

Social Responsibility Therapy in Forensic Foster Care: Part 2

Source: Yokley, J. (2011). The Treatment of Youth Referred for Sexual Behavior Problems in Forensic Foster Care: A Social Responsibility Therapy Program Description. In B. Schwartz (Ed.), Handbook of Sex Offender Treatment (Chapter 54). Kingston, NJ: Civic Research Institute [Updated & adapted for non-profit educational purposes only].

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Part 2

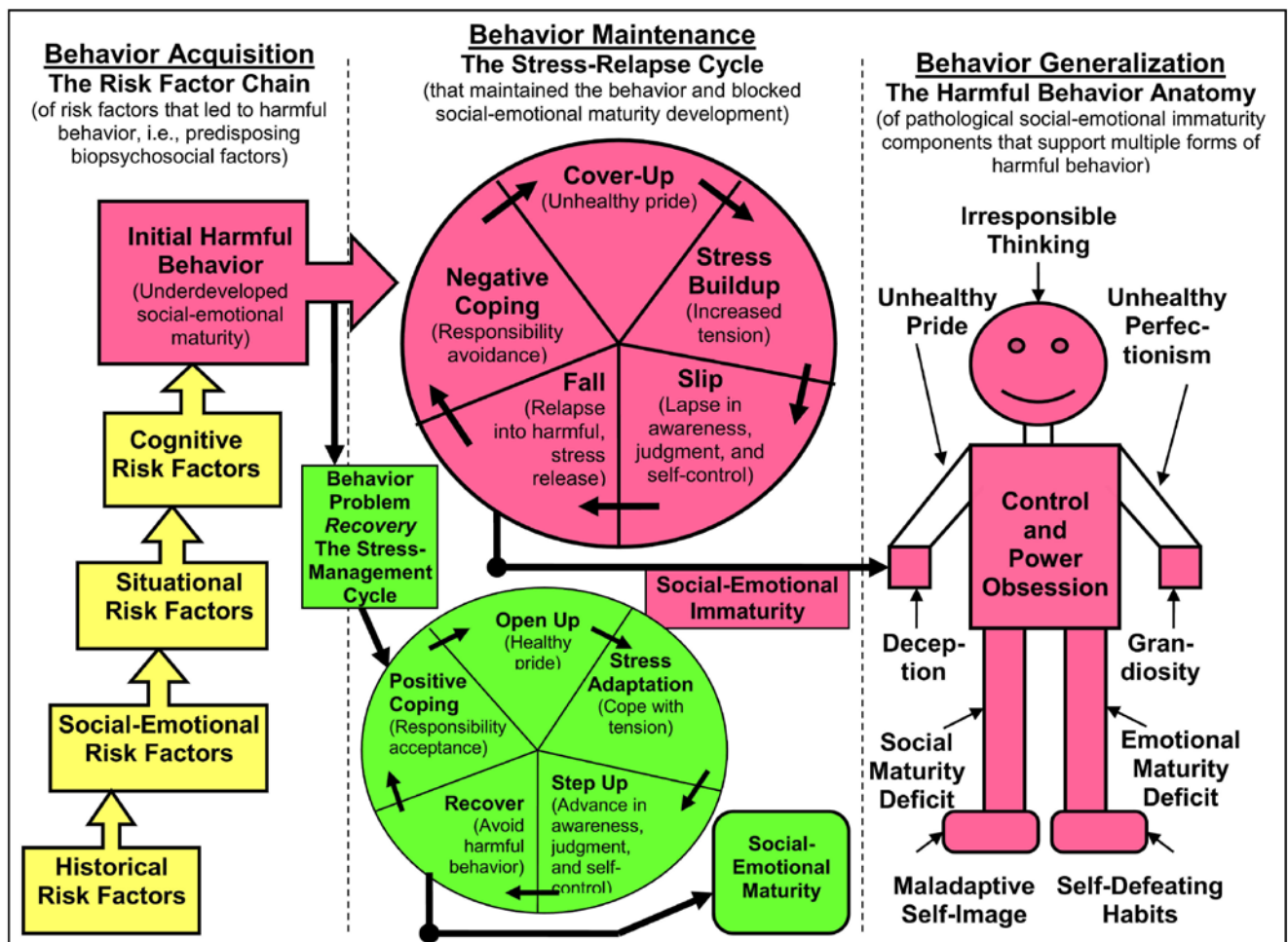
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Understanding Unhealthy, Harmful Behavior

“The power of man has grown in every sphere except over himself”
– Sir Winston Churchill (1874- 1965)

Another important component in SRT is case conceptualization. In SRT “The Problem Development Triad” (Figure 2) provides a client-focused case conceptualization (Sperry, 2005) to help clients understand how unhealthy, harmful behavior was acquired, maintained, and generalized to other problem areas. A client-focused case conceptualization elicits the client’s conceptualization of their condition and negotiates a common conceptualization with the clinician. This creates a therapeutic alliance with the client towards understanding etiology and development of their unhealthy, harmful behavior. During this treatment component, workbooks that are structured to help clients discover how their unhealthy harmful behavior was acquired, maintained and generalized to other problem areas are processed with their therapist. When completed the client makes a presentation on their Problem Development Triad (See Figure 2) to

Figure 2.
The Problem Development Triad: 1
How Harmful Behavior Was Acquired, Maintained, and Generalized



Source: Reprinted with permission from Yokley (2008).

1. Also referred to as “The Abuse Development Triad” in cases with sexually or physically abusive behavior.

internalize their understanding (i.e., “If you want someone to really understand something, have them teach it to others”). The Problem Development Triad presentation is made in the presence of group members and staff. Involved parties (e.g., probation/parole officers, human services case workers) and supportive significant others (e.g., relatives, parents, and partners) are invited. During this treatment component, the primary contributing factors to harmful, abusive behavior are learned in a relapse prevention effort to inhibit further abuse behavior episodes. This includes learning cognitive contributors to abuse formulated by Albert Bandura, Samuel Yochelson, and Stanton Samenow.

The broad focus on understanding unhealthy, harmful behavior in the Problem Development Triad expands the knowledge of factors that are important to be aware of or “keep up front” for ongoing relapse prevention. Most sexual abuse treatment programs use understanding the cycle that maintains sexual abuse as the primary focus and framework for their relapse prevention techniques. SRT expands this learning focus by helping youth understand how their unhealthy, harmful behavior was acquired, maintained, and generalized. The Problem Development Triad (Yokley, 1996, 2006, 2008) involves the risk factor chain that set the occasion for harmful behavior, the stress-relapse cycle that maintained it and the harmful behavior anatomy that supported multiple forms of unhealthy, harmful behavior enabling it to generalize to other areas (see Figure 2). A brief summary of research support for the risk factors in the Problem Development Triad is provided in Yokley (2002).

The Risk Factor Chain

“Those who cannot remember the past are condemned to repeat it” -- George Santayana

The Risk Factor Chain that led to unhealthy, harmful behavior is a conceptual model for understanding how that behavior was acquired. This research-informed model helps those with abuse behavior problems understand some of the primary contributing factors that led up to their unhealthy, harmful behavior (see Figure 2). According to this model, Historical Risk Factors interact with Social-Emotional Risk Factors, Situational Risk Factors and Cognitive Risk Factors to set the occasion for unhealthy, harmful behavior. Understanding the risk factor links in the chain that led up to the harmful, abusive behavior helps identify important personal issues that need to be dealt with to improve social-emotional maturity and avoid relapse. An [SRT workbook on "How did I get this problem?"](#) is structured to help clients discover how unhealthy, harmful behavior was acquired through the Risk Factor Chain (Yokley, 2010b).

