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ORIGINAL ARTICLE

Enhancing Treatment Outcomes for Male Adolescents with Sexual Behavior Problems: Interactions and Interventions

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Abstract This exploratory study identifies patterns of multidisciplinary interactions and interventions that aim to improve outcomes for juvenile sex offenders (JSOs). With a response rate of 63.45% at two major statewide conferences in Texas, data from 336 JSO service providers suggest that interactions among service providers should occur before the delivery of interventions. Factor analyses indicated that Protocol (26%), Collaboration (17%), and Role Clarity (15%) explain 58% of the variance in "Multidisciplinary Interactions," while Counseling (13%), Treatment Placement (11%), and Self-Discipline (10%) explain 34% of the variance in "Interventions." Treatment staff preferred the implementation of cognitive and person-centered treatment approaches. Additional research is needed to establish objectivity and increase awareness about the importance of service diversity with a common goal within this multidisciplinary community.

Keywords Juvenile sex offenders · Child sexual abuse · Multidisciplinary interactions · Intervention effectiveness

According to the U. S. Department of Justice (2010), juvenile sex offenders (JSOs) are typically between 13 and 17 years old, mostly male, 30%–60% with learning disabilities, 80% with a diagnosable psychiatric disorder, such as impulse control, 20%–50% being past victims of physical abuse, and 40%–80% with a history of child sexual abuse. Regarding their own offenses, statistics show that JSOs "account for up to one-fifth of all rapes and one-half of all cases of child molestation committed each year" (USDOJ, 2010, webpage) and represent "20% of arrests for all sexual offenses" (Pratt et al. 2001, p.1). In the literature, however, the number of known juvenile sex offenses may be underestimated as evidenced in a study that 33% of its sample of adult sex offenders who had no former record of sex offenses had committed sex offenses as adolescents (Prentky, Harris, Frizzel, & Righthand, 2000). Other studies indicate that at least 50% of adult sex offenders began sexual offenses during their adolescent years (Righthand & Welch, 2001), and 15% of these juvenile offenses occurred at the property of a school (Texas Department of State Health Services, 2010). From 1983 to 1992, violent juvenile crimes in the United States, including sexual offenses, rose by 55% (Portner, 1998). Nevertheless, it is promising to learn that recidivism rates during the same period dropped 5% among juveniles who have completed specialized programs (USDOJ, 2010; Worling & Curwen, 2000). Focusing on specialized JSO interventions, this study examines factors that service providers consider as effective components in programs that help young male sexual offenders to achieve rehabilitation.

Texas Experiences in Juvenile Offender Treatment

Researchers such as Becker and Murphy (1998) found that past sexual victimization can increase the likelihood of sexual aggressiveness; yet, over 70% of these past victims have never committed any sexual crime in their adult lives (USDOJ, 2010). With a hope that young offenders can learn from treatment programs to maintain a positive attitude about sexuality, an experimental treatment program

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designed for 58 treatment participants, with outcome results compared to 90 non-treatment teens, found treatment effectiveness to support the use of a strengths-based approach that aims to help JSOs gain insight and knowledge from past offending to correct thinking and behavior and, thus, enhance prosocial sexual attitudes and self-awareness (Worling, Littljoh, & Bookalau, 2010). From the emerging findings on treatment outcomes, researchers continue to stress the importance of community prevention and plan interventions that include a rehabilitative approach in specialized treatment programs along with probationary oversight.

Supervision and treatment of JSOs is a specialty field that involves multiple disciplines including probation/parole, law enforcement, protective services, social work, counseling, education, and health care specialists. This interdisciplinary group is generally referred to as the Juvenile Sex Offender Treatment Provider (J-SOTP) network or community. In Texas, the J-SOTP acronym provides an umbrella of recognition with an underlying assumption that network members endorse or support the guidelines of the Association for the Treatment of Sexual Abusers (ATSA), Center for Sex Offender Management (CSOM), Texas Council on Sex Offender Treatment (CSOT), and other professional and regulatory organizations with recognized oversight of clinical and judicial treatment of sex offenders. Providers who specialize in working with JSOs express that adolescent offenders and those who are in transition from juvenile to adult justice systems are amenable to rehabilitation when services are provided by a multidisciplinary team (Brandes & Cheung, 2009).

The mission of the Council on Sex Offender Treatment (CSOT), formerly the Interagency Council on Sex Offender Treatment, has evolved from its 1994 primary focus on juvenile sex offenders to a current role that includes oversight of sex offender treatment as a protected practice and responsibility to set licensing requirements and standards (CSOT, 2010). In 2006, a critical change proposed by the CSOT excluded treatment providers other than the Sex Offender Treatment Providers licensed by the CSOT from providing sex offender treatment with a strong basis that this type of treatment requires the offender to accept responsibilities and consequences. This exclusion act was supported by issuance of "cease and desist" orders by the Attorney General of the State of Texas prior to the rule's adoption and included a change from the voluntary registration of licensed mental health providers as Sex Offender Treatment Providers to a specifically and exclusively required licensure status. At that time, changes were met with mixed reactions, both from the J-SOTP community and other affected disciplines, that some members endorsed the intent of the CSOT proposal as a means of further professionalizing the specialty field. Alternately, others voiced concerns about exclusivity and the potential limitation of the diverse services offered to treat clients with co-morbid diagnoses.

Some members of the J-SOTP community opposed the licensing requirements as an unnecessary hindrance foreboding additional licensing examinations, fees, and insurance costs. Other licensing boards and professional organizations surfaced concerns that portions of the legislation, such as the requirement that clients waive confidentiality, violated ethical guidelines of primary mental health licensing entities. Licensing groups, such as the National Association of Social Workers/Texas Chapter, issued requests and provided testimony to counter the "cease and desist" orders and specific sections of the proposed rule changes. Nevertheless, the licensing rule was passed that "only a practitioner licensed under the Occupations Code, Chapter 110 as a Licensed or Affiliate Sex Offender Treatment Provider is qualified through training and experience to conduct the assessment and provide the appropriate treatment for sex offenders in Texas" (CSOT, 2010, webpage).

Although the legislation codified sex offender treatment as a discipline, responses to the legislation reflected the diversity of opinions about service orientation and approaches offered by multidisciplinary professionals involved in the supervision and treatment of juvenile offenders. Differences of opinion continue, but information about what types of services are considered most important in a codified discipline must be provided.

Theoretical Framework

The likelihood of positive change is strongly dependent upon both the desire of the youth and the effective interaction of the adults who propel the youth toward desired change through supervision and treatment (Henggeler, Melton, Brondino, Scherer, & Hanley, 1997). However, optimal types and intensity of interactions have not been studied. Effective interaction among supervision and treatment specialists supports change by challenging the youth to change, expecting the youth to change, giving substantive guidance to that change, and nurturing that change. Although one individual can make a difference in the choices a youth learns to make (Haskell & Yablonsky, 1978), collective efforts increase the likelihood of positive outcomes. As demonstrated by Borduin, Henggeler, Blaske, and Stein (1990) in their work with juvenile sex offenders, statistically significant positive change requires extensive collaboration between and among disciplines.

