Adolescent/Sibling Incest Perpetrators

Introduction
Although sexual offending is typically thought of as an adult crime, early studies determined that juvenile offending is also a problem (Doshay, 1943; Groth, Hobson, Lucey, & Pierre, 1981; Shoor, Speed, & Bartlet, 1966). Recent studies also support a need to study this population. In fact, Thomas and Rogers (1983) suggested that even though evidence strongly supports the view that intrafamilial sexual abuse occurs most often among persons of roughly the same generation, most literature and theory still focuses on father-daughter incest.

This chapter attempts to narrow this gap in the literature. The authors did a survey of juvenile offenders, which included 43 incest offenders who had been reported to the Illinois Department of Child and Family Services during 1986. Because protective service agencies typically focus on abuse by family members or care givers, the majority of these cases involved siblings or other youth in the home. This chapter reviews pertinent clinical findings and information relevant to the treatment of incestuous adolescents as well as pertinent observations made by the child protective service worker during the investigation.

Definitions of Juvenile Offending
Juvenile sexual offenders are youths under 18 who engage in sexual activities including exposure, genital fondling, oral, anal, and vaginal intercourse. The juvenile offender uses some type of manipulation or coercion—either threats or implied power—to engage the victim. Although many studies assume that the offender is older than the victim, some studies have shown that juvenile offenders are sometime younger than their victims (Pierce & Pierce, 1987).

It is difficult to determine how many juvenile offences actually occur because, unless a rape is committed, the offence is classified under the general category of assault. One-fifth to one-quarter of the rapes reported in the Uniform Crime Report are committed by individuals under 18 (Knopp, 1982). Twenty-three percent of these are committed by youths 14 and under. Thomas and Rogers (1983) found that of all sexual abuse cases reported to the staff of their unit at Children’s Hospital National Medical Centre in Washington, D.D., 54% involved a juvenile offender, with over 40% of those offences involving a family member.

It is even more difficult to determine the number of sibling offences that occur since these acts are often assumed to be experimentation or exploration and are not reported. Studies on reported sexual abuse cases suggest sibling abuse ranges from 6% (Pierce & Pierce, 1985) to 33% (Thomas & Rogers, 1983) of the cases investigated. De Young (1982) documented 5 cases of sibling incest in her sample of 80 incest victims; Meiselman (1978) found 11 cases of sibling incest compared to 38 of father-daughter incest; and Finkelhor (1980) discovered that 12% of his sample were sexually involved with siblings, although he feels this is an underestimate.

Sibling offences appear to fall into two categories. One category generally begins early as a mutual exploration and may end as the children realise their behaviour is not appropriate. If the relationship continues into adolescence, the siblings frequently have difficulty in subsequent sexual relationships, although Finkelhor (1980) did not find this to be true.

The second category involves one sibling forcing another to engage in sexual activities (de Young, 1982). Sometimes the offender is being sexually abused by a parent or relative and is participating in a promiscuous family life-style (Pierce, 1987). In other cases the offender may be copying the sexually precocious behaviour of abused siblings (de Young, 1982) or may be acting out other family problems.

Due to cultural, ethnic, geographic, and individual differences among offenders, the notion of a typical offender becomes a relative issue. Loredo (1982) warned that, before a label of offending is attached, the clinician should determine if the incest involves some aspect of victimisation, or two or more willing participants exhibiting some type of pathology. Longo and Groth (1983) categorised offenders into two groups: passive and aggressive. The behavioural dynamics of the passive offender (Shoor et al., 1966) are likely to be more subtle (i.e., touching or rubbing, exhibitionism, and compulsive masturbation). In contrast, the aggressive adolescent offender’s behaviours are interwoven in the complex relationship between violence and sex. These are the offenders who commit rape, engage in forced, same sex intercourse, or act out violent threats toward family members or friends.

Description of Juvenile Offenders
The offenders, in this study, ranged in age from 4 to 16 years of age with an average age of 13.1 years. Twenty percent of the victims were either sisters, stepsisters, or adoptive sisters. Nineteen percent were foster sisters, 16% were foster brothers, and 5% were brothers. The rest were other relatives, friends, or children the juvenile was babysitting (caretakers). Determination concerning family members and home conditions were taken from home study reports performed by child protective service workers during the assessment process.

Eighty-one percent of the offenders in this survey were male and 67% were white. The offender was usually the oldest child of his/her sex in the family (46% of the males and 13% of the females) or an only child.

Several patterns of offending appeared: Only 30% were involved in one known offence while 16% were involved in multiple, frequently occurring incidents. In 30% of the cases, the offences occurred infrequently over a long period of time, and, in the final group, several offences occurred over a short period of time. When there were multiple reports, the adolescents were older and described as more dysfunctional than in other categories. These offenders were also more likely to be classified as delinquents by their protective service worker.

