

Social Responsibility Therapy Lessons from Treatment

Source: Yokley J. & Boettner, S. Forensic Foster Care for Young People Who Sexually Abuse: Lessons from Treatment, In Calder, M. (Ed.), *Young people who sexually abuse: Building the evidence base for your practice*, Dorset UK: Russell House Publishing; 2002, Chapter 20 [Updated and adapted for non-profit educational purposes only].

Introduction

The present chapter reviews lessons learned from seven years of Social Responsibility Therapy in a forensic foster care program for youth with a history of sexually abusive behavior and other harmful behaviors in need of treatment. Program development, treatment issues, foster parent selection and foster parent retention are discussed. This mode of treatment provides another level in the continuum of care. Youth with harmful behavior problems can progress through a step-down treatment supervision process, from residential treatment to forensic foster care and finally into the traditional outpatient setting during family reunification or an independent living placement.

What is forensic foster care?

Forensic medicine applies medical knowledge to legal problems. Forensic Foster Care applies treatment knowledge to foster youth whose unhealthy, harmful behavior can or has resulted in legal problems. Forensic Foster Care offers a less restrictive environment than residential treatment for youth with abusive behaviors who are not candidates to complete treatment in the outpatient setting due to problems with placement in their family of origin. Forensic Foster Care offers another level in the continuum of care between residential and outpatient treatment for youth whose harmful behavior management needs require gradual re-entry back into the community under supervised conditions. In addition, 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 harmful, delinquent behavior. For example, incarcerated boys who were randomly assigned to a forensic foster care program designed to address that population (referred to as Multidimensional Treatment Foster Care) had significantly fewer criminal referrals and returned to live with relatives more often than those who received group home care (Chamberlain and Reid, 1998). In contrast to traditional therapeutic foster care where

treatment is typically conducted by mental health professionals during weekly community mental health center visits, forensic foster parents are an integral part of a multidisciplinary treatment team of harmful behavior specialists that implement a therapeutic community treatment approach throughout the week. Forensic foster care utilizes Social Responsibility Therapy in a cluster placement model to teach youth multicultural prosocial values and skills that compete with unhealthy, harmful behavior.

Who are These People? Demographic Characteristics of Foster Youth in General and of those who Sexually Abuse

Demographic characteristics of foster care youth

One third of foster youth in the United States are between the ages of 13 and 18, the remaining two thirds are elementary school age or younger (Benton Foundation, 2000). The most prevalent intervention used in cases of identified child sexual abuse is temporary or permanent placement of children into foster homes (Cooper, Peterson, and Meier, 1987) and at least half have experienced some form of reportable child abuse (Dubner and Motta, 1999). Children in foster care exhibit consistently high rates of mental health problems (e.g., Clausen et. al., 1998). Traditional foster care like other social service systems must focus on meeting the needs of the majority of its consumers. A large proportion of these consumers are elementary school aged victims of abuse or neglect.

Demographic characteristics of sexually abusive foster youth

Economic rule 1: Since returning forensic foster youth to the natural home for outpatient treatment is the least expensive treatment option, all who are able, go home. Thus, youth placed in forensic foster care have either failed multiple times in their natural

Table 1: Multiple abuse behavior in the population of youth who sexually abuse.

Study	Sexual abuse	Physical abuse	Property abuse	Substance abuse
Awad et. al., 1984	100%		44%	8%
Becker et. al., 1986	100%		41%	9%
Ferenbach et. al., 1986	100%	36% (also robbery)	38%	
Van Ness, 1984	100%	86%		52%

home placement or have no appropriate family placement. By definition this means that these youth are typically lacking in family adjustment ability and are in need of a treatment that teaches prosocial family values if a family-based placement is to be preserved.

Sexually abusive youth referred for treatment in forensic foster care tend to exhibit more than one type of unhealthy, harmful behavior requiring treatment. Demographic data from the forensic foster care program revealed that the average age was 16, 97 percent were male and 72 percent were Caucasian. The average number of different types of unhealthy, harmful behavior exhibited was 4.5 and 59 percent exhibited problems at admission with five types of harmful behavior (i.e., sexual abuse, physical abuse, property abuse, substance abuse and trust abuse). Fifty three percent were on probation or parole (Yokley and Boettner, 1999a). This multiple abuse behavior is consistent with prior studies of youth who sexually abuse others (see Table 1 above).

Each type of harmful behavior exhibited by these youth (i.e., sexual, physical, property, substance and trust) involves a maladaptive way to assert power, get what they want, meet their needs and make themselves happy, often at the expense of others. Each type of harmful behavior also involves a pathological level of social-emotional immaturity.

Many youth who sexually abuse suffer from “pan immaturity” in emotional/social adjustment (Fehrenbach et al., 1986; Shoor, Speed and Bartelt, 1966) and character disorder. This social-emotional immaturity and character disorder is conceptualized as “pathological social-emotional immaturity” (Yokley, 1996). This form of developmental delay involves:

- Immature, maladaptive social maturity in the form of a prosocial values deficit (i.e., a lack

of honesty, trust, loyalty, concern and responsibility) that impairs the ability to develop healthy, positive relationships.

- Immature, maladaptive emotional maturity manifest as: Inadequately developed self-awareness, self-efficacy and self-control (e.g., a lack of appropriate social behavior control, emotional control problems including low frustration tolerance, an emotional awareness deficit and justifying actions based on feelings). Maladaptive self-image and needs (e.g., low self-efficacy, a Control and Power Obsession, a sick need for acceptance, a sick need for excitement or sensation seeking, authority problem and criminal pride for “getting over” on others, winning by intimidation or other opportunistic exploitation that demonstrates a lack of empathy).

What to expect: Behavior norms for foster youth who sexually abuse - “The few, the proud, the resistant”

Behavior norm research on youth referred for sexually abusive behaviors in forensic foster care (Yokley and Boettner, 1999a) has revealed that it is not unusual for these youth to receive about six behavior incident reports per month fairly equally divided between problems in the home (45 percent) and community. An evaluation of the forensic foster care program incident reports revealed that on the average, a problem in the area of oppositional immaturity can be expected for each youth every week while an episode of more serious conduct problem acting out occurs about every other week. Despite the fact that the sexual abuse incident reports included a broad encompassing range of behaviors related to that problem, staff ratings indicate that the most frequent problem behavior is in the area of trust abuse (e.g., lying, deception). The second most frequent behavior problem was in the area of property abuse (i.e., stealing and borrowing without permission).

On average, youth violate their program rules about once a week and their probation/parole or legal statutes about once a month. The vast majority of behavior incidents related to social maturity problems in the areas of responsibility (44 percent) and concern (20 percent). Although not as frequent as the problem behaviors, prosocial behavior accomplishment awards can be expected once per month during active treatment. There was a significant treatment completion difference in mean number of incident reports per quarter. Specifically, forensic foster care youth that completed treatment had an average of nine behavior incident reports per quarter compared to 20 incident reports per quarter for those who did not complete treatment. Preparing forensic foster parents for what to expect in terms of these ongoing problem behaviors is considered to be an important stress inoculation procedure.

What about treatment? “No violence, no threats of violence and stay in your seat at all times”

Given the nature of the treatment population, effective forensic foster care requires a treatment approach that addresses the pathological social-emotional immaturity thought to support multiple forms of unhealthy, harmful behavior while preserving placement in the foster family setting by teaching prosocial, family values and behaviors. The treatment selected needs to be easily integrated into ongoing foster care with techniques that can be administered by foster parents who have the maximum contact and opportunity to implement behavior change procedures. The treatment applied needs to be accepted and thus should be consistent with existing parent intervention skills and foster family values. The treatment approach employed needs to use effective behavior change tools that can be implemented by foster parents with specialized training but that do not require a mental health professional license for foster parents to administer.

