

# Social Responsibility Therapy in Forensic Foster Care: Part 1

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## Overview

This chapter describes the treatment of youth referred for sexually abusive behavior along with other types of unhealthy, harmful behavior that warrant treatment (i.e., physical abuse, property abuse, substance abuse and trust abuse) with Social Responsibility Therapy in Forensic Foster Care. Forensic Foster Care is a family-based treatment setting for youth whose sexually abusive behavior and other unhealthy, harmful behaviors can result or has resulted in legal problems. Forensic Foster Care employs Social Responsibility Therapy to help youth control their unhealthy, harmful behavior by: developing social-emotional maturity as a competing response to harmful behavior; developing an understanding of how harmful behavior was acquired, maintained, and generalized; and demonstrating the social responsibility to make emotional restitution. Forensic Foster Care provides another level in the continuum of care between residential and outpatient treatment. This is important for youth whose harmful behavior management requires gradual reentry into the community under supervised conditions when no appropriate family placement exists.

## Introduction

Since the foster care population consists primarily of children removed from their homes as the result of neglect or abuse, a brief discussion of this population is warranted. As they get older, children who have been abused or neglected are more likely to perform poorly in school, commit crimes against persons, and experience emotional problems, sexual problems, and substance abuse (Sedney & Brooks, 1984; Starr, MacLean, & Keating, 1991).

Although family functioning moderates the impact of abuse on victims (Brock, Mintz, & Good, 1997), it appears that in general males tend to exhibit more externalizing reactions and are at greater risk for abuse toward others whereas females tend to experience internalizing reactions and are at risk for revictimization. For example, a seven-year foster care follow-up study revealed that physically abused boys were more likely than abused girls to engage in criminal (externalizing) behaviors as adults (Fanshel, Finch, & Grundy, 1989). Abused boys are more likely than abused girls to identify with the original aggressor and eventually to abuse their spouse and children (Carmen, Reiker, & Mills, 1984). Since the battering of women is associated with more physical aggression toward sons than daughters (Jouriles & Norwood, 1995), the modeling of externalizing behaviors in violent homes may have more of an influence on males than on females. In addition, since viewing self as a victim “is clearly a more difficult identity issue for males than for females in our society” (Cunningham & MacFarlane, 1996, p. 18) seeking relief by “identifying with the aggressor” and physically abusing others after being abused is inherently more likely in males.

This gender split also appears to occur with the impact of sexual abuse. National surveys consistently demonstrate that one in four girls and one in seven boys are sexually maltreated before puberty (Finkelhor, 1984). If both males and females who were molested went on to molestations at the same rate, there would be a great deal more female sex offenders. Despite the fact that almost twice as many child sexual abuse victims are female, most sexual abuse is by males on female children (Faller, 1989; Finkelhor, 1979; Russell, 1983; Wyatt, 1985). These data indicate, as many researchers have noted, that males tend to cope with abuse by externalizing their behavior whereas females tend to cope through internalization (MacFarlane, Cockriel, & Dugan, 1990; Summit, 1983). In other words, “boys appear to be more likely to turn their pain

into rage and project it outward onto others, while girls typically convert pain into depression and turn it inward on themselves” (Cunningham & MacFarlane, 1996, p. 18).

Therapeutic foster care, like other social service systems, must focus on meeting the needs of the majority of its consumers. Although no single symptom occurs in the majority of abuse victims, sexually and physically abused children frequently manifest internalizing problems such as posttraumatic stress disorder (PTSD), guilt, depression, anxiety, and withdrawal (e.g., Dubner & Motta, 1999; Livingston, 1987; Williamson, Borduin, & Howe, 1991). Dedicating resources for caretaker training and child treatment to the majority of consumers who are young female abuse victims with internalizing problems does not address the treatment and developmental needs of older, externalizing males. Caretaker training and child treatment with generic humanistic counseling or traditional supportive psychotherapy for the elimination of guilt, shame, depression, anxiety, and other internalizing symptoms does not provide the more structured, behavioral interventions needed to help relieve conduct problems, harmful behavior, and other externalizing symptoms.

Traditionally, therapeutic foster care has been in the difficult situation of having to provide for those exhibiting both internalizing and externalizing symptoms with generic therapeutic tools for caretaker training and child treatment. The “therapeutic parent model” was developed by adopting the generic client-centered therapist characteristics considered “necessary and sufficient” (Rogers, 1957) for therapeutic change that were common to all successful therapies regardless of orientation while avoiding the characteristics of abusive parents (Shealy, 1995). Thus in “the therapeutic parent model” youth caretakers were taught to demonstrate acceptance, empathy, and understanding while avoiding hostility, criticism, and mixed messages. Although many of these therapist characteristics that were put forth more than forty years ago (Rogers, 1957) are still considered “necessary,” they are no longer considered “sufficient” as therapeutic interventions have now become much more refined and specific. As the result of many advances in psychotherapy evaluation which directly relate to parenting problem children, research reveals that generic training and treatment approaches cannot be equally effective without modification to address specific disorders (e.g., Casey & Berman, 1985). Recent abuse specific treatments that address the internalizing reactions of child victims (e.g., Cohen, Mannarino, Berliner, & Deblinger, 2000) and the externalizing reactions of abusive youth (e.g., Chamberlain & Reid, 1998; Henggeler, Schoenwald, & Pickrel, 1995) are now available for integration into specialized foster care. Forensic Foster Care addresses the needs of externalizing youth with multiple forms of abusive behavior by integrating abuse treatment techniques into their caretaker training and youth treatment plans.

### **Forensic Foster Care**

Forensic medicine applies medical knowledge to legal problems. Forensic Foster Care applies treatment knowledge to foster youth whose externalizing, abusive behavior can result or has resulted in legal problems. Forensic Foster Care fulfills several important system-level treatment needs of youth who have been removed from their homes for sexually abusive behavior. First, Forensic Foster Care offers specialized treatment to youth with externalizing problems involving acting out emotions, conduct disorder, and multiple forms of harmful behavior. This is important because the primary focus of existing therapeutic foster care is on treating children who exhibit internalizing problems, including adjustment disorders and other conditions associated with

being a victim of abuse or neglect. Second, this treatment setting offers a less restrictive environment than residential treatment for sexually abusive youth who are not candidates to complete treatment in the outpatient setting due to problems with placement in their family of origin. Third, Forensic Foster Care offers another level in the continuum of care between residential and outpatient treatment for seriously abusive youth whose behavior management needs require gradual reentry into the community under supervised conditions. Sexually abusive youth may now enter a step-down treatment supervision process, progressing from residential treatment to Forensic Foster Care and, finally, to the traditional outpatient setting during family reunification or independent living placement.

Forensic Foster Care program youth are given an opportunity to live in the community in a family setting (i.e., specialized foster home), attend regular school, and receive their treatment as in a functional family with special supervision. There is some evidence that Forensic Foster Care offers a functional family treatment setting that is most conducive to helping youth with a history of behavior that can or has resulted in legal problems. For example, incarcerated boys who were randomly assigned to a Forensic Foster Care program designed to address their special needs (“multidimensional treatment foster care”) had significantly fewer criminal referrals and returned to live with relatives more often than did those who received group home care (Chamberlain & Reid, 1998). Thus, Forensic Foster Care is potentially a more cost-effective alternative to continued residential treatment. The Forensic Foster Care program discussed in this chapter was developed, evaluated, and refined over a 14-year period. Table 1, on the next page, provides a summary of three basic types of foster care.