The most frequent type of offence in which the juveniles in our study engaged was fondling (51%), with oral intercourse next (30%). Other frequently occurring acts were vaginal intercourse (22%), attempted intercourse (19%), anal intercourse (19%), and exposure (19%). Most often the offender used verbal threats to coerce the victim, but in many cases no specific type of force was mentioned, suggesting that perceived power is sufficient. Juveniles generally perpetrated against people who were younger. In 46% of the cases the victim was at least 5 years younger. In 13% of the cases the offender was 10 years older. In 13% of the cases the offender and victim were close in age, but, in 22% of the cases, the offender was younger than the victim.

Caseworkers described juveniles involved in this study as exhibiting many problems in their families and at school. In fact, it is difficult to determine if the problems are the result of the offending or if the juvenile offences are in response to dysfunctional families. In all probability, both play a role. Fifty-four percent of the juvenile offenders studied were described as aggressive toward family members, half had been involved in delinquent acts, and half had academic problems. Thirty-eight percent had other behaviour problems at home, such as running away, stealing from family members, or withdrawing. Thirty-eight percent had been placed in special classes in school, 30% had behavioural problems at school, and 14% was diagnosed as mentally retarded.

Groth and Loredo (1981) described similar findings. The offenders in their study were typically loners with little skill in “negotiating emotionally intimate peer relationships” (p. 38). Moreover, low self esteem, coupled with deep-seated feelings of inadequacy and emptiness, contribute to the juvenile’s inability to handle life’s demands. Shoor et al. (1966) discovered that, aside from being a loner, the juvenile offender prefers playing with younger children, tends to have a limited work history, and is generally immature in all areas of functioning.

Many of the offenders in our study, as has been the pattern in some other studies, were sexually victimised themselves—an indication of learned violence. Only three of the juveniles in our study were not reported as abused. Forty-three percent had been sexually abused by family members, 5% by others. Eleven percent were exposed to inappropriate sexual behaviour, 63% were physically abused, and 70% were neglected. Longo’s (1982) study shows that 47% of his subjects had been sexually assaulted in their childhood.

Not only have these children been abused, family problems predominate. Fifty-four percent of the juveniles’ parents were judged to be mentally ill by their caseworker during the initial intake in our study twenty-four percent of the parents were involved in substance abuse, and 15% were in prison. Over half of the parents had financial problems, and almost half needed better housing. In two families, children had died because of neglect.

The researchers returned to the protective service agency approximately one year later to initiate a follow-up study that would determine whether or not the juveniles continued to offend, what services were being used, and what services were lacking. Six cases were closed by the agency and further information was unavailable. Eight of the remaining 37 juveniles had reoffended, all of whom were male. Females

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continued to be involved sexually, but were no longer seen as the aggressor. For example, a 13 year old was involved in prostitution. Sexual offending was suspected but not substantiated in several other cases.

At this point, it was possible to identify a pattern of reoffending among these eight juveniles. One-fourth of them continued to be involved with younger girls, and one-fourth engaged in contact with same-sex peers. Other exposed themselves, attempted rape, or were involved in several kinds of sexual activity. None of the reoffenders remained at home, although 38% were in foster care. The rest were in residential care centres or detention. Hopefully, caretakers in these settings are alerted and providing protection for other residents. Half of the reoffenders had parents with mental problems, and 25% had parents in prison. The caseworkers assessed that the reoffender’s mentally ill parents were more disturbed than those in the total sample.

At the time of the follow-up, protective service workers felt the prognosis was fair or poor for almost 75% of the original juvenile offenders reported from their caseloads. Many offenders continued to have problems and appeared to lack the social skills needed to make friends. Workers frequently described these children as unlikable, which makes it even more difficult for them to receive help. On the other hand, one of the most likeable adolescents in the study was judged recovered by his therapist and immediately began offending again.

Treatment
Although adolescents appear to be exploring and talking more openly about their sexuality today than in past decades (Parry-Jones, 1985), this seems to have had only minimal effect on how they are responded to within the treatment arena. Perhaps treatment providers are not as accepting nor as open concerning these behaviours; in other words, this is where the communication stops. Since many parents and clinicians are themselves struggling with the issue of identifying what is typical or normal sexual behaviour and exploration among youth, the issue is frequently avoided. Thus, the juveniles who seem overly anxious, frightened, and confused about their sexual development, thoughts, and activities find little or no help upon confiding in adults about sexual matters. When this is compounded by the knowledge that the child had indeed sexually abused another, confronting the issue may be even more difficult. Juvenile offenders may threaten to abuse female therapists or may try to use seduction within the clinical setting. They are often frightening and difficult to work with unless the therapist is comfortable with his/her sexuality and with discussing sexual matters.

To juvenile offenders, sex represents the vehicle through which they give and receive attention. In this sense sex, in and of itself, appears to be secondary to what is supposedly brings: closeness, perceived caring, or importance. Waggoner and Boyd (1941) pointed out that juvenile offenders are insecure children who engage in aberrant sexual behaviours to gain approval and to release tension and anxiety. Helping the adolescent offender redirect his/her strong sexual drives into socially acceptable and desirable channels is one of several treatment issues facing clinicians. They also pointed out that offenders frequently reside in homes that are characterised as rejecting, tense, and unstable.

