THE SOCIAL NETWORKS AND SUPPORT OF JUVENILE SEX OFFENDERS
BEFORE, DURING AND AFTER THEIR TREATMENT

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Youth system (Zaff et al., 2016):

- Family (parents) – Emotional, instrumental, informational support
- Peers – validation support
- Teachers – validation support

Learning goals/objectives: after the presentation you have gained:

- Knowledge on how social networks and support are associated with the development of sexual offending in youths.
- Knowledge on the influence of social support during treatment.
- Knowledge on the influence of social support on treatment outcomes.
157 youths treated for committing a sexual offense
Mean age 14.4 ($SD = 2.03$)

Type of offense:
- 37% sexual assault
- 16% rape
- 29% multiple hands-on offenses
- 14% hands-off offense
- 4% sexual indecency

64% reported to the police, 36% not reported.
Risk assessment instrument developed by De Waag outpatient treatment center.

Contains most relevant items of: SAVRY, J-SOAP II, Youth Level of Service|Case management inventory (YLS\CMI) and Static-99

12 Domains:

1. Prior and current offending
2. School (and work)
3. Finances
4. Residential environment
5. Family
6. Social (peer) network
7. Leisure
8. Substance abuse
9. Personal/Emotional characteristics
10. Attitudes (toward the victim/offense)
11. Treatment and risk management
12. Sexual delinquency/deviancy
What is a network?

**Node:** entity in a network (person or in our case risk factors)

**Edge:** association between two nodes

This study: statistical associations, controlled for all other nodes (risk factors)
**Attitudes**
- H1 – Taking responsibility
- H2 – Empathy
- H3 – Cognitive distortions
- H4 – Deviant attitudes

**Family**
- G1 – Delinquent parents
- G2 – Drug/alcohol abuse parent(s)
- G3 – Psychological problems parent(s)
- G6 – Parenting skills
- G7 – Relationship quality parents
- G9 – Discontinuity in care (<12yr)
- G12 – Relationship siblings
- G13 – Support by adults

**Treatment**
- B3 – Parents cooperative in treatment

**Personal/emotional**
- P1 – Witnessed domestic violence
- P2 – Abuse (<12yr)
- P4 – Conduct disorder (<10yr)
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F1 – Divorce parents
F4 – Unemployment parent(s)
F5 – Domestic violence

Treatment
B3 – Parents cooperative in treatment

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P1 – Witnessed domestic violence
P2 – Abuse (<12yr)
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Personal/emotional
P1 – Witnessed domestic violence
P2 – Abuse (<12yr)
P4 – Conduct disorder (<10yr)
**Attitudes**
H3 - Cognitive distortions
H4 – Negative ideas

**Sexual delinquency**
X5 – Long offending period
X9 – Coping with sexual needs
X19 – Number of victims

**Personal/emotional**
P7 – Impulsive (previous 6 months)
P8 – Stressful events (previous 6 months)
P9 – Coping skills (stress previous 6 months)
P11 – Self image (previous 6 months)

**Social (peer) networks**
N1 – Adequate social contacts with peers
N2 – Rejection by peers
**Attitudes**
H3 - Cognitive distortions
H4 - Negative ideas

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**Social networks**
N1 - Adequate social contacts with peers
N2 - Rejection by peers
Attitudes
H2 - Empathy

Sexual delinquency
X1 – Hands-on sexual offense
X3 – Paraphilia
X6 – Offense planning
X8 – Excessive sexual behavior
X16 – Victim is a child (below age 10 and at least 4 years younger than the offender)
CONCLUSION: BEFORE

Three clusters of characteristics:

• Largest cluster problems with attitudes of the juvenile, family problems, limited support by adults, personal and emotional problems (related to family; domestic violence, abuse), and attitude of parents toward treatment.

• Second cluster shows high concentration of recent personal or emotional problems related to inadequate social networks with peers.

• Final cluster shows problems associated with sexual behavior.
THERAPEUTIC RELEVANCE

Focus treatment on risk factors with high strength centrality:

- **Highest strength centralities:** parenting skills, quality of relationship parents, self-image, discontinuity in care (<12yr), psychological problems parents, witness domestic violence, support by adults and deviant attitudes about sexuality.

- **Bridges:** cognitive distortions and coping with sexual needs.

**Weak strength centrality:** deceased parent(s) and attention deficit hyperactivity disorder.
Basic sample information:

- About 40% received individual treatment, 39% received a combination of treatments with involvement of family members.
- Mean face-to-face appointments: 29 \((SD=22.3)\)
- No association between the type of offense and the treatment.

Based on high strength centrality risk factors no differences in treatment.
Treatment readiness:
• Motivated
• Able to respond appropriately
• Finds treatment relevant and meaningful
• Has capacity to successfully enter treatment

(Ward et al, 2004)

Treatment amenability and the role of peer and family factors
• Association between parental assessment of the need for treatment and the youth’s amenability for treatment.
78.8% stated at the start they wanted to be involved in the treatment

“It is not relevant any more”, mother and stepfather - case #22.

“If it happened and I am not saying that it did, I call it playing doctor. Just like we did in the past”, mother - case #124

“I distanced myself from him. I am afraid I will hurt him once we butt heads over something minor”, father - case #184

“If he gets rid of it [sexual deviant behavior], than he gets rid of it, I do not need any help”, mother - case #107.
THE EFFECT ON THE PARENT(S)

Parents often have strong feelings about the offense

Impact of the offense for parent(s) and other family members:
• End of relationships (romantic or with relatives)
• Having to move
• Family life disrupted

Monitoring and trust

“We can not do this forever”, father – case #115
Significant influence by family risk factors, peers were less prominent

Peer networks during treatment

Pervasive developmental disorders
CONCLUSION: DURING

All individual cases

• Limited ability to focus treatment on family domain
• Parental opinion has significant influence on the youths’ opinion
• Consequences of the offense on family life were significant
• Parents appreciated treatment, but struggled with 24/7 surveillance
General outcome:

- Positive association between motivation at the start and treatment outcome ($r = .538$, $p < .001$)
- Youths with high centrality strength risk factors have significantly less positive treatment outcomes

No recidivism rates, but during treatment some reoffending occurred (7 cases)
CASE #121

Hands-off offense: hacking and exhibiting himself using his phone and webcam

- Relationship with parents described as good by the youth. Later during treatment he states he does not feel any attachment
- Accomplished liar
- Parents supportive, trusting
- Parents monitor him, but they do not discipline him
- Youth does not see his behavior as problematic

Treatment ended before accomplishing any of the goals.

Conclusion: parents very supportive, but enable his behavior (downplaying, no disciplining etc.)
AND NOW....

Recidivism rates

Social relations model
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