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CHAPTER 7

Profiles of parents of adolescent perpetrators of CSA

Yvonne Duane, Alan Carr, Joan Cherry, Kieran McGrath & Deirdre O'Shea

Multifactoral explanations of sexually abusive behaviour in adolescence argue that a range of developmental and contextual variables and personal attributes collectively contribute to the onset and maintenance of sexually abusive behaviour (e.g. Barbaree, Marshall and McCormack's, 1998; Vizard et al, 1995). Problematic parent-child relationships in early life and victimization experiences in childhood are among the commonly proposed developmental precursors of CSA perpetration in adolescence. It has also been proposed that sexually deviant behaviour in adolescence may be maintained by ongoing difficulties in the functioning of the nuclear family and poor parental adjustment.

Adolescents who engage in sexually abusive behaviour constitute a heterogeneous group. Their abusive behaviour may range from non-contact offences such as indecent exposure and phone calls to violent and sadistic rape. They may abuse alone or with other perpetrators and their victims may include both males and females ranging in age from the very young to the very old. Distinctions may also be made between non-adjudicated adolescents whose abuse behaviour has not led to court attendance and their adjudicated counterparts whose sexually abusive behaviour has led to involvement in the

legal system. This distinction is particularly useful in attempting to draw general conclusions from results of empirical studies of adolescent sex offenders.

Empirical studies in which self-reports of adjudicated adolescent CSA perpetrators were compared with those of other delinquent populations have found the two groups held much in common, with regard to family environment, developmental experiences and histories of victimization, but CSA perpetrators were distinguished by a higher incidence of exposure to family violence and by more frequent occurrence of physical and sexual abuse (Van Ness, 1984; Davis and Leitenberg, 1987; Lewis et al, 1979, 1981; Rubenstein et al, 1993; Ford and Linney, 1995).

Empirical studies of non-adjudicated adolescent CSA perpetrators have shown that while they differ from normal community control groups they hold much in common with clinical controls drawn from outpatient mental health clinics (Bischof et al.,1992; Bischof et al., 1995; Stith and Bischof, 1996; O'Reilly et al, 1998; O'Halloran et al, 2002). Bischof and colleagues found poorer communication between parents and non-adjudicated sexually abusive youngsters compared with normal controls. (Bischof et al.,1992; Bischof et al., 1995; Stith and Bischof, 1996).

O'Reilly et al (1998) compared a group of non-adjudicated Irish sexually abusive adolescents who had completed a community based treatment programme with a group of non-offending peers matched for age, sex, and socio-economic status. Physical abuse, parental separation, and school related educational and behavioural difficulties were more common in the histories of the sexually abusive adolescents than in the histories of their control group counterparts. Despite this, compared with the control group, the sexually abusive adolescents were found to have the same level of psychological and psychosocial functioning following treatment. This was interpreted tentatively as evidence for treatment effectiveness. However, it was acknowledged that this type of post-test only treatment design with a normal control group is not particularly robust. In this study it was also found that not all cases responded to treatment. When the sexually abusive adolescents were classified by treatment staff as those at high and low risk for reoffending following treatment, high risk cases who failed to

respond to treatment were found to have lower ability levels, lower levels of maternal and paternal care, and poorer levels of family functioning. On the Mc Master Family Assessment Device (Epstein et al, 1983) the high risk group obtained more deviant scores on the roles, affective responsiveness and affective involvement scales.

O'Halloran et al (2002) compared the self-reports of non-adjudicated Irish adolescent CSA perpetrators with those of clinical and community controls on the Family Environment Scale (Moos and Moos, 1986) and found that adolescent CSA perpetrators and clinical control showed more problematic family functioning in the areas of emotional expressiveness and behaviour control than the normal control group.

The present study aimed to expand our knowledge about the profiles of families of adolescent CSA perpetrators by comparing a group of parents of adolescent sexual offenders (PASO); a clinical control group (CC) of parents of non-offending adolescents attending a child and adolescent mental health service; and a normal control group (NC) of parents of non-offending adolescents in the community on a range of demographic, developmental, personal adjustment and family environment variables.

