

Social Responsibility Therapy Overview and Program Evaluation

Source: Yokley, J. Social Responsibility Therapy for Harmful, Abusive Behavior, *Journal of Contemporary Psychotherapy*, 2010, 40(1), p. 105- 113. [Updated and adapted for non-profit educational use only]

Abstract

Social Responsibility Therapy (SRT) aims to increase socially responsible behavior, decrease harmful, abusive behavior and address contemporary issues in harmful behavior-specific treatment. SRT combines evidence-based interventions that use different methods and pathways to increase intervention intensity and therapeutic pressure towards positive change. The strength-based aspect of SRT develops social maturity and emotional maturity as competing factors to harmful, abusive behavior. SRT exhibits strong social validity and initial outcome data on youth in a social service setting is encouraging.

Keywords: Social responsibility therapy; Harmful behavior treatment; Multimethod-multipath behavior therapy

Introduction

The present study provides a brief description and initial evaluation of Social Responsibility Therapy (SRT) in a social service treatment setting for youth with harmful, abusive behavior. Harmful behaviors are exhibited when an individual commits an action that is physically, socially or emotionally harmful to self or others. In this respect, SRT targets sexual abuse, physical abuse, property abuse, substance abuse and trust abuse. In SRT harmful

behavior is considered to be the primary symptom of a social-emotional maturity deficit and increasing social responsibility involves developing social-emotional maturity. Social maturity in SRT involves adequate honesty, trust, loyalty, concern, and responsibility while emotional maturity involves self-awareness, self-efficacy, and self-control. The goal of SRT is to develop social-emotional maturity characteristics as competing factors to harmful, abusive behavior and to promote positive personal as well as community adjustment by targeting harmful behavior directly. Harmful behavior-specific Twelve-Step programs span the harmful behavior continuum and cognitive-behavioral abuse-specific treatments limiting referrals to sexual abuse, physical abuse/domestic violence, substance abuse and food abuse/obesity are numerous. While all of these programs focus heavily in decreasing socially irresponsible, harmful behavior, a focus on increasing socially responsible, helpful behavior is lacking as are attempts to address all of the contemporary issues in harmful behavior treatment. SRT combines evidence-based interventions and procedures to increase socially responsible behavior, decrease harmful, abusive behavior and address contemporary issues that impede harmful behavior-specific treatment.

Contemporary Issues in Harmful Behavior-Specific Treatment

Contemporary issues that need to be addressed in harmful behavior-specific treatment include: harmful behavior comorbidity; comorbidity adverse impact; harmful behavior migration; negative social influence; intervention intensity; harmful behavior conceptualization and; multicultural recognition in treatment program design. The following is a summary of these issues which are described further in Yokley & Seeholzer (2009).

Harmful behavior comorbidity defined as co-occurring harmful behaviors is common in harmful behavior-specific treatment. For example when five types of harmful, abusive behavior (i.e., sexual abuse, physical abuse, property abuse, substance abuse, and trust abuse) were evaluated in youth referred to SRT for sexually abusive behavior, an average of 4.5 types of harmful behavior was detected at admission (Yokley, 2002). While there are many co-occurring harmful behaviors, substance abuse is a relatively prevalent co-occurring problem across harmful behaviors including sexual abuse, physical abuse, property abuse and food abuse/overeating (e.g., Baltieri & de Andrade, 2006; Basu, Paltiel & Pollack, 2008; Conason & Sher, 2006; Stuart et. al., 2008). This makes substance abuse an important co-occurring target for many harmful behavior-specific treatment programs which do not routinely treat multiple forms of harmful behavior.