The Forensic Foster Care program includes key components associated with foster parent retention. These components include highly specialized parent training (Chamberlain, Moreland, & Reid, 1992; Urquhart, 1989) and a team approach where foster parents are integrated into all aspects of youth treatment (Sanchirico, Lau, Jablonka, & Russell, 1998). In addition, a cluster placement model where youth are accepted into more than one foster home at placement admission acts to maximize foster parent support (Urquhart, 1989) and minimize any adverse impact that could be associated with home moves (Proch & Taber, 1985). Forensic Foster Care uses social responsibility therapy to teach youth prosocial alternatives to unhealthy, harmful behavior. Information on forensic foster program development and lessons learned from treatment is provided in Yokley (2002).

### **Placement Approach: The Foster Family Cluster**

“It takes a village to raise a child”

The high level of structure and positive peer culture are two of a number of important aspects of the highly successful therapeutic community treatment model that matches the needs of youth with abusive behavior problems. Although it is not possible to recreate every aspect of the closed therapeutic community milieu in the open outpatient environment, Forensic Foster Care simulates key aspects of the therapeutic community positive-peer-culture treatment environment. For example, youth are admitted into a foster cluster setting of several foster families who have a shared parenting and activity arrangement, which simulates the extended family milieu of the therapeutic community. The foster family cluster is like the therapeutic community environment in which fellow residents are viewed as “brothers” and “sisters” who must accept their mutual obligation to help each other and hold each other accountable as a family of humans. The

therapeutic community discouragement of sexual relationships between residents who are viewed as “brothers” and “sisters” is taken to the next level in Forensic Foster Care, where sexual relationships are viewed as “foster family incest” and are labeled a sex offense relapse.

**Table 1.**  
**Comparison and Contrast of Three Basic Types of Foster Care**

	<b>Regular Foster Care</b>	<b>Therapeutic Foster Care</b>	<b>Forensic Foster Care</b>
<b>Age</b>	66% are under age 13 <sup>1</sup>	66% are under age 13 <sup>1</sup>	100% are 13 and older
<b>Population Served</b>	Primarily serves neglected and dependent children <sup>2</sup> with home environment problems <sup>5</sup>	Primarily serves victims <sup>3</sup> of abuse (most are female) with internalizing <sup>4</sup> and adjustment problems (e.g., PTSD, depression, anxiety, withdrawal)	Exclusively serves youth offenders (most are male) with externalizing, conduct problems (e.g., harmful, abusive behavior, dishonesty, defiance, aggression)
<b>Focus</b>	Has strong family support focus	Has strong child support and protection focus	Has strong community protection focus
<b>Clients</b>	Child and parents are the “clients”	Child is the “client”	Youth and community are the “clients”
<b>Treatment</b>	Treatment is optional as needed	Treatment is provided separately from foster care typically by a general practitioner in weekly Community Mental Health Center visits	Foster parents are an integral part of a treatment team of abuse specialists who provide the therapeutic community treatment approach throughout the week

1. Benton Foundation, 2000
2. Neglect is by far the most common form of maltreatment, affects about twice as many children as do physical and sexual abuse (English, 1988). 68% of children removed from the home in California were as the result of neglect (42%) or dependency (caretaker absence or incapacitated 26%). Commission on California State Government Organization and Economy, 4/9/1992.
3. 20% of children removed from the home in California were as the result of physical (12%) or sexual (8%) abuse. Commission on California State Government Organization and Economy, 4/9/1992.
4. Sexually and physically abused children frequently manifest internalizing problems such as Posttraumatic Stress Disorder, guilt, depression, anxiety, and withdrawal (e.g., Dubner & Motta, 1999; Livingston, 1987; Williamson, Borduin & Howe, 1991). Thus, victim treatment requires interventions that address internalizing symptoms.
5. Neglected children seem to be less aggressive and more passive than are physically abused children (Green, 1978; Hoffmen-Plotkin & Twentyman, 1984) but have more school performance problems (Eckenrode, J., Laird, M. & Doris, 1993; Golden, 2000) making treatment referrals less urgent than in cases where symptoms are externalized through aggressive, harmful, abusive behavior.

In therapeutic foster care, different foster families have youth with different types of problems seeing different treatment providers, primarily in different individual therapy sessions. In Forensic Foster Care all the foster families in the forensic foster cluster have youth with harmful, abusive lifestyles seeing the same treatment providers in the same positive-peer-culture group setting exactly as in a residential therapeutic community. The phase system of responsibilities and privileges used in Forensic Foster Care is similar to the highly structured hierarchy of job functions and privileges found in therapeutic communities. The Social Responsibility Therapy focus on developing honesty, trust, loyalty, concern, and responsibility used in Forensic Foster Care is essentially the same as the therapeutic community focus on developing a positive lifestyle. Although therapeutic community learning experiences for unhealthy, harmful lifestyles

have traditionally been used in residential settings, these modifications have allowed the use of therapeutic community learning experiences to develop social-emotional maturity and self-control in the outpatient Forensic Foster Care setting.

### **Treatment Approach: Social Responsibility Therapy**

Forensic Foster Care uses Social Responsibility Therapy (SRT), a treatment approach that addresses harmful, abusive behavior directly while teaching prosocial alternatives. Social Responsibility Therapy is a hybrid treatment that combines interventions selected for their research support and application to multiple forms of unhealthy, harmful behavior. The multicultural prosocial/family values focus of SRT make it easily accepted and inherently adaptable for diverse foster parent participation. This unhealthy, harmful behavior treatment has been adapted across the years to accommodate abusive youth of different age groups in different settings. The forensic foster youth described in this chapter are youth with a history of sexually abusive behavior and other unhealthy, harmful behaviors requiring treatment (i.e., physical, property, substance, and trust abuse in addition to their sexually abusive behavior). Each type of abuse exhibited by these youth involves a maladaptive way for them to assert power, get what they want, and make themselves happy, often at the expense of others. Each type of abuse also involves a pathological level of social-emotional immaturity.

In SRT, youth develop a socially responsible, positive lifestyle by learning to demonstrate appropriate social behavior control and social-emotional maturity with an emphasis on honesty, trust, loyalty, concern, and responsibility. SRT was designed for individuals who have developed behavioral patterns that are unhealthy, harmful or destructive to themselves and/or others. In SRT, abuse is abuse and it is not sufficient for clients to stop sexually abusing others but continue other forms of abuse. SRT targets sexual abuse, physical abuse, property abuse, substance abuse, and trust abuse for relapse prevention directly and through social maturity development. In addition to an expanded treatment focus targeting more than one type of abuse, SRT has expanded the understanding of unhealthy, harmful behavior beyond the typical behavior maintenance cycle provided in most relapse prevention programs to encompass unhealthy, harmful behavior acquisition, maintenance, and generalization.

A final distinction to be made in SRT has to do with avoiding diagnostic labels that diminish the client's responsibility for his or her behavior and focusing on the impact of the client's behavior. Alcohol and drug treatment divides the seriousness of the problem into two levels by using definitions of abusers (basically, someone whose behavior is excessive but still under his or her willful control) and dependents (or addicts- basically, someone whose behavior is excessive and no longer under his or her willful control). The alcohol and drug treatment concept of addiction is not appropriate for the treatment of individuals whose abuse can or has hurt others. It is too tempting for interpersonal abusers to use a label of addiction as an "I couldn't help it" excuse to avoid responsibility for the impact of their abuse on others. In this respect, one addiction treatment handbook has already categorized those behavioral problems that primarily have an impact on others (e.g., sexual abuse, domestic violence, and the alcohol-affected family) as "socially destructive addictions" (L'Abate, Farrar, & Serritella, 1992). In SRT harmful behavior is evaluations on a continuum of severity and whether the client's behavior is primarily harmful to self, harmful to both self and others, or primarily harmful to others (See Table 2).