Communication underlies the effectiveness of both coordination and collaboration. Communication between a counselor and probation officer might refer to a telephone

call or the exchange of documentation. For example, the probation officer might provide the counselor with a copy of the Conditions of Probation. Likewise, the probation officer might receive oral or written communication from the counselor indicating that anger management was listed as a treatment goal. Coordination might build upon communication by incorporating "attended anger management counseling" as a component of the probation status report to the court or the progress review conducted by the probation officer with the JSO and the family of the JSO. However, collaboration would incorporate not only sharing information but also sharing an understanding of the connectedness of the goals and of the mutual responsibility to identify appropriate opportunities and the means of achieving the goals. Thus, communication is one aspect or ingredient within both coordination and collaboration. Differences between coordination and collaboration are less apparent and relate to intensity of interaction, complexity of purpose, collective ownership of goals and involvement of the participants in reflective activities to improve working relationships while strengthening goal-effectiveness (Bronstein, 2002).

Intensity of Interaction

Hall, Clark, Giorday, Johnson, and Van Roekel (Hall et al. 1977) conducted research into the dyadic relationships mandated by law among organizations that deal with problem youth. Defining coordination as "the extent to which organizations attempt to ensure that their activities take into account those of other organizations" (Hall et al. 1977, p. 459), these authors found the sequencing of activities to be the primary underlying component of coordination. Thus defined, coordination requires a less intense interaction than collaboration. The Council on Sex Offender Management (CSOM) endorses intense interagency and interdisciplinary involvement including participation of probation officers in clinical staffing (McKay, 2002).

Collective Ownership of Goals

Coordination is sometimes viewed as a construct of efficiency. A comparison of collaboration and coordination is reflected in research findings that "interorganizational coordination had a negative effect on service quality and no effect on outcomes in children's service systems" (Glisson & Hemmelgarn, 1998, p. 401). Glisson and Hemmelgarn measured coordination by looking at the efficiency of effort. They measured the number of authorizations and number of individuals involved in the process. From their perspective, separation of process participation from process monitoring increased the efficiency of the process. In light of this separation, process monitoring, while similar to program monitoring or conducting service reviews, does not suggest collective ownership of goals. On the other hand, collaboration includes participant involvement in process evaluation and improvement (Bronstein, 2002).

Perhaps counterintuitively, research has demonstrated that collaboration is the more effective approach for reducing duplication of effort, increasing effectiveness of service for complex needs, and assuring accountability for results (Sarbaugh-Thompson et al. 1999). Although effective collaboration might result in efficiencies, it also increases effectiveness. Flitton and Brager (2002) discuss the effectiveness of intervention, emphasizing the need for regularly scheduled progress reviews that include collaboration to organize and integrate services across agencies and disciplines. Thus, from a process management perspective, collaboration that represents collective ownership of goals is more complex than coordination.

Complexity of Purpose

Collaboration is a process that "facilitates the achievement of goals that cannot be reached when individual professionals act on their own" (Bronstein, 2002, p. 112). Collaboration is also defined as a step preceding implementation such that it includes participation in assessment and planning (Hunter, 2000). Multisystemic therapy has shown positive results in the treatment of JSOs, but the requisite consistency and complexity of the interagency and interdisciplinary interactions are labor-intensive (Henggeler et al. 1997) and can be challenging to implement due to resource constraints.

Reflective Activities

Definitions of collaboration are also implicit in the literature. Expectations for collaboration differ primarily based on the degree of commitment the participants have to extend beyond their own disciplinary or agency expertise to facilitate goal achievement. In an analysis of collaborative approaches to interdisciplinary research, Bruhn (1995) identified three levels of collaborative commitment: (1) informal consultation, (2) solicitation of observation, involvement, information, or advice, and (3) consensus-building interaction that includes defining the problem(s), determining ways to study the problem(s), analyzing the information, and writing the report. Although these three levels of collaboration were developed in reference to interdisciplinary research efforts, they represent the dynamics of interaction within the J-SOTP community. For example, CSOM, in describing its "collaborative effort", acknowledges controversial issues and provides references for researching multiple perspectives of them (CSOM, 1999). Likewise, in a grounded research approach, Younglove-Webb, Gray, Abdalla, and Thurow (1999)

identified working through conflicts of interest as a component of collaboration. This reflective activity does not appear in literature that focuses on coordination.

In summary, collaboration is a broader construct than communication or coordination. Expectations for communication are assumed within the constructs of both collaboration and coordination, and some of the components of coordination are also included in collaboration. But, collaboration and coordination differ in intensity of interaction, mutuality of goals, and commitment to work through difficult issues. Collaboration is more extensive than coordination and involves participation in planning, monitoring, resolution of conflicts, and ownership of ongoing improvements to the collaboration process. Although CSOT (2003) encourages collaboration in the supervision and treatment of sex offenders, literature does not provide clarification of how collaboration, as differentiated from related constructs of communication or coordination, is more appropriate for describing the nature of interagency and interdisciplinary interactions recommended by CSOT.

Construct Measurement

Collaboration is generally not measured. Although numerous disciplines argue for collaboration, there is no currently accepted model (Bronstein, 2002); therefore, it is difficult to find a scale that measures collaboration. The Guidebook to Collaborating with the Illinois Childcare Subsidy System (Illinois State Department of Human Services, 2001) provides an excellent glossary of terms related to collaboration and information on surveys to ensure consistency of collaboration specifically related to the effectiveness of that program; a scale is not provided.

Focus group and survey tools developed to measure collaboration are generally program-specific. For example, Gadja (2004) developed The Strategic Alliance Formative Assessment Rubric (SAFAR), a matrix-type tool for evaluation of collaborative endeavors specifically related to the development of strategic alliances. An 18-question individual interview assessing the level of collaboration, developed in the 1980's by Van de Ven and Ferry, still serves as the basis for program evaluations and research on collaborative effectiveness (Polivka, Dresbach, Heimlich, & Elliott, 2001; Yang, 2003). Research using grounded theory methodology explored relationships between collaboration and disciplinary chauvinism, contradictory worldviews, status disparities, logistical problems, and gender differences (Younglove-Webb et al. 1999) but yielded no measurement technique for assessing the level of collaboration.