The case of Mark was used to illustrate how sexually abusive behavior can be acquired through The Risk Factor Chain, maintained by The Stress-Relapse Cycle and generalized to other forms of unhealthy, harmful behavior in The Harmful Behavior Anatomy. Mark was a 15-year-old overweight Euro-American male referred for treatment of sexually abusive behavior and four other types of harmful behavior requiring treatment. Specifically, his harmful behavior included *sexual abuse* of 11 children involving both anal and vaginal penetration. Mark's *physical abuse* usually involved bullying younger children and making them cry. His *property abuse* involves both stealing from mother's purse and vandalism to get back at those who angered him. Mark exhibited a *food abuse/overeating* problem as well as *trust abuse* in the form of chronic lying and covering up harmful, abusive behavior.

Link 1: Historical Risk Factors.

Historical Risk Factors in the first link of the chain involve any predisposing physical, social, or emotional trauma, uncontrollable aversive biopsychosocial disadvantage or event that induces an aversive emotional state and inhibits social-emotional growth. Historical risk factors are numerous and some examples include a history of sexual abuse, physical abuse, child neglect, dysfunctional family, toxic parenting, removal from home, biological/learning problems, traumatic loss or injury; and impoverished or dangerous living environment. A brief case example illustrating some of Mark's Historical Risk Factors is provided in Exhibit 1.

Link 2: Social-Emotional Risk Factors

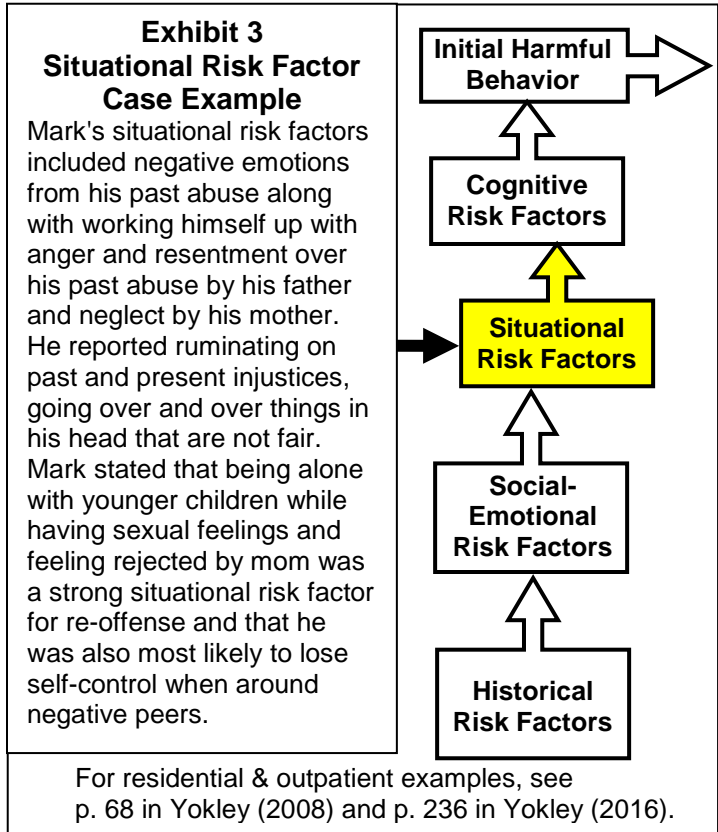
Social-emotional risk factors in the second link of the chain involve problems with the development of *social maturity* (i.e., multicultural prosocial values such as honesty, trust, loyalty, concern, and responsibility) and *emotional maturity* (i.e., self-awareness, self-efficacy and self-control). Social-emotional development problems leave the affected individual without adequate coping abilities to manage the unwanted feelings (e.g., angry, anxious, helpless, inadequate, ineffective) associated with their historical risk factors. Social-emotional maturity problems which include a lack of self-awareness of relapse triggers, a lack of prosocial values to compete with deviant fantasy interact with these unwanted feelings to increase vulnerability to Situational Risk Factors. A brief case example illustrating some of Mark's Social-Emotional Risk Factors is provided in Exhibit 2.

<p>Exhibit 1 Historical Risk Factor Case Example</p> <p>Mark reported a history of ongoing severe sexual abuse including anal rape and physical abuse by his alcoholic father over an eight-year period. This abuse included death threats to prevent him from telling anyone. His mother was rejecting, selfish, emotionally detached and would tell him she was busy whenever he had a problem needed to talk. At one point, Mark was removed from home for child neglect as mother was not cooking or cleaning the house.</p>	
<p>For residential & outpatient examples, see p. 63 in Yokley (2008) and p. 232 in Yokley</p>	

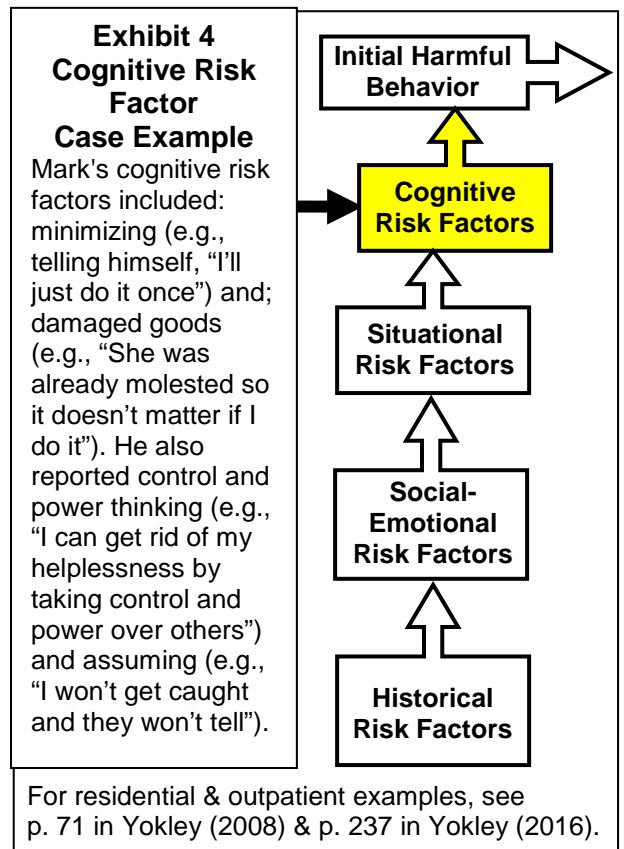
<p>Exhibit 2 Social-Emotional Risk Factor Case Example</p> <p>Mark was often dishonest and irresponsible. His past abuse left him with a lack of trust for authorities. He reported feeling helpless, powerless, disgusted, lonely and not understood. His feelings of self-disappointment, inadequacy, worthlessness and lack of confidence in school, sports or social activities prevented him from trying to apply himself or extend himself to others. He was too embarrassed to bring peers over to his filthy house and felt like he didn't fit in with anyone.</p>	
<p>For residential & outpatient examples, see p. 65 in Yokley (2008) and p. 234 in Yokley (2016).</p>	

Link 3: Situational Risk Factors

Situational Risk Factors include any situation that increases the risk of unhealthy, harmful behavior. Access to various types of harmful behavior is considered the most important situational risk factor in initial treatment. Situational risk factors are often referred to as "high risk situations" and include people (e.g., exposure to potential victims or negative social influence), places (e.g., where abuse has been committed in the past) or things (e.g., unwanted emotions, ruminating) that trigger unhealthy, harmful behavior or increase the risk of unhealthy, harmful behavior by disinhibiting self-control. A brief case example illustrating some of Mark's Situational Risk Factors is provided in Exhibit 3.