METHOD

Participants

The Parents of Adolescent Sexual Offenders (PASO) group contained 22 parents of adolescent boys who had committed at least one known sexual offence. The Clinical Control (CC) group contained 10 parents of adolescent boys who were attending an adolescent mental health service but had no history of sexual offending. The Normal Control (NC) group contained 19 parents of adolescent boys with no history of sexual offending and who had not attended an adolescent mental health service.

The PASO group was drawn from an Irish adolescent sexual offender treatment programme run by the Northside Inter-agency Project (NIAP) team in Dublin (Sheridan and McGrath, 1999). Since its inception in 1991, NIAP has included a parents group as an integral part of its service (McGrath, 1990, 1992; Cherry, 2000). The 22 members of the PASO group consisted of parents who had participated in the NIAP parents group programme. Individuals were included if their son was either at the time of the study or had in the past attended the NIAP adolescent treatment programme. The group consisted of 15 mothers and 7 fathers. Of the 22 sons, the type of sexual offence committed was almost evenly divided between intra-familial and extra-familial abuse.

The CC group was drawn from two outpatient mental health clinics on the North-side of Dublin in the Eastern Region Health Authority (ERHA). There were 9 mothers and one father in the group. The NC group was drawn from a pool of parents of adolescents attending a boy's secondary school on the North-side of Dublin. There were 13 mothers and 6 fathers in this group.

The distribution of the members of the three groups across social classes was similar, with the majority in each group coming from the Professional or Managerial and Technical workers class. Results of chi square analysis, confirmed that intergroup differences in distribution across social classes were not statistically significant ($\chi = 6.14$; df=4; $p > .05$).

However the groups were not matched for age. The PASO group was about four years older (M=48.95, SD=7.69) than the CC (M=44, SD=4.27) and NC (M=44.26, SD=4.72) groups. A one-way ANOVA confirmed that inter-group differences in parental age were significant at the .05 level, ($F(2,58)=3.802$, $p < .05$). There was a possibility that parental age might contribute to differences between groups on dependent variables. To address this problem correlations between parental age and all 30 dependent variables were computed. It was found that none of the 30 dependent variables correlated significantly with parental age. It could therefore be assumed that none of the dependent variables were influenced by parental age and so it was not necessary

to use statistical procedures such as analysis of covariance (ANCOVA) to control for differences in parental age across groups.

Instruments

The following instruments were used to assess demographic, developmental, personal adjustment and family environment variables:

Demographic and developmental characteristics

- Demographic and Developmental history Questionnaire (DDHQ)

Personal adjustment

- The General Health Questionnaire -12 (GHQ-12, Goldberg and Williams, 1988).
- Culture-Free Self-Esteem Inventory - General Scale - Form AD (CFSEI, Battle, 1992).
- The Child Behaviour Checklist (CBCL, Achenbach, 1991).

Family Environment

- The Family Assessment Device (FAD, Epstein, Baldwin and Bishop, 1983; Kabacoff, Miller, Bishop, Epstein and Keitner, 1990).
- Parent Satisfaction Scale (PSS, Guidubaldi and Cleminshaw, 1985).
- The Multidimensional Scale of Perceived Social Support (MSPSS, Dahlem et al., 1991).

Validity of responses

- The Marlow-Crowne Social Desirability Scale-Short Form (MCSDS, Crowne and Marlow, 1960, Strahan and Carrese-Gerbasi, 1972).

What follow is of a brief description of each instrument.

Demographic and Family History Questionnaire

This included items on age, gender, socioeconomic status, parental mental health, parental criminal history, parental history of victimization, adolescent's history of victimization and adverse family experiences.

The General Health Questionnaire -12

This 12 item self-report questionnaire was used to assess parents' mental health (Goldberg and Williams, 1988). All items have four point response formats ranging from "not at all" to "much more than usual". Internal consistency and test retest reliability coefficients for this instrument range from 0.7 to 0.9. Validity studies show that the GHQ 12 has good sensitivity (94%) and specificity (79%) in detecting psychological disorders evaluated by standardized clinical interviews.

Culture-Free Self-Esteem Inventory - General Scale - Form AD

The general self-esteem scale of the AD form of the CFSEI is a 15-item measure of self-esteem which yields a single score (Battle, 1992).. For all items a yes-no response format is used. The internal consistency and test-retest reliability coefficients for the scale are 0.8 and the scale has been shown to have construct and criterion validity.

