13</td>
<td></td>
</tr>
<tr>
<td><strong>FEMALES</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Sample</td>
<td>2.82</td>
<td>2.54</td>
<td>2.54</td>
<td>2.72&lt;sup&gt;d&lt;/sup&gt;</td>
<td></td>
</tr>
<tr>
<td>Norm</td>
<td>2.64</td>
<td>2.62</td>
<td>2.64</td>
<td>3.01</td>
<td></td>
</tr>
<tr>
<td><strong>MALES AND FEMALES</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>COMBINED</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Sample</td>
<td>2.66</td>
<td>2.91</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Norm</td>
<td>2.85</td>
<td>2.96</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<sup>a</sup><sub> t(17) = -2.18, p < .05 </sub>

<sup>b</sup><sub> t(17) = -2.03, p < .06 </sub>

<sup>c</sup><sub> t(17) = -2.20, p < .05 </sub>

<sup>d</sup><sub> t(11) = -1.90, p < .09 </sub>
Table A-8

Sample Anxiety Scores Compared to Norms of the RCMAS

<table>
<thead>
<tr>
<th></th>
<th>Total Anxiety</th>
<th>Physical Anxiety</th>
<th>Worry/Oversensitivity</th>
<th>Concentration</th>
<th>Lie Scale</th>
</tr>
</thead>
<tbody>
<tr>
<td>MALES</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Sample</td>
<td>15.61</td>
<td>4.17</td>
<td>5.78&lt;sup&gt;a&lt;/sup&gt;</td>
<td>3.44&lt;sup&gt;b&lt;/sup&gt;</td>
<td>2.22</td>
</tr>
<tr>
<td>Norm</td>
<td>13.35</td>
<td>3.77</td>
<td>4.04</td>
<td>2.74</td>
<td>2.80</td>
</tr>
<tr>
<td>FEMALES</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Sample</td>
<td>19.50&lt;sup&gt;c&lt;/sup&gt;</td>
<td>5.17</td>
<td>6.17</td>
<td>3.83</td>
<td>4.33&lt;sup&gt;d&lt;/sup&gt;</td>
</tr>
<tr>
<td>Norm</td>
<td>15.06</td>
<td>4.14</td>
<td>5.26</td>
<td>2.76</td>
<td>2.89</td>
</tr>
</tbody>
</table>

<sup>a</sup><sub>t(17) = 2.72, p < .02</sub>
<sup>b</sup><sub>t(17) = 1.89, p < .08</sub>
<sup>c</sup><sub>t(11) = 2.91, p < .02</sub>
<sup>d</sup><sub>t(11) = 1.89, p < .09</sub>
APPENDIX B

Demographic Data Form
SIBLING PROJECT: DEMOGRAPHIC INFORMATION

SUBJECT #: 

<table>
<thead>
<tr>
<th>D.O.B.</th>
<th>Race</th>
<th>Educ.</th>
<th>Occup.</th>
<th>Place of Residence</th>
<th>Marital Status</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Mother: N St A F / / 

Father: N St A F / / 

Sex D.O.B. Race Grade Place of Residence

Victim: N St H M F / / 

Subject: N St H M F / / 

Siblings:
1. N St H M F / / 
2. N St H M F / / 
3. N St H M F / / 
4. N St H M F / / 
5. N St H M F / / 

Perpetrator:

D.O.B. Sex Race Educ. Occup. Relationship Relationship to Sibling to Victim / / 

When was the sexual abuse first disclosed? 

By whom? 

How long had the abuse been going on? 

What was the nature of the incest (e.g., fondling, intercourse)?
Has the placement of any family members changed since the abuse was disclosed? Please describe:

What does your child (the one participating in this study) know about the abuse?

Has the victim been in treatment? YES  NO
How long (wks)?

Has the subject been in treatment? YES  NO
How long (wks)?
APPENDIX C

Family Attitude Questionnaire
Family Attitude Questionnaire

1. All families have problems. How much are the problems in your family like the problems in other people's families?

<table>
<thead>
<tr>
<th>Hardly any</th>
<th>Not too much</th>
<th>Somewhat much</th>
<th>Very much</th>
<th>EXTREMELY much</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
</tbody>
</table>

2. Before your family started coming here, how much time did you spend with...

your mother?