**Table 2.**  
**The Harmful Behavior Continuum: Selected Behavior Examples**

		Primary Area of Impact <span style="float: right;">→</span>		
		Harmful to Self	Harmful to Self and Others	Harmful to Others
B e h a v i o r  I m p a c t  S e v e r i t y  ↓		<b>Unhealthy Eaters</b> (Overeat/binge/purge/starve)		
		<b>Medication Non-adherence</b>		
		<b>Nicotine Abusers</b>		
		(Single)	<b>Workaholics</b> (with partners or family)	
			<b>Codependents</b> (Abuse enablers)	
			<b>Sexual Compulsives</b> (Unprotected sex, affairs, prostitution)	
			<b>Money Abusers</b> (Embezzlers, Credit fraud)	
		(Single shopaholics)	(Gamblers with partners/family)	
			<b>Substance Abusers</b> (Alcohol and drug abusers with partners/family)	(Drunk drivers, Drug dealers)
		(Single alcohol and drug abusers)		
		<b>Responsibility Abusers</b> (Work Neglecters) (Child Neglecters)		
		<b>Trust Abusers</b> (Partner cheating) (Professional con artist)		
			<b>Verbal/Power Abusers</b> (employee harassment)	
			<b>Property Abusers</b> (theft, vandalism, arson)	
			<b>Physical Abusers</b> (bullying, assault, child abuse)	
			<b>Sexual Abusers</b> (rape, child molestation)	
			<b>Contract Killers</b>	
			<b>Lust/Serial Killers</b>	
			<b>School/Mass Shooters</b>	
		<div style="border: 1px solid black; padding: 5px; width: fit-content; margin: 0 auto;">           Source: Adapted with permission from Table 1.1 in Yokley (2008)         </div>		

**Note:** “The more difficult the problem, the harder it is to change” may not always be the case. Less severe harmful behaviors which impact more people can be more difficult to change because of...

1. Impact Rationalization- It's low on the social impact continuum, e.g., “It doesn't hurt others, it only hurts me”
2. Availability and associated Normalization- It's normal to eat, smoke, spend and sometimes overdo it, e.g., “Everyone does it” or “Lots of people do it”. For example, smoking lapses “were more likely to occur when smoking was permitted, when cigarettes were easily available and in the presence of other smokers” (p. 64, Shiffman et. al., 1996).
3. Severity Minimization- It's the least on the severity continuum (above) and “It's not illegal”. You can get arrested for drinking or drugging and driving but you can't get arrested for overeating and driving. We have a highway patrol and drug court but there is no buffet patrol and the only food court that exists is in the Mall.

A detailed description of Social Responsibility Therapy is provided in [SRT for Adolescents and Young Adults: A Multicultural Treatment Manual for Harmful Behavior](#) (Yokley, 2008).

## **The Social Responsibility Therapy Forensic Foster Care Population**

Most cognitive-behavioral treatments focus on one specific type of abusive behavior (e.g., substance abuse, physical abuse, property abuse, sexual abuse, food abuse, or money abuse). SRT targets multiple forms of unhealthy, harmful behavior.

A brief justification for treatment of multiple forms of unhealthy, harmful behavior appears to be warranted given the prevailing focus on the need to provide “offense-specific treatment” for sexual abusers. The basic reason SRT targets multiple forms of unhealthy, harmful behavior is that the referral harmful behavior is not usually the only harmful behavior and one harmful behavior can trigger another.

### **Harmful Behavior Co-occurrence**

Youth with sexual behavior problems do not have the specific, entrenched sexual abuse behavior pattern (e.g., specific age, sex, and type of sexual behavior) that adult pedophiles exhibit. They also have not settled on a specific type of abusive behavior to use in externalizing (acting out) their feelings. Thus, various combinations of unhealthy, harmful behavior are quite common in youth with sexually abusive behavior. Exhibiting multiple forms of abuse in addition to other deviant behaviors (e.g., drug use, vandalism, theft, poor academic performance, sexual precociousness, personal aggression, and disregard for the law) has been demonstrated to be a common phenomenon among adolescents in the research literature (Andrews & Duncan, 1997; Jessor & Jessor, 1977). Adult sexual abusers also frequently commit nonsexual crimes. For example, a meta-analysis of sixty-one treatment studies (predominantly follow-ups) revealed that, on average, the sex offense recidivism rate was 13.4% and the recidivism rate for nonsexual violence was 12.2% (Hanson & Bussière, 1998).

Demographic data from the TASC Forensic Foster Care program revealed that average age was 16, 97% were male, and 72% were Caucasian. The average number of different types of abuse exhibited was 4.5, and 59% exhibited problems at admission with five types of abuse (i.e., sexual abuse, physical abuse, property abuse, substance abuse, and trust abuse). Fifty-three percent were on probation or parole (Yokley & Boettner, 1999).

These Forensic Foster Care abusive behavior data are consistent with other research reports of youth sex offenders which indicates that abusive youth do not limit themselves to exhibiting one specific type of abuse on the Harmful Behavior Continuum (see Table 2; Yokley, 2006). Youth who sexually abuse frequently have histories of other types of abuse and criminal activity. Sex abuser research indicates that 41% to 86% have histories of other types of abuse and criminal activity (Amir, 1971; Awad, Saunders, & Levene, 1984; Becker, Kaplan, Cunningham-Rathner, & Kavoussi, 1986; Fehrenbach, Smith, Monastersky, & Deisher, 1986; Shoor, Speed, & Bartelt, 1966; Van Ness, 1984; Yokley, 1996). Substance abuse between types of interpersonal abusers is roughly the same; for example, sexually abusive, physically abusive, and delinquent juveniles revealed the same level of use and binge pattern in all three groups (Tinklenberg, Murphy, & Murphy, 1981). Because sex offense relapse relates to general criminal behavior as well as specific sexual deviance and sex offenders frequently commit nonsexual crimes (Hanson & Bussière, 1998), comprehensive risk assessment and treatment of sexual abusers needs to address multiple forms of harmful/criminal behavior.



### **The “Vampire Syndrome” Is Not Always the Case**

Repetition compulsion or the “vampire syndrome” (i.e., committing the same type of abuse that was experienced) has been observed in a number of types of harmful behaviors. For example, 19% to 81% of adolescents with sexually abusive behavior were previous victims of sexual abuse (Becker et al., 1986; Fehrenbach et al., 1986; Friedrich & Luecke, 1988; Longo, 1982) and 38% of adolescents with sexually abusive behavior come from homes that evidenced sexual deviation (Awad et al., 1984).

However, the “vampire syndrome” is not always the case. In the “abuse conversion syndrome,” trauma from one form of past abuse is converted into any form of abusive behavior that can act to relieve the traumatic stress (i.e., a maladaptive coping reaction to relieve helplessness and increase feelings of power/control). This is seen in adolescents with sexually abusive behavior where an estimated 41% to 54% report having been physically abused or neglected (Van Ness, 1984). Child abuse and neglect are strongly related to later substance abuse (Ivanoff, Schilling, Gilbert, & Chen, 1995; Sheridan, 1995). In substance abusers, approximately 44% to 47% were victims of sexual abuse (Cohen & Densen-Gerber, 1982; Glover, Janikowski, & Benschhoff, 1995). Being exposed to sexual, physical, or emotional abuse correlates significantly with developing multiple forms of self-abuse (e.g., substance, food, or money abuse) in addition to sexual addiction (Carnes & Delmonico, 1996).