The Child Behaviour Checklist

This 113 item reliable and valid inventory is completed by parents so as to give a description of their children's behaviour problems (Achenbach, 1991). A three point response format is used for each item ranging from 0=not a problem to 2=often a problem. The CBCL yields scores on 3 broad band scales and 8 narrow band subscales. The total problem scale, the externalizing behaviour problem

scale and the internalizing behaviour scale are broad band dimensions. The narrow band subscales are: withdrawn, somatic complaints, anxious/depressed, social problems, thought problems, attention problems, delinquent behaviour, and aggressive behaviour. Internal consistency and test-retest reliabilities for subscales range from 0.7-0.9. Content, construct and criterion-related validity for the CBCL has been established.

The Family Assessment Device

This 60-item inventory evaluates perceived family functioning and yields scores on the following seven subscales: problem solving, communication, roles, affective responsiveness, affective involvement, behaviour control and general functioning (Epstein, Baldwin and Bishop, 1983; Kabacoff, Miller, Bishop, Epstein and Keitner, 1990). For all items a four point Likert response format is used with responses ranging from ‘strongly agree’ to ‘strongly disagree’. Internal consistency reliability coefficients for the various scales range from 0.7 to 0.9. The FAD has been shown to discriminate between clinical and non-clinical families and clinically a cut-off score of 2 on the general functioning scale may be used to identify families with significant adjustment difficulties.

Parent Satisfaction Scale

This 50-item self-report instrument yields scores on five factors: spouse support, parent-child relationship, parent performance, family discipline and control and general satisfaction (Guidubaldi and Cleminshaw, 1985). For each item a four-point Likert scale response format is used ranging from ‘strongly agree’ to ‘strongly disagree’. Internal consistency reliability coefficients for the subscales

range from 0.8 to 0.9. With regard to validity, the sub scales correlate strongly with criterion measures of marital and life satisfaction.

The Multidimensional Scale of Perceived Social Support

This is a 12 item self-report instrument which yields a total perceived social support score and three subscale scores indicating support from family, friends, and a significant other (Dahlem et al 1991). The MSPSS has strong internal consistency and test-retest reliability and factorial validity (Zimet et al., 1988; Zimet et al., 1990).

The Marlow-Crowne Social Desirability Scale-Short Form

This 10-item scales yields a single index of socially desirability response set (Crowne and Marlow, 1960, Strahan and Carrese-Gerbasi, 1972).. A true-false response format is used for all items. Internal consistency reliability coefficients for the MCSDS range from 0.6 to 0.7 across various studies and the scale has been shown to be responsive to ‘faking-good’ instructions. The scale evaluates respondents' tendency to respond to self-report items so as to represent themselves in a positive light. In the present study, to evaluate the extent to which self-report data were contaminated by a social-desirability response set, scores on the MCSDS were correlated with all self-report dependent variables. Where low correlations were obtained it was concluded that self-report data were valid insofar as they were largely uncontaminated by a social-desirability response set.

PROCEDURE

Ethical approval was obtained from involved agencies to conduct the study. Informed consent was obtained from all participants and confidentiality was

assured. The PASO group was recruited from the NIAP programme for parents of adolescent CSA perpetrators. The CC group was recruited, with the help of key-worker clinicians involved with potential participants, through adolescent mental health services. The CC group was recruited from a parent-teachers meeting of a secondary school for boys. All participants were mailed questionnaires with a stamped addressed envelope for returning completed protocols to the research team.

RESULTS

For categorical variables, the statistical significance of inter-group differences was evaluated using Fisher's exact probability test. For psychometric measures, the statistical significance of inter-group differences on dependent variables was evaluated using a series of one-way ANOVAs with Scheffe post hoc tests for unequal N designs. Because of the large number of dependent variables in this study, the p value for statistical significance in the Fisher's Exact Probability tests and the ANOVAs was set at .01 rather than .05 to reduce the probability type 1 error (accepting chance differences or correlations as significant).

Demographic and developmental characteristics

Parents in the PASO group differed significantly from those in the control groups in two important ways. From Table 7.1 it may be seen that 19% of the parents in the PASO group had been arrested or had a criminal record, whereas members of the control groups had no history of criminality. From Table 7.2 it may be seen that significantly more mothers and fathers in the PASO group had a history of child abuse compared with those from the control groups. For both mothers and

fathers in the PASO group emotional abuse was more common than physical or sexual abuse.