The Index of Interdisciplinary Collaboration (IIC) developed by Bronstein (2002) appears to contain elements suitable for use with the J-SOTP community. The IIC is composed of five subconstructs: interdependence, newly created professional activities, flexibility, collective ownership of goals, and reflection on the process (Bronstein, 2002). Face validity was established through a literature review, focus groups, and peer reviews. Bronstein includes within collaborative interdependence such functions as appropriate use of professional roles, formal and informal time together, formal and informal communication, respect for colleagues' professional opinions, seeking input for doing one's job, and using both oral and written forms of communication and reporting.

In terms of goal-setting, multidisciplinary involvement is an essential step toward identifying the problem definition, identification of alternatives, development of a plan, and achievement of goals. For example, if a caseworker is encouraging family reunification and the probation officer is enforcing family separation, intensive collaboration might include the judge and the counselor and might lead to improved client outcomes such as the development of family safety plans with monitored steps towards family reunification if encouraged.

In this study, although no formal scales could be identified to measure these constructs, development of statements based on staff input in its pilot stage clearly identified the types of interactions described in the literature and added specificity to multidisciplinary "Interaction" and the function of implementing various "Intervention" approaches.

Research Framework and Design

Texas experience has identified a need to study how to work with a client population when multidisciplinary involvement has been the norm. Kuhn's (1970) concept of a paradigm is helpful in understanding the distinction between multiple disciplines working with a common set of clients and the formation of a unitary discipline working toward a common goal. This paradigm explains how the J-SOTP network is formed as a discipline that shares a common view. Figure 1 depicts the focus and boundaries of the common view represented by CSOT's regulations for treatment of juvenile sex offenders. The broader view covers elements in the concentric circles as an inclusive view of treatment and supervision which expands the opportunities for interactions. The codified rule that governs treatment and prescribes professional interactions is represented in the oval shape outlined by a dotted line. The narrower view is represented by the regulation that depicts the emphasis upon behavioral, cognitive, and psychoeducational approaches with goals targeting JSO treatment. These approaches and goals can occur in individual and group modalities.

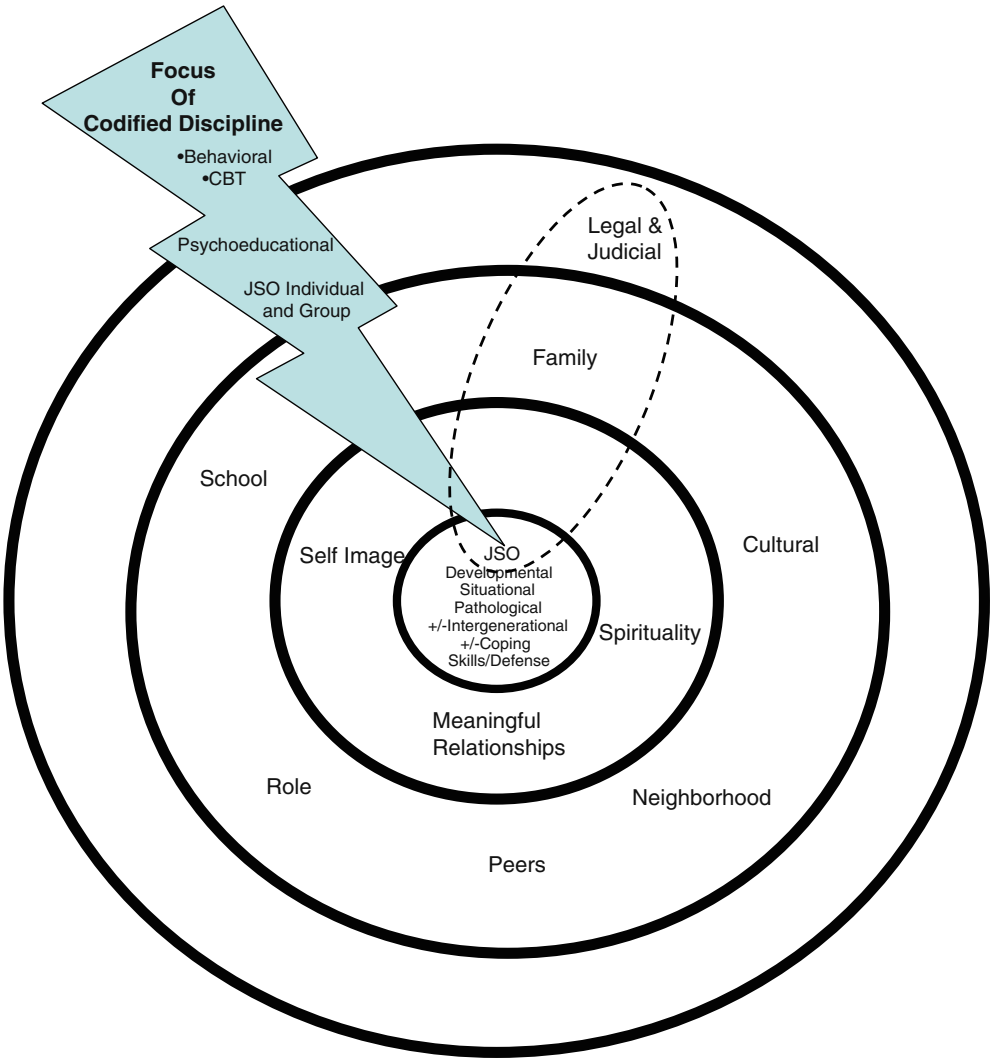

Fig. 1 Focus and boundaries of a codified discipline

Method

Participants

In Texas, when licensure requirements for treatment providers took effect in 2006, conferees at two J-SOTP conferences scheduled in June and July gathered to discuss service prioritization. These representatives came from multiple disciplines, including caseworkers and case managers, child welfare and social services personnel, community supervision officers, defense attorneys, judges, law enforcement personnel, polygraph examiners, prosecutors, school officials, treatment providers, victim advocates, and those involved in juvenile sex offender management. The June conference drew more representatives from disciplines associated with legal and probation services, while the July conference attracted more representatives from state agencies. Some attendees attended both conferences and were asked not to answer the survey twice.

Approximately 300 service and treatment professionals attended the June conference, and 400 participants attended the July conference, where 267 and 376 surveys were distributed, respectively. The sample in this analysis consists of 342 survey respondents, 161 from June (60% response) and 181 from July (66.5% response), with an overall response rate of 63.45%.

Instrument

The "Provider Opinions of Treatment and Supervision of Juveniles with Sexual Behavior Problems" survey was used as the instrument to identify providers' viewpoints. The survey was developed from current literature on JSBP with 31 items–5 demographic items, 17 intervention items, and 9 interaction items. Within the intervention items, 3 items were designed to identify views on emerging issues including timing for sexual addiction treatment, use of polygraphs, and victim-offender reunification; 7 items

measured utilization of treatment approaches to achieve positive outcomes; 7 items measured treatment goals. Each item was designed to obtain data about the respondents' experiences that have led to positive outcomes for young male sex offenders. A 4-point Likert-type scale was used in questions regarding outcome-based experience in which a score of one represented a most favorable answer and four showed the opposite. The emerging issues were measured using a 3-point scale with 1 = never and 3 = always.