Social Responsibility Therapy is used in the Forensic Foster Care of youth referred for sexual abuse treatment as it addresses the aforementioned treatment needs. Social Responsibility Therapy targets five basic types of

unhealthy, harmful behavior (i.e., sexual abuse, physical abuse, property abuse, substance abuse and trust abuse). A primary goal of Social Responsibility Therapy is to block unhealthy, harmful behavior while teaching prosocial alternatives to that behavior. Another important goal of Social Responsibility Therapy is to support relapse prevention by helping youth and their foster parents understand the Problem Development Triad. This case conceptualization model helps explain how unhealthy, harmful behavior was acquired, maintained and generalized to other problem areas. A brief case example illustrating the Problem Development Triad is provided in Appendix A. Detailed description of the Problem Development Triad with multiple case examples is provided in Chapter 2 of [the Social Responsibility Therapy treatment manual](#) (Yokley, 2008) and case illustrated treatment applications are provided in Chapters 10- 12 in [The Clinician’s guide to Social Responsibility Therapy](#) (Yokley, 2016). A third important goal of Social Responsibility Therapy is to demonstrate social responsibility by offering emotional restitution to abuse survivors and their families (e.g., Yokley, 1990). Thus far in forensic foster care, the use of Social Responsibility Therapy eliminated the need for seclusion and restraint through ongoing proactive intervention that relieves stress build-up.

Social Responsibility Therapy in residential care utilizes a therapeutic community approach that teaches multicultural values, prosocial behaviors and integrates professional with paraprofessional staff. This makes foster parents equal partners with psychologists, counselors and social workers in the treatment process. The therapeutic community social learning experiences used in Social Responsibility Therapy foster prosocial behaviors, decrease unhealthy, harmful behaviors in forensic foster youth and can be effectively implemented by forensic foster parents (Yokley, 1999a, 1999b). Although originally developed to address the multiple criminal behaviors of heroin addicts, therapeutic community learning experiences have been demonstrated to be effective with the multiple types of harmful behavior exhibited by sexually abusive youth (Yokley, 1999a). These learning experiences help get youth 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 and Feshbach, 1982). This is critical to the treatment goal of making genuine emotional restitution to survivors in the Emotional Restitution Training portion of Social Responsibility Therapy (Yokley, 1990; Yokley and McGuire, 1990; 1991). A brief case example illustrating emotional restitution to survivors during Emotional Restitution Training is provided in Appendix B. A detailed description of Emotional Restitution Training is provided in Yokley (2011).

Treatment truth in advertising: The labeling issue

Multiple abuse behavior treatment in Social Responsibility Therapy has a number of advantages for youth who have been sexually abusive. In addition to targeting other forms of harmful behavior that can cause adverse impact on the community, result in re-arrest or trigger sex offense relapse, providing treatment to “forensic foster youth” for multiple abusive behaviors buffers the potentially damaging labeling effects of providing treatment to “youth sex offenders”. While not as much of an issue for adults, recent labeling concerns for “youth sex offenders” have 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 and MacFarlane, 1996). Offering treatment to “forensic foster youth” for multiple abusive behaviors recognizes that the referral type of abuse may not be the only type of abuse and does not label youth with a specific harmful behavior pattern that they may not retain later in their adult years.

Treatment Program Issues with Forensic Foster Care youth

Forensic foster care program development

The first program development task is to locate and implement a treatment approach that addresses the needs of the treatment program population. Existing client-centered, support focused therapeutic foster parent training does not adequately address the serious externalizing problems of seriously abusive youth. Thus, the first order of business for an effective Forensic Foster Care program is to incorporate behavioral interventions and learning experiences designed to address the unhealthy, harmful behavior

population. While there are a number of good cognitive-behavioral treatment approaches for unhealthy, harmful behavior, the therapeutic community approach is a well-established method that integrates paraprofessional and professional staff in an abuse treatment setting where accountability is program-wide and everyone is responsible, i.e., “You are your brother’s keeper”. In this approach, interventions are built directly into foster parenting to increase the impact by providing treatment intervention 24 hours a day, 7 days a week. This is easily done in foster parent training sessions. A detailed discussion of this approach is provided in Yokley (1999a; 1999b).

Secondly, from a practical standpoint it is important to remember that “The best behavior intervention is one that all the staff will use”. All of the behavioral interventions that are developed and implemented must be as inconvenient on the youth as possible and as convenient on the staff and foster parents as possible. If this is not the case, the interventions are not likely to be implemented consistently. Inconsistency is extremely dangerous because it sets up a variable ratio reinforcement schedule, which is most resistant to behavior extinction. This is particularly important in forensic foster care where treatment is continuous through constant foster parent contact.

A third important program development point is to implement a behavior monitoring system that will allow objective progress reporting on periodic reviews to referral sources. The forensic foster care program established a computer-assisted behavior tracking system that allows an objective treatment plan review based on behavior incident reports.

Behavior norms for treatment intervention decisions were constructed based on 2110 behavior reports in the program computer database. The results of this computer-assisted behavior tracking provide objective data for comparison to past progress and support for treatment plan review decisions. In addition to providing an overall number of incident reports per quarter, this system generates behavior data on the type of abuse, severity, social maturity problem, area where the incidents primarily occur and intervention impact. An excerpt of this computer-assisted progress report is provided on Table 2.

Table 2: Excerpt from a progress report on Greg (Incident report section).

Individual Service Plan Summary: Second Quarter

Behavior Report Summary. Total number of incident reports in past 90 days = 33

- Number of learning experiences or behavior consequences that had to be increased in order to contain problem behavior: None.
- Summary of learning experience benefit: The majority (45%) of behavior reports indicated a very strong level of benefit from the learning experience.
- Location or environment where the majority of behavior problems occurred: 25 (76%) of the behavior incidents occurred in the community.

Behavior Incident Report Breakdown

Type of Abuse		Problem Severity		Problem Area	
Sexual	0	Program rule violation	19	Honesty	0
Physical	0	Probation or Parole violation	7	Trust	3*
Property	0	Legal violation	7	Loyalty	7
Substance	7			Concern	5
Trust/verbal	26			Responsibility	18

* = Decrease from previous 90-day review.

Incident Report Summary:

- The majority (79% n= 26) of behavior incidents were in the area of problems with trust or verbal behavior control.
- The average behavior incident severity level was 1.6 (1= low; 2 = moderate; 3 = high).
- The majority (58% n= 19) of behavior incidents were program rule violations.
- The majority (55% n= 18) of behavior incidents related to problems with responsibility.

Epilogue: Greg went AWOL seventeen days after this report. This illustrates the practical utility of the research finding that having above 20 incident reports per quarter is a risk factor for not completing treatment (Yokley and Boettner, 1999a).

Effective supervision: The therapists best liability insurance

Social Responsibility Therapy in foster care includes twelve basic home safeguards and twelve basic community safety procedures that involve innovative uses of available communication, behavior tracking and monitoring technology. Since people do not consistently follow plans they do not agree with, 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 (e.g., youth, therapist, foster parents, caseworker, parole or probation officer) must sign both the home and community behavior contracts.

Forensic foster home safeguards include youth observation and evaluation procedures, room

monitoring, direct communication links with professional staff and emergency removal procedures. Evaluation procedures include use of polygraph examination to verify victim lists, monitor compliance with safety contracts and serve as a child protective service. The forensic foster care program has found consistent increases in disclosure of abuse behavior problems with the implementation of polygraph examinations. A summary of the basic forensic foster home safeguards is provided in Table 3. A brief case example illustrating lessons learned from one of these procedures (i.e., random room search) is provided in Appendix C. 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. A summary of the basic forensic foster care community safety and security procedures is provided in Table 4. A brief case example illustrating lessons learned relating to one of

Table 3: Twelve basic forensic foster home safeguards.

1. A treatment behavior contract signed by the youth, their guardian, treatment providers and probation or parole officer which details program rules agreed upon by all parties. The contract 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 stay in control at all times). This includes not abusing others (sexually, physically, verbally), self (using drugs, porno, 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.
2. Incident report behavior maintenance system. 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 where foster parents have control over problem behavior but are not the target of revenge for discipline decisions.
3. Video or audio tape of forensic foster youth treatment sessions for behavior management and youth, foster parent and probation or parole officer feedback.
4. Abuse behavior pattern and arousal assessment. Includes gathering complete records of youth behavior problems in their home and community environments.
5. Regular and random polygraph examination - prevents unnecessary home moves due to false accusations; promotes child protection in high-risk situations and reverses past false abuse admissions for secondary gain (e.g. to end interrogation or look "honest" in treatment).
6. Random drug or alcohol screening. Deters relapse from substance induced impaired judgment (e.g., Alcohol impairs judgement, increases the probability of aggression and disinhibits sexual behavior, Dermen and Cooper, 1994).
7. Door alarm. During orientation and as needed when relapse signs are exhibited.
8. Room baby monitor. During orientation, when more than one forensic foster youth shares a room and as needed when relapse signs are exhibited.
9. Random room search to check for abuse related items. A brief case example illustrating lessons learned about this issue is provided in Appendix C.
10. Initial and PRN Psychological and Psychiatric evaluations to evaluate emotional stability and help maintain behavior control by providing medical treatment when needed.
11. Ability to contact staff at all times (wallet contact card with all pager, cell phone, e-mail, FAX numbers). Daily contact from staff includes reports on forensic foster youth behaviors to monitor. E-mail feedback after treatment sessions includes learning experiences to implement for behavior management.
12. Ability to remove youth from the foster home immediately (respite system with group home transfer as a backup procedure to respite).

these procedures (i.e., community safeguards in church) is provided in Appendix D.