Alcohol impairs judgment, increases the probability of aggression, and disinhibits sexual behavior (e.g., Dermen & Cooper, 1994). Lifetime drinking problems significantly predict current criminal behavior (Greenfield & Weisner, 1995). Crimes most frequently involving alcohol abuse are sexual abuse (34%–75% in four rape studies: Lightfoot & Barbaree, 1993; Scully & Marolla, 1984); physical abuse (20%–80% in twelve wife abuse studies: Carden, 1994); and homicide (19%–83% in ten study reviews: Fendrich, Mackesy-Amiti, Goldstein, Spunt, & Brownstein, 1995). In their review of the literature, Sees and Clark (1993) noted that that abstinence from other substances was enhanced by abstinence from nicotine. Cigarette smoking, in addition to posing its own health risks, is often associated with use of other substances. Continued smoking appears to place abstinent alcohol and drug abusers at elevated risk for relapse. Cross or substitute addictions are conditions associated with (drug/alcohol) relapse (Chiauzzi, 1989; DeLeon, 1997). One report revealed that 19% of those in treatment turned to one new addiction before a full-blown relapse, whereas 43% developed two or more (Chiauzzi, 1989).

In summary, SRT has a number of advantages for youth sex offenders. In addition to targeting other forms of abuse that can have an adverse impact on the community, result in re-arrest, or trigger sex offense relapse through the abstinence violation effect, multiple abuser treatment buffers the damaging effects of labeling. Although labeling may be helpful for those adults who experience some relief at finally being able to identify the condition that has caused them so much difficulty, this is not the case for children whose conditions are still in the formative stages. It is one thing for youth to have to tell their peers that they are in an abuse behavior group and quite another to have to tell them they are in a youth sex offender group. Recent labeling concerns for youth sex offenders have already resulted in changes for the youngest of this population. To avoid unnecessary labeling or stigmatizing of young children, at least one author now refers to preteen sex offenders as “abuse reactive children” (Cunningham & MacFarlane, 1996). Not only does treating “externalizing youth” or “multiple abuser youth” recognize that the

referral type of abuse may not be the only type of abuse, but it does not label youth with a specific abuse behavior pattern, which they may not retain later in their adult years.

### **Abusive Youth Tend to Exhibit Pathological Social-Emotional Immaturity**

Many sexually abusive youth suffer from “pan-immaturity” in emotional/social adjustment (Fehrenbach et al., 1986; Shoor et al., 1966) and character disorder. Character disordered/antisocial youth with multiple forms of unhealthy, harmful behavior have been described as having serious emotional maturity with self-awareness, self-efficacy, and self-control<sup>1</sup> along with serious social maturity problems involving problems with:

- Honesty (i.e., telling blatant or pathological lies: American Psychiatric Association, 1980, 1987, 1994; Buss, 1966; Cleckley, 1976; Hare, 1985; Karpman, 1961);
- Trust (e.g., conning or behaving manipulatively: American Psychiatric Association, 1987, 1994; Hare, 1985; Karpman, 1961);
- Loyalty (e.g., shifting loyalties, inability to form meaningful relationships, inability to sustain relationships: American Psychiatric Association, 1952, 1968, 1980, 1987, 1994; Buss, 1966; Davis & Feldman, 1981; Gray & Hutchison, 1964);
- Concern (i.e., lacks feeling for others; callous to feelings, rights, suffering of others; lacks empathy; self-centered: American Psychiatric Association, 1968, 1987, 1994; Cleckley, 1976; Craft, 1965; Davies & Feldman, 1981; Gray & Hutchison, 1964; Hare, 1985); and
- Responsibility (i.e., irresponsible, unreliable: American Psychiatric Association, 1968, 1980, 1987, 1994; Cleckley, 1976; Davies & Feldman, 1981; Gray & Hutchison, 1964; Hare, 1985).

### **Theoretical Underpinnings of Social Responsibility Therapy**

SRT is a multimethod-multipath behavior therapy that utilizes awareness training, responsibility training, and tolerance training methods across internal control (e.g., cognitive restructuring), external control (e.g., operant conditioning), and social learning (e.g., therapeutic community techniques) pathways to increase the therapeutic pressure toward positive change. An overview of the SRT approach is provided by Yokley (2010) and a summary of the social learning aspect follows. SRT has a strong social learning focus on the development of social-emotional maturity as key factors, which are incompatible with abuse behavior. Teaching clients behaviors/responses that are incompatible with the problem behavior/response dates back over 20 years to the highly successful behavioral treatment of tension and anxiety by teaching the incompatible response of relaxation (Wolpe, 1995). The theoretical approach of reciprocal inhibition or counter-conditioning is straightforward. Teaching the competing behavior inhibits or blocks the problem behavior. In the case of anxiety, humans simply cannot be tense and relaxed at the same time. Thus, if they are taught to relax as an automatic response (or first line of defense) during tense situations, anxiety attacks are not triggered. This approach was originally used with anxiety and other neurotic problems, and a 90% significant improvement rate was reported (Wolpe, 1958). This approach has also been used successfully with a number of other clinical treatment problems, including inhibiting anger reactions (Hearn & Evans, 1972) and sexual behavior problems such as exhibitionism (Lowenstein, 1973), sexual intercourse genital pain (Haslam, 1965), and frigidity (Chapman, 1968). Variations of this approach continue to be implemented. For example, the residential therapeutic community model teaches the practice of “Acting as if” you can control emotions and behaviors along with “Going to the

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**Footnote 1:** Most criminal offenders lack self-control (Gottfredson & Hirschi, 1990).

opposite extreme to meet the median” (i.e., practicing opposite extreme positive behaviors during treatment so that after treatment when self-control naturally relaxes, you will still meet the median community norms). The outpatient Dialectical Behavior Therapy recommendation to “Do the opposite” of the emotional action (urge) is another example. A summary of developing social-emotional maturity characteristics as competing factors to unhealthy, harmful behavior is provided in Yokley (2011, August).

It is not possible to exhibit negative abuse behavior and positive social-emotional maturity (i.e., prosocial values and appropriate social behavior control) at the same time. Put another way, it is not possible to be an out-of-control abuser while caring about others and controlling one’s self. Thus, social-emotional maturity includes important competing responses to abuse behavior that youth need to learn (i.e., prosocial values and appropriate social behavior control).

SRT teaches youth the multicultural prosocial/family values of honesty, trust, loyalty, concern, and responsibility to compete with antisocial abusive behavior. Teaching these family values is necessary to promote family relationships, support, and bonding, which has been found to reduce psychological distress in women and general deviance in men, to produce academic motivation, to reduce substance (marijuana) use in younger adolescents, and to reduce future poor parenting (Andrews & Duncan, 1997; Newcomb, 1997; Newcomb & Loeb, 1999).

In SRT, therapeutic community learning experiences are adapted to the foster cluster treatment group environment and are considered an important part of the intervention tools used to develop social-emotional maturity as well as appropriate social behavior control. Like a number of other sex abuser treatment approaches (e.g., relapse prevention and Twelve-Step groups), therapeutic community learning experiences were also adapted from the substance abuse field. Therapeutic communities have been treating this type of socially immature, irresponsible, acting-out character disorder since 1958 when Synanon began to offer residential treatment to heroin addicts who engaged in multiple forms of abuse and crime (Yablonsky, 1969).