Table 7.1. Status of the parents of adolescent sexual offenders, normal controls and clinical controls on demographic and personal variables

	VARIABLE	PASO Group (N=22)	NC Group (N=19)	CC Group (N=10)
Marital Status	**Single or Widowed**	1 5%	1 5%	2 20%
	Married or Cohabiting	15 68%	17 90%	7 70%
	Separated or Divorced	6 27%	1 5%	1 10%
Mental Health	**History of mental health problems**	6 27%	3 16%	3 30%
Criminality	**Arrest history**	3 14%	0 0%	0 0%
	Criminal record	1 5%	0 0%	0 0%

Note: PASO= parents of adolescent sexual offenders. NC= normal controls. CC= clinical controls.

Parents in the three groups also shared a number of similarities. From Table 7.1 it may be seen that the three groups of parents did not differ significantly in marital status or the proportion of their members that had a history of mental health problems. From Table 7.3 it may be seen that mothers and fathers in the PASO group and the control groups did not differ significantly in the frequency with which they reported a family history of drug or alcohol abuse, psychological disorder or police involvement.

Table 7.2. Mothers' and fathers' history of child abuse

	VARIABLE	PASO Group (N=22)	NC Group (N=19)	CC Group (N=10)
History in mothers' family	**Child abuse***	12 54%	2 11%	1 10%
	Sexual abuse	3 14%	1 5%	0 0%
	Emotional abuse	7 32%	0 0%	0 0%
	Physical abuse	2 9%	1 5%	1 10%
History in fathers' family	**Child Abuse***	9 41%	1 5%	2 20%
	Sexual abuse	1 5%	0 0%	0 0%
	Emotional abuse	6 27%	1 5%	1 10%
	Physical abuse	2 9%	0 0%	1 10%

Note: PASO= parents of adolescent sexual offenders. NC= Normal controls. CC= clinical controls. *On child abuse in mothers' family of origin, Fishers exact probability test for PASO vs NC&CC combined, $p<.01$. *On child abuse in fathers' family of origin, Fishers exact probability test for PASO vs NC&CC combined, $p<.01$

Adolescents of parents in the PASO group differed significantly from those in the control groups in three important ways. From Table 7.4 it may be seen that significantly more adolescents of parents in the PASO group had experienced child abuse compared with adolescents of parents in the control groups, with emotional abuse was more common than physical or sexual abuse. Significantly more adolescents of parents in the PASO group had witnessed parental drug or alcohol abuse compared with adolescents of parents in the control groups.

Table 7.3. Problems in Mothers' and fathers' families of origin

	VARIABLE	PASO Group (N=22)	NC Group (N=19)	CC Group (N=10)
History in mothers' family	**Drug or alcohol abuse**	3 14%	5 26%	2 20%
	Psychological disorder	1 5%	3 16%	2 20%
	Police involvement	1 5%	0 0%	0 0%
History in fathers' family	**Drug or alcohol abuse**	6 28%	3 16%	1 10%
	Psychological disorder	3 14%	1 5%	1 10%
	Police involvement	3 14%	0 0%	1 10%

Note: PASO= parents of adolescent sexual offenders. NC= Normal controls. CC= clinical controls.

Also, while 18% of adolescents of parents in the PASO group had been placed in care outside their home either as a result of their abusive behaviour or because of other family difficulties, no adolescents of parents in the control groups had experienced such placements.

Adolescents of parents in all three groups also shared a number of similarities. Adolescents of parents in the PASO group did not differ significantly from controls in the frequency with which the following forms of victimization occurred: bullying, harsh physical punishment, being yelled at frequently and neglect. There were also no significant intergroup differences in the frequency with which adolescents had witnessed in their homes family violence, excessive shouting, their fathers being arrested or pornographic movies and magazines.