The hypothesis was tested to see if there was a common worldview that indicated unity and a shared paradigm within the field, thus supporting the codification of a single discipline. Patterns of shared opinions of treatment approaches and goals would indicate support on the use of certain intervention models.

Results

Multidisciplinary Interactions and Interventions

The first test on the data was an exploratory factor analysis which aimed to identify the dimensionality of the "Interaction" and "Intervention" constructs and subconstructs in relation to successful treatment outcomes.

First, the nine variables within the "Interaction" construct were analyzed to determine whether the factors that emerged represented the three subconstructs based on the literature: Communication, Coordination, and Collaboration. As part of the decision to determine the number of extracted factors for the full solution, principal components analysis was conducted to assess the absolute and relative magnitudes of the eigenvalues. The correlation matrix revealed that, other than the correlation of .616 between joint meetings with the juvenile and his family (JOINT_MEETING) and collaborative mutuality (MUTUALITY), correlations ranged from .257 to .540. As there were no high correlations, three factors were rotated using Varimax rotation procedure. The rotated solution, as shown in Table 1, did not support the three dimensions of Communication, Coordination, and Collaboration; however, it yielded three interpretable factors labeled here as Protocols, Collaboration, and Roles within the "interaction" construct (see Fig. 2). Protocol accounted for 26% of the variance, Collaboration accounted for 17% of the variance, and Roles accounted for 15% of the variance.

Table 1 Factor analysis of interaction variables

Items	Factors		
	Protocol	Collaboration	Roles
Protocol items			
(TIMELINESS) When working with juveniles with sexual behavior problems, the ability of multiple disciplines and agencies to meet deadlines and schedules for reports and written information affects client outcomes.	.462	.140	.392
(NETWORKING) When working with juveniles with sexual behavior problems, the ability of multiple agencies and disciplines to attend joint conferences and network together at workshops and training opportunities affects client outcomes.	.551	.238	.313
(RESPONSIVENESS) When working with juveniles with sexual behavior problems, the ability of multiple disciplines and agencies to respond promptly to emails and telephone calls affects client outcomes.	.667	.145	.159
(JOINT_STAFFING) When working with juveniles with sexual behavior problems, the ability of multiple disciplines and agencies to attend joint staffing when requested affects client outcomes.	.616	.268	284
(RELATIONSHIP) When working with juveniles with sexual behavior problems, the ability of multiple disciplines and agencies to work together on the interdisciplinary relationship affects client outcomes.	.647	.152	.259
(INFORMATIVE) When working with juveniles with sexual behavior problems, the ability of multiple disciplines and agencies to exchange information on staffing, case assignments, telephone numbers, and email addresses affects client outcomes.	.624	.126	
Collaboration			
(JOINT_MEETING) Working with juveniles with sexual behavior problems can only be effective when the representatives from multiple disciplines and agencies are willing to participate in joint meetings with the client and family upon request.	.1789	.978	.103
(MUTUALITY) Working with juveniles with sexual behavior problems can only be effective when multiple disciplines and agencies collaborate on ways to achieve positive client outcomes.	.178	.561	.149
Roles			
(ROLE_CLARITY) When working with juveniles with sexual behavior problems, the ability of multiple disciplines and agencies to establish and maintain clear roles and responsibilities affects client outcomes.	.335	.140	.928

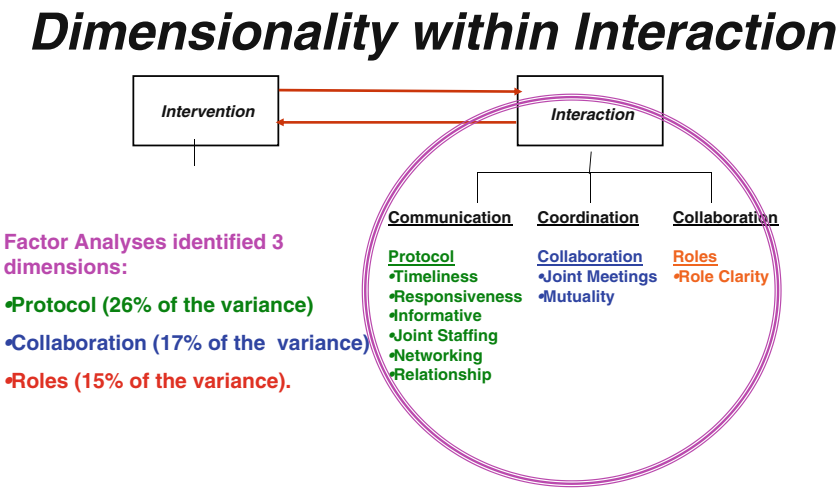

Fig. 2 Factor analysis of "interaction"

The second factor analysis examined the 17 variables within the "Intervention" construct to determine whether factors emerged that represented the three subconstructs: traditional Approaches, Goals, and Controversial approaches. None of the solutions included the variables for the behavioral approach, the school performance goal, or the three controversial issues (sex addiction programs, use of polygraphs, and victim-offender reunification). The three-factor rotated solution using Varimax rotation procedures, shown in Table 2, yielded three interpretable factors: Counseling, Placement, and Self-Discipline (see Fig. 3). The first factor, Counseling, accounted for 13% of the variance, the second factor, Placement, accounted for 11% of the variance, and the third factor, Self-Discipline, accounted for 10% of the variance.

The third factor analysis examined the seven variables for the subconstruct of Approach within the Intervention construct. The solution did not include the variable for the behavioral approach (BEHAVIORAL). The two-factor rotated solution using Varimax rotation procedures, shown in Table 3, yielded two interpretable factors. The first factor, labeled Integrative, accounted for 23% of the variance, and the second factor, labeled Cognitive, accounted for 17% of the variance (see Fig. 4).

The fourth factor analysis examined the seven variables for the subconstruct of Goals within the Intervention construct. The correlation matrix revealed that correlations ranged from .167 to .535, with two correlations significant at $p<.001$, and the remainder significant at $p<.0001$. As there were no high correlations, solutions from Varimax and Promax rotation procedures for two factors were compared. Neither solution included the variable SCHOOL. The solution using Promax rotation procedures had only two variables in the second factor. The solution using Varimax rotation had four variables in the first factor and three variables in the second factor. With a .35 cut-off, both procedures resulted in one complex variable, peer relationships (PEERS). Due to similarities of the solutions, the simpler Varimax rotation procedure was selected. The two-factor rotated solution using Varimax rotation procedures, shown in Table 4, yielded two interpretable factors. The first factor, labeled Social Functioning, accounted for 25% of the variance, and the second factor, labeled Support, accounted for 20% of the variance (see Fig. 5).