Link 4: Cognitive Risk Factors. Cognitive Risk Factors include predisposing irresponsible thinking that increases the risk of unhealthy, harmful behavior including: thoughts that avoid social responsibility or concern for others; attitudes that justify or rationalize unhealthy, harmful behavior; and perceptions that minimize or normalize it. SRT utilizes a 20 item Irresponsible Thinking summary (Yokley, 2008) that integrates cognitive risk factors from three respected sources. Basic thinking errors from *The Criminal Personality* (Yochelson & Samenow, 1976) are combined with cognitive components from the social learning theory of aggression (Bandura, 1973) along with a set of cognitive distortions designed to help the substantial offender population with comorbid depression (Burns, 1980) and anxiety. A brief case example illustrating some of Mark's Cognitive Risk Factors is provided in Exhibit 4.



Link 5: Initial Harmful Behavior

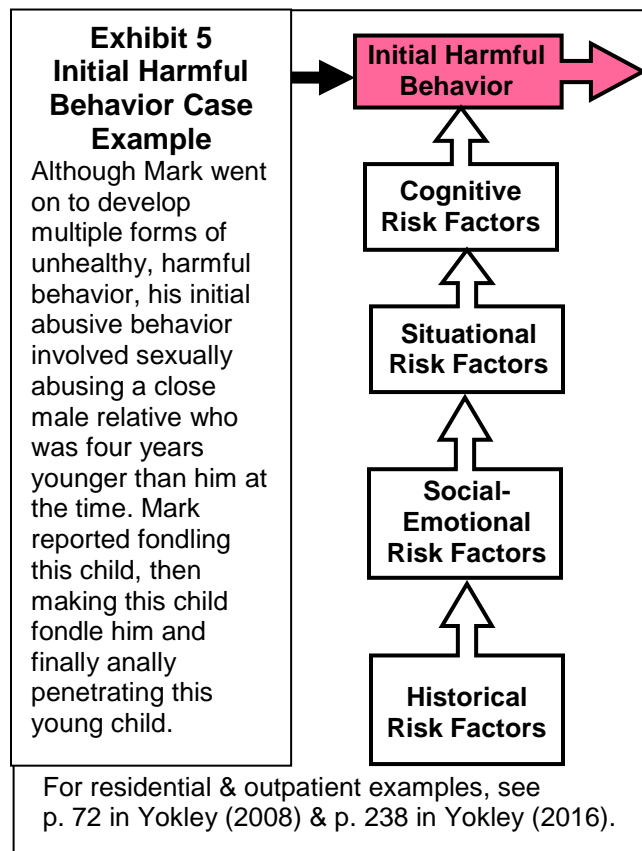
In the final link of the risk factor chain, Historical, Social-Emotional, Situational and Cognitive risk factors interact to result in unhealthy, harmful behavior. While, the unhealthy, harmful behavior can temporarily relieve stress buildup or artificially increase self-efficacy (i.e., decrease helplessness by taking control over others), eventually it results in treatment referral, hospitalization, or incarceration. A brief case example illustrating Mark's Initial Harmful Behavior is provided in Exhibit 5.

Positive vs. Negative Coping:

The entrance point to social maturity or harmful behavior maintenance

After committing the initial unhealthy, harmful behavior there is a crossroads where one can either use negative or positive coping, cover it up or open up, let stress build up or use stress adaptation methods, slip backward or step up, fall back into or recover from further harmful behavior. Whether positive or negative coping is used after an abuse behavior or episode ultimately determines whether the individual will enter a stress-management cycle and avoid further problems or enter a stress-relapse cycle and repeat unhealthy, harmful behavior (see Figure 2)

The transition from harmful behavior acquisition to maintenance depends on coping. Positive coping (i.e., problem acceptance, honesty, role reversal, and concern) is the more difficult path to take after an initial abuse behavior or episode because problem admission usually brings unwanted consequences. In addition to reclaiming dignity through honesty, trust, loyalty, concern, and responsibility, positive coping develops emotional maturity in the form of the humility, healthy pride, and emotional control needed to hold one's self accountable. Developing social-emotional maturity through positive coping allows better attachments to others as well as decreased life stress, which sets the stage for resilience and slip/lapse avoidance in a positive stress adaptation cycle (see Figure 21.3). Negative coping through responsibility avoidance enables entering the stress-relapse cycle, which develops social-emotional immaturity, inhibits learning from experience, and sets the stage for other forms of unhealthy, harmful behavior. The stress-relapse cycle in SRT involves the following steps: negative coping, cover-up, stress buildup, slip (lapse), and fall (relapse).

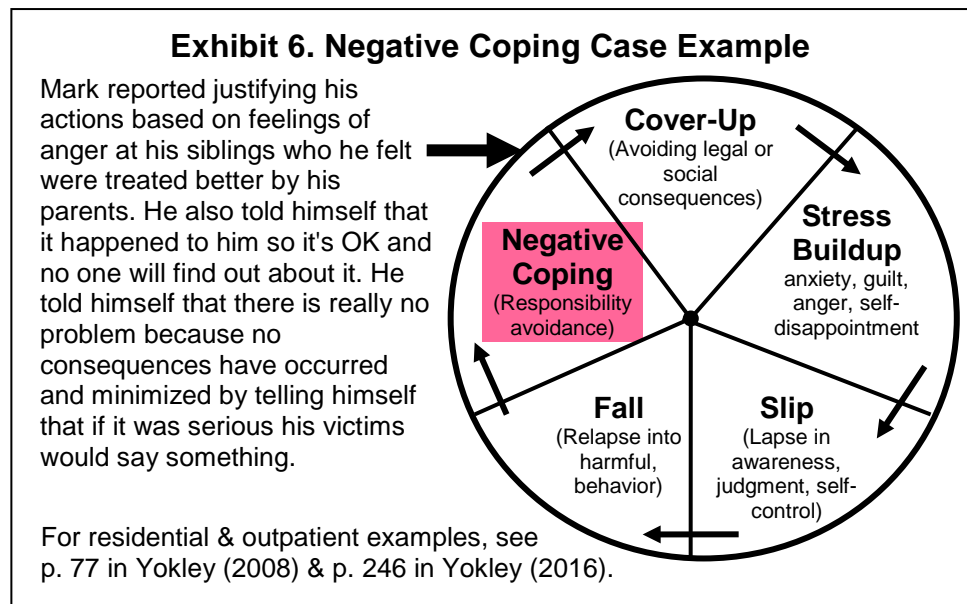


The Stress-Relapse Cycle

The stress-relapse cycle is a conceptual model to help abusive youth, their caretakers, and significant others understand how the abuse behavior was maintained. This model helps those with unhealthy, harmful behavior problems understand the components of the cycle that maintained their behavior. Understanding this cycle is considered extremely important in relapse prevention planning as all involved parties need to learn methods to interrupt key components in the cycle of abuse. An [SRT workbook on "Why do I keep doing this?"](#) is structured to help clients discover how unhealthy, harmful behavior problems were maintained by the Stress-Relapse Cycle (Yokley, 2011a).