Table 7.4. Adolescents' status on developmental variables

	VARIABLE	PASO Group (N=22)	NC Group (N=19)	CC Group (N=10)
History of abuse	**Child abuse***	14 64%	3 16%	0 0%
	Sexual abuse	4 18%	0 0%	0 0%
	Emotional abuse	7 32%	2 11%	0 0%
	Physical abuse	3 14%	1 5%	0 0%
History of victimization	**Bullying**	8 36%	9 47%	4 40%
	Harsh physical punishment	3 14%	1 5%	3 30%
	Being yelled at frequently	4 18%	3 16%	3 30%
	Neglect	1 5%	0 0%	0 0%
Witnessed in the home	**Family violence**	4 18%	0 0%	1 10%
	Excessive shouting	9 41%	2 11%	3 30%
	Drug or alcohol abuse*	8 36%	1 5%	0 0%
	Father being arrested	1 5%	0 0%	1 10%
	Pornographic movies or mags	2 10%	3 16%	0 0%
Out of home placement		4 18%	0 0%	0 0%

Note: PASO= parents of adolescent sexual offenders. NC= Normal controls. CC= clinical controls. *On child abuse, Fishers exact probability test for PASO vs NC&CC combined, p<.01 *On drug and alcohol abuse, Fishers exact probability test for PASO vs NC&CC combined, p<.01

Personal adjustment

From Table 7.5 it may be seen that the mean scores of the three groups for the GHQ-12 and the CFSEI did not differ significantly, indicating no significant intergroup differences in parental psychological distress or self-esteem. None of the groups mean scores were above the cut-off point of 24 for psychiatric caseness (Goldberg and Williams, 1988).

Table 7.5. Status of the parents of adolescent sexual offenders, normal controls and clinical controls on the General Health Questionnaire and a self-esteem scale

Instrument	Subscale		PASO Group (N=22)	NC Group (N=19)	CC Group (N=10)	F
GHQ-12	Total	M	15.64	10.32	11.8	3.88
		SD	7.8	5.35	3.08	
CFSEI	General Self-Esteem	M	11.59	13.42	10.9	3.48
		SD	3.02	1.42	3.92	

Note: GHQ-12=General Health Questionnaire. CFSEI= Culture Free Self Esteem Inventory M= mean. SD= standard deviation PASO= parents of adolescent sexual offenders. NC= Normal controls. CC= clinical controls.

From Table 7.6 it may be seen that parents in the PASO and clinical control groups reported, on the CBCL, that their adolescents had significantly more behaviour problems than those in the normal control group. Parents in the PASO group reported that their adolescents had significantly more internalizing behaviour problems than normal controls, whereas parents in the clinical control group reported that their adolescents had significantly more externalizing behaviour problems than normal controls. On the narrow-band subscales of the CBCL, a distinct pattern occurred where, compared with normal controls, significantly more problems with social withdrawal uniquely characterised the adolescents of parents in the PASO group and significantly more problems with delinquent and aggressive behaviour uniquely characterized adolescents of parents in the clinical control group. However, parents in both the PASO and clinical control groups reported that their adolescents showed significantly

greater levels of anxiety, depression and social problems compared with normal controls.

Table 7.6. Status of adolescent sexual offenders, sons of normal controls and clinical controls on the Child Behaviour Checklist

CBCL Subscale		PASO Group (N=22)	NC Group (N=19)	CC Group (N=10)	F	Group Diffs
Total	M	36.50	16.63	45.70	6.85*	PASO&CC>NC
	SD	25.55	16.92	23.06		
Internalising	M	11.04	4.05	10.70	5.47*	PASO>NC
	SD	9.49	3.95	5.80		
Externalising	M	13.5	6.47	21.20	8.44*	CC>NC
	SD	9.54	7.27	12.06		
Withdrawn	M	3.95	1.42	4.10	5.32*	PASO>NC
	SD	3.68	1.46	1.97		
Somatic Complaints	M	1.86	0.68	0.80	3.26	
	SD	2.07	1.05	1.03		
Anxious/ Depressed	M	5.77	2.00	6.40	5.14*	PASO&CC>NC
	SD	5.62	2.16	3.97		
Social Problems	M	2.59	0.84	3.70	7.30*	PASO&CC>NC
	SD	2.10	1.30	2.9		
Thought Problems	M	1.05	0.42	0.90	1.70	
	SD	1.43	0.77	0.74		
Attention Problems	M	6.09	3.21	8.00	4.84	
	SD	4.84	3.27	4.10		
Delinquent Behaviour	M	4.00	1.42	6.30	5.13*	CC>NC
	SD	4.50	2.50	5.14		
Aggressive Behaviour	M	9.50	5.05	14.9	8.45*	CC>NC
	SD	6.20	5.20	7.81		

Note: Raw scores were used for all CBCL subscales. M= mean. SD= standard deviation PASO= parents of adolescent sexual offenders. NC= Normal controls. CC= clinical controls. *p<.01.