When clinicians examine the multiplicity of problems facing juvenile offenders and their families, it becomes obvious that treatment must focus on several issues. The family and the juvenile must be involved in treatment if the juvenile is to return home, especially if the victim is still in the home. Involvement of the family may be difficult because of the tendency to deny the abuse, but it is an integral component of most treatment programmes.

Treatment begins with individual and group sessions for the offender. During this time, the victim and family members are also seen, but this discussion will examine areas of concern in treatment of the juvenile. Most programmes ask that the offender be removed from the home, at least during the initial phases of treatment (Thomas & Rogers, 1983). Care must be taken to ensure that the youth is not placed with other vulnerable children, who, themselves, will perpetrate the abuse. If the offender is placed in a foster home, the foster parents should be well-trained concerning the behaviours they may expect and the appropriate responses to those behaviours.
When working with the juvenile offender in a treatment setting, five interrelated areas that must be addressed are:

1. the low feeling of self-esteem experienced by the offender;
2. the offender’s own victimisation; this can help the offender gain some empathy for the victim;
3. the social isolation experienced by offenders; they often have few social skills and few friends;
4. that offenders need sex education; they must learn acceptable ways of acting out their sexual feelings; and
5. that offenders need to learn their pattern of response and offending.

**Low self-esteem.** As has been noted, juvenile offenders frequently come from dysfunctional families. They have received little warmth or support from parents and are functioning at a much younger age developmentally than their chronological age would imply. Therapy must supply or replace much of the structure and consistency missing in the youth’s life. As the therapist supports the youth and encourages the youth to explore issues and change behaviour, the therapist can also point out those areas in which the youth is successful.

**The offender’s own victimisation.** A large number of juvenile offenders have been sexually victimised. Others have been physically abused and neglected. The offender should be helped to acknowledge his/her feelings of anger, shame, and worthlessness. The offender may also feel some responsibility for his/her abuse and may be attempting to overcome these feelings by abuse others. Once offenders can accept their own victimisation, they can be helped to empathise with victims and they are more likely to feel remorse for their acts. Groth (1982) cautioned that some offenders may become depressed when they reach this point.

**Social isolation.** As noted earlier, many juvenile offenders have few social skills. They often need assertiveness training, as well as social skills training. Many report difficulty in forming relationships and feel uncomfortable around the opposite sex. In addition, they feel put down and ignored when trying to express their needs and often respond by being aggressive or passive (Long, 1983). Group sessions are particularly helpful in this respect.

**Sex education.** Because most juvenile offenders come from families in which sex is either presented as something dirty or in which there are few sexual boundaries, most have little idea of what a loving sexual relationship involves. They are used to taking what they want and have little concept that decisions can be made around sexual matters. Adolescents who have been involved in same-sex abuse may wonder about their sexual orientation and will need help resolving this issue. Most have minimal knowledge of anatomy and sexual response. Sex education should start with basics and assume nothing.

**Patterns of response.** Each offender has a pattern of behaviour antecedent to incestuous activity. It is important for him/her to recognise the behaviours that lead to the sexual offence and to find other ways to respond. Many adolescents can be helped to understand the situations that result in sexual arousal and can develop alternative responses.

After the juvenile offender has been in treatment for a while, usually longer than with other kinds of problems, the family can be seen together. Thomas and Rogers (1983) described how this occurs in their programme. Because the family faces many situational/environmental problems as well, clinicians must also have access to community resources or must be willing to advocate for changes in the services available.

**Summary**

Although juvenile sexual offending, particularly sibling abuse, appears to be the most common type of incest, the research and literature in this area have not yet caught up to that on father-daughter incest. It does appear that juvenile offenders frequently reside in families where they receive minimal warmth and care. Many offenders have been victimised themselves and, thus, have few social skills. Findings also suggest that many offenders begin to have problems at an early age, but families and communities refuse to regard this behaviour as serious.

To be successful in treating adolescent offenders, interventions must occur on several levels: with the offender, the offender’s family, and the offender’s community. With a greater understanding of the
offender’s problems, the clinical community will be better prepared to effectively intervene. Suggestions for treatment will be developed as more juvenile offenders are being reported and mandated to receive treatment. The classification and identification of these young offenders should be a high priority for treatment providers and researchers, eventually leading to more adequate treatment diagnosis with this population.

References

Doshay, L. (1943). The boy sex offender and his later career. New York: Grove and Stratton.
Lois H. Pierce & Robert L. Pierce The Incest Perpetrator. A Family No One Wants to Treat.
Anne L. Horton, Barry L. Johnson, Lynn M. Roundy, Doran Williams (Eds)Sage Publications; 1990 California