Input from Treatment Staff

To determine if there were significant differences in opinion between treatment staff and other service providers, one-way analysis of variance (ANOVA) procedures were conducted. The results identified four variables with significant differences between preferences of treatment staff "CLINICAL" and other providers. The dichotomous grouping variable (CLINICAL) had a 191–145 split, representing roughly a 1.32–1 ratio of treatment staff to other providers. Table 5 shows the mean, standard deviation, 95% confidence interval, minimum, and maximum for each of the four variables.

The importance of applying behavioral therapeutic approaches (BEHAVIORAL) differed significantly between treatment staff and other providers ($F(1,334) = 8.622$, $p=.004$). Treatment staff's opinions ($M=2.64$, SD .768) showed more disagreement toward the use of behavioral approaches than other respondents ($M=2.39$, SD .748).

Opinions about the importance of using cognitive therapeutic approaches (COGNITIVE) differed significantly ($F(1,334) = 9.693$, $p=.002$), with treatment staff's opinions ($M=1.23$, SD .455) showing more agreement than other service providers ($M=1.39$, SD .489) to a statement that cognitive therapy was important to treatment outcomes for male juveniles with sexual behavior problems. Responses from treatment staff reflected a broader range of opinions than responses from other providers.

Table 2 Factor analysis of intervention variables

Items	Factors		
	Counseling	Placement	Self-Discipline
Treatment Items			
(COGNITIVE) For a positive outcome to occur, supervision and treatment must include modification of thinking and beliefs to correct cognitive distortions and stop minimization or denial of sexually inappropriate behavior.	.533	.181	.155
(HUMANISTIC) For a positive outcome to occur, supervision and treatment must include helping the juveniles open up to feelings, express emotions, respond to the emotions of others, and use authentic expression as a means of socially appropriate functioning.	.643	.270	.036
(GROUP) For a positive outcome to occur, supervision and treatment must include group work that incorporates giving and receiving peer feedback, presenting and discussing individual progress and difficulties, practicing newly learned behaviors, and improving social skills.	.458	.298	.017
(PSYCHOED) For a positive outcome to occur, supervision and treatment must include education in legal and social expectations regarding touching, harassment, and sexual abuse, with emphasis on ways of thinking and acting that do not demean or degrade others based on gender.	.593	.076	.144
(SYSTEMS) For a positive outcome to occur, management, supervision, and treatment must include involvement of parent/guardian in treatment or psychoeducational sessions, implementation of a safety plan, and home visit(s) during probation or prior to placement decisions.	.466	.451	−.033
(PERSON-CENTERED) For a positive outcome to occur, sex offender treatment must include establishment of a positive therapeutic relationship to enable transfer of learning to other relationships.	.497	.176	.083
(EMPATHY) Prior to completion of sex-offender treatment and release from probation, a male juvenile with a history of sexual behavior problems should be required to articulate the impact of the sexual abuse on the victim, family, and others and to anticipate and describe the feelings of others in a variety of scenarios or situations.	.408	.271	.286
Placement Items			
(SYSTEMS) For a positive outcome to occur, management, supervision, and treatment must include involvement of parent/guardian in treatment or psychoeducational sessions, implementation of a safety plan, and home visit(s) during probation or prior to placement decisions.	.466	.451	−.033
(SUPPORT) A juvenile with a history of sexual behavior problems should not be released from treatment or probation unless the juvenile has a support structure that includes adequate housing, food, clothing, and a safe environment (no on-going domestic abuse or substance abuse).	.114	.628	.194
(STABILITY) A juvenile with a history of sexual behavior problems should not be released from treatment or probation unless the juvenile's parent(s) or guardian has demonstrated acceptance of responsibility for communication with school, probation, and treatment providers, and for developmentally-appropriate supervision of the juvenile.	.058	.782	.195
Self-Discipline Items			
(PEERS) Prior to completion of sex offender treatment and release from probation, a male juvenile with a history of sexual behavior problems should participate for 2 months in a least 1 weekly age-appropriate adult-supervised social activity (no social isolation), and should have increased peer relationships with non-deviant juveniles and decreased peer relationships with deviant juveniles.	.159	.330	.367
(RESPECT) Prior to completion of sex-offender treatment or release from probation, a male juvenile with a history of sexual behavior problems should have consistently obeyed curfews and adhered to rules without disrespecting others for at least one (uninterrupted) month.	.168	.160	.972
(SELFCONTROL) Prior to completion of sex-offender treatment or release from probation, a male juvenile with a history of sexual behavior problems should be required to demonstrate self-discipline and impulse control by respecting the boundaries of self and others (no fighting or explosive behavior at home or school) for at least 1 month.	.321	.212	.609

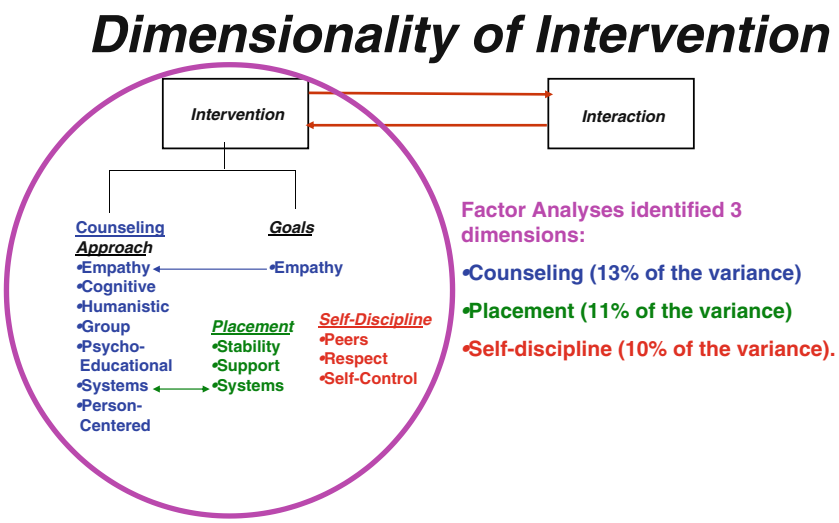

Fig. 3 Factor analysis of "intervention"

The importance of the therapeutic relationship (PERSON-CENTERED) differed significantly between treatment staff and other providers ($F(1,334) = 5.351$, $p=.021$). Treatment staff's opinions ($M=1.54$, SD .578) showed more agreement than other respondents ($M=1.69$, SD .559) to a statement that a positive therapeutic relationship was important to treatment outcomes for male juveniles with sexual behavior problems.