SRT uses therapeutic community learning experiences to address abuse behavior and develop social-emotional maturity for a number of important reasons. First, this approach targets the abusive “criminal lifestyle” characterized by substance abusive, irresponsible (e.g., history of unstable employment), immature (i.e., usually younger) individuals with maladaptive thinking (e.g., procriminal attitudes) and high-risk (i.e., criminal) peer associates (Gendreau, Little, & Goggin, 1996) by developing a competing prosocial lifestyle (DeLeon, 1989).

Second, therapeutic community learning experiences address the special needs of the abuser population. Because socially and emotionally immature youth are not good vicarious learners and learn best by experience, therapeutic community learning experiences employ experiential treatment approaches that frequently require action on the part of the client.

Third, the therapeutic community approach has been successfully applied to multiple forms of unhealthy, harmful behavior including the ability to address self-harm (such as sex with high-risk people, unprotected sex, or needle sharing), sexual abuse/offense (including prostitution and promiscuity), physical abuse (violent crime), property abuse (property crime), substance abuse (including drug trafficking), and trust abuse through honesty development (e.g., Boswell and Wedge, 2003; Clarke, 2002; Cooperman, Falkin, and Cleland, 2005; DeLeon, 2000; De Leon et al., 2000; Jainchill, Hawke, and Messina, 2005; Messina et al., 2002). The Therapeutic

Community model has received meta-analytic research support in the community and corrections-based settings (Lees, Manning, and Rawlings, 2004; Pearson and Lipton, 1999). The therapeutic community model has also been successfully implemented with adolescents and recognized in the National Registry of Evidence-based Programs and Practices (Morral, McCaffrey & Ridgeway (2004).

Fourth, this approach targets a similar population. Both youth referred for therapeutic community substance abuse treatment and those referred for sexual abuse treatment exhibit pathological social-emotional immaturity. This has been documented in the form of immaturity in emotional/social adjustment, a lack of empathy, character disorder, problems delaying gratification, lying, manipulation, and irresponsible acting out (DeLeon, 1989; Fehrenbach et al., 1986; Sgroi, 1982; Shoor et al., 1966). The therapeutic community approach fosters emotional maturity and empathy get the abuser in touch with the feelings of others, provide role-reversal experiences, and develop emotional expression responding, which satisfies the three-component model of empathy (Feshbach & Feshbach, 1982) found to facilitate prosocial behavior and reduce aggressive behavior (Eisenberg & Miller, 1987; Miller & Eisenberg, 1988).

Fifth, the therapeutic community is a multicultural intervention. With respect to one type of unhealthy, harmful behavior (i.e., substance abuse), the therapeutic community approach has been referred to as “The predominant residential modality for treating addictions from Chile to China” (Waters et al., 2002, p. 113).

### **Social Responsibility Therapy in Forensic Foster Care**

The three basic treatment components of SRT in Forensic Foster Care involve socially responsible, research-informed treatment procedures and abuse rules with a community safety and security priority. The three basic components are:

1. Learning socially responsible behavior by developing appropriate social behavior control and social-emotional maturity as competing responses to abusive behavior.
2. Maintaining socially responsible behavior by mastering basic behavior management skills and developing an understanding of how abusive behavior was acquired, maintained, and generalized.
3. Beginning a socially responsible lifestyle including emotional restitution to both direct and indirect victims of abuse during emotional restitution training (see Yokley, 2011, Chapter 56).

After orientation and evaluation where basic assessment and relapse prevention occur during a probation period prior to admission, SRT has three basic phases. During these phases, abuser privileges and community supervision are directly linked to their level of treatment progress, social maturity, and responsibility. The Orientation/Evaluation, Phase 1, Phase 2, Phase 3, and aftercare components in Forensic Foster Care are described in Yokley (1993). These three basic responsibility phases are associated with the aforementioned three treatment components. Figure 1 provides a summary of SRT Forensic Foster Care program phases.

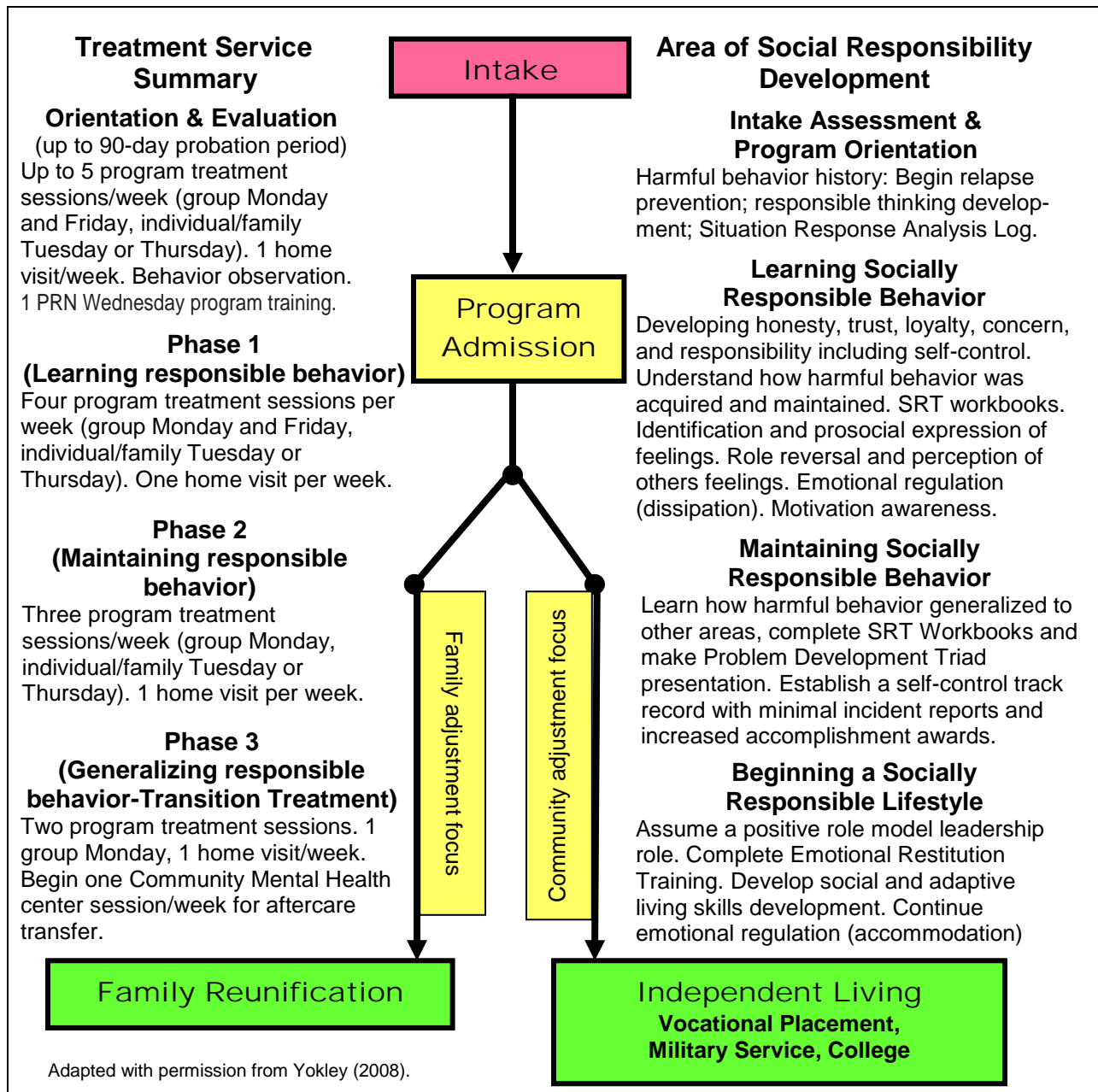
### **Learning Socially Responsible Behavior**

“You’re only young once, but you can be immature your whole life.” SRT addresses unhealthy, harmful behavior by developing appropriate social behavior control and social-emotional maturity as competing responses to abuse. Treatment plans that focus on internal attitude change with the expectation that external behavior change will follow are not sufficient for abuse behavior

treatment. Since many abuse behaviors are self-reinforcing, treatment providers have to stop the behavior externally before they can get the client to implement internal behavior change procedures to maintain abuse abstinence. Stopping unhealthy, harmful behavior by developing self-control and social-emotional maturity as competing responses to abuse is accomplished through the following:

- *The use of therapeutic community learning experiences* (i.e., social learning through experiential, participant modeling procedures originally developed by Charles Dietrich and Albert Bandura).