<table>
<thead>
<tr>
<th>Hardly any</th>
<th>Not too much</th>
<th>Some much</th>
<th>Very much</th>
<th>EXTREMELY much</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
</tbody>
</table>

your father?

| 1          | 2            | 3         | 4         | 5              |

your sister?

| 1          | 2            | 3         | 4         | 5              |

your friends?

| 1          | 2            | 3         | 4         | 5              |

3. After your family started coming here, how much time do you spend with...

your mother?

<table>
<thead>
<tr>
<th>Hardly any</th>
<th>Not too much</th>
<th>Some much</th>
<th>Very much</th>
<th>EXTREMELY much</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
</tbody>
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your father?

| 1          | 2            | 3         | 4         | 5              |
your sister?

1 . . . . 2 . . . . 3 . . . . 4 . . . . 5

your friends?

1 . . . . 2 . . . . 3 . . . . 4 . . . . 5

4. How much time would you like to spend with...

your mother?

Hardly any Not too Some Very EXTREMELY
at all much much much

1 . . . . 2 . . . . 3 . . . . 4 . . . . 5

your father?

1 . . . . 2 . . . . 3 . . . . 4 . . . . 5

your sister?

1 . . . . 2 . . . . 3 . . . . 4 . . . . 5

your friends?

1 . . . . 2 . . . . 3 . . . . 4 . . . . 5

5. How much attention do you get from...

your mother?

Hardly any Not too Some Very EXTREMELY
at all much much much

1 . . . . 2 . . . . 3 . . . . 4 . . . . 5

your father?

1 . . . . 2 . . . . 3 . . . . 4 . . . . 5

your sister?

1 . . . . 2 . . . . 3 . . . . 4 . . . . 5

your friends?

1 . . . . 2 . . . . 3 . . . . 4 . . . . 5
6. How much attention does your sister get from...

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| your father?             |       |       |       |       |       |
| 1     | 2     | 3     | 4     | 5     |

| you?                     |       |       |       |       |       |
| 1     | 2     | 3     | 4     | 5     |

7. How often do your mother and father have arguments?

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| you father?              |       |       |       |       |       |
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| you?                     |       |       |       |       |       |
| 1     | 2     | 3     | 4     | 5     |

8. How much do you think this person is to blame for problems in your family?

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| you father?              |       |       |       |       |       |
| 1     | 2     | 3     | 4     | 5     |

| you sister?              |       |       |       |       |       |
| 1     | 2     | 3     | 4     | 5     |

| you?                     |       |       |       |       |       |
| 1     | 2     | 3     | 4     | 5     |
9. How much do you like the way things are now?

Hardly Not too Somewhat Very EXTREMELY
at all much much much

1 . . . . 2 . . . . 3 . . . . 4 . . . . 5

10. How nervous do you feel around...

your mother?

Hardly Not too Somewhat Very EXTREMELY
at all much much much

1 . . . . 2 . . . . 3 . . . . 4 . . . . 5

your father?

1 . . . . 2 . . . . 3 . . . . 4 . . . . 5

your sister?

1 . . . . 2 . . . . 3 . . . . 4 . . . . 5

11. How different are the problems in your family from other family's problems?

Hardly Not too Somewhat Very EXTREMELY
at all much much much

1 . . . . 2 . . . . 3 . . . . 4 . . . . 5

12. How often do you get punished by...

your mother?

Hardly Not too Sometimes Very EXTREMELY
at all often often often

1 . . . . 2 . . . . 3 . . . . 4 . . . . 5

your father?

1 . . . . 2 . . . . 3 . . . . 4 . . . . 5

your sister?

1 . . . . 2 . . . . 3 . . . . 4 . . . . 5
13. How often does your sister get punished by...

your mother?

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<th>Hardly at all</th>
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14. How much did you like the way things were before you started coming here?

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15. How much do your mother and father get along?

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APPENDIX D

Parental Consent Form
SIBLING PROJECT

Although great efforts have been made to provide help for victims of child sexual abuse and their parents, little attention has been directed toward the brothers and sisters of these children. Only recently have treatment programs for siblings of victims been developed and encouraged. Still, there is much to be learned about siblings and about their relationships with other family members. I am presently conducting a research project at various agencies in this area in an effort to learn more about what it is like to be the brother or sister of an incest victim.

The requirements for participation are a child:
1. Male or female
2. Age 8 to 14
3. Having a sibling age 6 to 16 who has been sexually abused by a member of your family

If you have any children meeting these requirements, I hope that you will encourage the victim's brother or sister to participate in this short project. About 1 and 1/2 hours of your child's time will be needed to complete some questionnaires regarding their relationship with family members and their feelings and concerns about themselves. The questionnaires are administered somewhat informally and
should not cause any children to become upset or nervous. None of the questions asked are particularly stressful or anxiety provoking.