Crisis behavior management

An effective abuse relapse cycle interruption method must be selected and foster parent training implemented prior to the foster home placement of any seriously abusive youth. In addition to teaching the abuse cycle and basic relapse prevention techniques, the forensic foster care program inhibits youth falling back into their abuse relapse cycle by holding their emotional attention with therapeutic community learning experiences. These learning

experiences include a large and creative array of natural and logical consequences, which address the socially immature, irresponsible, acting out involved in multiple forms of abuse/crime. In general, therapeutic community learning experience research with the forensic foster youth population (Yokley, 1999a) produce clinically significant improvements in:

- Behavior management (i.e., less incident reports, less serious types of violations and less serious types of abuse).

Table 4: Twelve basic forensic foster care community safety and security procedures.

1. A community behavior contract signed by the youth, their guardian, treatment providers and probation /parole officer which details program rules agreed upon by all parties including permission to monitor the youth's behavior in the community and consequences for contract violation. For example, 24-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, sleep alone, obey the law, respect others rights of privacy and no negative contracts.
2. A clear list of responsibilities and privileges which limits community access based on behavior (five pages). Forensic foster care utilizes a three-phase social maturity level system. Orientation/Evaluation: Restricted to home, room monitor, door alarm, no visitors, uniform.
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, get a job, no regular room monitor.
Phase 3: Overnight visits with appropriate family. Foster home telephone use. No door alarm.
3. Abuse plan (or cycle) interruption methods to use when detention center is full and hospitalization is not possible (e.g., House Arrest, Shadowing, Abbreviated boot camp).
4. Three-step community safety notification system (Green light: no notification or disclosure of forensic foster youth problems to those in contact with the forensic foster youth, yellow light: partial disclosure, red light: full disclosure) and meetings on a risk level basis with teachers, employers, clergy or others with youth contact.
5. A Clergy Opinion Survey on Sex Offenders Attending Religious Services to determine appropriate type of supervision and relapse prevention. A brief case example illustrating lessons learned about this issue is provided in Appendix D.
6. Pager Supervision (only staff /foster parents have pager number, youth has 15 minutes to call when paged).
7. Shadowing (escort by adult who is aware of his problem) at all times when in the community.
8. Alternative schooling (as needed given risk), e.g., home instruction, Internet school, day treatment, adult GED classes.
9. Computer-Assisted behavior incident report tracking system for behaviorally objective progress reporting and behavior pattern "profiling".
10. Gradual supervised community re-entry with negative peer screening- 24-hour line of sight supervision on Orientation/Evaluation; Strength buddy system on Phase 1; Approved associates list on Phases 2 and 3.
11. AWOL precautions (e.g., pajamas and slippers only).
12. AWOL notification plan (e.g., digital photographs and descriptions of dangerousness made up in advance and e-mailed directly to police station upon AWOL).

- Treatment participation (i.e., treatment homework completion, helping self or others in group therapy and higher group grades).
- Treatment satisfaction (i.e., by both youth and staff) without an adverse impact on forensic foster youth emotional well-being as measured by psychological testing.

Since "The wheels of justice turn slowly", effective methods to create a "holding environment", block destructive acting out and halt progression of the relapse cycle while waiting for the legal system to act are needed (e.g., Yokley, Laraway and Clough, 1997). Family-based community treatment programs for harmful, abusive behaviors need to have at least one

effective cycle interruption method in place. If the program placement policy adopts the philosophy of "It takes a village to raise a child" and implements a cluster placement approach where the youth is accepted by multiple foster homes, immediate emergency home changes are possible. As a backup plan, a working relationship with a local group home with adequate staff coverage and supervision is recommended. Abbreviated boot camp appears to be one effective in-home cycle interruption method but it may be important to keep the duration short for positive effects. Initial evaluation of this approach (Yokley, Laraway, and Clough, 1997) has revealed the following:

- Psychological test results indicated significant emotional benefits to the youth (i.e., decreases in symptoms of depression and anger) with no adverse impact on the community or those in close contact with them.
- Emotional and social maturity impact ratings on the youth indicated that abbreviated boot camp held their emotional attention while improving self-control, frustration tolerance and responsibility acceptance.
- Consumer satisfaction data indicated that youth prefer the abbreviated boot camp over other typical interventions employed when youth begin to lose behavior control.

The majority of forensic foster youth are diagnosed with conduct disorder. Conduct disorder commonly co-occurs with depression (Angold and Costello, 1992; Cole and Carpentieri, 1990) and regular exercise is a viable treatment for mild to moderate depression (Tkachuk and Martin, 1999). Thus, the positive abbreviated boot camp outcome may in part relate to the impact of exercise on the dependent measure of emotional states, particularly depression. The action orientation of the youth in general may also be a factor. Other less favorable boot camp research has not evaluated the impact on emotional state and has used longer boot camps.

Medical treatment for sex drive reduction is a crisis management option for sexually abusive youth whose community placement is in question as a result of their problems with deviant fantasy and behavior control. There is some evidence for positive impact in terms of keeping youth in the community using this approach (e.g., Gottesman, Yokley and Bobek, 1994). However, anti-androgen medication needs to be used in addition to group and individual therapy and close supervision must be maintained as well. It is recommended that the benefits and possible side effects (e.g., possible impact on the developing hypothalamic pituitary axis, Becker and Kavoussi, 1989) of anti-androgen medication be discussed in a meeting with the youth, their physician and guardian and an informed consent document be signed. In addition, traditional child psychiatrists may want to address underlying causes such as depression, anxiety or impulsivity as opposed to treating the deviant arousal level directly through anti-androgen medication. In this regard, although anti-androgen medication has been the mainstay in [adult] sex offender treatment, the use of antidepressant medications, specifically selective

serotonin re-uptake inhibitors is another option that may be considered [for youth] (Greenberg and Bradford, 1997). Medical treatment of deviant sexual behavior may be helpful for those whose intellectual ability or impulse control problems inhibits cognitive-behavioral relapse prevention methods or who have resistant deviant masturbatory fantasy. This approach is an option when community safety standards are not being followed, polygraph exams on relevant safety issues are failed, the client is asking for help to contain his behavior and medication has not been forced by court order without medical examination and recommendation (Miller, 1998). Medical treatment to reduce deviant arousal level helps provide community safety and security for others while preserving the least restrictive placement for the client.

Forensic foster care treatment sabotage

In any unhealthy, harmful behavior treatment setting there are always client enablers and rescuers. “Parentectomy” via foster placement is not the cure. Forensic foster youth who have successfully manipulated destructive parent alliances in their home of origin will find new ones after placement in forensic foster care. Different types of enabling require different interventions. Two basic types of client enabling are professional conflict and client enmeshment. Professional conflict enabling can occur when human service caseworkers with expertise in working with young victims in therapeutic foster care are assigned to monitor the progress of a teen-aged offender in forensic foster care. When those trained in the supportive client centered therapy and unconditional positive regard (Rogers, 1957) necessary to develop abuse survivor trust, become involved with abusive adolescents there is the risk that they may initially apply victim advocate techniques to offenders. A brief case example illustrating lessons learned about this issue is provided in Appendix E.

Client enmeshment enabling occurs when forensic foster youth are successful in manipulating friends, relatives or professionals to feel sorry for them and become enmeshed or emotionally overinvolved to the point of believing the forensic foster youth and taking their side against the treatment program staff. A brief case example illustrating lessons learned about this issue is provided in Appendix F.

Issues with Forensic Foster Youth

Behavior problem binges: Two common causes

Extinction burst and successful manipulation are two common causes of behavior problem binges.