**Figure 1**  
**Social Responsibility Therapy Forensic Foster Program Phases**



- *Teaching competing responses to abusive behavior* (i.e., learning incompatible responses and promoting change through cognitive dissonance with procedures originally developed by Joseph Wolpe and Leon Festinger).
- *Implementing research-informed community safeguards* and abuse behavior rules.

### **The Use of Therapeutic Community Learning Experiences**

Therapeutic community learning experiences aid in tolerance training, treatment motivation enhancement, learning to delay gratification, and other key factors in the development of self-control and social-emotional maturity. Learning to control abuse behavior is the social responsibility of all youth and the first important component in SRT. This is accomplished by incorporating therapeutic community learning experiences into the treatment regimen along with special parenting skills (i.e., ten three-hour sessions each year) and special supervision methods designed to meet the specific needs of this externalizing, abusive population.

Since there are always advances one can make in the area of social-emotional maturity, this treatment component extends throughout the duration of SRT. The basic goal of this treatment component is to block immature, unhealthy, harmful, destructive behavior by learning competing mature, prosocial, constructive behavior. Developing social-emotional maturity and appropriate social behavior control is accomplished through the use of therapeutic community learning experiences in conjunction with selected cognitive-behavioral interventions and relapse prevention techniques for unhealthy, harmful behaviors. Therapeutic community learning experiences consist of a combination of natural and logical consequences, which can be viewed as behavior therapy or social learning within the context of a positive peer culture and experiential framework. Since these learning experiences effectively address antisocial, abusive behavior, they serve the purpose of protecting the safety and security of the community while benefiting the abuser. See Yokley (2011), Chapters 33 and 49, for a more detailed description of therapeutic community learning experiences.

### **Teaching Competing Responses to Abusive Behavior**

Key factors in the development of self-control and social-emotional maturity include such competing responses as honesty, trust, loyalty, concern, and responsibility. In SRT, these five prosocial competing factors are used to block five types of antisocial abuse behavior (i.e., sexual, physical, property, substance, and trust abuse).

When operationally defined for treatment purposes, some basic examples of social maturity used in treatment goals include the following:

- Being honest enough to hold one's self accountable by disclosing problems that otherwise would not be discovered.
- Trusting others enough to drop criminal pride by sharing real feelings of helplessness, hurt, and inadequacy and allowing the tears that accompany these feelings to be seen in group.
- Being loyal to program rules and what the youth knows is right when peers are pressuring him or her to do otherwise. Pushing past authority problems to make connections with appropriate adults and reestablish positive family loyalty.
- Having enough concern to accept the social responsibility to provide emotional restitution and make amends to direct and indirect victims of abusive behavior. Using confrontation with concern for those who are slipping. Doing things for others when there is nothing to be

expected in return. Considering the impact of actions on others as well as their viewpoints and feelings.

- Being responsible enough to take initiative; do tasks at home, school, and work without being told; complete tasks that have been started, making a 100% effort.

When operationally defined for treatment purposes, some basic examples of emotional maturity used in treatment goals include the ability to do the following:

- Identify feelings being experienced; perceive and understand feelings in others (empathy);
- Exhibit adequate frustration tolerance,<sup>2</sup> block justifying actions based on feelings, and redirect feelings into constructive outlets;
- Form positive social attachments, express love while not mistaking intensity for intimacy, and derive satisfaction out of helping others;
- Push past feelings of tension, anxiety, and insecurity to reach out to others and try new things;
- Delay gratification regarding getting even or acting out;
- Adapt to change and suppress fight-or-flight responses when under stress (i.e., face problems without going AWOL, assaulting, or using drugs/alcohol);
- Consider the future and plan ahead long range;
- Exhibit appropriate social behavior control, which includes knowing how to do the following:
  - Recognize and correct maladaptive thinking;
  - Recognize and avoid high-risk situations;
  - Analyze responses to situations;
  - Resolve conflict without physical violence;
  - Accept constructive feedback;
  - Hold self accountable for own behavior;
  - Accept the consequences of behavior without blaming others or acting out feelings (of self-disappointment either for losing control or for getting caught);
  - Role-reverse, consider the impact of your behavior on others as well as “do unto others as you would have others do unto you”; and
  - Think ahead, play social chess under stress, “If I do this, they’ll do that” (i.e., ability to consider immediate consequences of your behavior under pressure).

An important step in the social-emotional maturity development for youth seriously abusive behavior is to reclaim their dignity through their honesty and to develop appropriate social behavior control through therapeutic community learning experiences. Youth with abusive behavior pass through three important phases on their path to reclaiming dignity through honesty and emotional restitution:

- Phase 1: Pass their first honesty exam, which involves a presentation to their treatment group and significant others (e.g., guardians, relatives, parents, and partners) after passing a polygraph exam on who the victims were and what the abuse did to them.
- Phase 2: Develop an understanding of their abuse behavior and clarify this understanding in a presentation to their treatment group and significant others.
- Phase 3: Clarify their social responsibility for their behavior and apologize to both direct and indirect abuse victims in a supervised session in which all victim questions are answered.

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**Footnote 2:** Low frustration tolerance has been viewed as the childish insistence on indulgence that underlies multiple addictions (Ellis, 1995).

Competing responses to abuse behavior (i.e., honesty, trust, loyalty, concern, and responsibility) are continually improved through the CARE (Computer-Assisted Incident Report Evaluation) system which helps identify problem behavior patterns that require therapeutic community learning experience intervention (Yokley & Boettner, 1999).

**Implementing Research-Informed Community Safeguards and Abuse Rules**

Many children removed from their homes exhibit externalizing disorders involving disruptive behavior (Pilowsky, 1995). Forensic Foster Care directly addresses foster family and community safety concerns (e.g., Horton, 2000; Wilkenson & Baker, 1996) with special safeguards. Since abuse behavior relapse means both harm to others as well as removal of the youth abuser from community treatment, community safety and security are priorities. The SRT Forensic Foster Care program provides twelve basic home safeguards and twelve basic community safety/supervision procedures. Program rules are research-informed and community access is earned on a level system linked to behavior control. State-of-the-art communication, behavior tracking, and supervision technology are employed.

The SRT use of “going to the opposite extreme” with abuse abstinence treatment goals was influenced by the previously discussed research indicating that one type of abuse can trigger another along with the abstinence violation effect literature (Marlatt & Gordon, 1985, 1987). Another influence was an important study in the area of controlled use (“moderation management or harm reduction”) versus abuse abstinence by Hall, Havassy, and Wasserman (1989), who followed treated alcoholics, opiate users, and smokers until relapse. These investigators found that abuser relapse was predictable from their self-control goals. Specifically, subjects with the most restrictive absolute abstinence goal were less likely to slip, were less likely to relapse after a slip and had more time between first use and relapse than did subjects with less demanding goals. With respect to setting overall abuse treatment rules policy, these findings tend to indicate the following: “Aim for the stars, fall in the trees, aim for the trees, fall on the ground.”