Harmful behavior comorbidity enables comorbidity adverse impact and harmful behavior migration. In *comorbidity adverse impact*, some harmful behaviors set the occasion for or trigger others while in *harmful behavior migration*, harmful behavior migrates to a co-occurring harmful behavior during treatment when the referral behavior is under observation and then shifts

back afterwards. *Negative social influence* impedes treatment by modeling and verbally encouraging multiple forms of harmful behavior. Negative social influence, comorbidity adverse impact and behavior migration contribute to the severity and resistance of harmful, abusive behavior. These combined problems warrant increased *intervention intensity* in terms of treatment contact frequency, harmful behavior confrontation and behavior monitoring across multiple settings. Comorbidity in harmful behavior-specific treatment, requires *harmful behavior conceptualization* to be comprehensive covering harmful behavior acquisition, maintenance and generalization. Harmful, abusive behavior occurs across cultures and *multicultural recognition in treatment program design* has been recommended to address cultural minority treatment problems including high dropout rates, infrequent session use and poor level of functioning at the end of treatment (Maramba and Hall, 2002). SRT provides a more inclusive path for multicultural recognition in harmful behavior treatment by identifying cultural similarities to celebrate in addition to the traditional approach of developing awareness of cultural differences to respect. A summary of the methods and procedures used in SRT to address these contemporary issues in harmful behavior treatment is provided in the following section and detailed description is provided in Yokley (2008; 2009).

Combining Evidence-Based Interventions and Procedures in Social Responsibility Therapy

SRT increases *intervention intensity* by combining interventions and procedures demonstrated effective in achieving behavior change using different methods and pathways. Awareness Training in SRT develops self-awareness across a broad range of internal, external and social

learning events. The most important responsibility in SRT is self-control and Responsibility Training in SRT involves self-control development across multiple forms of harmful, abusive behavior. Among other things, Tolerance Training in SRT develops both social tolerance and multicultural interaction self-efficacy as well as emotional tolerance and emotional regulation self-efficacy. Intervention methods in SRT are integrated across pathways such that the development of self-awareness and self-efficacy enables self-control success which enhances self-efficacy. Intervention pathways are categorized in SRT as primarily utilizing internal control (e.g., cognitive restructuring), external control (e.g., operant conditioning) or social learning (e.g., modeling). A summary of how SRT intervention methods in each intervention pathway address contemporary issues in harmful behavior-specific treatment (in italics) is outlined below.

SRT utilizes internal control procedures to address *harmful behavior comorbidity*, *comorbidity adverse impact* and, *harmful behavior migration* through interventions and procedures that target primary contributing factors to multiple forms of harmful behavior. For example, self-awareness training on recognition of 20 irresponsible thinking types along with cognitive, social and emotional triggers of multiple forms of harmful behavior is used in self-control responsibility training involving cognitive restructuring to avoid harmful behavior relapse. Self-awareness training on knowledge of: the three-step social responsibility plan; three reality scales for decisional balance and; the basic steps in socially responsible problem solving are used in self-control responsibility training for relapse prevention. Three structured workbooks address the *harmful behavior conceptualization* issue by helping clients

develop self-awareness of how they acquired, maintained and generalized their harmful behavior. *Multicultural recognition* is addressed in self-awareness training on multicultural prosocial values along with motivational enhancement to actualize them. Self-awareness training on the basic cognitive processing steps involved in emotional regulation is used in emotional tolerance training as follows. SRT adopts a Rational Emotive Behavior Therapy approach in “The ABC’s of letting feelings go” to dissipate emotional stress below the threshold of harmful acting out while “The ABC’s of holding on to feelings” are used to help clients accommodate to emotional stress and avoid acting it out. Mindfulness can be quite useful in emotional accommodation, is easily integrated into “The ABC’s of holding on to feelings” and is particularly helpful when it is not possible for clients to channel feelings to the right place at the right time. Knowledge development of these tools contributes to harmful behavior change self-efficacy. A simple “REDS” acronym helps clients remember the relapse prevention, emotional control, decision-making and social problem-solving skills needed to manage their harmful behavior. A substantial evidence base for the type of internal control (cognitive) procedures employed in SRT is provided in the research literature (e.g., Dowden & Andrews, 2007; Gonzalez et al., 2004; Lösel & Beelmann, 2005; Stein, Ives-Deliperi & Thomas, 2008; Wilson, Bouffard & Mackenzie, 2005).