Phase 1: Negative Coping. Negative coping can be used after a single abuse episode or a period of abuse. Negative coping involves socially and emotionally immature thoughts and behaviors after abusing that avoid getting honest with self about having a problem, the impact on others and accepting responsibility. There are many types of negative coping that enable offenders to avoid responsibility including justifying actions based on feelings (e.g., "They deserved it after what they said/did to me"), the victim view/blaming (e.g., "It wasn't my fault") and minimizing/normalizing (e.g., "I only did it once,"

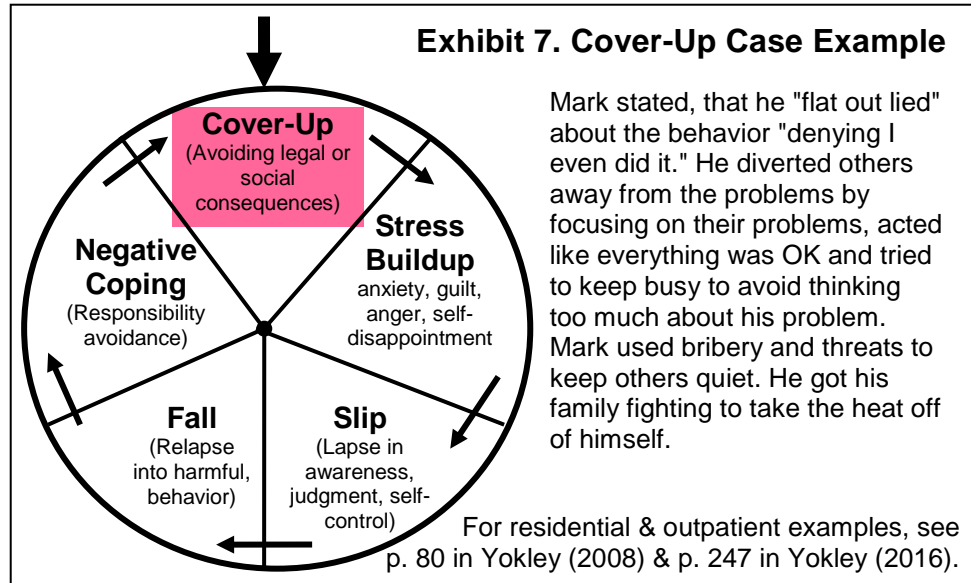
"Others have done worse"). Avoiding accepting responsibility, fault, or blame, through negative coping justifies Cover-up behavior to avoid consequences which are viewed as unjust. A brief case example illustrating some of Mark's Negative Coping is provided in Exhibit 6.



Phase 2: Cover-up. In addition to avoidance of legal consequences, cover-up behavior is also triggered by avoidance of social consequences. Cover-up tactics involve trust abuse by misleading others. Of the many cover-up tactics, three common types are denial, diversion, and division. Denial cover-up tactics involve actively misleading others by lying, acting as if nothing happened, and avoiding discussion of responsibility for problem behaviors. Active obstructions associated with denial include attempting to block others from telling the truth about negative behavior by using bribery, threats, or blackmail to cover up the problem. Diversion tactics also involve avoidance of confrontation through word games to mislead others such as omitting key pieces of information, reframing the situation, reordering the facts or rephrasing statements to put a positive or less negative light on the situation while "acting as if" nothing happened and returning to the everyday routine. Cover-up by division involves "divide and conquer" damage

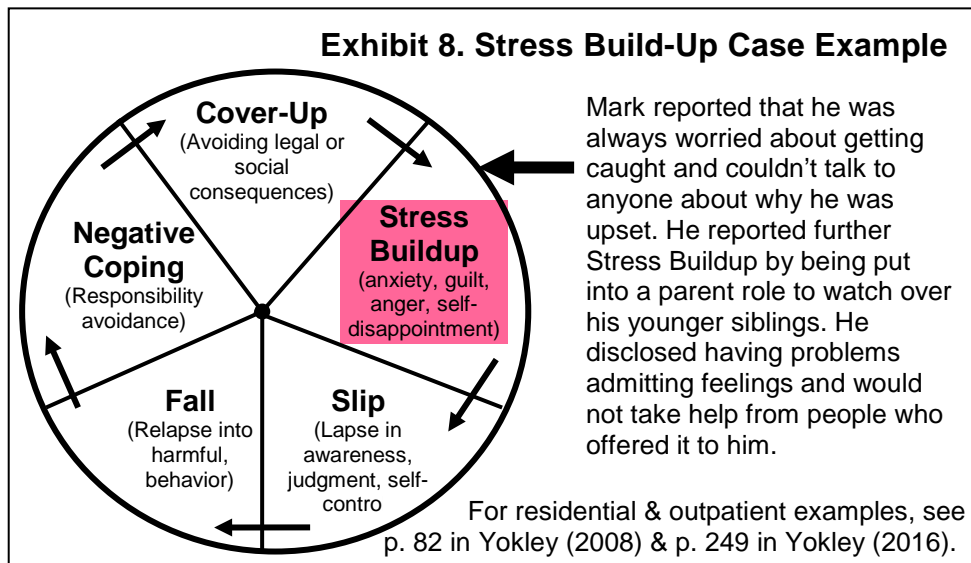
control strategies damage control strategies aimed at dividing the opposition and creating a communication breakdown in order to prevent exposure of the harmful behavior. Energy devoted to cover-up tactics exacerbates inner conflict over reality (i.e., the truth) and public

image (i.e., the cover-up) which causes Stress Buildup. A brief case example illustrating some of Mark's Cover-up tactics are provided in Exhibit 7.



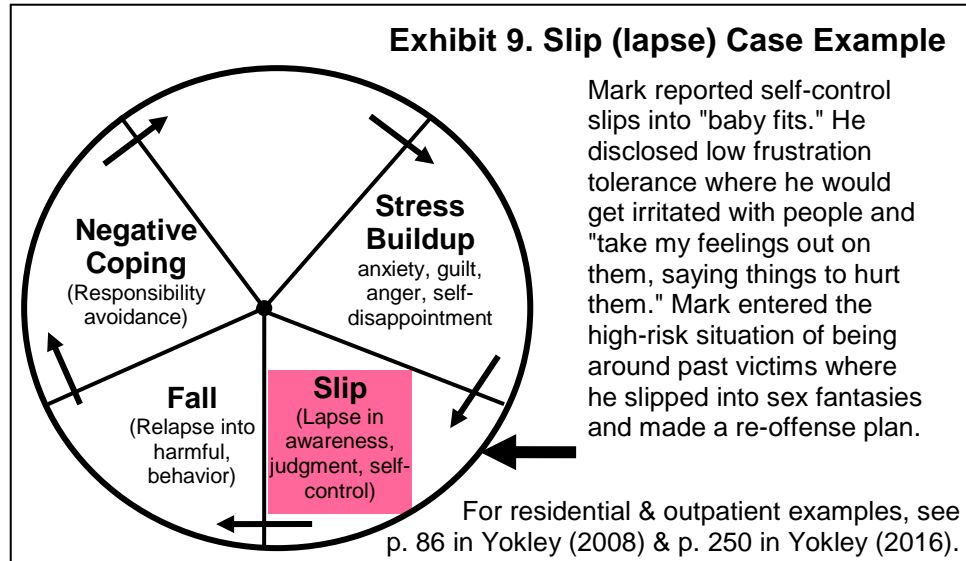
Phase 3: Stress Buildup. In Stress Buildup, anxiety about cover-up tactics not working, being caught and receiving consequences combines with self-disappointment over getting in trouble in the first place and sometimes guilt about caving in to problem behavior urges. Since stress is cumulative, "if you are not working on the solution, you are part of the problem." While there are many factors that contribute to Stress Buildup, refusal to accept responsibility, lack of effort, and not dealing with feelings are three important contributing factors. Stress is cumulative; it builds up until the threshold of acting out is reached and a slip/lapse occurs.