Opinions about family reunification in cases of sibling sexual abuse (REUNIFICATION) differed significantly between treatment staff and other providers ($F(1, 334) = 5.098$, $p=.025$). Treatment staff ($M=2.07$, SD .325) indicated less willingness to work towards victim/offender reunification than did other providers ($M=2.17$, SD .518) (see Table 6).

The differences in support underscore the importance of views about rehabilitative approaches as compared to correction or punishment approaches when working with juvenile sex offenders. Behavioral modification does not necessarily change or modify the individual and the way the individual thinks about behavior. In essence, the goals of behavioral therapy can be achieved without rehabilitating the way the individual considers the impact of actions upon others. In the treatment of juvenile sex offenders, behavioral therapy is used mostly to correct behavior rather than to rehabilitate youth. Cognitive therapy strives to rehabil-

Table 3 Factor analysis of "approach" variables

Items	Factors	
	Integrative Therapy	Cognitive Therapy
Integrative Therapy		
(HUMANISTIC) For a positive outcome to occur, supervision and treatment must include helping the juveniles open up to feelings, express emotions, respond to the emotions of others, and use authentic expression as a means of socially appropriate functioning.	.548	.344
(GROUP) For a positive outcome to occur, supervision and treatment must include group work that incorporates giving and receiving peer feedback, presenting and discussing individual progress and difficulties, practicing newly learned behaviors, and improving social skills.	.541	.125
(PSYCHOED) For a positive outcome to occur, supervision and treatment must include education in legal and social expectations regarding touching, harassment, and sexual abuse, with emphasis on ways of thinking and acting that do not demean or degrade others based on gender.	.527	.263
(SYSTEMS) For a positive outcome to occur, management, supervision, and treatment must include involvement of parent/guardian in treatment or psychoeducational sessions, implementation of a safety plan, and home visit(s) during probation or prior to placement decisions.	.600	.191
(PERSON-CENTERED) For a positive outcome to occur, sex offender treatment must include establishment of a positive therapeutic relationship to enable transfer of learning to other relationships.	.572	.126
Cognitive Therapy Item		
(COGNITIVE) For a positive outcome to occur, supervision and treatment must include modification of thinking and beliefs to correct cognitive distortions and stop minimization or denial of sexually inappropriate behavior.	.204	.978

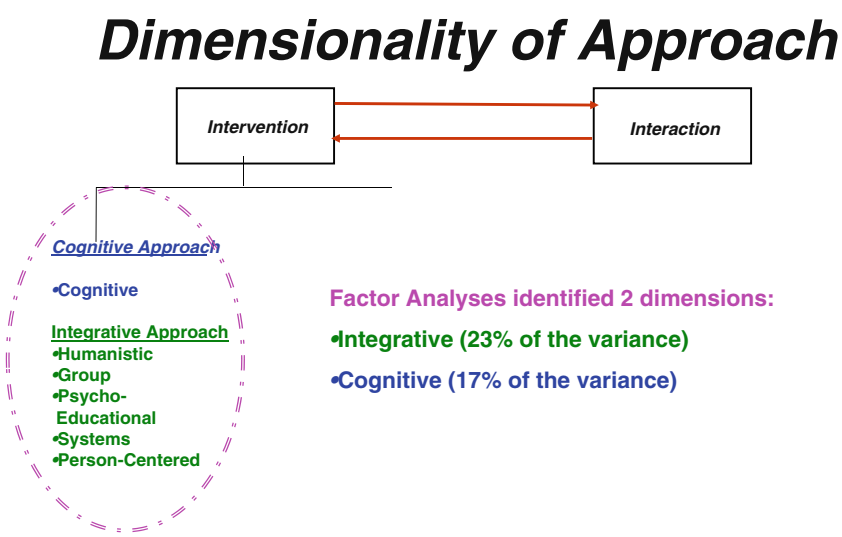

Fig. 4 Factor analysis of "approach"

itate the juvenile by changing thinking and beliefs that lead to changes in feelings and behavior. Similarly, in person-centered therapy, the therapeutic relationship aims to effect changes in feelings and beliefs that can be transferred to other relationships, resulting in changes in behavior that stem from having developed positive abilities to create and maintain successful relationships. The focal points of cognitive and person-centered therapies are rehabilitative, while the focus of behavioral modification is corrective. As indicated by participant comments, differences in views of family indicate more awareness on the part of treatment staff than other service providers of the complexities to be

Table 4 Factor analysis of "goal" variables

Items	Factors	
	Social Functioning	Support
Social Functioning items		
(EMPATHY) Prior to completion of sex-offender treatment or release from probation, a male juvenile with a history of sexual behavior problems should be required to articulate the impact of the sexual abuse on the victim, family, and others and to anticipate and describe the feelings of others in a variety of scenarios or situations.	.403	.303
(PEERS) Prior to completion of sex offender treatment or release from probation, a male juvenile with a history of sexual behavior problems should participate for 2 months in a least 1 weekly age-appropriate adult-supervised social activity (no social isolation), and should have increased peer relationships with non-deviant juveniles and decreased peer relationships with deviant juveniles.	.397	.361
(RULES) Prior to completion of sex-offender treatment or release from probation, a male juvenile with a history of sexual behavior problems should have consistently obeyed curfews and adhered to rules without disrespecting others for at least one (uninterrupted) month.	.849	.215
(SELFCONTROL) Prior to completion of sex-offender treatment or release from probation, a male juvenile with a history of sexual behavior problems should be required to demonstrate self-discipline and impulse control by respecting the boundaries of self and others (no fighting or explosive behavior at home or school) for at least 1 month.	.749	.212
Support Item		
(SUPPORT) A juvenile with a history of sexual behavior problems should not be released from treatment or probation unless the juvenile has a support structure that includes adequate housing, food, clothing, and a safe environment (no on-going domestic abuse or substance abuse).	.209	.673
(STABILITY) A juvenile with a history of sexual behavior problems should not be released from treatment or probation unless the juvenile's parent(s) or guardian has demonstrated acceptance of responsibility for communication with school, probation, and treatment providers, and for developmentally-appropriate supervision of the juvenile.	−.182	.735
(PEERS) Prior to completion of sex offender treatment or release from probation, a male juvenile with a history of sexual behavior problems should participate for 2 months in a least 1 weekly age-appropriate adult-supervised social activity (no social isolation), and should have increased peer relationships with non-deviant juveniles and decreased peer relationships with deviant juveniles.	.397	.361