Family Environment

From Table 7.7 it maybe seen that the family environments of parents in the PASO and clinical control groups differed significantly in a number of important respects from those of the normal controls. Compared with normal controls,

parents in both the PASO and clinical control groups reported more difficulties on the FAD with general family functioning, roles, affective responsiveness, affective involvement and behaviour control within the family. In addition

Table 7.7. Status of the parents of adolescent sexual offenders, normal controls and clinical controls on psychosocial variables

Instrument	Subscale		PASO Group (N=22)	NC Group (N=19)	CC Group (N=10)	F	Group Diffs
FAD	Problem Solving	M	2.00	1.68	1.96	8.17*	PASO>NC
		SD	0.35	0.29	0.17		
	Communication	M	2.16	1.90	2.18	4.51	
		SD	0.39	0.26	0.19		
	Roles	M	2.38	1.88	2.58	24.25*	PASO& CC>NC
		SD	0.36	0.23	1.21		
	Affective Responsiveness	M	2.08	1.63	2.00	8.27*	PASO&CC>NC
		SD	0.36	0.37	0.39		
	Affective Involvement	M	2.20	1.81	2.23	7.47*	PASO&CC>NC
		SD	0.46	0.24	0.24		
	Behaviour Control	M	1.95	1.39	1.87	25.38*	PASO&CC>NC
		SD	0.29	0.26	0.19		
	General Functioning	M	2.08	1.66	2.15	10.14*	PASO&CC>NC
		SD	0.34	0.33	0.35		
PSS	Total	M	103.6	85.42	111.1	6.01*	PASO&CC>NC
		SD	24.89	17.33	16.23		
	Spouse Support	M	20.41	17.11	26.33	3.52	
		SD	9.48	6.80	9.73		
	Child-Parent Relationship	M	19.13	15.26	19.00	3.25	
		SD	6.11	3.62	5.40		
	Parent Performance	M	23.72	19.63	25.1	4.16	
		SD	6.35	4.42	5.15		
	Family Discipline & Control	M	21.86	18.00	23.20	2.79	
		SD	7.36	5.40	5.30		
	General Satisfaction	M	20.64	17.05	19.66	4.27	
		SD	4.80	3.06	3.24		
MSPSS	Total Support	M	5.65	5.95	5.09	2.50	
		SD	1.02	0.83	1.17		
	Significant Other	M	6.07	6.09	5.40	1.35	
		SD	1.29	0.86	1.39		
	Friends Support	M	5.68	5.82	5.45	0.34	

	SD	1.23	1.07	1.26	
Family Support	M	5.22	5.93	4.42	4.83
	SD	1.45	1.01	1.23	

Note: MSPSS=Multidimensional Scale of Perceived Social Support. FAD= Family Assessment Device. PSS= Parent Satisfaction Scale. M= mean. SD= standard deviation PASO= parents of adolescent sexual offenders. NC= Normal controls. CC= clinical controls. *p<.05. **p<.01.

compared with normal controls, parents in the PASO group reported more difficulties on the FAD with family problem-solving. Mean scores for the PASO group on all of these dimensions of the FAD with the exception of 'behaviour control' fell at or above the clinical cut-off score of 2. The groups also differed significantly in their levels of parental satisfaction as assessed by the total score on the PSS. Compared with normal controls, parents in both the PASO and clinical control groups reported more problems in achieving parental satisfaction. However, the groups did not differ significantly in their levels of perceived social support as assessed by the MSPSS.

Validity of Responses

An important concern is the validity of the self-report data used in this study and the extent to which it was contaminated by a social-desirability response set. To evaluate this possibility, a measure of social desirability response set, the MCSDS, was correlated with all 30 self-reported psychometric dependent variables. None of these correlations was greater than .3 and none were statistically significant at $p<.01$. Where correlations greater than an absolute value of .3 occur, this indicates that a substantial amount (more than 9%) of the variance in the dependent variable may be accounted for by a social desirability response set. Thus, it may be concluded that self-report data were largely uncontaminated by a social-desirability response set.

