An Evaluation Study of ‘Romeo’

a Dutch intervention program for adolescent boys involved with sexual harassment

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Abstract (ENG)

In the Netherlands, sexual harassment still appears to be a problem in adolescence. The current evaluation study focused on the ‘Romeo’ intervention. This intervention is a program for adolescent boys who engage in sexual harassment behavior and are at risk for recidivism. This mixed methods study had investigated the extent to which the sexual interaction competence of the adolescent boys have changed after the intervention as well as different perspectives on the quality of the implementation of the intervention. In total 22 boys were eligible for the quantitative analyses, as only they reported on their sexual interactional competence on the pretest and posttest. Furthermore, ten care workers were interviewed to examine their perspectives on the quality and implementation of the program. The sexual interactional competence of boys did not improve significantly after the intervention. Despite this insignificant result, a positive trend was noticed. In addition, the care workers reported the program to be useful and were positive about the quality of the implementation. They recommended to adjust and update the program continuously and mentioned the importance to focus more on mild intellectual disabilities and sexuality since this involves many clients. It is important to evaluate programs such as Romeo. This intervention program has potential to improve the sexual interactional competence of boys and subsequently the sexual health of adolescents.

Keywords: adolescence, intervention, evaluation, sexual harassment, sexual interactional competence

Abstract (NL)

Seksueel grensoverschrijdend gedrag onder jongeren blijkt nog steeds een probleem te zijn in Nederland. Dit onderzoek betreft een evaluatie onderzoek naar de interventie ‘Romeo’. Deze interventie is ontwikkeld voor jongens die specifieke zorg en aandacht nodig hebben, omdat zij

betrokken zijn geweest bij seksueel grensoverschrijdend gedrag. Dit *mixed-methods* onderzoek heeft zich enerzijds gericht op de verandering van de seksuele interactie competentie van deelnemende jongens na de interventie. Anderzijds zijn verschillende perspectieven op de kwaliteit van de implementatie van de interventie bevraagd door middel van interviews. In totaal werden 22 jongens geïncludeerd voor het kwantitatieve deel, omdat deze jongens zowel voor- als nameting hadden ingevuld. De verandering in seksuele interactie competentie van jongens tussen de voor- en nameting was niet significant. Desondanks was er wel een positieve trend zichtbaar. In de interviews rapporteerden de hulpverleners bovendien erg positief over de interventie te zijn, die door hen als zeer bruikbaar en zinvol bestempeld werd. Continue aanpassing en vernieuwing van het programma werd echter als vereiste gezien. Voornamelijk de aandacht voor seksualiteit en licht verstandelijke beperkingen werd benadrukt. Concluderend kan gesteld worden dat het erg belangrijk is om programma's als Romeo te evalueren. Het interventie programma Romeo heeft veel potentie om de seksuele interactie competentie van jongens te vergroten en uiteindelijk de seksuele gezondheid van adolescenten te verbeteren.

Kernwoorden: adolescentie, interventie, evaluatie, seksueel grensoverschrijdend gedrag, seksuele interactie competentie

Introduction

Problem statement

In recent years, there has been an increase of sexual health in adolescence (De Graaf, Kruijer, Van Acker & Meijer, 2012). Sexual health not only include the absence of diseases and dysfunctions, but also managing meaningful and respectful relationships with others (Mouthaan & van der Vlugt, 2015). Despite these improvements, sexual harassment is still a problem (de Graaf et al., 2012). This entails the undesirable sexual behavior and crossing boundaries of the comfort zone of victims and is considered a influencer of sexual health in adolescence (de Haas, 2012; Mouthaan & van der Vlugt, 2015). Since the prevalence of sexual harassment remains present among adolescents between the age of 15 and 25 years old, this subject and therefore the prevention and intervention concerning sexual health and sexual harassment still requires attention (de Haas, 2012).

According to Mouthaan & van der Vlugt (2015), interventions focus on respect towards others and expression and recognition of sexual desires and limits. Furthermore, it also includes the broad definition of sexual health and recreational sex. Due to the extent of effectiveness, accessibility of adolescents and the large amount of control during the intervention, interventions are mostly implemented at schools (Mouthaan & van der Vlugt, 2015). Many interventions are based on the improvement of the *sexual interactional competence*, since the Graaf et al., (2005) mentioned the importance of developing this competence in adolescence. This complex concept involves the knowledge, capabilities, and attitudes concerning healthy sexual contact and relations. Several sexual health interventions for adolescents have been developed in recent years, but none has been evaluated *effective* for young people in secondary schools (NJI, 2018). Therefore, more research is required to expand knowledge about the effectiveness of the interventions as well as practice based evidence to acquire more insight

about the active principles in practice (de Graaf et al., 2015; Mouthaan & van der Vlugt, 2015; Wartna, Vaandrager, Wagemakers & Koelen, 2012).

This study focused on the 'Romeo' intervention designed by Qpido; a youth care organization specialized in adolescent sexual assertiveness. The intervention is a program for adolescent boys who engage in sexual harassment behavior and are at risk for recidivism. This study will investigate the extent to which the sexual interactional competence of the adolescent boys has changed after the intervention as well as different perspectives on the quality of the implementation of the intervention.