Selection of the therapeutic community philosophy “you have to go to the opposite extreme to meet the median” has defined treatment rules both between and within types of abuse that are listed in the SRT program treatment and community behavior contracts. A few examples follow:

<u>Between types of abuse</u>	<u>Within types of abuse</u>	
Don't abuse yourself	Sexual abuse	No pornography
Don't abuse others	Physical abuse	No threats
Don't abuse your treatment	Property abuse	No borrowing
	Substance abuse	No smoking
	Trust abuse	No excuses

Since abuse is self-reinforcing, a critical step in helping youth develop social-emotional maturity as a competing response to abuse is learning enough emotional constraint to be able to comply with basic supervision, safety, and treatment (e.g., relapse prevention) rules. While there are divided opinions on sexual abuser treatment effectiveness, failure to complete treatment has been found to be a significant predictor of both sexual and nonsexual recidivism (Hanson & Bussière, 1998). The reliable evidence that sexually abusive clients who attend and cooperate with treatment are less likely to reoffend indicates that treatment programs can contribute to community safety through their ability to supervise and monitor risk (Hanson & Bussière, 1998). Put another way, treatment develops social-emotional maturity and consequent appropriate social



behavior control through structure and supervision. Effective supervision is critical to multiple abuser treatment and is “the therapist’s best liability insurance.”

SRT implements twelve basic home safeguards and twelve basic community safety procedures that include innovative uses of available communication, behavior tracking, and monitoring technology. Forensic foster home safeguards include youth observation and evaluation procedures, room monitoring, direct communication links with professional staff, and emergency removal procedures. Forensic Foster Care community safety procedures include direct communication links with community youth contacts, viable abuse cycle interruption methods, and containment procedures that limit community access.

Since people do not consistently follow plans if they do not agree, the first safeguard procedure for both the home and community is to get everyone involved to agree on the supervision plans and procedures. Lack of agreement on the supervision plan enables the youth to sabotage supervision efforts by appealing to a team member who does not agree. Thus, all individuals involved with the youth (other youth, therapist, foster parents, caseworker, and parole/probation officer) must sign both the home and the community behavior contracts.

### **Twelve Basic SRT Home Safeguards**

**Home Safeguard 1: A treatment behavior contract.** The contract is signed by the youth, their guardians, treatment providers, and probation/parole officers. The contract details program rules agreed on by all parties. It outlines what is expected of the youth in the home and treatment setting regarding appropriate social behavior control (e.g., no violence, no threats of violence, and staying in control at all times). This includes not abusing others (sexually, physically, verbally), self (using drugs, pornography, going AWOL), or treatment (through denial, negative contracts, hole punching, splitting, assignment refusal). It also includes not entering home or treatment situations that are high risk for abuse (such as unsupervised access to potential victims). Consequences for contract violation are specified and an advanced directive request by the youth to contact authorities to help contain their behavior (if they become a danger to others) is included (Yokley, 1993).

**Home Safeguard 2: A structured behavior management system.** Forensic foster parents give the youth the choice of changing their behavior or completing an incident report on themselves. Foster parents give the incident reports to staff who administer therapeutic community learning experiences and behavior consequences based on those reports. This achieves a balance in which foster parents have control over problem behavior but are not the target of revenge for discipline decisions.

**Home Safeguard 3: Treatment session feedback.** Used for behavior management and youth, foster parent, and probation/parole officer feedback. This safeguard prevents youth from creating problems between adults that can result in distraction that effects supervision.

**Home Safeguard 4: Assessment of unhealthy, harmful behavior.** Includes gathering complete records of youth behavior problems in their home and community environments along with contacting past treatment providers for behavior pattern information.

**Home Safeguard 5: Honesty examination.** Investigation of collateral contacts to verify treatment compliance and behavior management. Regular and random polygraph examination. Investigation of collateral contacts to verify treatment compliance and behavior management

may be used to clarify the treatment plan by verifying victim lists and abuser behaviors. In addition, this safeguard prevents unnecessary home moves due to false accusations, promotes child protection in high-risk situations, and reverses past false abuse admissions for secondary gain. For example, some youth make false admissions to end previous interrogation. Others report trying to continue to look “honest” in treatment and earn privileges by continuing to disclose abuse information, which eventually results in disclosing crimes that were never committed.

**Home Safeguard 6: Random drug/alcohol screening.** Deters relapse from substance-induced impaired judgment. This is considered important because alcohol impairs judgment, increases the probability of aggression, and disinhibits sexual behavior (Dermen & Cooper, 1994).

**Home Safeguard 7: Door alarm.** An electronic movement-sensitive door alarm is used during orientation and as needed when relapse signs are exhibited.

**Home Safeguard 8: Room monitor.** A sound-transmitting room baby monitor is used during orientation, when more than one abuser shares a room and as needed when relapse signs are exhibited.

**Home Safeguard 9: Random room search.** Random searches to check for abuse-related items such as pornography, weapons, and drugs are considered critical to managing abuser behavior.

**Home Safeguard 10: Psychological and Psychiatric evaluations.** Initial and as-needed assessments to evaluate emotional stability and help maintain behavior control by providing medical treatment when needed are considered important behavior management safeguards.

**Home Safeguard 11: Emergency contact information.** Ability for forensic foster parents to contact staff at all times. Parents receive a wallet contact card with all staff pager, cell phone, e-mail, and fax numbers. Daily parent contact from staff includes reports on abuser behaviors to monitor. Feedback to parents after treatment sessions includes learning experiences to implement for behavior management as well as problems requiring closer observation.

**Home Safeguard 12: Emergency placement procedures.** Ability to remove youth from the foster home immediately. The SRT Forensic Foster Care program has a respite system involving an immediate transfer to another lower-risk home (e.g., in another school district where the target person does not attend) with group home transfer as a backup procedure to respite.

## **Twelve Basic SRT Community Safety and Security Procedures**

**Community Safety Procedure 1: A community behavior contract.** The contract is signed by the youth, their guardians, treatment providers, and probation/parole officers. The contract details program rules agreed on by all parties including permission to monitor the youth’s behavior in the community and consequences for contract violation (e.g., twenty-four-hour line-of-sight supervision on orientation, total hands-off policy, do not enter community high-risk situations, no contact with victims or potential victims, no baby-sitting, approved associates list, room monitoring, obey the law, respect others’ rights of privacy, and no negative contracts, Yokley, 1993).

**Community Safety Procedure 2: Behavior-based community access.** Includes clear list of responsibilities and privileges which limits community access based on behavior. The Forensic Foster Care program uses a three-phase social maturity level system after admission (Yokley, 1993). First there is an orientation/evaluation period, a thirty to ninety-day probation period prior to admission, during which the youth is restricted to home (room monitor, door alarm, no visitors, uniform). Then:

- Phase 1: Approved school-related supervised activities; approved associates can visit.
- Phase 2: Activities with approved associates added, office visits with appropriate family, office telephone privileges, allowed to get a job, no regular room monitor.
- Phase 3: Overnight visits with appropriate family; foster home telephone use; no door alarm.