A brief case example illustrating some of the Stress Buildup Mark experienced is provided in Exhibit 8.



Phase 4: Slip (or lapse). A slip or lapse is a "gateway to relapse" (i.e., a relapse antecedent). A slip involves self-defeating thoughts or behaviors which set the stage for relapse by giving up self-control. This includes letting concern for self and recovery slide by not keeping the abuse problem "up front" as a priority and letting motivation for ongoing relapse prevention planning

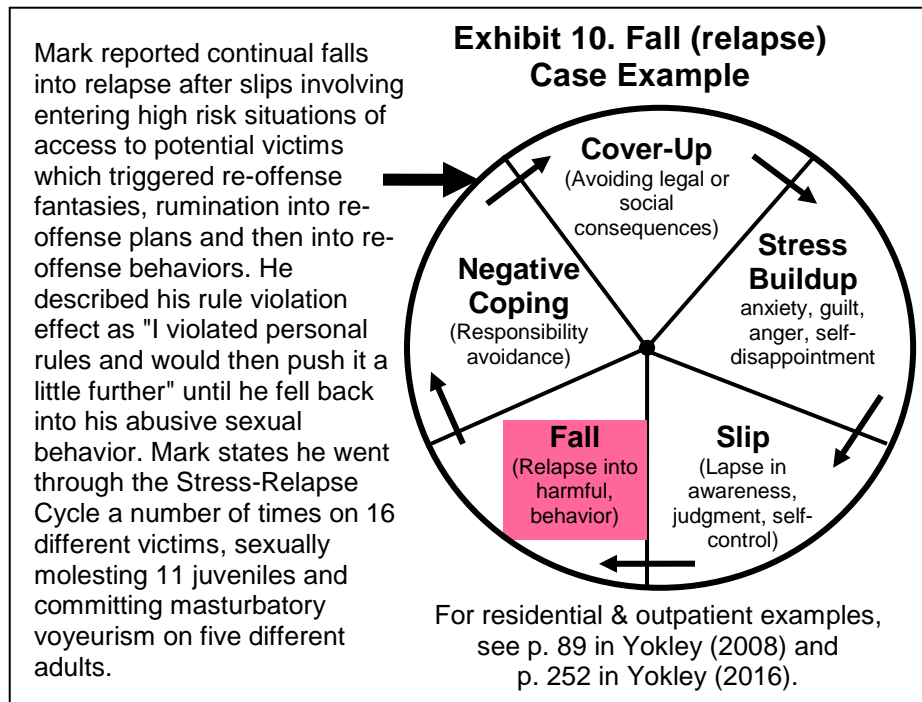
slip, dropping guard, getting careless, and allowing self to slide back into defeating habits, which set the occasion for relapse. While there are many types of slips, three common types involve problems with self-awareness and self-control, both of which to some degree can



involve slips in judgment. Entering a high-risk situation for relapse can be due to lack of self-awareness, lack of self-control, poor judgment or the interaction of all three. Exhibit 9 provides a brief case example illustrating the Slip phase of the Stress-Relapse Cycle for Mark.

Phase 5: Fall (or relapse). The fall or relapse phase of the cycle, involves violating responsibility to care for self and others by letting go of appropriate social behavior control, indulging self and falling back into unhealthy, harmful behavior. Falling back into abuse behavior involves acting out feelings and relieving stress in a manner that is harmful to self and/or others. Three common contributors to a fall or relapse include: seeking a reinforcing, pleasurable state attached to the harmful behavior (i.e., sensation seeking without considering the consequences); seeking expected relief or temporary alleviation of negative affect including escape/distraction

from current problems or aversive self-awareness (i.e., a maladaptive release of stress buildup) and; the rule (or abstinence) violation effect (i.e., a set of negative self-statements that enable a slip to continue into a fall). When a fall relates to the rule violation effect, "all or nothing," thinking about recovery justifies giving up on self-control after making a single mistake (slip) during a



period of self-control success. Exhibit 10 provides a brief case example illustrating the Fall phase of the Stress-Relapse Cycle for Mark.

The Harmful Behavior Anatomy

In SRT, a pathological level of social-emotional immaturity is considered to be a primary contributing factor to multiple forms of unhealthy, harmful behavior that allows the generalization of one type of abuse to others. While many models of behavior understanding seek to determine the contributions of independent contributing factors, the anatomy model seeks to establish how key components interact to sustain one another and support unhealthy, harmful behavior. The Harmful Behavior Anatomy is conceptually similar to the way key organs of the human body interact to support human life. An [SRT workbook on "How did my problem spread?"](#) is structured to help clients discover how unhealthy, harmful behavior problems were generalized to (or substituted with) other problems through the Harmful Behavior Anatomy (Yokley, 2012). There are clearly many characteristics associated with social-emotional maturity problems and multiple forms of unhealthy, harmful behavior. However, for treatment purposes the following ten components were selected to encompass the anatomy of harmful behavior.

In SRT, Irresponsible Thinking (Anatomy Component 1) can be viewed by clients as the head of the harmful behavior anatomy that controls the type, frequency, and severity of harmful behavior that has been learned and gets expressed. Unhealthy, harmful behavior involves problems with self-control and the control of others. Because many youth and adult survivors of abuse exhibit a tendency to compensate for past feelings of helpless with maladaptive control responses, the body or torso of this model involves a Control and Power Obsession (Anatomy Component 2). Unhealthy Pride (Anatomy Component 3) and Deception (Anatomy Component 4) can be considered the right arm and fist of unhealthy, harmful behavior because they maintain the veil of secrecy that makes abuse possible. Unhealthy pride blocks one's ability to admit mistakes, accept responsibility, make amends, apologize, or settle differences. Deception is the logical extension of unhealthy pride and serves to protect that pride. A social maturity deficit (Anatomy Component 5) involving problems with honesty, trust, loyalty, concern, and responsibility provides a strong support leg for multiple forms of harmful behavior as these characteristics set the occasion for developing a negative lifestyle, harmful behavior and resistance to treatment.

A maladaptive self-image (Anatomy Component 6) provides firm footing for multiple forms of unhealthy, harmful behavior. A maladaptive irresponsibility-based self-image is defined by antisocial values, unhealthy pride and pathological social-emotional immaturity with a goal of looking out for self without consideration of others through avoidance of responsibility and taking without giving. This often results in a lack of work ethic along with negative peer loyalty. Unhealthy Perfectionism (Anatomy Component 7) can act as another strong arm in the commission of multiple forms of unhealthy, harmful behavior. Unhealthy self-oriented perfectionism can set the person up to quit treatment, give up on self, and relapse while unhealthy other-oriented perfectionism can set the stage for building oneself up by putting others down and unhealthy socially prescribed perfectionism can support the need to "excel at any cost," including violating the rights of others to get power and then "conceal at any cost" to protect the perfect public image.