Theoretical basis and empirical basis

Sexual health among adolescents. Adolescence is considered a period characterized by physical, psychological and behavioral changes (Duke, Litt & Gross, 1980). Besides biological changes associated with puberty, this stage of life is also involved with upcoming sexual behavior and thereby managing intimacy and sexuality in relationships with others (DeLamater & Friedrich, 2002). Although the development of sexual health continues throughout ones live, it accelerates in adolescence. According to the World Health Organization (WHO, 2006) sexual health is *"a state of physical, emotional, mental and social well-being in relation to sexuality and not merely the absence of disease, dysfunction of infirmity"*. The development of sexual health during adolescence is important, because it affects the ability to develop and maintain meaningful interpersonal relationships. In addition, Tolman et al., (2003) mention the importance of appreciating one's own body, the respectful and appropriate interaction with both genders and the expression of affection, love and intimacy with one's own values. Therefore, it is necessary to make adolescents familiar with healthy sexuality, since they enter the sexual world in adolescence and insufficient developed sexual health could have large consequences in life later on (Glomb, Munson, Hulin, Bergman & Drasgow, 1999).

Sexual health education & interventions. Sexual harassment can be a consequence of unhealthy sexual development of adolescents (De Haas, 2012). Given the high prevalence rates of sexual harassment, it is very important to continue paying attention to this topic. De Graaf (2017) stated in her study *Seks onder je 25e* that 2% of boys and 11% of girls below 25 years are still victim of sexual harassment. Sexual harassment may be either physical or non-physical. It is all about the fact that the perpetrator's sexually orientated behavior is crossing personal boundaries of the victim (De Haas, 2012). Because this still appears to be a problem, prevention is required. In the Netherlands a lot of attention is paid to sexual education in secondary schools (Van den Bongardt, Mouthaan & Bos, 2009). These school-based education programs, which are mainly focused on knowledge and attitudes, are designed to improve the sexual health of adolescents. Primarily, they include several themes including physical, mental, and social changes in adolescence as well as love, relations, reproduction and STDs (Kocken, Weber, Bekkema, Dorst, Kesteren & Wiefferink, 2007). Although these preventive school-based programs focus on the improvement of sexual health among adolescents, there are still relatively high numbers of adolescents who are confronted with sexual harassment (De Graaf, 2017; De Haas, 2012). Many of them show high rates of internalizing problems and alarming psychosocial developments. This means that they score under level on sexual development based on their age and IQ (Hart-Kerkhoffs, Jansen, van Wijk & Bullens, 2009). Intervention programs have been developed for this group of adolescents, for whom mere sexual education is insufficient. The majority of these Dutch intervention programs are group-based, but also a few individual intervention programs (NJI, 2018). According to Boonstra & van der Rijken (2010) a group intervention can also result in unintended side-effects. Various studies have shown that attention and the stories of others can reinforce negative behavior of adolescents in a group (Cho, Hallfors & Sanchez, 2005; Dekovic, 2010).

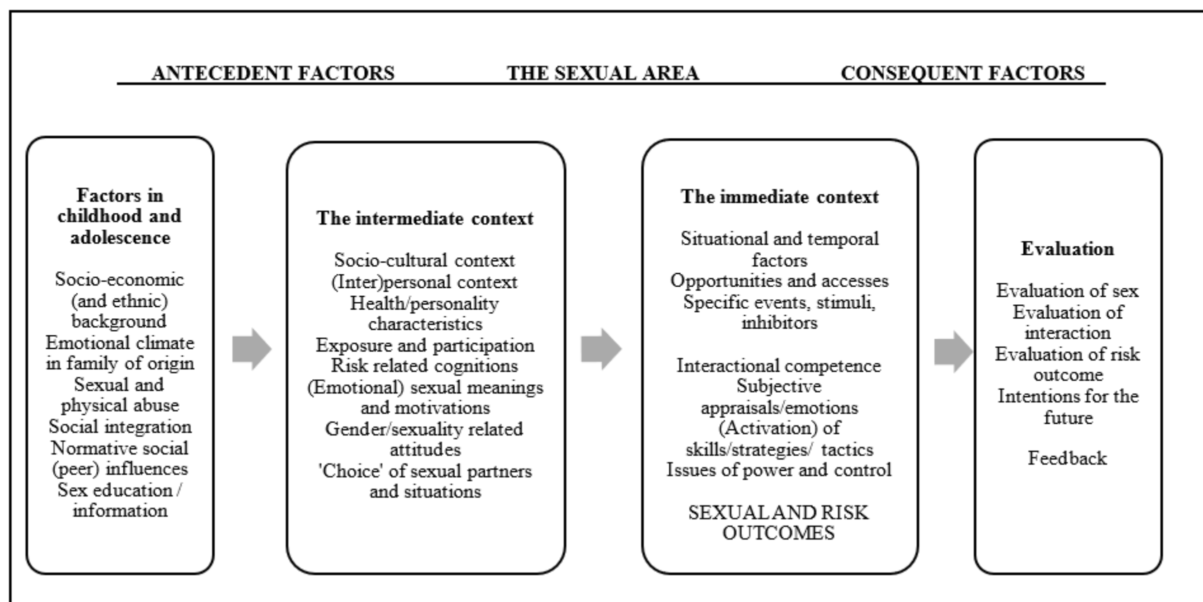
Besides group or individual treatments, gender specific programs can also be selected as they may have a more positive effect on the client. In many cases it ensures that the client feels comfortable with the similarities they share with their male/female mentors in terms of sex, gender and social context (Nicolai, 1992). Although many sexual health interventions have been developed over the past years, there is limited information available about the implementation and effectiveness (Kocken et al., 2007; Mouthaan & van der Vlugt, 2015; NJI, 2018). Conditions for effective intervention are outlined in the study of Kirby, Laris & Rolleri (2005). According to this study, the following eight characteristics are required. Firstly, sexual education should be provided before the start of puberty and requires a broad focus on the subject. Furthermore, it is important to accept the sexuality of adolescence and the lessons need a clear and appropriate age- related message. Moreover, attention should be paid to knowledge, skills, values, norms and attitudes of adolescence concerning sexuality. Lastly Kirby et al., (2015) emphasizes the collaboration between different youth care organizations and the importance of adolescent participation.