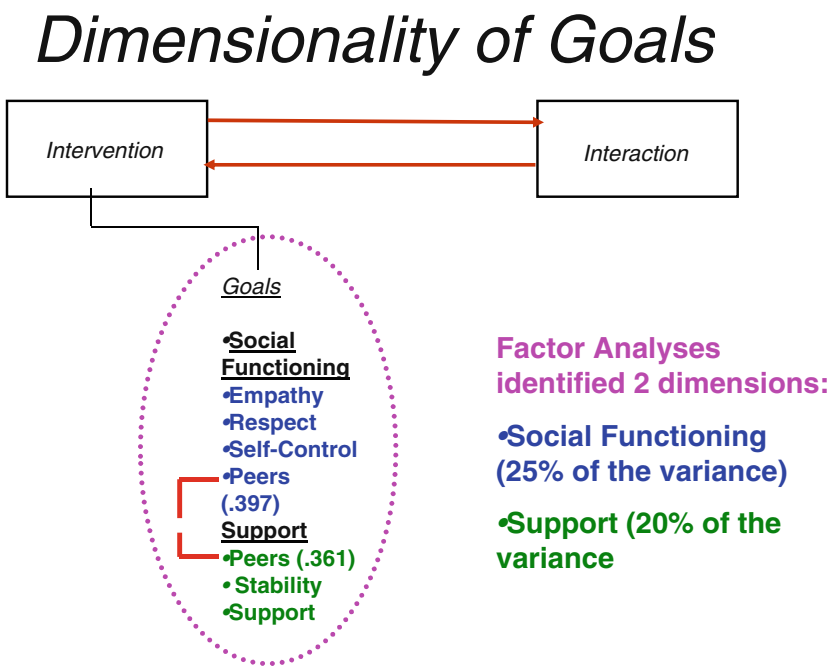

Fig. 5 Factor analysis of "treatment goals"

addressed when considering reunification. Treatment staff's comments indicated a desire to consider additional information beyond the facts provided by the survey statement, suggesting that corrections to behavior provide an insufficient basis for the decision of whether to support reunification (see Fig. 6).

Implications for Social Work and Suggestions for Future Research

The CSOT rules enacted under Texas Regulations 4431 are expected to influence provider use of treatment alternatives and, over time, influence the pattern of support for treatment alternatives. This effect is likely to be restrictive and to discourage innovation and diverse approaches. Follow-up research is needed to understand the effect of the regulations upon the preferences and practices within the J-SOTP community. Implications for social work are anticipated, as social workers are part of the J-SOTP community and as a result of NASW voicing a strong opinion in the debate surrounding the rule changes. Research by social workers can enlighten NASW and support future revisions of law as appropriate to the preferences and needs of the community and the clients and for the protection of the public.

This study identified three controversial issues and provided empirical evidence of a small number of areas of divergent opinions with the J-SOTP community. Although the CSOT rules contained specific requirements for the use of polygraph exams with juveniles, more research is needed

Table 5 ANOVA results between treatment staff and other providers

Treatment Variable		Sum of Squares	df	Mean Square	F	Sig.
Behavioral	Between Groups	4.973	1	4.973	8.622	.004
	Within Groups	192.666	334	.577		
	Total	197.640	335			
Cognitive	Between Groups	2.139	1	2.139	9.693	.002
	Within Groups	73.692	334	.221		
	Total	75.830	335			
Person-Centered	Between Groups	1.737	1	1.737	5.351	.021
	Within Groups	108.406	334	.325		
	Total	110.143	335			
Reunification	Between Groups	.898	1	.898	5.098	.025
	Within Groups	58.805	334	.176		
	Total	59.702	335			

Table 6 Descriptive statistics for ANOVA

Treatment Variable	Type of Providers	N	Mean	SD	Std Error	95% C.I. for the mean		Min.	Max.
						Lower Bound	Upper Bound		
Behavioral	Treatment Staff	191	2.64	.768	.056	2.53	2.75	1	4
	Other Providers	145	2.39	.748	.062	2.27	2.52	1	4
	Total	336	2.53	.768	.042	2.45	2.62	1	4
Cognitive	Treatment Staff	191	1.23	.455	.033	1.16	1.29	1	4
	Other Providers	145	1.39	.489	.041	1.31	1.47	1	2
	Total	336	1.29	.476	.026	1.24	1.35	1	4
Person-Centered	Treatment Staff	191	1.54	.578	.042	1.46	1.63	1	3
	Other Providers	145	1.69	.559	.046	1.60	1.78	1	3
	Total	336	1.61	.573	.031	1355	1.67	1	3
Reunification	Treatment Staff	191	2.07	.325	.024	2.02	2.11	1	3
	Other Providers	145	2.17	.518	.043	2.09	2.26	1	3
	Total	336	2.11	.422	.023	2.07	2.16	1	3

to understand how the use of polygraphs fits within an intervention and interaction model. As polygraphs become more common, more consistent questions about their importance to treatment outcomes can be expected to emerge. Future research is encouraged to determine whether the J-SOTP community begins to view polygraphs as useful in improving outcomes. It is important that social workers involve themselves in this follow-up research to ensure appropriate advocacy for the client and to use the influence of social work professionals to enlighten the courts and other government representatives in understanding the exam process and effects.

Similarly, this study identified the need for additional research to determine the best-practice approaches and goals for victim-offender reunification. Social workers are affected by this issue because of their roles as caseworkers, victim advocates, and treatment providers. It would be beneficial for new research on reunification to include the victims' perspectives through input from victim advocates and treatment providers who work directly with the victims. Involvement of social workers, along with other service providers, in this type of research will ensure a balanced, interdisciplinary perspective.

This study also provided a vehicle for assessing the perceived importance of multidisciplinary interaction, with strong implications for social work which is sometimes set apart from other mental health disciplines due to its close ties to multiple disciplines. It is expected that the results of this study will help social work continue to build upon a rich history of collaboration with other professional disciplines for a better understanding and agreement on what constitutes the best practices for serving the public and, specifically, adolescents with sexual behavior problems. Gains in understanding multidisciplinary interaction are important for policy and program implementation, affecting the delivery of many types of services, and have