Grandiosity (Anatomy Component 8) lends another hand in the commission of harmful behavior. Risk of relapse is increased by a grandiose sense of superiority and overconfidence in ability to

avoid consequences or talk self out of trouble. Grandiose super-optimistic memory makes euphoric recall a much higher probability than dysphoric recall which also increases relapse risk. Grandiose uniqueness discounts identification with others and inhibits ability to benefit from group therapy. An Emotional Maturity Deficit (Anatomy Component 9) in self-awareness, self-efficacy and self-control provides another strong support leg for multiple forms of unhealthy, harmful behavior because in order to manage unhealthy, harmful behavior, it is necessary to have: 1) enough self-awareness to identify thoughts, feelings and situations that can trigger the behavior; 2) enough self-efficacy (confidence) to try solutions to manage the behavior and; 3) enough self-control to delay gratification long enough to implement behavior management skills. Self-Defeating Habits (Anatomy Component 10) also provides firm footing for multiple forms of unhealthy, harmful behavior. Since the number of self-defeating habits in the behavioral repertoire of human beings is almost limitless, the present treatment approach must focus on the basic self-defeating deficits in prosocial values/behaviors characteristics (i.e., ruminating, procrastinating, and giving up) and exaggerated needs (i.e., acceptance, excitement, and attention) that can support unhealthy, harmful behavior. A brief summary of Mark's problems in the ten anatomy components that support multiple forms of unhealthy, harmful behavior is provided in Exhibit 11.

The Harmful Behavior Time Line. The harmful behavior time line is used to develop self-awareness of the relationship between significant life events and behavior by plotting the harmful, abusive behavior that the client experienced on the top portion of the time line and the harmful, abusive behavior that the client has done to self or others on the bottom. A brief case example illustrating Mark's Harmful Behavior Time Line is provided in Exhibit 12.

The Problem Development Triad Presentation. In the problem development triad presentation youth explain their harmful, abusive behavior to their treatment group and significant others. This presentation results in clients having to rethink and conceptualize their problem behavior history in terms that others can easily understand. Formulating interpretations with their therapists helps them internalize the self-awareness discoveries made during their structured triad exercises and discussions.

Beginning a Socially Responsible Lifestyle

Developing a number of basic prosocial skills such as assertiveness, empathy, and age-appropriate social interaction ability is considered important in beginning a mature, socially responsible, positive lifestyle for youth with sexually abusive behavior. One key prosocial skill that abusive youth need to develop to help both themselves and others is the ability to demonstrate honesty, trust, loyalty, concern, and responsibility through emotional restitution to both direct and indirect victims of their abuse. Making emotional restitution in a safe, supervised, structured setting is considered a social responsibility, which is accomplished during emotional restitution training using the graduated exposure procedure pioneered by Joseph Wolpe (Yokley, 1990).

“Doing the right thing is a lot harder than knowing the right thing”. This third important component of SRT includes specific training to help youth demonstrate social responsibility through emotional restitution to abuse victims and their families in a manner that is therapeutically beneficial to all involved (Yokley, 1990; Yokley & McGuire, 1991). This treatment component is called Emotional Restitution Training and involves demonstrating social

Exhibit 11. The Harmful Behavior Anatomy

(of the pathological social-emotional immaturity components that support multiple forms of unhealthy, harmful behavior)

List all forms of abuse problems here-
Sexual abuse of 11 children
Physical abuse, bullying younger kids
Property abuse, vandalism & theft
Food abuse, overeating, stealing food
Trust abuse, serious, ongoing lying

Justifying actions, "Mom pissed me off". Victim view, "It wasn't my fault, my dad did it to me so I didn't know any better, but I did". Told others "I can't", told self "I won't". Assuming, "I can get away with it" & "They are messing with me on purpose".

Told myself that I must be perfect or not try. Put things off that I needed to do. Compared myself to others and felt that I am not good enough to fit in. Would quit if I made one mistake or give up if I couldn't do things perfect. Impatient with others who didn't do things just right or the way I wanted it.

I have found it hard to admit my mistakes to other people. I have had to have the last word. I have not admitted my feelings to others. I got attitude after mom would ignore me, gave up & refused to ask anyone for help.

1. Irresponsible Thinking

3. Unhealthy Pride

7. Unhealthy Perfectionism

Used assenting & appeasing. Thought that being honest had done nothing but get me in trouble. Had the attitude that anyone who lied has no right to tell me not to lie. Been dishonest by omission

Resented people who get in my business or tell me what to do to help me. Been selfish. Had low frustration tolerance and would get impatient easily. "I felt that everybody owed me something"

4. Deception

8. Grandiosity

Problems with lying, changed the subject accusing those who don't trust me of not caring. Negative loyalty depending on undependable people. Not caring about self or others, minimizing problems & responsibility avoidance

Wasn't aware of feelings or motivations to get even. Had confidence problems & self-control problems needed to vent my feelings, couldn't hold on to them & relapsed.

5. Social Maturity Deficit

9. Emotional Maturity Deficit

6. Maladaptive Self-image

I was afraid of not being the person that others wanted me to be. I didn't feel like I was worth much, tried to keep nice guy image & I act the way that I thought others wanted me to.

10. Self-defeating Habits

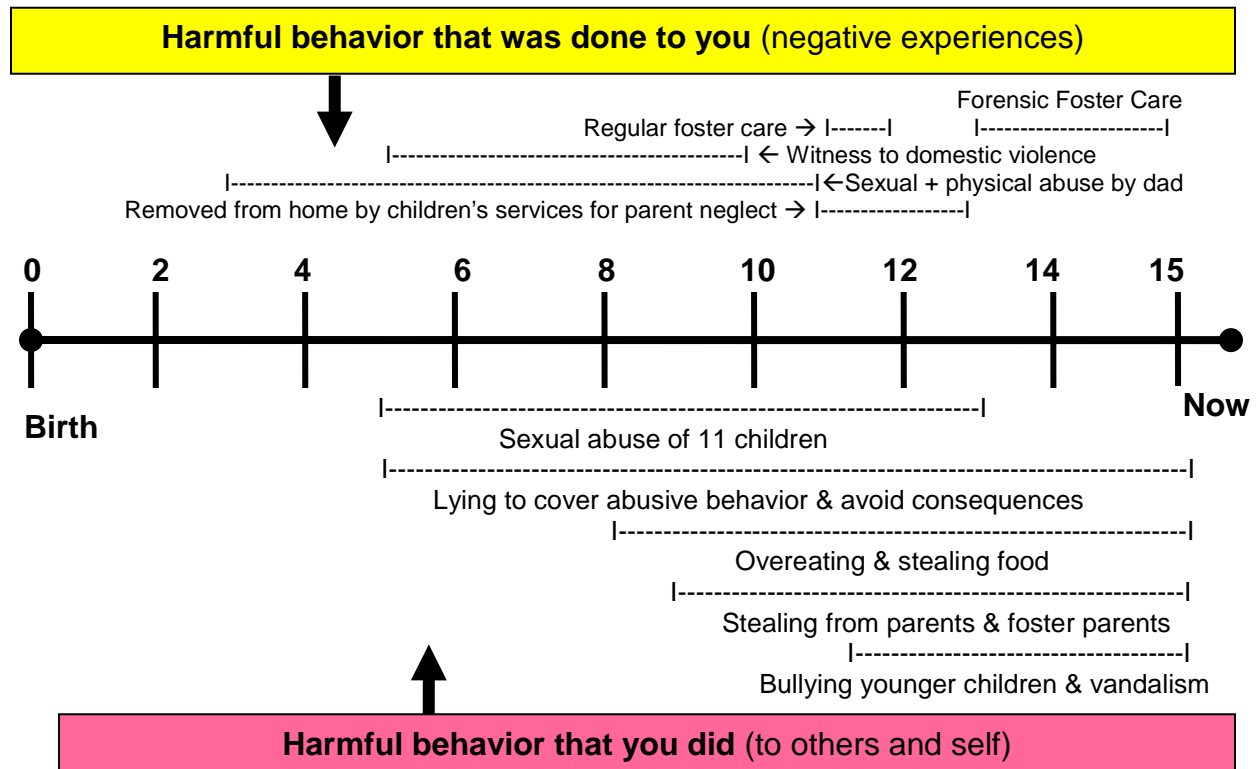
Had planning problems; Had a sick need for acceptance & attention. I would do things for acceptance or attention that I knew were wrong like cursing teachers to fit in. Made irresponsible decisions, not thinking about consequences to self or others Told myself "I can't" so why try?