Sexual interactional competence model. Many sexual intervention programs for adolescents are based on the *sexual interactional competence model* (Figure 1) developed by Vanwesenbeeck, van Zessenz, Ingham, Jaramazoviĉ & Stevens (1999). This model involves the knowledge of, capability for and attitudes towards healthy sexual contact and relations, while relying on the idea that sexual health behavior is strongly sensitive to context and interaction with the partner (Vanwesenbeeck et al., 1999; De Graaf et al., 2005). Negative outcomes concerning one's sexual health behavior cannot be simply explained by one's individual character, but are a construction of socio-sexual developmental, contextual and interactional factors. Figure 1 explains in which manner the sexual interactional competence develops. Firstly, it shows antecedent factors developed in childhood and adolescence, which contains their social-economic background as well as knowledge and attitudes formed by

education and earlier experiences. Vanwesenbeeck et al., (1999) state that, especially antecedent factors, are of importance, because they affect sexual encounters in adolescence. Consequently, those factors influence the immediate context and the interactional competence, e.g. skills, strategies and tactics on how to deal with sexual issues. Additionally, issues of power and control are also covered in this area. Eventually, this model shows that sexual health is a result of all these influencing factors and contexts.

Figure 1

The sexual interactional competence model (Vanwesenbeeck et al., 1999)



To further explain this *sexual interactional competence model* by Vanwesenbeeck et al., (1999) in relation to sexual health and sexual harassment in adolescence, the study of Hart-Kerkhoffs et al., (2009) is used. According to this study mistaken perceptions of power and control in sexuality could be a result of antecedent incidents. Especially problematic familial circumstances, insufficient sex education, and internalizing and psychosexual developmental problems are mentioned as determinants for limited sexual interactional competence and may cause juvenile sex offenses later in adolescence. Concluding, antecedent factors, e.g. sexual abuse in childhood, could have large consequences in later life. It could entail in negative sexual

related norms, values, and attitudes, which could eventually manifest itself in negative sexual outcomes, e.g. sexual harassment (Vanwesenbeeck, 1999; Hart-Kerkhoffs et al., 2009).

Effectiveness of interventions. Effectiveness of interventions concerning sexual health depends on both the quality of the program itself and the quality of the implementation (Schutte, Mevissen & Kok, 2014). In the literature, several definitions of implementation are mentioned. According to Stals (2012), implementation is the transmission of an innovation. The implementation consists of four stages (Davis & Tailor-Vaisey, 1997). Firstly, the diffusion phase, in which those involved get familiar with the content of the intervention. Secondly, the target group should be convinced by the intervention and develop positive attitudes to implement the intervention. To implement the intervention successfully, it is also necessary to integrate it as a routine in normal life, instead of using it by occasion. Lastly Davis & Tailor-Vaisey (1997) mention the importance of the maintenance of the program and the importance of frequent evaluation and innovation of the program. Finally, the conclusion that correct implementation is one of the most important conditions for an effective intervention can be drawn. If the intervention is not implemented as intended by the program designers, this may lead to the intervention not operating effectively.

Intervention program 'Romeo'. As explained previously, sexual harassment still appears to be a problem in the Netherlands. For both boys and girls, the perpetrator appears to be, in most cases, male (De Graaf, 2017) Therefore, in this study the focus will be on the intervention program 'Romeo'. This gender specific program, designed by Qpido, focusses on adolescent boys between 12 and 18 years who are involved with sexual harassment behavior, are at risk for recidivism or experience other problems concerning their sexuality. The boys who are eligible for this program show high rates of internalizing problems or alarming psychosexual development, as a result of an undeveloped sexual interactional competence. They require more care than average and can register themselves or being referred by

professional youth care organizations. The program is voluntary in nature, therefore motivation is required from the participants.

Current study

The current study aims to explore to what extent the sexual interactional competence of the participatory adolescent boys have changed after the intervention as well as different perspectives on the quality of the implementation of the intervention. Based on the model by Vanwesenbeeck (1999) it is expected that the sexual interactional competence of the adolescent has improved after the intervention. Therefore, the following research questions will be answered. 1) To what extent the sexual interactional competence of adolescent boys had changed after the intervention? And 2) How do different involved parties experience the quality of the intervention 'Romeo'? The first aim will be investigated by quantitative analyses, whereas for the second aim qualitative methods will be used.