SRT utilizes external control procedures to address *harmful behavior comorbidity*, *comorbidity adverse impact* and, *harmful behavior migration* through interventions and procedures that target multiple forms of harmful behavior directly. In younger clients and those needing a high level of structure, SRT utilizes a response-cost Token Economy operant conditioning model to address the *multicultural recognition issue*.

Multicultural prosocial values and behaviors are directly reinforced as competing factors against harmful behavior while direct consequences for multiple forms of harmful behavior are provided. In older clients and those who require less structure, SRT implements a behavior feedback slip system that provides reinforcement and targets *negative social influence*. Peers, partners and parents/family are involved as agents of change in a positive support circle. The slip system increases *intervention intensity* by extending intervention out of the treatment setting to everyone around the client. In both of these external control procedures self-awareness training on behavior responsibilities, expectations and contingencies is an integral part of self-control responsibility training on behavior regulation. Self-awareness training includes therapist review of Situation Response Analysis logs on managing harmful behavior triggers and high-risk situations. Self-awareness training on twelve home and community safeguards includes caretakers who institute self-control training through supervision with intensity based on behavior severity, and approved associates to address *negative social influence*. Self-control responsibility training also includes behavior commitment contracts for relapse prevention and successful behavior adaptation to external control procedures enhances behavior compliance self-efficacy. The research literature provides a solid evidence base for the type of external control procedures employed in SRT to target harmful behavior involving the Token Economy model, behavior feedback prompting with consequences, behavior contracting and behavior supervision (e.g., Barnes et al., 2005; Field et al., 2004; Kluger & DeNisi, 1996; Smith et al., 2004).

SRT utilizes social learning procedures to address *harmful behavior comorbidity*,

comorbidity adverse impact and, harmful behavior migration through interventions and procedures that target multiple forms of harmful behavior with reinforced modeling. SRT implements a number of social learning experiences in Structured Discovery social learning groups that are structured to help clients discover self-efficacy in managing harmful behavior and engaging in prosocial behavior. A simple "PRAISE" acronym helps SRT therapists remember the social learning procedures used to facilitate Structured Discovery groups by pulling people into the group process, responsible reinforcement, acknowledgement of contributions, instant identification, social mathematics to discover common participant denominators and enabling responsibility. Positive modeling is reinforced in group with therapist acknowledgement, calls for "instant identification" support through a show of hands and responsible reinforcement applause which further enhances self-efficacy. Written accomplishment awards for client modeling of multicultural prosocial values and relapse prevention skills are also provided. Participant modeling and covert modeling are used to correct *negative social influence* that occurs when clients exhibit social maturity problems and to help clients develop self-efficacy in emotional regulation skills. Client presentation of their *harmful behavior conceptualization* is a personal self-awareness benchmark and a self-efficacy developing demonstration that understanding how harmful, abusive behavior was acquired, maintained and generalized can be mastered. The culturally diverse social learning group addresses *multicultural recognition* by identifying shared values in a therapeutic setting that develops multicultural interaction self-efficacy. All of the basic types of social learning experiences employed in SRT (i.e., positive peer modeling, social behavior

feedback, structured groups where clients encounter their feelings and attitudes) are utilized in the residential Therapeutic Community social learning model which has meta-analytic support in the literature (e.g., Lees, Manning & Rawlings, 2004).

Although there appear to be no deconstruction studies on the components of the Therapeutic Community social learning model, meta-analytic support is provided in the research literature for modeling and cognitive-behavioral group therapy along with group therapy with offenders (e.g., Morgan & Flora, David, 2001; Petrocelli, 2002; Taylor, Russ-Eft & Chan, 2005). Further review of the behavior change evidence base for internal control, external control and social learning procedures combined in SRT is provided in Yokley (2008).