I will need to meet with you only briefly (5 to 10 minutes) at your convenience. I’ll be very glad to answer any questions that you might have about this project and ask you a few simple questions at that time.

By participating in this project you and your children may be helping other families who have had similar experiences. We need to understand more about factors that are related to child sexual abuse, especially from children’s perspective. Your participation is completely voluntary and at any time you may withdraw your consent and discontinue participation in this study. If you wish, you may also instruct your children that they may quit the study at any time.

All information will be kept strictly confidential. No one here or anywhere else will have access to the information I collect on each person. The results of the study will be reported so that no child is identified or singled out in any way.

I anticipate having the research completed in about 6 months. If you would like to know the results of this study or have any questions at a later time, you may contact me here. You may also contact my dissertation advisor, Dr.
Marshall, at the University of North Texas, Department of Psychology, Denton, Texas, 76203.

Your help is greatly appreciated.

Sincerely,

Jeffrey S. Adler, M.S.
Informed Consent

NAME OF CHILD: ________________________________

1. I hereby give consent to Jeff Adler to perform the following investigational procedure:
   About 1 hour of my child's time will be needed to complete some questionnaires regarding his or her relationship with other family members and his or her feelings and concerns about themselves.

2. I have read the description of this project and fully understand the procedures and requirements. I willingly give my consent to have my child complete the necessary information. I also understand that the research information gathered will be kept strictly confidential and that participation in this project is completely voluntary and I may withdraw my consent at any time.

SIGNED: ______________________________________
Parent/Legal Guardian

DATE: ______________________________________

SIGNED: ______________________________________
Witness
APPENDIX E

Children’s Consent Form
Children's Consent Form

Hi, I'm Jeff. Today we are going to be talking together and I am going to ask you some questions. I will give you some paper and all you have to do is circle an answer on the paper. You do not have to write any words. If there is any part you don't want to do or want to ask me about, that's fine. Just let me know if you are uncomfortable with any part and we'll stop. It's okay to stop and nothing bad will happen if you say you don't want to do something.

Do you have any questions? YES NO
Is it okay to start? YES NO

Name

Date
Problems that Brought Families into Treatment

Participants who did not indicate that the sexual abuse was a reason for their being in treatment gave these responses:

1. A) My mother and father fight.  
   B) School work is bad.

2. A) My sister and mother don’t get along.

3. A) My sister yells alot.  
   B) My sister and I fight.

4. A) My family moved around alot.

5. A) Kids (at home) don’t get along too well.

6. A) We used to fight alot.  
   B) My step-father yells.  
   C) My mother is divorced.

7. A) My mother works too much.

8. A) The way father’s girlfriend treats my sister. By ignoring her and yelling at her for nothing.  
   B) The way my sister and I argue all the time.  
   C) The new baby brother causes everyone to kind of ignore my sister.

   B) My dad is real stubborn.

10. A) My sister doesn’t listen to mother.  
    B) My sister doesn’t clean up.

11. A) Dad being gone and not being able to see him at work furlough.

Participants who did indicate that the sexual abuse was a reason for their being in treatment gave these responses:

1. A) My father molested my sister.

2. A) My grandpa died.  
   B) My dad molested my sister.  
   C) My mom has another boyfriend.

3. A) My father messed with my sister.
4. A) We can’t live with our dad.
   B) My dad is in jail.
   C) He touched my sister.

5. A) Kim says she’s a spoiled little brat.
   B) My sister is a loud mouth.
   C) My sister’s been child abuse—my grandfather went to jail.

6. A) Basically I don’t want to do dishes.
   B) My sister doesn’t want to take a bath.
   C) My father molested my sister.

7. A) Dad and mother got divorced.
   B) My sister got touched and can’t go to grandpa’s.

8. A) Bills.
   B) Step-father touched half-sister in wrong way.
   C) Doesn’t see her father alot.

9. A) My dad bought one ticket and snuck into another movie.
   B) My father molested my sister.

10. A) Sick father... not his fault.
    B) He molested my sister.

11. A) My mother cheating on my dad (led to divorce).
    B) Bill molested my sister.

    B) Secrets.
    C) Sex abuse.

13. A) My sister was molested.
REFERENCES


structure of the Children’s Manifest Anxiety Scale.  