Methods

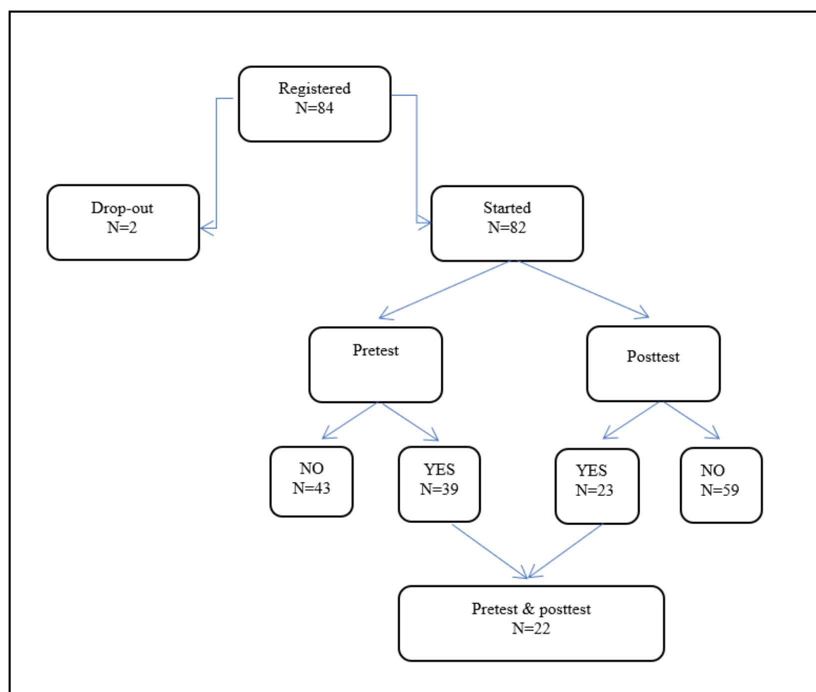
Quantitative

Participants & procedure. This intervention is implemented by youth care organization Qpido. Predominantly, participants are referred by professional youth care organizations such as *Spirit, OKT, JeugdzorgPlus, Halt, Raad van de Kinderbescherming, and Veiligheidshuis*. A behavioral specialist from Qpido was responsible for the intake of boys. This specialist decided whether or not the boys were eligible to engage in the intervention program based on the following criteria: the boy was in the age range of 12-18, showed sexual harassment behavior based on *Risicotaxatie-instrument Seksueel grensoverschrijdend gedrag (RIS)* (Eighenraam, Bartelink, Daru, Kooiman & van Gastel, 2014) or *Vlaggensysteem* (Frans & Franck, 2010) or experienced problems with love, sexuality and relations himself. Reasons for exclusion of the intervention program were boys who already have been prosecuted for sexual harassment, were addicted to alcohol or drugs, have an IQ below 70 or were in need of

other or more intensive youth care. After being admitted to the program, boys filled out a questionnaire twice; before the intervention started (T0) and again about 12 meetings after the intervention was completed (T1) in presence of a mentor. Data from participants were anonymized by assigning an unique code to each participant and so privacy of the participants was guaranteed. As shown in Figure 2, of all 84 boys who were registered for the 'Romeo' intervention program in the year 2014 up to and including 2017, 82 boys actually started the program. Of these 82 boys, 39 boys completed the pretest and 23 boys the posttest. In total, 22 boys filled out both the pretest and the posttest and were eligible for the analyses, as only they reported on their sexual interactional competence at baseline (T0) and follow up (T1).

Figure 2

Respondent flow-chart



Instruments. The sexual interactional competence of adolescents is measured by the organization Qpido with the SIER (sexual interactional and relationship) questionnaire. This questionnaire consisted of 40 questions broken down into parts with various themes (Table 1). Six questions focused on *emotions and behavior*, e.g. "Others know when I am angry or happy".

The second part *safe sex* consisted of three questions. Part three consisted of seven questions dealing with *self-esteem*. In part four, respondents were to answer five questions about *conversation partner and friendship*. Part five had four questions on *approaching others*. The sixth part asked respondents five questions about *personal boundaries in relations* and *image of sex* consisted of 10 questions. The scores on the pretest indicate the areas in which the boys experience problems at the start of the 'Romeo' program. The SIER pretest serves as a tool to assess in which area the boys need more education. By comparing the answers of the pretest and the posttest, the extent of change of the sexual interactional competence can be measured. Answers could be filled out on a 4 point Likert-scale (1= strongly disagree, 2= disagree, 3= agree, 4= strongly agree). There was also an option (99) to reply *not applicable* if boys were not (yet) familiar with the subject in question. For the questions where *not applicable* was filled out, the score was replaced by the average of the other items. Negative formulated scale questions were automatically re-coded in the *BergOp* database (where all questionnaires are stored online). Effects were statistically significant at $p < .05$. The SIER questionnaire had high reliability, Cronbach's, α =.85.

Table 1

Questionnaire scales and items

Scale SIER questionnaire	**Number of items**	**Example of items**
Emotions and behavior	6	Others know when I am angry or happy
Safe sex	3	Using only a condom is safe enough
Self-esteem	7	I am satisfied with my looks
Conversation partner and friendship	5	I discuss my problems with friends
Approaching others	4	In case of intimate contacts or sex I try to find out what the other person wants
Personal boundaries in sexual relations	5	When I have experienced something special during sex I will not tell anyone
Image of seks	10	Internet and television present the incorrect image of sex
Total (N)	40	

Analyses. First, the sample of participating boys were described in relation to all variables of interest (age, nationality and reason of registration). Data were analyzed in IBM SPSS Statistics 25. Firstly, means and SD's were calculated for each outcome. Then, mean difference scores and the effect size (Cohen's *d)* between pretest and posttest were measured. To examine the change between the sexual interactional competence of the boys from T0 to T1, a paired sample t-test was used. The paired sample t-test can be used when the same entities participate in both conditions of the intervention. It compares the mean differences on sexual interactional competence of boys between the pretest and the posttest, and the difference we expect to find between the population means (Field, 2014).

The 'Romeo' intervention program. The participating boys of the 'Romeo' program are individually mentored by the same male professional. During several meetings (with an average care treatment duration of M = 251 days, SD = 142.57), sexual themes are discussed with the aid of different exercises. After the intake and the selection of the boys, the program has a rigid structure. On average, there were 33 days between the registration date and the actual start of the program (SD = 53.92). Firstly, the boys' situation is investigated, e.g. with questionnaires, home-visits and analyses. Then follows the implementation of the program, which includes conversations and exercises to improve knowledge and develop, or change attitudes towards sexuality. During role-playing, conversations, and discussions, the professional remains on the background to stimulate the reasoning of the boys. Moreover, the boys are frequently challenged to approach the situation from different perspectives. Hence, the goal of the 'Romeo' intervention program is to improve the sexual interactional competence, general sexual health and subsequently stimulate the decrease of sexual harassment of adolescent boys.