The Strength-Based Aspect of Social Responsibility Therapy

Social maturity and emotional maturity are considered important personal strengths developed in SRT to support positive change. Social maturity development in SRT draws on multicultural values theory (e.g., Schwartz et al., 2001) to select basic prosocial values accepted by multiple cultural groups. Consumer preference for the multicultural prosocial values selected for development in SRT has been validated in structured clinical exercise surveys of multicultural population youth, their caretakers and clinical staff (Yokley, 2008). In addition to increasing socially responsible behavior while decreasing harmful, abusive behavior, SRT develops social maturity (i.e., multicultural prosocial values) to improve interpersonal and occupational relationships and develop community unity (i.e., a position referred to as “Diversity within Unity”- Etzioni, 2001 in Yokley, 2008). With respect to emotional maturity development in SRT, self-awareness of internal and external influences on affect

and behavior are prerequisite to the cognitive restructuring and emotional regulation important in harmful behavior treatment. Developing emotional self-awareness has been an important treatment objective in multiple forms of harmful behavior including sexual abuse, physical abuse, substance abuse and food abuse/overeating (e.g., Bowen et al., 2006; Moriarty et al., 2001; Proulx, 2008; Rathus, Cavuoto & Passarelli, 2006). Self-efficacy, empowers clients to persist in efforts to control harmful behavior and be more resistant to pressures or temptations to re-engage in harmful behavior. This makes it important in the treatment of multiple forms of harmful behavior including sexual abuse, physical abuse, substance abuse, smoking and food abuse/overeating (e.g., Bogenschutz et al., 2006; Marshall et al., 2008; Morrel et al., 2003; Patten et al., 2008; Wolff & Clark, 2001). Self-control is a critical strength to target for development in harmful behavior treatment and a key treatment focus in multiple forms of harmful behavior including sexual abuse, physical abuse, property abuse, substance abuse, smoking and food abuse/overeating (e.g., Chapple & Hope, 2003; Feng, 2005; Harris, Mazorelle & Knight, 2008; Higgins, 2005; van den Bos & de Ridder, 2006; Wills et al., 2008). Targeting both social and emotional maturity for development is important as self-control appears to be bolstered by the presence of prosocial moral values (e.g., Schoepfer & Piquero, 2006).

A detailed description of the SRT methods, procedures and research support is provided in the [SRT treatment manual \(Yokley, 2008\)](#) and case illustrated treatment applications are provided in the [Clinician’s Guide to SRT \(Yokley, 2016\)](#).

Evaluation of Social Responsibility Therapy vs Treatment as Usual on the Treatment Development Population

SRT began its development in the abuse-specific clinical treatment setting with youth and young adults in custody for sexually abusive behavior. The treatment development agency required that youth referred for sexually abusive behavior be admitted directly from custody to Social Responsibility Therapy in Forensic Foster Care (i.e., specialized treatment foster care) without being waitlisted or transferred to less intense treatment as usual. This is a good example of public service setting requirements that respect the best interest of the client and community but impose research limitations. A study of behavior incident reports generated by Social Responsibility Therapy in Forensic Foster Care (SRT) compared to Treatment as Usual in regular foster care (TAU) was conducted.

Subjects

Subjects in the present study were 148 youth who were removed from their homes and referred to the same social services agency for group home or foster care placement. Those referred for sexually abusive behavior along with other co-occurring forms of harmful behavior were assigned to SRT. The rest received TAU involving regular foster care placement with a referral to counseling on an as needed case by case basis. TAU counseling referrals typically involved weekly individual counseling often for pre-placement behavioral issues compounded by post-placement adjustment issues. Since almost all of the youth referred for SRT were male, gender was controlled by removing females from the study. This left 80 male subjects, 26 assigned to SRT and 54 receiving TAU. SRT subjects had a mean age of 15.8 ($SD= 1.6$) and 69% were

Caucasian. TAU subjects had a mean age of 13.7 ($SD= 3.3$) and 51% were Caucasian.