Behavior problem binges due to extinction burst simply involve a flurry or burst of the problem behavior (that was previously reinforced) before that behavior extinguishes. In extinction burst, “Things always get worse before they get better.” When youth who in the past have been good at getting “my way” encounter foster parents who are good at being consistent with discipline, youth clients often exhibit a flurry of emotional button pushing prior to abandoning their efforts at getting “my way”. When addressing extinction burst, since we are dealing with clients whose actions present a danger to self and others, it is important to stop the harmful behavior first and uncover motives later. As it turns out, stopping the behavior can sometimes help uncover the behavior motivation. A brief case example illustrating lessons learned about this issue is provided in Appendix G.

Behavior problem binges due to successful manipulation start out with the youth testing the limits of inconsistent discipline, trying to get away with things in the treatment setting, foster home or school and gradually pushing back the line until they are in an unruly state. Successful splitting (i.e., manipulating people against each other) gives forensic foster youth the confidence they need to test the limits of program rules and the continuity of staff-foster parent communication.

When addressing behavior binges due to successful manipulation, foster parents and staff must agree on whatever discipline is implemented to prevent client manipulation and splitting. Since successful manipulation requires discipline inconsistency and communication breakdown, discipline consensus gets priority over discipline content. While intervention methods are important, staff need to be flexible. The consistency of discipline can be as important as the type of discipline. Manipulation outbursts are inhibited if foster parents adopt the “My Way” rule of thumb. Whenever forensic foster youth ask one parent for something that parent needs to assume that they were already turned down by the other parent and are simply trying to get “my way”. The “My Way” rule of thumb requires that forensic foster parents

respond to all youth requests by asking the youth what the other parent said and then verifying the youth’s statement.

Parenting the impossible: “you’re damned if you show emotions and you’re damned if you don’t

The self-fulfilling prophecy of the neglected and rejected: “Why they have to push your buttons”

Concerning the rejected, the fields of psychotherapy and forensic foster parenting have some differences and what would be considered counter transference in psychotherapy can be considered emotional involvement in forensic foster care. Pushing emotional buttons can be a behavior test of foster parent concern. The goal of this can be to determine if foster parents care enough to show patience and restraint instead of venting their feelings on the youth with rejecting comments about them as a person, as opposed to their irritating behavior. On the other hand, some forensic foster youth will feel like foster parents don’t care unless they are emotionally involved enough to raise their voice. This is a judgment call. Forensic foster parents must make a decision and realize that there is no such thing as a perfectly managed case.

Rejection prevention is relapse prevention

Youth in out-of-home placements are often from homes of neglect, abuse or dysfunctional chaos (Cates, 1991; Heap, 1991; Tjaden and Thoennes, 1992). As might be expected, their parents often exhibit emotional problems (Bath, Richey and Haapala, 1992) and evidence of substance abuse (Gabel and Shindledecker, 1990). Youth in forensic foster care have often been rejected and disappointed by significant others in their dysfunctional families. As a result, many have adopted a belief that negative attention is better than no attention at all. From this point of view, one youth stated, “It’s better to be wanted by the police than not wanted by anyone”. Thus, the “goal” of a youth’s rule-violating behaviors could involve a means of obtaining predictable (albeit negative) social feedback (Wahler, 1990).

The letter policy: A behavior test of family rejection or investment

Despite feelings of rejection and disappointment, forensic foster care youth either continue to express desire for family contact or do not tell their Human

Services caseworkers that family visits are deeply upsetting. Their pathological social-emotional immaturity prevents them from letting go of naive hopes and seeing that they are setting themselves up for failure. They don't realize that while that are getting treatment to change, their parents are not. Thus, they continue upsetting, unrewarding family contact and repeatedly displace feelings after disappointing visits on their staff and foster parents. Actually, this is a complement because it demonstrates that they trust their staff and foster parents enough to express their feelings even inappropriately. When confronted about this some openly admit that they would never respond to their family in that manner for fear of physical violence. A second consequence of contact with a rejecting, dysfunctional family is in an increase in their sick need for acceptance by negative peers to compensate for rejection by family. This often results in further legal problems. Unlike telephone contact, writing and mailing a letter requires considerable more planning, time and effort. Letter writing effort indicates at least some investment in the relationship. The "Letter Policy" prohibits any contact with anyone who does not care enough to invest the same energy and time by answering several letters that are written by the youth.

No eject, no reject policy

Providers concerned with community safety need to be aware that treatment termination can result in the forensic foster youth being placed in a less supervised environment. Much of sex offender treatment has been modeled after substance abuse treatment (e.g., relapse prevention and 12 step concepts). Although it is routine for contemporary substance abuse programs to eject failing residents, this is counter to theory which indicates that "addictive behavior is more likely to ensue when a person is cast out of the group of origin for the outcast will find a compatible, but possibly substance abusing, subculture with which to attach" (Houts, 1995, p.26). Traditional therapeutic communities did not reject those who arrived for treatment under the influence and did not eject those who used during treatment. Those who came in under the influence were detoxed "cold turkey" (i.e., total abstinence without gradual decreases in substance dose) and those who relapsed during treatment were given an opportunity to reintegrate themselves into treatment through a commitment contract that demonstrated serious self-discipline and treatment motivation.

In traditional foster care after an initial interview or trial visit, the foster parents have the option of rejecting the youth. The forensic foster care policy of admitting youth into a foster family cluster of homes inherently blocks rejection of appropriate youth since admission involves the majority vote of the foster cluster as opposed to one family. In addition, since more than one family has accepted the youth, ejection from treatment does not occur because when youth behavior problems require a move, they are placed with another family in the foster cluster. In forensic foster care the youth has had ongoing involvement with the other families in the cluster where parents watch each other's youth and weekend visits to other cluster family homes are common. This form of shared parenting environment reduces the possibility of any mutual youth-caretaker rejection or alienation that in theory is expected from home moves (Proch and Taber, 1985).

Frustration tolerance and attachment issues: "They're not my kids", "I'm not your son"

One powerful foster parent frustration with forensic foster youth is not understanding their seemingly senseless behavior which can lead to just giving up and stating, "They're not my kids". Given their expected attachment issues and hypersensitivity to anticipated rejection, foster parents need to let the youth grow up and reject them (Lowenstein, 1985). Exaggerated real world preparation speeches can trigger treatment sabotage. Given this situation it is important to know what not to say. No matter how much the youth complain about being held back from advancement and discharge, it is important not to remind them of any placement or program time limits. State prisoners or involuntary psychiatric patients may warmly receive statements such as "We like you but you can't stay here forever" but this approach in forensic foster care is likely to result in youth running away. The hypersensitivity of these youth leads them to combat their rejection anticipation, helplessness and loss of control by rejecting their caretakers before they are rejected.

"I'm not your son" is expressed by immature youth who take every opportunity to state "you don't understand me" and then fail to give any logical explanation for their behavior. In addition to displaying aggression, drug use, theft and manipulation, the destructive behavior of therapeutic community youth may include refusing to develop

anything but a superficial relationship with adults (Lowenstein, 1985). This actually makes sense from a developmental perspective because there is no explanation for pathologically socially immature behavior except being totally unsocialized as the result of never learning to adapt to a functional family setting. Their lack of supervision has left them with no sense of appropriate social behavior control, boundaries and the omnipotent attitude of “What I want to do is right and the reason it’s right is because I want to do it” (aka Dysfunctional Family Law). This dysfunctional family logic explains why these adolescents typically frustrate adults by responding with “I don’t know” when asked why they did something. The reason they did it is simple. They are pathologically socially immature, functioning under Dysfunctional Family Law and are following the aforementioned one statute which can be applied to all their interactions. It is important to teach foster parents the “Simple Man” concept for understanding the behavior of pathologically socially immature youth. In this conceptualization, the simplest, most immature and embarrassing motive for the behavior has the highest probability of being accurate and is often confirmed through overt emotional, defensive, denial.

Limits of forensic foster parent involvement: The second shift analogy

Experienced foster parents will comment that they treat their foster children like their natural children in terms of responsibilities and consequences but not privileges, which require earning trust. This can be a problem for foster youth who are being placed because they have done things wrong and therefore must earn the trust of their foster parents. Their history of past abuse and neglect has left them preoccupied with injustices. As a result, they may feel entitled to trust at the onset in a sort of “innocent until proven guilty” mentality and resent having to prove themselves to foster parents because they have abused the trust of others. This is an example of a first shift problem as it relates to how the youth was treated in a prior setting (i.e., earlier shift).