Qualitative

Participants and procedure. For the qualitative part of this study a total of four

freelancers, three behavioral specialists, two interns and a PHD- researcher of the program were approached. In some cases, the instructors were face-to-face asked to participate in the study, while in other cases, the freelancers, were recruited by email or telephone. All of them were willing to participate and had experience in mentoring boys, except for the researcher. The ten participants were in the age from 22 till 37. The interns had just started their first treatments, but the majority had mentored between two and seven boys. With exception of one of the caregivers, they all completed a study related to youth care. All participants were invited to participate in the qualitative interview by a formal letter describing the aim of the study. By using an informed consent form (Appendix A) participants gave permission for the interview and the recording of it. The interviews were conducted by one researcher and lasted approximately 40 minutes each.

Measures. The experiences of the instructors about the quality of the intervention were questioned by semi-structured depth interviews. An interview guide was developed to maintain structure in these interviews (Appendix B). Although structure can be an advantage, it is also important to be flexible and adjust to the situation. Therefore, an interview guide was developed for this study with questions and topics, but this guide was not rigid throughout the complete research (Patton, 2002). The structure of each interview contains an introduction of the researcher and the study (including aim of the study). Furthermore, several themes concerning the experiences about the quality of 'Romeo', i.e. general opinion, training & supervision and the change of the sexual interactional competence were discussed. All questions were formulated as open-ended questions to better assess feelings, and attitudes of the respondent. Furthermore, probing questions were used to gain more information during the interviews.

Analyses. The recorded interviews were first transcribed verbatim. The data has been analyzed using the thematic analysis theory (Patton, 2001). Those fragments which were relevant for the study were coded in Atlas Ti. By entering codes in the data (Appendix C), it

was possible to make connections between the various interviews and combine the results in the conclusion. For this part of the study an inductive approach is used (Patton, 2001).

Results

Quantitative

Characteristics. Of the 22 boys included for this study, the youngest was 10 years and the oldest 18 years (M = 14.91, SD = 2.27). Most of them (27.3%) were registered by *Wijkteam, GGD & GGZ* and almost half of them (45.5%) had a Dutch nationality. The other boys were of Moroccan (1), Portuguese (1), Pakistani (1), Surinamese (2) and Turkish (2) origin. Of the remaining 5 boys, their background was unknown. On the variables age ($t(82) = .452$, $p = .597$), and nationality ($t(82) = -1.049$, $p = .288$) the 22 boys included to the study did not differ significantly from the boys who were excluded.

Registration. In the past few years from 2014 till 2017, the number of clients increased considerably. There were only five registrations in the first two year (22.7%), whereas in 2016 and 2017 there were 17 registrations (77.3%). Boys can be registered to the intervention program for more than one reason. The most common reason for registering boys to the 'Romeo' program is *learning about sexual boundaries and desires*. As shown in Table 2, 59.1% of the boys experienced problems with this subject. In addition, *sexual education and developments* (54.5%) and *sexual harassment* (31.8%) has also been indicated as an important reason. Over the years, the main reasons for registration have remained more or less the same. Only *sexual harassment* and *sexting & grooming* occurred more frequently over time.

Table 2

Registration reasons over time

Registration reasons	**Total (N)**	**Total (N) in %**	**2014**	**2015**	**2016**	**2017**
Sexual education and behavior	12	54.5%	1	2	6	3
Resiliency	3	13.6 %	1	0	0	2
Love and relations	1	4.5%	0	1	0	0
Sexting and grooming	5	22.7%	0	1	1	3
Sexual harassment	7	31.8%	0	0	2	5
Confidant	5	22.7%	0	1	4	5
Sexual boundaries and desires	13	59.1%	1	3	4	5
Self-esteem	2	9.1%	0	0	2	0

Sexual interactional competence. In order to gain insight to what extend the sexual interactional competence of participatory boys had changed after the intervention, the pretest and the posttest of the SIER questionnaire were analyzed. On average, respondents scored higher on the post-test (M = 3.27, SE = .27) than on the pre-test (M = 3.13, SE = .20). However, this difference, .14. BCa 95% CI [-.01, .27], was not significant $t(21) = 1,89$, $p = .073$, and represented a small effect, $d = .40$. Despite this insignificant result, a trend seems to be noticeable which shows an increase in sexual interactional competence of participatory boys over time.

Evaluation of the program. At the last question of the posttest the boys were asked by which grade they assessed the program. Scores assigned to the program ranged between 6 and 10 (M = 8.4, SE = 1.23), which shows that boys evaluate the program as very positive.

Qualitative

'Romeo' intervention program. All respondents reported the 'Romeo' program as an appropriate and useful intervention for boys who have problems involving their sexuality. According to the participants, this gender specific intervention has many advantages. In their opinion young boys feel more free and open to talk about their sexuality with a same sex care worker. Additionally, respondents also emphasized that they are functioning as a role model. Boys look up to their mentors since they act as big brother and conversation partner.

'Romeo' manual & training. The participants confirmed they all received a manual at start which contains information about the program and target group. This manual listed that the care workers have to attend a five-day training before becoming a professional 'Romeo' care worker at Qpido. However, none of the participants did hear about, or attended in this training. The majority of the respondents indicated that they already had experience in youth care and mentioned that because of their gathered knowledge and work experience they had not missed the training. However, the two interns said more training could be useful, especially for mentoring mild intellectual disabled boys in sexuality. Although in the manual this is mentioned as contraindication, all the participants emphasized the increasing inclusion of boys with mild intellectual disability, with an IQ below 70, in the program. Several participants said a 'Romeo manual 2.0' should be designed for sexuality and boys with mild intellectual disability.