DISCUSSION

In this study parents of adolescent CSA perpetrators and their youngsters were profiled. The profiles of the PASO, CC and NC groups are summarized in Table

7.8. Compared with clinical and normal controls, more parents of sexually abusive adolescents reported that they had been arrested or charged for a criminal offence; had personally experienced child abuse; and more of their adolescents had experienced child abuse, with emotional abuse being the most common form of abuse for both parents and adolescents.

Table 7.8. Profiles of parents of adolescent sexual offenders, normal controls and clinical controls

Scale	Subscale	Parents of Adolescent Sexual Offenders	Normal Controls	Clinical Controls
DDHQ	Mothers' history of child abuse	+	-	-
	Fathers' history of child abuse	+	-	-
	Adolescents history of child abuse	+	-	-
	Parental criminality	+	-	-
	Drug or alcohol abuse in Adol's home	+	-	-
	Adolescent placed in care	+	-	-
CBCL	Total	+	-	+
	Internalising	+	-	-
	Externalising	-	-	+
	Scale1: Withdrawn	+	-	-
	Scale 3: Anxious/Depressed	+	-	+
	Scale 4: Social Problems	+	-	+
	Scale 7: Delinquent Problems	-	-	+
	Scale 8: Aggressive Behaviour	-	-	+
FAD	Problem Solving	+	-	+/-
	Roles	+	-	+
	Affective Responsiveness	+	-	+
	Affective Involvement	+	-	+
	Behaviour Control	+	-	+
	General Functioning	+	-	+
PSS	Total	+	-	+

Note: DDHQ=Demographic and Developmental History Questionnaire. CBCL= Child Behaviour Checklist. FAD= Family Assessment Device. PSS= Parent Satisfaction Scale. - = The feature was at a low level. + = The feature was at a high level. +/- = The feature was at an intermediate level.

Compared with clinical and normal controls, more adolescent CSA perpetrators had witnessed parental drug or alcohol abuse and had been placed in care outside their home. While parents of sexually abusive adolescents did not differ from

clinical or normal controls in terms of personal adjustment, their youngsters had significantly more internalizing behaviour problems than normal controls, whereas adolescents of parents in the clinical control group had significantly more externalizing behaviour problems than normal controls. Compared with normal controls, parents of adolescent CSA perpetrators and parents in the clinical control group reported more difficulties with general family functioning, roles, affective responsiveness, affective involvement and behaviour control and lower levels of parental satisfaction. But the groups did not differ significantly in their levels of perceived social support.

Methodological Limitations

This study had a number of limitations. First, the groups were convenience samples, not random samples. Thus, our results may not be generalized to the whole population of adolescent CSA perpetrators. However, they may probably be generalized to those non-adjudicated sexually abusive adolescents who engage in treatment at Irish outpatient clinics. Second, our groups, particularly the clinical control group, were small and this limited the power of statistical tests to detect intergroup differences. But this does allow us to place considerable confidence in the intergroup differences which were found. Third, most of the dependent variables were based on self-reports and so the validity of variables based on these self-reports could have been compromised by response set. When we correlated a measure of social desirability response set with all self-report dependent variables, none of the correlations were greater than .3 indicating that, the self-report data were uncontaminated by a social-desirability response set. In view of these limitations and our attempts to deal with them we are fairly confident that the profiles we found in this study are valid for the groups we studied and may be generallized to similar populations from which the samples were drawn.

Comparison with Other Studies

Our findings are consistent with multifactoral explanations of sexually abusive behaviour in adolescence which argue that a range of developmental and contextual variables and personal attributes collectively contribute to the onset and maintenance of sexually abusive behaviour (e.g. Barbaree, Marshall and McCormack's, 1998; Vizard et al., 1995).

While some of the findings of the present study were consistent with those reported previously in the literature, some were not. With respect to demographic characteristics, the finding that rates of single-parent homes were the same for the families of adolescent CSA perpetrators and both normal and clinical control is not consistent with findings from other studies where higher rates of single parent homes were found among adolescent CSA perpetrators (Kaplan et al., 1990; Graves et al., 1996; O'Reilly et al., 1998; Hsu and Starzynski, 1990; Browne and Falshaw, 1998; Manocha and Mezey, 1998; Gray et al., 1999). It is, however, consistent with Bagley's (1992) results where it was found that the majority of his sample of adolescent sexual offenders came from intact families.