In cases where the foster parent has made an emotional connection or developed a trust bond with the youth, some feelings of disappointment or responsibility can be expected when youth display resistance or rejection. However, an important difference between forensic foster parenting and natural parenting exists which foster parents must be

made aware of to help buffer these feelings. Unlike natural parenting, the responsibility for seriously abusive youth placed in forensic foster care is somewhat like factory work divided across three shifts. The first shift is usually the responsibility of institution staff in the facility where the youth is incarcerated, receiving treatment and awaiting parole to a community setting. In cases where the youth was never incarcerated for their harmful behavior, the first shift was the parenting they received in their family of origin. Forensic foster parents, treatment staff and a probation/parole officer or human services worker typically assume the responsibility for the second shift when the youth is placed in forensic foster care treatment and is gradually exposed to increasing privileges and responsibilities. The youth’s probation or parole officer or human services worker staffs the third shift when the youth returns home typically with the assistance of an individual outpatient therapist at a community mental health center. Foster parents need to keep their focus on their shift. Getting preoccupied with what already happened to the youth on the first shift or worried about what may happen to them on the third shift distracts from the important supervision and Social Responsibility Therapy parenting that is required on the second shift.

Systems Issues that Effect Forensic Foster Care

Systems issues that affect forensic foster care include conflicts in professional training, professional roles and agency policies. With respect to professional training conflicts, there is a fair possibility that forensic foster parents and treatment program staff may have more accountability based cognitive behavioral training with abusive adolescents while case workers or human services staff may have more support-based client-centered training with elementary school aged victims. Caseworkers and human services staff may view forensic foster parents and treatment program staff as responding to their abusive youth client with too much confrontation and not enough appropriate concern. Forensic foster parents and treatment program staff may view caseworkers as responding to the abusive youth with too much concern (i.e., enabling abuse) and not enough appropriate confrontation. These training perspectives can clash even without the different professional roles of forensic foster parent/treatment staff and caseworker/human services staff.

The basic professional role conflict that can occur between human services caseworkers who place the abusive youth in the foster home and the forensic program staff who treat them can be summed up as “client advocacy versus community protection”. Caseworkers caught up in a client advocate role can view the forensic foster care placement evaluation as a job interview by their client where projecting the favorable attributes of the youth is the goal. This can conflict with the program staff role to gather as much detailed information as possible about any youth abusive behavior that could pose a danger to others for the purpose of constructing a sound community treatment and safety plan. It is important not to let these roles conflict to the point where the youth views the admission interview like past dysfunctional family situations where they felt caught in the middle between one parent putting them down and the other taking up for them.

Agency policy conflicts in forensic foster care vary but one common conflict that may occur can be stated as “family reunification versus child protection”. Human services policies for natural family visitation may conflict with parole/probation rules, which protect forensic foster youth by prohibiting them from associating with known criminal parents. Visitation between youth who have been abused and abusive parents can trigger more deviant fantasies by abusive parents, which increases the risk of re-victimization. Sex abusers with family visitation where survivors are present have significantly more deviant fantasies about survivors than those who do not have family visitation (Davis, Yokley and Williams, 1996). In addition to triggering deviant thoughts in criminal parents, visitation can also conflict with the need for a bonding period between forensic foster youth and their forensic foster parents as well as trigger past traumatic thoughts on the part of the youth. Since youth placed out of the home often experienced neglect, abuse or dysfunctional chaos (Cates, 1991; Heap, 1991; Tjaden and Thoennes, 1992) from parents with emotional problems (Bath, Richey and Haapala, 1992), behavior de-compensation can occur after mandated natural parent visitation. Given this situation, treatment program staff may view the human service family visitation policies as interfering with treatment while human services staff may view the program orientation period where no visitors are allowed as interfering with their family reunification policy.

A second agency policy conflict that may occur in forensic foster care can be viewed as “foster placement preservation versus community safety preservation”. Different variations of human services policies, which basically discourage home moves are based on the needs of elementary school aged victims for home environment consistency. One example of a placement preservation policy would be requiring a waiting period after a foster home move has been requested so that caseworkers have time to try interventions to preserve the foster placement before making the move. In addition to placement preservation policy, clinical interventions have also been aimed at preventing the disruption of foster care placements for quite some time (e.g., Aldgate and Hawley, 1986). Under placement preservation policies, all home moves are negatively labeled as “placement disruptions” despite the lack of conclusive research evidence regarding harm from home moves (Proch and Taber, 1985) and there is no “placement accommodation” label for positive home moves. Given the estimates that nearly one third of the children in foster care experience three or more placements and that this number is substantially higher for adolescents (i.e. 7-10 placements) in foster care (Fanshel, Finch, and Grundy, 1989), it seems unlikely that all of these moves were negative “placement disruptions”. It is more likely that some home moves are in fact positive “placement accommodations” to meet the special environmental needs of the youth or safety needs of the community.

Broad enforcement of home “disruption” policies for all age groups and diagnostic categories of foster youth (i.e., adolescent offenders as well as the child victims) do not address the needs of the community for safety and security. In forensic foster care, human services policies that provide incentives to preserve placements (or disincentives for home disruption/moves) basically encourage keeping seriously dangerous, forensic foster youth in situations that are high-risk for harm to others in the community. Treatment program staff may feel that a human services placement preservation policy waiver for seriously abusive youth is needed in order to remove them from the difficult position of having to undermine human services policies to preserve community safety and security. Human services policy makers may feel that any placement preservation policy waiver for seriously abusive youth (i.e. which would remove incentives for placement preservation or sanctions for placement disruption)

could destabilize the foster care system and may be open to abuses. From this viewpoint, providing placement preservation policy waivers could open the floodgates to moves of many irritating (but not abusive) youth by labeling them as seriously abusive just for the purpose of getting them moved without delay and not because they pose any real danger to the community.

Foster Parent Selection: “Beggars Can’t Always be Choosers”

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.

Two heads are better than one: Four eyes are better than two

When considering appropriate learning experiences for forensic foster youth, “two heads are better than one”. With respect to providing an appropriate level of community supervision for forensic foster youth, four eyes are better than two. With forensic foster youth, quantity time is more important than quality time. Many forensic foster youth have already failed in homes where a single parent had to work and was not available to provide them with enough attention, guidance and supervision. With these youth the most important thing for foster parents to do is be there and be consistent. While this is certainly possible for retired foster parents with established, stable relationships, it is not always possible for single parents who are still working and trying to establish relationships. However, extended family and relatives can help considerably with supervision. The importance of supervision by as many adults and extended family as possible cannot be over emphasized for this population with respect to the issue of community safety and security. Given their history of serious family problems (e.g. Awad, Saunders and Levene, 1984), lack of supervision and structure in the past, youth referred to forensic foster care have often had 24 hours a day, 7 days a week of pathologically socially immature, “my way” indulgence.

Foster parent characteristics: tenacity is job 1

Forensic foster parents need to stick with the youth and stick with their decisions. Good forensic foster parent characteristics include tenacity, assertiveness, stability and experience. Tenacity and endurance are important forensic foster parent characteristics. By embroiling the family in conflict, seriously delinquent youth behavior wears down the socialization forces (e.g., supervision, setting limits) that could direct youth into more prosocial patterns of adjustment (Chamberlain and Reid, 1998). Thus, forensic foster youth need forensic foster parents who model tenacity and endurance while teaching youth to “never give up” and “always finish what you start”. A good forensic foster parent attitude to convey to youth is “If you’re not working on the solution, you’re part of the problem”.

Assertiveness, decisiveness and enthusiasm are valuable commodities to own when trading verbal exchanges with resistant forensic foster 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. A sense of value-based commitment is important in selection. If forensic treatment staff want seriously 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. In selection, tenacity is more important than technique, which can be modified through training. Forensic foster youth don’t need friends, they need parents and parents don’t always agree with their children. Peer associates always agree, friends agree most of the time but parents are only supposed to agree when it’s good for their children. Being able to tolerate criticism helps since in forensic foster care there is no such thing as a perfectly managed case and complaints about parenting decisions are common. Forensic foster youth can be expected to play the victim role with their human services guardians if they receive firm, consistent discipline. In summary, good forensic foster parents can handle the fact that “Not to make a decision is to make a decision”. The personality profile (i.e. 16PF) 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 and Horner, 1990).