Quasi-experimental Method

A comparison of youth behavior incident reports in SRT and TAU was conducted as follows. The behavior report database for the SRT group had an active incident report system which monitored both behavior incident reports and prosocial behavior accomplishment awards. Active incident report systems typically used in behavior therapy Token Economies or Therapeutic Communities, actively seek input data by assigning certain staff, peers and parents the job function of consistently monitoring target behaviors. Having assigned individuals actively looking for target behaviors to reinforce or report and confront creates a more sensitive and powerful incident report system that routinely captures more behavior data than the passive incident report systems typically required in social service and mental health agencies to monitor adverse incidents as required by state statutes. For the purposes of the present study, the prosocial behavior accomplishment awards were removed from the SRT active incident report system and only behavior incident reports were evaluated.

The database for the TAU group involved incident reports that related to both youth behavioral and non-behavioral issues recorded by a passive incident report system. The passive incident report systems typically required by state statutes in social service and mental health agencies to monitor adverse incidents do not actively seek input data through assigned individuals looking for target behaviors to confront, do not reward positive behaviors and typically are limited to documenting behaviors that are discovered, not actively sought out. In the treatment evaluation agency, these

reports were filed under two basic categories, major unusual incident reports which included behaviors that pose harm to self or others, requiring corrective action for consumer safety (e.g., sexual abuse, physical abuse, run away or emergency room visits) and regular incident reports documenting the less serious problems and rule infractions. For the purposes of the present study, TAU incident reports relating to non-behavioral issues (i.e., medical problems, abuse allegations and past abuse reports) along with incident reports from group home programs were removed. In summary, the present comparison procedure evaluated only the behavioral issue incident reports of youth in the SRT and TAU groups.

As with all quasi-experimental evaluations, discussion of potential sources of expected bias is warranted. The utility of examining youth behavior incident reports as a measure of treatment effectiveness is directly dependent on the accuracy of the caretakers making these reports. Caretaker report has a long history of research support as a useful and accurate source of child and adolescent behavior observation in behavior checklists with meta-analytic support for the use of caretaker report in clinical and community samples (e.g., Warnick, Bracken & Kasl, 2008). An argument can be made that in harmful, abusive behavior which can result in incarceration or other substantial consequences, caregivers may be expected to provide more frequent and more accurate incident reports than would be expected from youth self-report. Furthermore, the SRT active incident report system with its caretaker training in supervision, confrontation and documentation of harmful behaviors can be expected to generate a conservative bias against the SRT group with more frequent and severe behavior reports expected than from the passive incident report system used in TAU. Finally,

the behavior problem severity level of the SRT treatment development population of youth referred for sexually abusive behavior made them a community safety risk and ruled out being able to remain in the community on a treatment waiting list or even being able to receive a referral to the less intense TAU condition. This differential treatment population severity level can be considered another source of conservative bias against the SRT group which would predict more frequent and severe behavior reports than generated by those youth whose lower behavior severity level allowed placement in less the intense TAU control group.

Results

The overall incident report frequency rates of about six behavior incident reports per month for the SRT group and one every other month in the TAU group reflects the nature of the active vs passive incident report systems used to capture the incident report data on these two groups. Attributing the higher frequency of incident reports in the SRT group to the active incident report system used (as opposed to the alternative hypotheses of the more severe population being treated) was supported during the first agency quarter of the fiscal year. At that time one employee from regular foster care transferred to the SRT forensic foster care program but continued to use the regular foster care passive incident report system on the forensic foster care youth receiving SRT. Although, the number of incident reports and time period was relatively limited, the results revealed no significant differences between the number of behavior incident reports recorded by the passive incident report system on youth in the SRT group and those receiving TAU during that three month period, $t(16) = 1.3$, $p = .206$. These results tend to indicate that the active incident report system used in SRT detects

more incidents. This means that statistical tests comparing the frequency of behavior incident reports on youth in SRT vs TAU cannot be utilized without addressing the expected bias against SRT as a result of its use of an active incident report system that is more sensitive, powerful and routinely captures more incident reports than the TAU passive incident report system. One way to address this incident report system bias is to compare the ratio of positive to negative outcome indicators within each population measured by each incident report system.