"Or we just stick to the original manual, but in that case we should not include those boys in the intervention program" (R1)

R2 stated that, in particular, training from Qpido's behavioral specialists about these disorders should be provided because this target group requires a completely different approach. Firstly, the information transmission differs. The professionals should transmit information more

slowly and extensively in contrast to youth with average IQ. Secondly, information should be reiterated many times for achieving concrete results. For example, R3 stated:

“You know what.. Mild intellectual disabled youth, they do pretend like they understand, but often they don’t! For that reason, it is important to continually ask counter questions . But mostly, if asked to reproduce the given information, I find out they didn’t understand or it went in one ear and out the other”.

Supervision & intervision. Consequently, the supervision from Qpido was reported to have been sufficient. The participants felt satisfied about the balance between independence and control. The ones with more experience as youth care worker required less assistance than the interns.

“Let me say it like this. I prefer to work independently and do whatever I want to do for as long as I still achieve my goals. But I imagine there are others who doesn’t have that same confidence and experience. Perhaps they prefer more structure and assistance” (R4).

But in all situations, participants emphasized that if problems or questions occurred they all felt supported by the behavioral specialists and other colleagues.

“It’s just okay. I know where to find help if needed. Everyone is there. The only thing you have to do is ask” (R5).

As a Qpido youth care worker, own initiative and asking for assistance if necessary is required since there is less intervision. Although, currently most meetings are cancelled because of low

attendance, all participants reported their preference for more intervision meetings. Those were mentioned to be extremely educational and would improve the team spirit. This may be helpful since it now appears that all care workers work as individuals and there's less team spirit present. According to all the participants, more of those intervision meetings would improve the quality of the 'Romeo' intervention. One of them responded:

"I would love to have more intervision meetings, like once a month or something.. Just so we all can discuss our cases and learn from each other's experiences and solution" (R3).

Sexual interactional competence & SIER questionnaire. Respondents reported that the change of knowledge as a result of the intervention was difficult to assess. Although in some cases large progress was made, respondents mentioned that often cases were not completed with satisfaction. In multiple cases, treatments were prematurely ended, mostly because the boys were not motivated enough or had too extensive problems and were therefore referred to other youth care organizations. Improvement of their sexual interactional competence was measured by the SIER questionnaire. Most respondents were positive about this questionnaire. After the treatment, the majority seemed to have learnt something, but the respondents indicate they never know whether this actually means a change in knowledge and behavior regarding sexuality in the long term. In most of the cases the level of difficulty was considered achievable for all boys. In some cases, mostly for mild intellectual disabled boys, some further explanation of the questions was required. Even though respondents were positive about the quality of the questionnaire, they all reported to have problems with the registration in the database. According to them, the procedure is too time-consuming. Many of them suggested a digitized questionnaire to increase the number of registered SIER questionnaires.

Innovation and improvement. The major part of the manual was reported useful. However, respondents were telling to skip themes and exercises they do not consider necessary. Although the manual is structured in such a way that all exercises and themes should be treated with a client, many of the respondents said they did only choose the exercises and themes that they consider relevant to the client's problems. Respondents also noted that some exercises were outdated or not relevant. They all stressed the importance of continuous renewal and improvement of the program. Especially exercises to inform about social media, sexting and grooming should be updated. This increasingly important subject requires more attention and innovation.

Discussion

It is important to evaluate intervention programs (McKenzie, Neiger & Thackeray, 2017). Based on registrations of Qpido there are still many adolescents who experience problems concerning their sexuality or are involved with sexual harassment. This study focused on the intervention 'Romeo', a program that is developed with the aim to prevent for (repetition of) sexual harassment as well as improvement of boys' sexual health. These boys show high rates of internalizing problems or alarming psychosexual development, as a result of an undeveloped sexual interactional competence (Vanwesenbeeck, 1999). To investigate the extent of change of the sexual interactional competence, quantitative analyses were used. For the description of different perspectives on the quality of the intervention, qualitative measures were used.

Compared to the pretest, no significant differences were found on the posttest regarding the sexual interactional competence of participating boys. Despite this insignificant result, a positive trend was noticed. Additionally, most care workers do belief that the intervention is increasing the sexual interactional competence of boys, yet whether this also results in behavioral changes is questioned. The respondents reported to be positive about the quality of

the ‘Romeo’ intervention program. They consider the program useful and their function as mentor and role model important. Nevertheless, they stress the need for continuous updating and improvement of the program. For example, they said that an adapted version of the manual should be drawn up for young people with mild intellectual disability and that more attention should be paid to the growing problems concerning social media, sexting and grooming. Finally, in order to improve the quality of the program and team spirit among the caregivers, case and intervision meetings should be organized.

The main strength of this research is the mixed methods. The scores on the SIER questionnaires can be substantiated with the interviews (Patton, 2002). Although the quantitative results only show a positive trend in the increase of the sexual interactional competence, the program is very positively evaluated by the participating boys. The answers given by the respondents in the interviews support and substantiate this result in the posttest. They indicate to have a good relation with the boys and often see them develop.

This study has contributed to the need to collect more theory about the effectiveness of sexual interventions in adolescence. ‘Romeo’ is the only intervention focused on boys individually (NJI, 2018). Furthermore, it is the only intervention that is both preventive and supportive for boys who have already been involved with sexual problems (NJI, 2018). Since little information is available about the effectiveness of sexual interventions for boys, it is difficult to compare this with earlier research in the Netherlands. Additionally, not only little effective interventions are documented in the Netherlands, but this is also the case at international level (Oakley, Fullerton, Holland, Arnold, Dawson, Kelley & McGrellis, 1995). Insignificant results in this study may also be explained by boys being influenced by today's society in order to behave in a certain way in relation to (mainly) girls. Frequent exposure to, for example, sex-stereotyped games can result in a shifted norms and greater tolerance of sexual harassment (Dill, Brown & Collins, 2008). In addition, sexual harassment seems to have

increasingly become part of the life of an average secondary school student. Nowadays, sexting and touching others in a sexual way seems to be normal behavior (De Lijster, Felten, Kok & Kocken, 2016). Timmerman (2011) questions in her study whether sexual harassment should be seen as an incident or institutionalized behavior at secondary schools.