Emotional stability and being well balanced are cornerstones in parenting forensic foster youth. Forensic foster parents don't have to be young, strong, rich or physically healthy, just mentally healthy and socially mature. Pathologically socially immature youth with multiple abusive behaviors need foster parents who are honest, trustworthy, loyal, concerned and responsible. This doesn't mean easy going in style. Since socially immature youth with authority problems have needs to act those problems out on someone, easy going foster parents make it hard going for treatment staff who the youth are more likely to target for authority conflicts. Likewise, easy going treatment staff make it hard going for foster parents who then become the likely targets of authority conflicts. 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 like bearing, courage and dependability can help with authority problems. In this respect, the personality profile (i.e. 16PF) of successful therapeutic foster fathers suggests that they are likely to be somewhat more conservative than the norm (Ray and Horner, 1990).

Experience is important in forensic foster parent selection but it isn't everything. Sometimes retraining therapeutic foster parents to be forensic foster parents is more difficult than starting from scratch. This is because traditional foster parents usually have received training by a Human Services system whose primary population is elementary school aged victims, not adolescent abusers. A shift from traditional therapeutic foster parenting emphasis on reflective listening, unconditional positive regard, trust and support mode to forensic foster parenting investigative questioning, "trust but verify" and "confrontation with concern" is needed. Forensic foster parents need to adopt the "Kite Analogy" of balancing confrontation with concern. In this analogy, if you provide appropriate, positive resistance and pull against the kite, it rises to its maximum potential. If you stand still and don't pull against it but also don't give in, the kite maintains its present level. If you give in, go the direction the kite is pulling or run after the kite, it crashes.

Foster Parent Retention

Keep them through empowerment policies and procedures

The 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 where foster parents are integrated into all aspects of youth treatment as well as communication. A cluster placement model to maximize foster parent support while respecting their family diversity and minimizing any adverse impact that could be associated with home moves is an additional empowerment procedure.

Forensic foster care empowerment policy 1- Relevant, quality foster parent training: "It's not just a job, it's an adventure"

Specific, frequent, quality training with relevant content has been identified as a foster parent retention factor (Chamberlain, Moreland and Reid, 1992; Denby and Rindfleisch, 1996; Urquhart, 1989). In addition to the mandated sessions for all regular foster parents and on the job training during home visits, forensic foster parents receive 30 hours of annual training on topics relating specifically to youth with abusive behavior problems. Lecture topics include: characteristics of forensic foster youth; understanding how unhealthy, harmful behavior was acquired, maintained and generalized; irresponsible thinking of forensic foster youth; socially responsible parenting of forensic foster youth; the foster parent role in relapse prevention; community supervision, safety and security; victim impact and; stress management for forensic foster parents.

Forensic foster care empowerment policy 2- An inclusive treatment team: "One for all and all for one"

The therapeutic community approach used in forensic foster care blends paraprofessional and professional staff together in a unified treatment team where the specialized training and forensic parenting experience of program foster parents is respected as a critical aspect of treatment. Since "the best behavior program is one that everyone uses", the basic program rules and consequences (including therapeutic community learning experiences) were established by consensus

of the treatment team (i.e. foster parents, social worker and psychologist). Even the intake/placement selection process is inclusive of foster parents. Forensic foster youth have an intake interview during a treatment group where all of the treatment staff including foster parents are present and program admission requires a majority vote. This team approach effectively addresses the lack of foster parent involvement in types of children placed with them (Denby and 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.

Forensic foster care empowerment policy 3- Communication continuity: “A team is only as effective as it’s least informed member”

As an integral part of the treatment team, forensic foster parents are directly connected into the treatment feedback loop 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, they typically sit in during the first 10-15 minutes of treatment group sessions to disclose behavior problems and issues that have occurred in the home. Feedback to foster parents on treatment group content, process as well as therapeutic community learning experiences that were implemented is provided. The continuity of the forensic foster care program addresses the foster parent retention factor concerning the quantity and quality of agency-foster parent interaction (Urquhart, 1989).

Forensic foster care empowerment policy 4- The foster cluster model: “It takes a village to raise a child”

In the forensic foster care program youth with abusive behaviors are admitted into a foster cluster of several homes. This 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 them. If possible, having the youth accepted into several families at once maximizes the

probability of getting the basic Social Responsibility Therapy treatment messages through to them in a different family home if they didn’t get it their first family cluster home. The foster family cluster approach enhances foster parent retention by addressing their expressed need for mutual support among themselves (Urquhart, 1989).

Forensic foster care empowerment policy 5- Respect for family diversity: “When in Rome, do as the Romans do”

Supporting foster parent 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, the rules of the foster homes in the cluster are not standardized. The forensic foster care policy that “Every house has its own rules” establishes a basic set of treatment program rules that all professional staff and foster parents agree on while supporting the foster parents individual house rules supporting values “diversity within unity” (Etzioni, 2001). The program requires that youth pass a quiz on the foster parent’s individual house rules. This family diversity policy mirrors the real-world environment by teaching the youth that each setting is different and they must learn to adapt to the rules of each setting (i.e. home, school, work and treatment) they encounter as “Every house has its own rules”.

Conclusion

Forensic Foster Care offers a less restrictive and more cost-effective alternative than continued residential treatment for youth with a history of sexually abusive behavior and other harmful behaviors in need of treatment who are not candidates for outpatient treatment in their family of origin. The present chapter described lessons learned along with procedures developed, evaluated and refined in forensic foster care program over the past seven years. ZXZX

The level of pathological social-emotional immaturity that these forensic foster youth exhibit at treatment admission prevents them from reaching out to their foster parents and staff for advice, help or even basic support. Although some are overt while others

are covert, resistance, rebellion and rejection are the prominent avoidance responses that they display towards their caretakers. If program foster parents and staff have made any emotional connection with these externalizing, forensic foster youth, that connection should survive discharge. Approximately 76 percent of forensic foster youth contact foster parents or staff after discharge (Yokley and Boettner, 1999b). Reaching out to foster parents and staff to stay connected after leaving treatment is an indicator that these youth have started to learn the value of positive human relationships which is an important part of their social-emotional maturity development.

Appendix A

Case example illustrating the Problem

Development Triad: How abusive behavior was acquired, maintained and generalized

Greg was a 15-year-old African American male admitted with five types of abuse including 13 sex offence victims, homicide threats during rape, gang involvement and physical assault. He had four prior foster home failures (six sex offences in two foster homes, theft in one) and prior residential sex offender treatment where physical restraint was required to contain his aggressive behavior. Greg progressed through the other phases of treatment, learning prosocial behavior skills and arousal management. The following is a summary of his work on developing an understanding of how his abuse behavior was acquired, maintained and generalized.

1. *The Risk Factor Chain (how abusive behavior was acquired)*

The first link in the risk factor chain that leads up to initial abusive behavior is **Historical risk factors**. These problems consist of biopsychosocial disadvantages, trauma and other predisposing historical factors that could not be controlled by the youth. Greg's historical risk factors included being a victim of sexual abuse, physical abuse and neglect. He lists his mother's death due to drugs as the most intense, followed by being physically and emotionally abused by his mother and her boyfriends. He was told numerous times in his life that he was a worthless nothing and was "shit for a son" by his mother. His father was absent from his life.

These historical risk factors involving abuse and rejection supported **Social-Emotional Risk Factors**

(i.e. the second link in the risk factor chain that leads to abuse). He stated "I would feel as though no one really cared and there was nothing else to be positive about so I acted immature in order to feel better". His lack of self-efficacy and social-emotional immaturity was exemplified by a phrase that he repeated during treatment, "why even try if you know you're gonna die." The need to artificially build up his low self-efficacy along with his social-emotional immaturity gravitated him towards **Situational Risk Factors** for committing unhealthy, harmful behavior. Greg handled his feelings of rejection and worthlessness in a socially and emotionally immature manner by gang membership and using drugs to build himself up, make him feel powerful and in control.

While in High Risk Situations such as being with the gang, Greg would experience **Cognitive Risk Factors** such as "I want what I want, when I want it", "They shouldn't be fucking with me", and believing that his actions didn't affect others or matter.

This combination of high risk peer group and irresponsible thinking resulted in an **Initial Harmful Behavior** problem of assault and drugs. In Greg's words, "I would use drugs to ease the pain, I would physically abuse people who I thought were stupid. I would sell drugs and I would do crimes for the thrill." Greg's participation in gang wars would leave him feeling high on power, and "looking for victims". His inability to cope with these feelings led him into a behavior cycle that supported repeated acting out and set the occasion for expanding his acting out into repeated sexual abuse.