**Community Safety Procedure 3: Emergency relapse prevention methods for abuse plan/cycle interruption.** Detention centers are frequently full or require waiting too long for a juvenile court hearing prior to admission. Moreover, out-of-control abusive youth behavior rarely reflects a mental health problem that makes involuntary hospitalization possible. Thus, Forensic Foster Care requires abuse-cycle interruption methods such as house arrest, shadowing, home move and abbreviated boot camp which can be implemented without delay.

**Community Safety Procedure 4: A community safety notification system.** The legal system continues to wrestle with the issue of under what circumstances mental health professionals and program staff need to notify the community in general and potential victims specifically. Until the courts resolve this issue, SRT in Forensic Foster Care has instituted a three-step notification procedure summarized as follows: When an abuser enters treatment, he has the “green light” in terms of notification, where no disclosure of abuser problems is made to those in contact with the abuser. At the first indication of a loss of appropriate social behavior control, the abuser gets the “yellow light,” which involves a partial disclosure of his general behavior control problems. When the abuser is observed in a high-risk situation for relapse or committing high-risk behaviors, he receives the “red light,” which involves full disclosure about his abuse behavior problems in meetings with teachers, employers, clergy, or others who have contact with the abuser.

**Community Safety Procedure 5:** A clergy opinion survey. A survey on sex offenders attending religious services is used to determine the appropriate type of supervision and relapse prevention during religious services (Robinson, Yokley, & Zuzik, 1995).

**Community Safety Procedure 6: Pager supervision.** The youth receives a pager and only staff/foster parents have the pager number. Whenever the staff/parents page, the youth has fifteen minutes to call back to avoid an incident report and associated consequences for going AWOL.

**Community Safety Procedure 7: Shadowing.** The abuser is escorted by an adult who is aware of his problem at all times when he is in the community. This procedure has been used successfully to manage the behavior of unruly, abusive youth in alternative schools. There, school administrators have parents of unruly children sign behavior contracts and escort their children in school all day during periods when they exhibit behavior control problems (“Discipline,” 1995).

**Community Safety Procedure 8: Alternative schooling.** Alternative education procedures for youth who have not graduated from high school such as home instruction, Internet school, day treatment, adult GED classes, and community college courses for high school credit are used as needed given the abuser's behavior pattern and risk level.

**Community Safety Procedure 9: A behavior incident report tracking system.** An important community safety procedure is to implement a behavior monitoring system that provides objective monitoring of unhealthy, harmful/problem behaviors in addition to healthy prosocial behavior. For example, entering behavior incidents on a computer spreadsheet provides objective incident report data on current behavior for comparison to past baseline target behavior levels (Yokley & Boettner, 1999). In addition to providing the overall number of incident reports per quarter, this approach can generate behavior data on the type of abuse, severity, social maturity problem, area where the incidents primarily occur, and intervention impact. Any method of collecting behavior reports and organizing them into selected categories for behavior pattern detection will do. However, use of a spreadsheet behavior tracking system expedites incident report review and behavior pattern "profiling" for community safety decision making. Incident reports need to be reviewed regularly and result in appropriate corrective action without delay.

**Community Safety Procedure 10: Gradual supervised community reentry.** The safety components of this procedure involve negative peer screening, twenty-four-hour, line-of-sight supervision during orientation/evaluation, a "strength" buddy system during Phase 1, and an approved associates list during Phases 2 and 3.

**Community Safety Procedure 11: AWOL precautions and deterrent.** The traditional AWOL precaution of hospital gown and slippers, although acceptable for other types of youth, is clearly inappropriate for youth with sexually abusive behavior due to program rules about being completely clothed. In addition, orange prison inmate jumpsuits are too costly. Thus, the TASC program typically uses pajamas or full-length thermal underwear with briefs underneath and slippers during an AWOL risk period. Color digital photographs and descriptions of dangerousness are made up during orientation/evaluation. The descriptions under the photos are assigned to each youth who are told that they are to make up a "Wanted" poster of themselves that is so graphically accurate that the thought of seeing it stapled to community telephone poles would prevent them from even considering running away from treatment. The act of each TASC youth making up his or her own "Wanted" poster description has covert sensitization deterrent qualities that add to this community safety procedure.

**Community Safety Procedure 12: AWOL notification plan.** Ability to e-mail color digital photographs and descriptions to the local police station upon a youth's going AWOL. Local bus stations, school officials, and other parties who may come in contact with the AWOL youth may also be contacted. Youth who are found and returned typically receive a community risk polygraph on the detailed whereabouts essay they are required to write. They are also escorted by staff to the places they stayed to notify those who harbored them of their situation and the need to contact staff immediately should the youth return requesting a place to stay while AWOL from treatment.

## **Maintaining Socially Responsible Behavior**

Maintaining socially responsible behavior involves mastering behavior management skills along with understanding the etiology of unhealthy, harmful behavior both of which develop self-awareness, self-efficacy, and self-control. For example, self-awareness is developed on high-risk situations for relapse, trigger emotions, irresponsible decisions, and thinking along with stress buildup from daily living problems. Self-control skills are taught for relapse prevention through escape and avoidance of high-risk situations, regulation of trigger emotions, responsible decision making, and thinking along with solving life problems that contribute to stress buildup. Self-efficacy (confidence) in managing harmful behavior is developed through successful practice and implementation of these harmful behavior management skills.

### **Harmful Behavior Management Skills**

Most foster youth at some time in their life have been told that “Your ACTS speak louder than your words”. The four basic SRT skills for managing unhealthy, harmful behavior can be remembered with the ACTS acronym: Avoid trouble (relapse prevention); Calm Down (emotional regulation); Think it through (Decisional balance); and Solve the problem (social problem solving). Relapse prevention basics include managing recovery perfectionism along with avoiding and escaping high-risk situations for relapse. Managing recovery perfectionism involves learning to maintain self-control after making a mistake and breaking a perfect recovery track record by avoiding falling into the rule violation effect. *Avoid trouble* involves avoidance of high-risk situations for relapse through self-awareness development of these situations and development of positive planning skills. Escape from high-risk situations involves mastery of the 3 G’s responsibility plan (i.e., Get out, Get Honest and Get responsible). *Calm down* involves learning emotional regulation skills. This means developing the ability to manage feelings with emotional dissipation skills along with emotional accommodation skills and when to use both. Emotional dissipation in SRT involves learning “the ABC’s of letting feelings go” in order to dissipate emotions down below the threshold of acting feelings out. Emotional accommodation involves learning “the ABC’s of holding on to feelings” and accommodating to them in order to decrease the need to act feelings out. *Think it though* involves using the reality scales, fantasy fast-forward, and socially responsible thinking to make responsible decisions. Decisional balance with the reality scales involves weighing out the benefits and drawbacks of an action with “the 3 S’s” on the Survival Scale (i.e., is it needed for survival); the Success Scale (i.e., is it needed to succeed in life) and; the Severity Scale (i.e., how severe will the consequences of taking the action be on self and others). In SRT using “fantasy fast-forward” to play the mental tape of an action being considered through to its end is used to avoid foresight slips (i.e., “foresight deficit decisions”) that often result in entering or remaining in high-risk situations. Knowing and correcting a set of twenty socially irresponsible thinking characteristics is also an important part of responsible decision making. *Solve the problem* in SRT involves learning a simple three-step social problem-solving skill for healthy interpersonal relationships and positive goal achievement. The SET social problem-solving skills involves: Setting your goal; Evaluating your progress and options, then; Taking responsible action. A detailed description of these skills with case examples is provided in [The Clinician’s Guide to SRT](#) (Yokley, 2016).

### **Footnotes and References**

Please use the CONTACT US form on the HOME page of [www.srtonline.org](http://www.srtonline.org) to request References (6 pages).