When the ratio of less severe program rule violations to more severe legal violations was examined, the SRT group exhibited 83% rule violations compared to 17% legal violations (i.e., about a 5:1 positive to negative outcome ratio) while the TAU control group exhibited 44% rule violations compared to 56% legal violations (i.e., an almost equal 1:1.3 positive to negative outcome ratio). This difference represents a significant outcome improvement of the SRT group over the TAU control group on rule violation severity, $\chi^2(1, N= 1952)= 159.9, p<.001$.

When type of harmful, abusive behavior was examined, a significant difference between the SRT and TAU control group was revealed on the relative frequency of behavior incident reports involving trust abuse, substance abuse, property abuse, physical abuse and sexual abuse, $\chi^2(4, N= 1933)= 276.6, p<.001$. Examination of the relatively large trust abuse category revealed that 7% of the SRT trust abuse incident reports were for run away while 61% of the TAU trust abuse incident reports involved run away. When the ratio of less severe abusive behavior (i.e., incident reports on trust abuse, substance abuse and property abuse) to more severe abusive behavior (i.e., incident reports on physical abuse and

sexual abuse) was examined, the SRT group exhibited 92% less severe abusive behavior incident reports compared to 8% more severe abusive behavior reports (i.e., about a 11:1 positive to negative outcome ratio) while the TAU group exhibited 56% less severe abusive behavior reports compared to 44% more severe abusive behavior reports (i.e., about a 1.3:1 positive to negative outcome ratio), representing a significant outcome improvement of the SRT group over the TAU control group on abuse behavior severity, $\chi^2(1, N= 1933)= 213.9, p<.001$.

When social maturity was examined, a significant difference between the SRT and TAU control group behavior incident reports was revealed on the relative frequency of honesty, trust, loyalty, concern and responsibility problems, $\chi^2(4, N= 1933)= 118.9, p<.001$. Pronounced differences were observed in the areas of concern and responsibility where the SRT group exhibited 30% of the more severe concern problem incident reports (which included abusive harmful behavior towards self and others) compared to 70% of the less severe responsibility problem reports (which included non-compliance, defiance, and other irresponsible behaviors reflecting poor decisions and immature actions) while the TAU group produced mirror image opposite results exhibiting 70% of the more severe concern problem incident reports compared to 30% of the less severe responsibility problem reports, representing a significant outcome improvement of the SRT group over the TAU control group on this measure of social maturity development, $\chi^2(1, N= 1264)= 81.7, p<.001$.

When behavior problem location was examined, a significant difference between the SRT and TAU control group behavior incident reports was revealed in the relative

frequency of behavior problem locations (i.e., foster home, treatment setting, school or work and community), $\chi^2(3, N= 1933)= 40.5, p<.001$. Pronounced differences were observed on behavior problems in the home vs community where the SRT group exhibited 41% of their behavior problem incident reports in the foster home compared to 59% in the community while the TAU group again produced almost mirror image opposite results exhibiting 58% of their behavior problem incident reports in the home compared to 42% in the community. This difference represents a significant outcome improvement of the SRT group over the TAU control group on this measure of foster family adjustment, $\chi^2(1, N= 1933)= 19.9, p<.001$. This finding tends to indicate better foster family adjustment by the SRT group and is supported by the breakdown of trust abuse incident reports which revealed almost 9 times less run-away reports from foster homes by the SRT group than the TAU control group. A summary of the relative frequency of behavior incident reports in the SRT and TAU control group appears in Table 1.