2. *The Stress-relapse cycle (how abuse behavior was maintained)*

Greg's **Negative Coping** after his abusive behavior involved minimizing the extent of his behavior, blaming others along with justifying his physical and sexual abuse because his victims "made me angry". Greg repeated these thoughts until he successfully cycled himself into a **Cover-up** phase where he would act like everything was all right, focus on other things and tell himself that "everything is under control". If anyone questioned his behavior, Greg would lie, e.g., "That was then, this is now." Lying and trying to maintain the consistency of a series of lies that cover up abusive behavior created a **Stress Build-up** which was exacerbated by Greg "stuffing"

his feelings and getting in verbal conflicts with authority figures. After a period of Stress Build-up, Greg would **Slip (Lapse)** into minor rule violations with criminal friends to see how far he could push back the line before being stopped. When caught he would create a crisis by running away (approximately 12-15 times) and **Fall (Relapse)** into the Rule Violation Effect where he would seek out his negative peers, use drugs, sell drugs, get violent, get sexually abusive and generally go on a “my way” gratification binge. After the relapse, Greg would use the aforementioned negative coping and re-enter his Stress-Relapse Cycle.

3. *The Harmful Behavior Anatomy (how abuse behavior was generalized to other problem areas)*

The Risk Factor Chain that Greg experienced helped develop his initial pathologically socially and emotionally immature way of venting his feelings through abusive acting out. Repeated iterations of the Stress-Abuse Cycle not only maintained his abusive behavior but acted to further develop pathological social-emotional maturity problems that supported multiple forms of abuse. Pathological social-emotional maturity problems that supported his multiple abusive behaviors included: a control and power problem (sensation seeking and authority problem); deception (usually telling people what they want to hear); unhealthy pride (not asking for help); grandiosity (mostly selfishness and entitlement); unhealthy perfectionism (“you’re either a hero or a zero”); self-defeating habits (creating a crisis as opposed to dealing with feelings and issues) and; a maladaptive self-image (“A man is tough”. He didn’t even cry at his mother’s funeral).

Epilogue

Although Greg was able to accept enough Social Responsibility Therapy to help him stop his interpersonal abuse (i.e. he had no need for physical restraint and no sexual or physical re-offense), his problems with substance abuse required a transfer to a residential facility for drug and alcohol treatment. He graduated from his drug treatment program and was recently in the local newspaper for his positive volunteer work as a speaker and role model for other youth with a history of harmful, abusive behavior.

Appendix B

Case example of Emotional Restitution Training

Keith was a 17-year-old Caucasian male admitted with five types of abuse including 11 child sex offense victims, physical restraint during vaginal rape and frequent fights. He was a learning disability student with borderline intellectual functioning who failed prior treatment and sexually re-offended while on parole. Keith progressed through the other phases of treatment, learning prosocial behavior skills, arousal management and understanding how his abusive behavior developed. The following is a summary of his work in Emotional Restitution Training designed to help him develop empathy and demonstrate responsibility towards the survivors of his sexual abuse.

Intervention 1 (Survivor news articles on abuse impact)

The first intervention requires a bibliotherapy assignment of reading newspaper articles on the impact of the sexual assault. After reading the articles and answering the review questions, Keith’s responses revealed having learned some of the thoughts and feelings of survivors as being, “dirty and extremely sensitive, and feelings of “anger, depression, powerlessness.” He was able to discuss the hesitancy of survivors to disclose feelings to other people and the lasting, often lifelong, repercussions of their sexual assault. Keith was also able to describe some of the possible stages of coping that a survivor may experience and stated that the intervention “made me think about how my offences hurt the survivor in ways I never knew they could.”

Intervention 2 (Letters written by survivors on abuse impact)

After reading letters by unrelated survivors of sexual abuse and answering the review questions, Keith was able to list “Loss of dignity, no trust of others” as some short-term consequences of sexual abuse and again recognized feelings of anger, guilt and hurt. He listed some sexual abuse recovery steps as “not to go into denial of problem, vent their feelings ... to keep them from leaking out on others.” Keith also acknowledged that “this person may adjust physically,

yet mentally and emotionally they may never adjust” to the sexual molestation.

Intervention 3 (Survivor videotape on abuse impact)

In this intervention, Keith watched a videotape documenting the impact of sexual abuse on survivors. Four real-life survivors of sexual abuse (two males and two females) discussed the actual abuse events, their thoughts, feelings and coping mechanisms employed. After viewing the videotape, Keith’s thoughts and self-reported benefit increased from an average of “quite a bit” in the previous two interventions to “a great deal” in this intervention. Regarding what affected him the most, he wrote “How the fact that even today they blame themselves for the offence when it was the offenders fault, not theirs.”

Intervention 4 (Survivor impact group)

In the survivor-impact group an unrelated sexual abuse survivor (or survivors) discloses the impact sexual abuse on their life in a face-to-face group session with the sexual abusers while sitting between the survivor and abuser therapists. Psychological testing (i.e. Beck Depression Inventory, Beck Anxiety Inventory) is administered pre- and post-session to all survivors who attend to ensure that there was no adverse impact that requires intervention.

Keith participated in a survivor-impact group with Jane, an adult survivor of sexual abuse and six other youth from his forensic foster care program. Keith sat diagonally from Jane in the circle. Jane disclosed the specific details of her repeated sexual abuse and the resulting consequences on her life and those close to her. She discussed her struggle with obesity, depression, suicide attempts and daily fear. Jane confronted Keith on his offending behavior and he was honest about his behavior with her. On completing his learning experience questionnaire, he responded that this intervention held his emotional attention and he experienced anxiety, self-disgust, guilt, anger, and fear during the session. Keith also indicated that he was able to look at his behavior from Jane’s point of view and stated that excuses he told himself during his sexually abusive behavior gave him no right to commit that behavior.

Jane’s psychological testing revealed that both her levels of depression and anxiety which were clinically

elevated before the impact group, dropped to within normal limits after the session and further decreased at a two-month follow-up. Thus, not only was there no adverse impact on Jane, there appeared to be some therapeutic benefit from the structured intervention with the forensic foster youth (Keith).

Intervention 5 (Apology/clarification letter to indirect abuse survivor)

In intervention 5, Keith had to use what he learned about the impact of sexual abuse and victim empathy in the previous four interventions to write an apology letter clarifying his problem and responsibility to an indirect survivor of his sexual abuse. Keith chose to write to his grandmother who was the guardian of him and his two sisters at the time of the offences. He had several sessions of revising and reviewing his letter with his treatment group and therapists for critiques and approval. His letter included the following, “I am writing to apologize for the pain I have caused you by offending your granddaughters Denise and Debbie, people that I should have cared about more, yet I did not ... what I did was my fault and no one else’s ... I was extremely jealous and made a plan to hurt them ... That is why I chose to sexually offend. I want to again apologize for my sick, selfish behavior. Sincerely, Keith.” Keith’s grandmother indicated that she was willing to receive his personal apology and a session was scheduled.

Intervention 6 (Apology/clarification session for indirect abuse survivor)

Keith met with his grandmother with his therapist present. He apologized again, clarified how he developed his sexually abusive behavior, took responsibility and answered all of her questions to the best of his ability. In a follow-up questionnaire, Keith’s grandmother said that the apology session helped her to accept what he had done to be able to discuss the abuse more openly. She also expressed that her feelings and thoughts of guilt, anxiety, and anger decreased after receiving the apology letter and even more so after the apology session.

Intervention 7 Apology/clarification letter to direct abuse survivor)

With the approval of his grandmother, Keith wrote an apology letter to his direct survivors, Denise and Debbie, his sisters, which was mailed to their therapist to process with them in a session. Again, his letter was

read, discussed and revised with the help of his treatment group. Keith's letter apologized to Denise and Debbie for his "sick, disgusting and inhumane behavior for abusing you both." He clarified that as an older brother he should have been looking out for his little sisters, not taking advantage of them and he owned responsibility for his behavior. He clarified that "my behavior was an abuse of power and control. It was a violation of privacy" and explained that he let his "anger build into a rage ... if I hurt you physically it would leave scars ... this is one of the reasons I chose to sexually offend you." Keith's letter ended with "I know that I didn't care for you both as a brother should and would like to start by showing you I care by apologizing to you both. Sincerely, Your brother Keith". Keith's sister Denise and her therapist indicated that they wanted to meet with him in an apology/clarification session.