Based on this study it was not possible to prove an effect on the outcome measures of 'Romeo'. One of the reasons for this may be that ‘Romeo’ is not always implemented as intended. For example, the insignificant result on the SIER can be explained by the fact that the care workers reported to not consistently discuss all themes and exercises from the manual with their clients. The SIER questionnaire has a broad sexual focus and is based on the manual. If topics were not discussed with the boy because the care worker considered this to be irrelevant to their problems, this may explain a lower overall score on the SIER. This example shows that the effectiveness of an intervention is determined by the quality of its implementation (Davis & Tailor-Vaisey, 1991). The structure and vision of the program are elaborated in the manual. Explanations for insignificant increase of the sexual interactional competence of boys may be the result of the intervention not being implemented as was intended. The manual states that the program is designed for boys between 12 and 18 years old. However, research has shown that boys from the age of 10 were also included. In addition, the treatment of light intellectual disabled boys appears to be a major problem. The manual is not designed for this target group and the care workers often are not specialized and do not have the knowledge and expertise to manage the problem properly. These aspects of incorrect implementation of the intervention may be part of the explanation that the sexual interactional competence of boys has not significantly increased after the intervention.

Furthermore, this mixed methods study has some methodological limitations to mention. Firstly, due to lack of time and resources in this study, no control group was used. In addition, the sample was relatively small. During this study, it became clear that the database

with all the registrations of Romeo's was not carefully maintained over the past few years. It is intended that all participating boys in the intervention program are registered in *BergOp* with the application form as well as a SIER pretest and posttest (if the care process was completed). Unfortunately, data for many boys was found to be missing, mostly as a result of poor administration. The researcher has been able to retrieve some of the data for ongoing, or recently completed cases from the care workers. However, it was not possible to obtain information about cases that had been completed earlier. Because the relatively small sample size, it is difficult to generalize the results to the population. However, the sample did not differ significantly in terms of age an nationality, which means that the sample was representative on these variables. Questionnaires were filled out by the boys themselves while their mentor was present for assistance if necessary. Self-report can have consequences for the validity of the study. In this case it could have resulted in socially desirable answers because of the presence of their mentor and their concerns being judged negatively (Paulhus, 2002). In some cases, the boys have not yet experienced the requested situation and are also unable to imagine being in the situation. Therefore, when interpreting the results, it is also important to take into account the possible risk of incorrect answering of questions by the respondents (De Lijster, 2016).

Qualitative research is pre-eminently the method of gaining insight into the different interpretations and opinions of respondents (Patton, 2002). However, there are some specific limitations to this study. Firstly, the respondent bias must be taken into account. The respondents were familiar with the researcher (who worked as an intern at the same office). This may have ensured that respondents had answered in a way that they think will lead to being accepted and liked. Furthermore, only a limited number of care workers participated in this study, which implies that results cannot be generalized with certainty. For this reason, creation of a group as heterogeneous as possible was attempted. During the series of interviews, the ultimate aim was saturation of information. This saturation point means repetition of reactions

and that no new information is gathered. For this reason, conclusions can be drawn for this study based on the answers of these respondents (Guest, Bunce & Johnson, 2006).

Recommendations

The results of this study highlighted the importance for further research. A control trial with a large sample size is recommended to measure the effectivity of the intervention. In addition, the program manual needs to be continuously updated and improved. The contraindications must be reviewed and a decision made as to whether the manual should be amended or a new version should be developed for boys who are not ye eligible for the program (due to their age or light intellectual disability). Finally, more and better training and intervision is required for the care workers. Meetings should be planned in which the care workers will be informed about the structured manner in which the intervention should be implemented. It is not until the intervention has been implemented correctly that the success rate of the desired effect can be measured. Interventions like Romeo are extremely relevant. These programs are aimed at prevention and reduction of sexual harassment and are in the long term very important in promoting the sexual health of young people in the Netherlands. Based on this study, the program seems to have great potential to increase the sexual interactional competence of boys. However, in order to prove this, further research and modification of the program is required.

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Appendices

Appendix A: Informed consent form

Introductie en doel van het interview:
Mijn naam is Nina Faulstich. Ik ben master student Jeugdstudies aan de Universiteit Utrecht. Voor mijn thesis doe ik binnen de jeugdhulpverleningsorganisatie Qpido onderzoek naar de kwaliteit van het interventie programma 'Romeo'. Met behulp van dit onderzoek wordt geprobeerd inzicht te krijgen in hoe verschillende betrokkenen de inhoud en de uitvoering van de interventie ervaren.

Uw antwoorden:
Uw antwoorden, en de antwoorden van de anderen geïnterviewde, worden uitzonderlijk gebruikt in bovengenoemde thesis. In deze thesis zullen de verkregen inzichten en ervaringen worden gerapporteerd als tevens ook eventuele aanbevelingen.

Anonimiteit:
De interviews zullen worden opgenomen met een recorder. Dit is met de reden te waarborgen dat uw woorden, uw woorden blijven. Ik, Nina Faulstich, zal de enige zijn die deze opnames zal afluisteren en transcriberen. In de transcripten zullen schuilnamen worden opgenomen, zodat anonimiteit gewaarborgd wordt. Na het transcriberen zullen de opnames direct worden verwijderd.