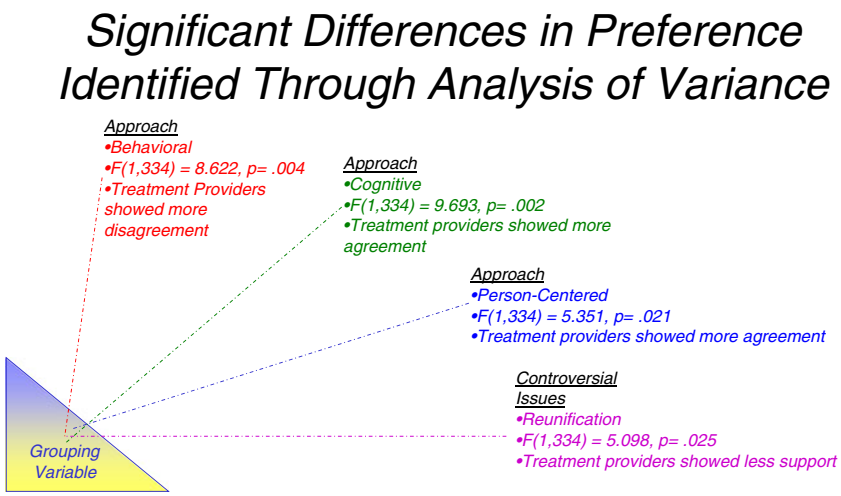

Fig. 6 Four differences in preference

implications for social work roles, skills, and education related to a variety of social work concentrations. Frey and George-Nichols (2003), discussing social work in a school environment, stated, "Social workers have a unique role in supporting best practices" (p. 97). They identified factors that contribute to the uniqueness of social workers in a multidisciplinary environment–consultation and collaboration–as applicable to multiple social work endeavors. These skills are needed by social work clinicians who are members of the J-SOTP community. Social work is positioned to be the catalyst of major changes in defining best practices for multidisciplinary interactions that improve outcomes for adolescents with sexual behavior problems. Perhaps more than any other discipline, social work, with its historical ties to sociology and social reform, is also positioned to identify and advocate for needed changes in legislation and professional guidelines pertaining to the supervision and treatment of adolescents with sexual behavior problems. Information from this study, especially as it pertains to multidisciplinary interactions, can help leverage the professional image of social work by building upon the inherent strengths relevant to effective multidisciplinary interaction.

Conclusion

This study identified three patterns of preferences of treatment approaches, goals, and multidisciplinary interaction: Therapeutic Coordination, Patient Communication, and Outcome-Focused Protection. Identifying these dominant patterns can inform the development of intervention and interaction models; additional research that tests such models will then inform policy and program decisions. For example, models might differ based upon treatment provision (whether treatment is provided in an out-patient clinic or in a secure or locked environment such as a detention center), diagnosis, and/or dynamic presentations of youth and their families that demand different approaches to attain positive outcomes. The identification of added dimensions in the treatment model has implications for social work skill development, education, and advocacy, for which this study provides a starting point. (see Fig. 7).

In light of current U.S. media focus on sex offenders in Texas and beyond, it is hoped that this study will be followed by additional research to understand patterns of convergence and divergence within the J-SOTP community. Further research is needed to determine whether recent regulation in Texas is influencing treatment providers to adopt a treatment model that aligns more closely with the roles of probation officers and caseworkers and diverges from and detracts from the roles of clinicians. Implications of this exploratory study suggest a need to examine differences between rehabilitative and corrective perspectives and to clarify the goal of juvenile sex offender treatment accordingly. Although the Juvenile Justice System differs from the Criminal Justice System and is espoused to recognize that juveniles are more amenable to rehabilitation than adults, the results of this study underscore the need for caution to avoid over-reliance upon policies, practices, and treatment regulations for adult sex offenders when instituting or developing policies, practices and treatment regulations for juveniles.

Additional research to validate or refine the models that emerged in this study would allow us to better understand how roles and treatment setting affect treatment model preference. Potential hypotheses for future research could be that outpatient treatment provider roles support Therapeutic Coordination, institutional roles support Patient

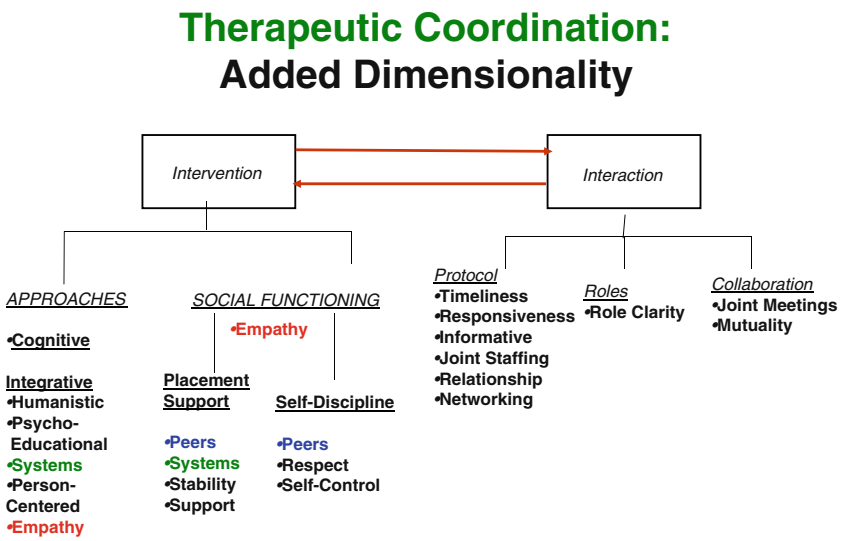

Fig. 7 Added dimensionality to the model

Communication, and field probation roles support Outcome-Focused Protection. Through enhanced understanding, professionals fulfilling each role could work together to support the policy and regulatory needs of one another, leveraging their influence to create legislative and judicial system changes that protect society while encouraging and supporting the rehabilitation of juveniles with sexual behavior problems.

The current divisiveness about appropriate responses to approaches for management of juvenile sex offending behaviors continues a pattern that has existed in American society for over 200 years. Objective analysis is needed to support constructive change in the way the legal system, probation, protective services, institutional casework, and therapeutic professions work together. One way to increase objectivity and overcome divisiveness is through further study. It is hoped that findings from this study will promote additional study within the social work field, encourage development of meaningful policies, and leverage greater support of multidisciplinary efforts to assure positive outcomes for the broader population of adolescents with sexual behavior problems. It is specifically hoped that professionals in the field of social work will assume a leadership role to ensure that policy, programs, and practice regulations for juveniles respect the importance of a rehabilitative rather than a corrective approach. This need speaks to the social work heritage of recognizing and understanding the issues that differentiate special populations, individuals with special needs, and the developmental needs and capabilities of juveniles. This need also speaks to the importance of continued social work involvement in public policy debate about CSOT licensing requirements that create redundancy and a privileged group of treatment providers to the exclusion of treatment specialists for special populations within the identified population of adolescents with sexual behavior problems. Social work, more than any other counseling or treatment discipline, is positioned to clarify the policy needs and surface the issues for effective advocacy and policy enactment.

The juvenile justice system reflects the social dichotomy. On one hand, the system seeks to protect society through incarceration or supervised probation of juvenile sex offenders. On the other, the system mandates juvenile sex offender participation in sex offender treatment programs. Literature reveals that within the last 20 years, awareness of the need to address juvenile sexual offending has increased, and the number of treatment programs has risen significantly, although little is known about the success of specialized treatment until recently (Worling & Curwen, 2000; Worling et al. 2010). Professionals should examine the use of a practice framework that explains the connection between interactions and interventions when multidisciplinary interactions are expected within a newly codified discipline.

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