The results of the present study hold up well under the Bonferroni adjustment of $p < .007$ to control for alpha across the seven statistical tests performed with all of the present findings meeting this more stringent level of statistical significance (Table 1).

Summary of Findings

In summary, a significant improvement of Social Responsibility Therapy over the Treatment as Usual control group was revealed across all of the outcome measures evaluated in the present study. Specifically, regarding rule violation severity, the SRT group exhibited a significantly higher positive to negative outcome ratio than the TAU control group on: program rule vs legal violations; less severe vs more severe

abusive behaviors and; less severe responsibility problem reports vs more severe concern problem incident reports. With respect to behavior problem location, the SRT group exhibited a significantly higher positive to negative outcome ratio of behavior problems occurring in the home vs community than the TAU control group. This finding in conjunction with the dramatically reduced AWOL rate, tends to indicate better foster family adjustment in SRT which is considered critical for family reunification, a major treatment goal and desired outcome in this population.

Taken together, these positive outcome findings tend to indicate that Social Responsibility Therapy in Forensic Foster Care decreases both rule violation and abuse behavior severity by increasing social maturity, particularly concern for others resulting in better foster family adjustment than Treatment as Usual in general foster care. These improvements are considered critical for family reunification, a major treatment goal and desired outcome for the specialized treatment foster care population. The clinically significant reduction in SRT AWOL rates is particularly important in treatment foster care where reducing home disruption is an important target outcome goal and in residential Therapeutic Community treatment where AWOL is a pronounced treatment compliance problem. A statistical limitation of this study is its lack of random assignment of youth referred for sexually abusive behavior to wait list control groups or less intense treatment as usual, making it quasi-experimental in nature. Recommendations for improving measurement of social maturity include limiting future evaluations to honesty, concern and responsibility since they are relatively easy to discriminate. It is important to clarify that this is a research evaluation recommendation, not a clinical

Table 1.
Relative Frequency of Behavior Incident Reports in
Social Responsibility Therapy (SRT) vs Treatment as Usual (TAU Control Group)

Behavior Problem Category (Incident reports)	Relative Frequency	
Broken down by:	Category Proportion	
Severity-	SRT¹ TAU²	
Rule violations (less severe) ³	83%	44%
Legal violations (more severe) ⁴	17%	56%
	100%	100%
	(5:1 vs 1:1.3)	
	p<.001	
Abuse Type-	SRT¹ TAU²	
Trust Abuse ⁵	81%	46%
Substance Abuse ⁶	3%	2%
Property Abuse ⁷	8%	8%
Physical Abuse ⁸	4%	35%
Sexual Abuse ⁹	4%	9%
	100%	100%
	Less severe 92% 56%	
	More severe 8% 44%	
	100% 100%	
	(11:1 vs 1.3:1)	
	p<.001	
Social Maturity Area-	SRT¹ TAU²	
Honesty problems	8%	14%
Trust problems	14%	13%
Loyalty problems	13%	1%
Concern problems	20%	50%
Responsibility problems	45%	22%
	100%	100%
	Concern 30% 70%	
	Responsibility 70% 30%	
	100% 100%	
	p<.001	
Location-	SRT¹ TAU²	
Foster home problems	41%	58%
Treatment setting problems	19%	3%
School or work problems	15%	20%
Community problems	25%	19%
	100%	100%
	In home 41% 58%	
	Out of home 59% 42%	
	100% 100%	
	p<.001	

Note: Severity, Type & Location are behavior observations. Social Maturity area involves clinical judgment calls.