2. CAPO

Rule breaking (for thrills, to see if could get away with it or to get over on authorities). Manipulating to get my way. Had problem hearing the word no & would get in power struggles, "They can't stop me from getting what I want, I'll sneak around them"

**Control
And
Power
Obsession**

Exhibit 12. Harmful Behavior Time Line- Mark



Case Example Summary. Self-awareness connections made by Mark during his abuse development triad work include, awareness of his repetition compulsion involving being sexual and physically abused over time and becoming sexually abusive and power abusive to others along with developing a trust abuse habit to cover up his other forms of abuse. He later displaced his anger and resentment over being abused, rejected and neglected into overeating, bullying younger children and stealing from adults. Another important point that he realized from his timeline was a two-year delay where stress built up while he was being abused before he started to take it out on others.

responsibility through emotional restitution. Since this treatment component involves youth in abuse behavior treatment interacting with survivors of abuse, it is strictly supervised and only begins after a track record of positive change. This includes developing adequate social-emotional maturity as a competing response to unhealthy, harmful behavior as well as learning how their unhealthy, harmful behavior was acquired, maintained, and generalized.

Emotional restitution training is implemented to provide emotional restitution for victims and their significant others by youth during the course of SRT. During Phase 1 of SRT, it is a youth social responsibility to disclose all sexual abuse victims so that they may be provided with treatment. It is also the social responsibility of the abusive youth to provide any abuse details requested by the victims' therapists as an aid to their treatment. During Phase 2, youth assume the social responsibility of developing an understanding of their abuse and disclosing how they developed their problem to significant others. During Phase 3 of SRT, youth complete Emotional Restitution Training during which they clarify why they were abusive along with other critical information relevant to victim recovery and provide a sincere apology/clarification to both the

direct and indirect victims of their abuse when requested by the abuse survivor and their therapist.

The basic treatment goals of the emotional restitution training are the development of victim impact understanding, victim empathy, and the demonstration of social responsibility by making emotional restitution to both direct and indirect victims of abuse (Yokley, 1990; Yokley & McGuire, 1990, 1991). Chapter 56 in Yokley (2011) describes emotional restitution training in detail.

Forensic Foster Parent Recruiting and Selection, Training, and Retention

Recruiting and Selection

Problems occur whether recruiting forensic foster parents from an existing population of regular or therapeutic foster parents or whether recruiting from the community. Recruiting from populations of existing regular and therapeutic foster parents whose training focus has typically been on elementary-school age victims requires reeducation and offender-specific training if they are to manage teenage abusive youth. Past foster parent training focused on child victims can result in treating offenders like victims by trusting without verification, concern without confrontation, and offender enabling, all of which can present community safety hazards. On the other hand, recruiting from the community at large presents an information overload problem related to having to teach new candidates to become effective foster parents while simultaneously training them to deal with serious abuse behaviors.

Thus, recruiting foster parents to take youth who have committed sexually abusive behavior into their homes is predictably difficult. However, some forensic foster family selection characteristics can be offered. With respect to providing an appropriate level of community supervision for abusive youth, four eyes are better than two. With abusive youth, quantity time is more important than quality time. With these youth the most important thing for foster parents to do is be there and be consistent. The importance of supervision by as many adults and extended family members as possible cannot be over emphasized for this population with respect to the issue of community safety and security.

Assertiveness, decisiveness, and enthusiasm are valuable commodities when trading verbal exchanges with resistant abusive youth. Forensic foster parents must be able to make difficult decisions without delay, be firm in their convictions, and enthusiastic about behavior maintenance or progress. If forensic treatment staff want abusive youth to learn prosocial values and not compromise them, they need to select foster parents who stick by what they believe to be right even if the treatment staff do not agree with all of the foster parent's values or methods. Abusive youth can be expected to take the victim stance with their human services guardians if they receive firm, consistent discipline. Being able to tolerate criticism helps because in Forensic Foster Care there is no such thing as a perfectly managed case and complaints about parenting decisions are common. The personality profile (i.e., from the 16 Personality Factor Questionnaire) of successful therapeutic foster mothers suggests that self-discipline, maturity, ability to face reality, and enthusiasm, combined with ability to make decisions based on logic, were related to better foster parent functioning (Ray & Horner, 1990).

Tenacity and endurance are important forensic foster parent characteristics. By embroiling the family in conflict, seriously delinquent behavior itself wears down the socialization forces (e.g., supervision and setting limits) that could direct youth into more prosocial patterns of adjustment (Chamberlain & Reid, 1998). Thus, abusive youth need forensic foster parents who model tenacity and endurance while teaching youth to “never give up” and “always finish what you start.”

Emotional stability and being well balanced are cornerstones in parenting abusive youth. Both foster parents and staff have to provide mature objection to immature behavior. Part of developing social maturity and appropriate social behavior control is learning to function with rules that set limits on externalizing behavior. This is where father figures with strong leadership traits such as bearing, courage, and dependability can help with authority problems. In this respect, the personality profile of successful therapeutic foster fathers suggests that they are likely to be somewhat more conservative than the norm (Ray & Horner, 1990).

Training

Foster parent training varies by state, but thirty hours of certification training and twenty-four hours of annual continuing education are currently recommended (Foster Family-Based Treatment Association, 1995). In addition to some therapeutic foster parent training in the area of the impact of abuse on victims, offender-specific training is provided. Forensic foster parent training is much more extensive than regular or therapeutic foster parent training and offers actual “on the job” experience where Forensic Foster Care parents are an integral part of the treatment team and are actively involved in ongoing interventions.

In forensic foster parent training, investigative questioning and a focus on teaching concern for others are added to the traditional therapeutic foster parenting emphasis on reflective listening and concern/support for the youth. Conditional behavior-based acceptance through “confrontation with concern” and “trust but verify” are substituted for the unconditional positive regard and trust typically promoted in regular or therapeutic foster parent training. Forensic foster parent training uses the “kite analogy of confrontation with concern.” In this analogy, if one provides appropriate, positive resistance and pulls against the kite (i.e., provides consistent confrontation with concern), the kite rises to its maximum potential. If one stands still and does not pull against it but also does not give in (i.e., fails to provide any more structure than was received in the past), the kite maintains its present level. If one gives in, goes in the direction the kite is pulling, or runs after the kite (i.e., “goes along to get along” with the youth), the kite crashes. Finally, if one yanks too hard (i.e., provides too much confrontation and not enough concern) the string breaks and the kite is lost (i.e., the youth shuts down and/or runs away)

Behavior management training in Forensic Foster Care includes how to implement and monitor therapeutic community learning experiences assigned by staff in a shared parenting discipline arrangement which reduces offender-foster parent conflict. This ongoing, proactive, experiential approach relieves stress buildup, eliminates the need for seclusion/restraint, and has a demonstrated positive impact on developing appropriate social behavior control in youth sex offenders (Yokley, 2011, Chapter 49). The emphasis on multicultural prosocial values as competing responses to unhealthy, harmful behavior are consistent with the values and parenting style of most foster parents, are easily accepted, and are easily integrated into ongoing behavior

management. What to expect regarding the behavior norms of youth sex offenders in Forensic Foster Care (Yokley & Boettner, 1999) is included in the training. Table 3 provides examples of offender-specific training topics in Forensic Foster Care.