Uitleg over het interview:
In het interview zal ik vragen stellen met betrekking op de kwaliteit van het interventie programma Romeo. Daarnaast zullen er ook persoonlijke vragen gesteld worden. Indien liever niet geantwoord wordt op deze vragen, kan dit worden aangegeven. Bovendien betreft dit interview vrijwillige deelname, dus kan er ten aller tijden gestopt worden met het interview.

Toestemmingsverklaring:
Voordat met het interview kan worden begonnen is toestemming voor deelname nodig, daarom vraag ik u antwoord te geven op de onderstaande vragen.

Hierbij verklaar ik het volgende:

Ik begrijp het doel van dit onderzoek en begrijp wat de interviewer van mij vraagt
0 Ja 0 Nee

Ik ben ouder dan 18 en stem ermee in geïnterviewd te worden voor dit onderzoek
0 Ja 0 Nee

Ik stem ermee in dat dit interview wordt opgenomen
0 Ja 0 Nee

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Naam deelnemer	Datum	Handtekening

Appendix B: Interviewguide

Introductie

Beste Romeo trainer,

- Voorstellen + doel interview
  Fijn dat je wilt mee werken aan de evaluatie van het interventie programma 'Romeo'. Om een goed inzicht te krijgen over de uitvoering en kwaliteit van het programma zijn jullie ervaringen met het programma van belang.
- Informed consent formulier
- Anonimiteit garanderen
- Wees a.u.b. zo eerlijk mogelijk bij de beantwoording van de vragen. Op basis van deze antwoorden zal een evaluatie rapport met daarbij behorende aanbevelingen voor verbeteringen van het programma worden geschreven
- Tijdsduur

Vragenlijst

1) Achtergrond
   a) Leeftijd
   b) Opleiding
   c) Hoe lang bij Qpido?
   d) Hoeveel jongens begeleid in welk tijdsbestek?
2) Heb jij voordat je Romeo begeleider werd deelgenomen aan de vijfdaagse training die is ontworpen voor beginnende trainers?
   a) Wat vind je van de training?
   b) Wat zijn verbeter punten?
   c) Geef jij zelf ook training? Hoe gaat dat?
3) Wat is jouw algemene mening over het Romeo programma?
4) Wat is naar jouw mening de beoogde doelgroep voor het Romeo programma?
   a) Bereikt Romeo de beoogde doelgroep?
   b) Wat voor jongeren begeleid jij en vind je dat deze passen in de beoogde doelgroep?
   c) Meer / andere hulp nodig?
5) Met welke reden wordt naar jouw mening de Romeo hulpverlening sekse specifiek uitgevoerd?
6) Met welke reden wordt naar jouw mening de Romeo hulpverlening individueel (ipv groepsverband) uitgevoerd?
7) Wat zijn jouw ervaringen met de seksuele interactie en relaties- vragenlijst (SIER-lijst)?
   a) wat vind jij er goed aan?
   b) wat vind jij er minder goed aan?

8) Vul jij ten aller tijden de SIER- lijst in bij intake en afsluiting?
   a) indien nee, wat zijn hier de redenen voor?

9) Wat zijn jouw ervaringen met werken met het Verliefdheid en seks- boekje?
   a) wat vind jij er goed aan?
   b) wat vind jij er minder goed aan?

10) Van welke lesmethodes maak jij gebruik zoals deze staan vermeld als in de handleiding?

11) Welke oefeningen uit de ‘Romeo’ handleiding vind jij belangrijk/goed, en waarom?

12) Welke oefeningen uit de ‘Romeo’ handleiding vind jij minder belangrijk/goed, en waarom?

13) Wat zijn de opvallende verschillen in de begeleiding van de verschillende jongens?
    a) Hoe speelt het programma in op de verschillende eigenschappen/problematiek van de jongens? (In handleiding staat bijvoorbeeld IQ ondergrens genoemd, is dit ook zo?)

14) Hoe veranderd naar jouw idee
    a) de kennis van jongens ten opzichte van seksualiteit en relaties is veranderd als gevolg van het ‘Romeo’ interventie programma?
    b) de attitude van jongens ten opzichte van seksualiteit en relaties is veranderd als gevolg van het ‘Romeo’ interventie programma?

15) Begeleiding
    Hoe ervaar jij de begeleiding/samenwerking met collega’s vanuit Qpido?
    a) waar zouden verbeterpunten liggen?
    b) Indien zelf ook hulpverleners begeleiden:
        Hoe ervaar jij de communicatie met Romeo begeleiders?
        Waar zouden verbeter punten liggen?

16) Wat zijn naar jouw idee verbeteringen t.a.v. het ‘Romeo’ interventie programma?

Afsluiting en bedanken

Appendix C: Nodes

Nodes

Name

- Achtergrond hulpverlener
- Doelgroep
  - Alternatieve problematiek
- Hulpmiddelen begeleiding
  - Bolletjesschema
  - Negatief
  - Positief
    - Sociogram
  - Structuur hulpmiddelen
  - V&S boekje
    - Verbeteringen
- Individueel aangepaste begeleiding
- Individueel vs groep
- Jongeren leren
- LVB jongeren
- Methodiekhandleiding
- Motivatie jongeren
- Rol hulpverlener
  - Rolmodel
- Seksespecifiek
- SIER lijst
  - Dubbele vragen
  - Informatie verzameling
  - Registratie
  - Veroudering
- Structuur
- Sturing organisatie
  - Teamgevoel
- Training
  - Casuistiek
  - Training begeleiding
- Traject duur
  - Vroegtijdige beeindiging
- Uiteenlopende problematiek
- Verandering houding en attitude jongeren
- Verandering kennis jongeren
- Veranderingen gedrag jongeren
- Verbeteringen programma