1. Forensic Foster Care with Social Responsibility Therapy
2. Regular Foster Care with counseling referral as indicated (i.e., typically weekly individual sessions)
3. Includes less severe problem behaviors such as rule refusal, immature actions, temper tantrums, disrespect, irresponsible decisions, negative peer support, being late or sneaking out but returning, school suspension, etc.
4. Includes more severe problem behaviors such as sexual abuse/deviance, physical abuse, property abuse, substance abuse, verbal assault/menacing, etc., that can be considered or result in legal violations, probation or parole violations, status offenses (e.g., run away, school expulsion, unruly charges)
5. Includes dishonesty, truancy, sneaking out and not returning when trusted with community privileges
6. Includes both alcohol/drug abuse and trafficking
7. Includes both theft and property damaging/vandalism
8. Includes menacing/verbal assault
9. Includes both sexual offense and sexual acting out

recommendation to remove trust and loyalty from the multicultural prosocial values and behaviors being developed in SRT. Trust is

particularly important in therapeutic relationship development and loyalty to positive friends along with prosocial values

is particularly important in positive behavior maintenance.

An important strength of this study is its social validity. Social validity is a term coined by behavior analysts to refer to the social significance (importance) of study treatment goals/outcomes and the social acceptability of study procedures (Foster & Mash, 1999). With respect to the study social significance, the importance of developing behavioral self-control in this population is self-evident and underscored by the National Crime Victimization Survey (2005) results revealing over 500,000 incidents of sexual abuse and the FBI Uniform Crime Reports (2005) estimating about 117,000 sex offense arrests (not including prostitution). Regarding the social acceptability of the procedures, this study was conducted within the confines of the public service setting in compliance with public service requirements to provide treatment in a timely manner and protect community safety by not assigning clients who present a danger to others to a wait list control group or a less intense treatment as usual.

Recommendations for future research include replication on a less severe abuse-specific population in a more controlled setting that does not impose research limitations for community safety. Extension to other populations on the harmful behavior continuum requires initial application potential studies to confirm harmful behavior comorbidity treatment needs. SRT application potential studies measuring five types of harmful behavior (i.e., sexual abuse, physical abuse, property abuse, substance abuse and trust abuse) have thus far been consistent with prior research in revealing harmful behavior comorbidity. For example, regarding behavior considered both harmful to self and others, population study of male youth substance abuse referrals revealed that

of the five types of harmful, abusive behavior evaluated, the average number reported was 3.7. The top three types of harmful, abusive behavior in this referral population was trust abuse, property abuse and physical abuse. With respect to behavior considered primarily harmful to self, population study of adult female food abuse/overeater referrals with morbid obesity revealed that of the five types of harmful, abusive behavior evaluated, the average number reported was 4.0. The top three types of harmful, abusive behavior in this referral population was trust abuse, substance abuse and property abuse.

Conclusion

SRT adds to the harmful behavior treatment literature by identifying and addressing the contemporary issues that plague harmful behavior treatment. SRT also contributes to the literature by focusing directly on increasing social responsibility through the development of multicultural prosocial values as healthy behavior success skills and competing factors to harmful, abusive behavior. Honesty, trust, loyalty, concern and responsibility are what we want from peers, partners, parents and employers who also want these characteristics from us. The value of these characteristics cannot be underestimated. They are the commodities needed to develop the relationships we want, avoid the harmful behavior we don't want and establish the self-esteem we need to succeed in life. While further research is needed, the results of the present study are encouraging for the target referral problem considered primarily harmful to others. SRT application potential studies reveal harmful behavior comorbidity treatment needs in substance abusers with behavior considered harmful to both self and others as well as food abusers/overeaters with behavior considered primarily harmful to self. While research is needed to determine efficacy, clinical practice application of SRT to these

other populations on the harmful behavior continuum has thus far revealed a relatively good treatment fit, requiring no significant modifications. The number one responsibility in SRT is self-control. Responsibility involves a willingness to assume self-control over one's behavior;

clients are more likely to benefit from treatment when they are willing to assume responsibility and should be held responsible for their own behavior which makes promoting responsibility an important contemporary psychotherapy focus (Overholser, 2005).

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