Table 3
Examples of Training Topics in Forensic Foster Care

<p>Basic Training for All Staff</p> <ol style="list-style-type: none">1. Introduction to Social Responsibility Therapy in Forensic Foster Care2. Multicultural Values Parenting in Social Responsibility Therapy3. Supervising Youth with a History of Harmful Behavior: SRT Home and Community Safeguards4. Helping Problem Youth Break Their Cycle of Abuse: Understanding the SRT Stress-Relapse Cycle <p>Further Training for Program Implementation and Direct Care Staff</p> <ol style="list-style-type: none">5. Social Responsibility Therapy program content part 1: Orientation and Phase 36. Social Responsibility Therapy program content part 2: Phases 2 & 37. Social Responsibility Therapy with preteens8. The Art of Social Responsibility Therapy program: Intervention Methods and Procedures9. The Therapeutic Community for unhealthy, harmful behavior: Social Maturity Development for Lifestyle Change10. Understanding and Managing Harmful Behavior Through the Problem Development Triad

Retention

The SRT Forensic Foster Care program includes policies and procedures that are associated with foster parent retention. These empowerment procedures include highly specialized forensic foster parent training and a team approach in which foster parents are integrated into all aspects of youth treatment as well as privy to all communication. A cluster placement model to maximize foster parent support while respecting family diversity and minimizing any adverse impact that could be associated with home moves is an additional empowerment procedure.

Specific, frequent, quality training with relevant content has been identified as a foster parent retention factor (Chamberlain et al., 1992; Denby & Rindfleisch, 1996; Urquhart, 1989). In addition to the mandated sessions for all regular foster parents and on-the-job training during home visits, SRT forensic foster parents receive thirty hours of annual training on topics relating specifically to youth with multiple forms of unhealthy, harmful behavior (see Table 2). Further information on training is available through a contact request at www.srtonline.org.

The therapeutic community approach used in SRT Forensic Foster Care blends paraprofessional and professional staff together in a unified treatment team in which the specialized training and forensic parenting experience of foster parents is respected as a critical aspect of treatment. The research-informed program rules and learning experiences are discussed and accepted by the treatment team (i.e., foster parents, social worker, and psychologist). The intake/placement selection process is inclusive of foster parents. After a screening evaluation by staff, admission candidates have an intake interview during a treatment group where all of the treatment team members (i.e., staff and foster parents) are present and admission requires a majority staff vote as well as acceptance into at least two homes. The treatment team approach effectively addresses the lack of foster parent involvement in types of children placed with them (Denby & Rindfleisch, 1996) as well as service planning (Sanchirico et al., 1998), both of which have been identified as retention factors commonly responsible for foster parent dissatisfaction.

As an integral part of the treatment team, Forensic Foster parents are directly connected into the treatment feedback loop. This is accomplished through centralized and as-needed in-home treatment services, daily communication with on-call staff (pagers, cellular telephones, and e-mail), weekly home visits, and brief meetings before or after individual sessions. In addition, forensic foster parents typically sit in during the first ten to fifteen minutes of treatment group sessions to disclose behavior problems and issues that have occurred. Feedback to forensic foster parents on treatment group content, process, and therapeutic community learning experiences that were implemented is provided. The continuity of the TASC Forensic Foster Care program addresses the foster parent retention factor concerning the quantity and quality of agency-foster parent interaction (Urquhart, 1989).

In Forensic Foster Care, youth are admitted into a foster cluster of several homes which increases support through shared parenting responsibility and facilitates providing respite visits (i.e., a relationship vacation) during trying times. The foster cluster placement approach makes immediate emergency placement from one home to another easy to accomplish if needed and reduces foster parent burnout associated with keeping a stressful youth simply because there is no other placement for him. Having the youth accepted into more than one family maximizes the probability of getting the basic treatment messages through to them in a different family if they did not get it the first time around (i.e., “It takes a village to raise a child.”). The cluster approach enhances foster parent retention by addressing foster parents expressed need for mutual support among themselves (Urquhart, 1989).

Supporting foster parents discipline decisions and their own house rules with a program policy that respects individual family differences is important. Since teenagers compare responsibilities and privileges at school, they are aware of the diverse differences in family rules. Thus, although the overall treatment program rules are the same for everyone, the rules of the foster homes in the cluster are not standardized and “every house has its own rules.” This policy mirrors the real-world environment and teaches the youth to honor diversity by accepting that each setting is different and they must learn to adapt to the rules of each setting they encounter (e.g., home, school, work, and treatment).

Conclusion

Forensic Foster Care provides an important level in the continuum of care for sexually abusive youth. Implementing this service allows a step-down treatment supervision process from residential treatment to Forensic Foster Care and finally to the traditional outpatient setting during a family reunification or independent living placement. This chapter described innovative techniques and procedures used in a model Forensic Foster Care program for sexually abusive youth whose behavior management needs or family circumstances prevented treatment in their natural family setting. Since a functional family setting is considered most conducive to helping youth with a history of abusive behavior to develop prosocial family values, the family-based setting employed in Forensic Foster Care is considered the treatment setting of choice. Forensic Foster Care includes key components associated with foster parent retention, a cluster approach to minimize any adverse impact associated with youth home disruption that might occur, and a team approach in which foster parents are integrated into all aspects of youth treatment decision making.

Social Responsibility Therapy addresses five basic types of unhealthy, harmful behavior (i.e., sexual abuse, physical abuse, property abuse, substance abuse, and trust abuse) that can co-occur in referrals for sexually abusive behavior. This makes it the logical treatment approach for parenting youth with multiple forms of unhealthy, harmful behavior. Internal control, external control and social learning interventions are implemented to increase the therapeutic pressure towards positive behavior change. SRT teaches social-emotional maturity characteristics as competing responses to unhealthy, harmful behavior, making it easily accepted and integrated into ongoing behavior management by parents. In addition, SRT helps the youth and their foster parents understand how the unhealthy, harmful behavior was acquired, what maintained it, and how it generalized into other problem areas. One of the strong points of SRT is its supervision protocol with twelve basic foster home safe-guards and twelve basic community safety/supervision procedures that target the youth in treatment as well as negative peers. Program evaluation and case study data have demonstrated efficacy with treatment components involving the behavior incident report system (Yokley & Boettner, 1999), use of therapeutic community learning experiences for behavior management (Yokley, 2011, Chapter 49), and Emotional Restitution Training (Yokley, 1990; Yokley, 2011 Chapter 56). Initial comparison of SRT in Forensic Foster Care to foster care treatment as usual has produced promising results (Yokley, 2010). A published treatment manual detailing SRT methods procedures and literature support approach is available (Yokley, 2008) and case illustrated treatment applications to several referral populations are provided in a clinician's guide to SRT (Yokley 2016).

In summary, SRT for youth referred for sexual behavior problems in Forensic Foster Care combines the logical treatment of choice with the logical setting of choice for this treatment population. This research-informed multicultural treatment approach provides a necessary step in the continuum of care for youth with sexually abusive behavior who need to develop appropriate social behavior control, social maturity and emotional maturity prior to family reunification or independent living.

Footnotes and References

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