The finding of higher rates of past child abuse among adolescents CSA perpetrators is consistent with reports from several studies (O'Reilly et al., 1998; Manocha and Mezey, 1998; Gray et al., 1999). The finding of higher rates of past child abuse among parents of adolescents CSA perpetrators is also consistent with reports from other studies, but typically these have found higher rates of sexual rather than emotional abuse (Kaplan et al. 1988; Kaplan et al., 1990; Manocha and Mezey, 1998; New et al., 1999).

The finding that the parents in the three groups did not differ in rates of history of mental health problems or mean levels of psychological adjustment on the GHQ and self-esteem is inconsistent with the results of other studies where parents of adolescent CSA perpetrators were found to have significant mental health difficulties (e.g. Hsu and Starzynski, 1990).

Our finding that adolescent CSA perpetrators had high levels of internalizing behaviour problems and lower levels of externalizing behaviour problems is consistent with those of Bagley (1992) who found that a sample of juvenile sexual offenders were less delinquent than a clinical comparison group of juveniles in residential care. In contrast, some studies have found that adolescent CSA perpetrators showed significant levels of delinquent behaviour (Hastings et al, 1997; James and O'Neil, 1996).

The finding of significant problems in family functioning in the present study is consistent with previous similar findings (Bischof et al,1992; Bischof et al, 1995; Stith and Bischof, 1996; O'Halloran et al, 2002).

One possible explanation for the discrepancy between our findings and those of other studies which found higher rates of single parent families, externalizing behaviour problems and parental mental health problems in group of adolescent CSA offenders may lie in the way cases are recruited into treatment programmes in Ireland. Such programmes in Ireland are community-based and voluntary. Adolescent CSA perpetrators from less functional families with more significant behavioural and mental health problems may not be recruited into our programmes (O'Halloran et al, 2002. Referral and attendance depend upon the willingness of the adolescent and their family to engage in treatment and so it is suggested that adolescents and their families whose difficulties are mainly at the milder end of the continuum are attending Irish treatment programmes.

Implications for Research

The results of our study require replication in larger scale controlled studies. Observational studies are required to throw light on the detailed family processes which underpin the areas of difficulty identified in this study through self-report instruments. The parents and families of adolescents who have sexually offended are a heterogeneous group and there is also considerable variability in the sexually abusive behaviour patterns among adolescent sexual offenders.

Research on different types of adolescent sexual offenders and the profiles of their families is required. Currently there are no mandatory treatment programmes for unmotivated adjudicated adolescent sex offenders in Ireland. Should such programmes be developed it would be valuable to replicate the current study on that population.

Implications for Practice

Our findings highlight the importance of involving families in treatment from the outset, both to disrupt problem-maintaining family behaviour patterns and also to contribute to the development of protective and preventative family behaviour patterns.

SUMMARY

A group of 22 parents of adolescent sexual offenders (PASO) was compared with a group of 19 normal controls (NC) and 10 clinical controls (CC) on demographic, developmental, personal adjustment and family environment variables. The assessment protocol included the General Health Questionnaire – 12, the Culture-Free Self-Esteem Inventory, the Child Behaviour Checklist, the Family Assessment Device, the Parent Satisfaction Scale, and the Multidimensional Scale of Perceived Social Support. Compared with clinical and normal controls, more parents in the PASO group reported that they had been arrested or charged for a criminal offence; had personally experienced child abuse; and more of their adolescents had experienced child abuse, with emotional abuse being the most common form of abuse for both parents and adolescents. Compared with clinical and normal controls, more adolescents of parents in the PASO group had witnessed parental drug or alcohol abuse and had been placed in care outside their home. While parents in the PASO group did not differ from clinical or normal controls in terms of personal adjustment, their adolescents had

significantly more internalizing behaviour problems than normal controls, whereas adolescents of parents in the clinical control group had significantly more externalizing behaviour problems than normal controls. Compared with normal controls, parents in both the PASO and clinical control groups reported more difficulties with general family functioning, roles, affective responsiveness, affective involvement and behaviour control and lower levels of parental satisfaction. But the groups did not differ significantly in their levels of perceived social support.

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