Intervention 8 (Apology/clarification session for direct abuse survivor)

In the final intervention, Keith met with Denise who sat between her therapist and Kevin's therapist. As a survivor safeguard, Denise received psychological testing (i.e. Beck Depression Inventory, Beck Anxiety Inventory, State-Trait Anger Expression Inventory) before and after the apology/clarification session. On the post session questionnaire, Denise indicated that the session helped her "know that he cares about me ... and that he's sorry for what he did." She also stated that such sessions would be helpful for all survivors "so they can understand about the feelings of themselves and to open up". Denise's psychological testing showed no adverse effects from the session with a decrease in anxiety. Her therapist's response included "it is helpful and therapeutic for the survivor to be placed in a position of being in control" and that Denise is "more positive as a result" of the apology/clarification session. Keith's responses indicated a pronounced benefit in understanding the impact of his actions upon his sister. He disclosed feelings of self-disgust as well as empathy. He concluded with, "When my sister cried, I wanted to take the pain away yet I could not," indicating a genuine connection and desire to make emotional restitution.

Epilogue

Keith completed his treatment at the forensic foster care program for and was discharged to regular foster care after 15 months. During his treatment he had one

incident of indecency in his home but no sexual re-offence and no further fights.

Note: Not all forensic foster youth develop enough empathy to qualify for face-to-face meetings. The decision to offer emotional restitution is only made if the survivor requests it and the survivor's therapist believes it will be therapeutic.

Appendix C

Random room search vignette

During treatment, a random room search was conducted on Chip, a 15-year-old, white male forensic foster youth with a history of seven child and peer sexual abuse victims. Chip also had a history of alcohol abuse, physical assault, pornography use and five placement failures over the past seven years. The random room search revealed a pair of panties and a written log with people and times listed on it. Investigation revealed Chip had broken into the home of Tracy, a 14-year-old female by climbing through her window and had stolen her panties. He had been masturbating to rape fantasies of her to the point that a rape plan was fully formed. Chip had been watching Tracy through her window for some time and the log he constructed had a list of all of the other family members living in the home along with the times that they came and left except for Tracy's brother. After Chip figured out her brother's schedule, his plan was to climb in Tracy's window at a time that he knew there was no one home but her and hide until she returned to her room. At that point Chip admitted he planned to assault Tracy, tie her up with her own panty hose and rape her. He also disclosed thoughts of strangling her afterwards. Chip was placed in detention to protect Tracy. The room search interrupted Chip's re-offence plan and saved Tracy from a traumatic sexual assault.

Epilogue

The important lesson learned from this case is that supervision in forensic foster care for youth with a history of sexual abuse and other harmful behaviors requiring treatment must extend beyond the boundaries of traditional psychotherapy and beyond the boundaries of traditional parenting in order to protect the boundaries of potential victims.

Appendix D

Vignette on sex abusers at religious services: the need for community safeguards in church

Mack was a 17-year-old learning disabled white male referred to forensic foster care as the result of a history of molesting male children. He was given community safety standards requiring 24-hour line of sight supervision by an adult who is aware of his problem and excluding him from all child access including his Sunday school. Mack's mother filed a grievance against his forensic foster care treatment providers on the grounds that the treatment program rules violated his constitutional rights to freedom of religion. She also expressed a strong belief that "spiritual counseling" was best for her son and was pressing the local authorities to transfer him from the forensic foster care that targeted his sexually abusive behavior to general counseling in a Christian children's home. An informal compromise of treatment rules was reached where Mack would not attend Sunday School but would attend church and sit between his parents who agreed to provide his supervision. Mack had no reported behavior problems in church for three weeks. Shortly thereafter, the church youth pastor contacted the program staff with complaints that Mack had made sexual advances towards two children in his Sunday school and had exposed his penis to them in a church stair well. His parents stated that he was with them at all times "except when he excused himself to use the rest room".

Epilogue

Church can be an easy victim target area for sexual abusers especially since most in attendance do not feel that they have to keep their guard up against crime in this setting. The important lesson learned from this case is to develop an effective religious service risk reduction plan for sexual abusers. This plan needs to protect the religious rights of those in treatment for sexually abusive behavior as well as the rights of potential victims by including their clergy opinion. This can be done by sending a clergy opinion survey (Roberson, Yokley and Zuzik, 1995). When clergy were surveyed on what type of sex abuser program support they would like, their first church supervision preference was that sexual abusers sit next to their treatment program staff. With respect to relapse prevention methods, the first preference of clergy is that sexual abusers take careful notes to keep their

minds on the service and away from potential victims (Roberson, Yokley and Zuzik, 1995).

Appendix E

Professional conflict enabling vignette

Greg, a 14-year-old African American male had failed in four different foster homes and was admitted to the forensic foster care program after completing residential sex offender treatment. At admission Greg disclosed a history of sexual abuse (rape and molestation of 15 male and female children as well as fondling adults), physical abuse (fights and gang involvement), property abuse (theft, burglary, vandalism), substance abuse (marijuana, alcohol abuse and drug dealing) and trust/verbal abuse (violent threats, constant lying). Greg's Human Services caseworker refused to sign his consent form for regular polygraph examination, a procedure that from her humanistic client advocate prospective did not show unconditional positive regard or basic client trust. After learning this, Greg's behavior began to deteriorate. He became involved with negative peers doing drugs while stating that he was following the program rules. Eventually he got out of control to the point where a return to residential treatment was necessary.

Upon admission to residential treatment, his caseworker refused to sign consent for urinalysis in keeping with her client advocate position. Greg's consequent substance abuse relapse resulted in another placement failure. He was referred back to the forensic foster care program where the relationship between his caseworker enabling him to avoid abuse monitoring procedures (i.e., polygraph and urinalysis) and his continued placement failure was taken up with the Human Services authorities. Upon case review by the authorities, Greg received regular polygraph examination, random urinalysis and a new caseworker.

Epilogue

With respect to treatment tools, the saying, "If you only have a hammer, you tend to see every problem as a nail" (Abraham Maslow, 1908- 1970) makes sense. However, it is also important to remember that "If your only tool is glue, all of your clients look like they can bond". In summary, there are problems with applying offender confrontation approaches to victims and victim advocate approaches to offenders. This

case teaches us two important treatment lessons. First, since many abusive offenders have been victims as well (e.g., Fehrenbach et al., 1986), a treatment toolbox, which includes tools for both populations is needed and second, intake interviews should evaluate caseworker treatment support as well as youth behavior problems.

Appendix F

Client enmeshment enabling vignette

Jesse was a 16-year-old, white male, referred to the forensic foster care program. At admission he disclosed a history of sexual abuse (fondling the penis of a four-year-old foster brother and deviant sexual contact with males at two group homes), physical abuse (fighting in school), property abuse (theft and vandalism), substance abuse (alcohol) and along with trust and verbal abuse (constant lying and manipulation). Jesse urinated all over his room and claimed urinary incontinence as a medical necessity to have his night door alarm removed so he could use the bathroom without activating the alarm. When the alarm was removed, he ran away six times and filed false police reports of being physically abused in his foster home on several occasions when he was caught.

After finally getting arrested for his delinquency, Jessie successfully identified a vulnerable institution social worker and manipulated her into becoming enmeshed with him. He then told his worker that the forensic foster care staff had abused him and used another incarcerated sex offender that he was having oral and anal intercourse with to corroborate his story. She filed a police report stating that Jesse was a victim of abuse by forensic foster care staff.

Following a short sympathetic incarceration, Jessie was discharged to a group home setting where he failed to follow the rules or even maintain his basic hygiene. He was referred back to the forensic foster care program after his group home placement was terminated. His parole officer, placement coordinator and program staff were present at his first group when the first two days in solitary confinement including meals in your cell, this actually meant total and complete time out on the weekends for abusive behavior during the week. During the course of his extinction burst, he spent the first, second, third, fourth, fifth and sixth weekends in a row in detention. After that there were no further detentions during the following year of his therapy. He was discharged without further episode of violent abusive behavior.

Jesse openly admitted that he lied about being abused by forensic foster care staff. It was not considered necessary to provide this feedback to his institutional social worker as she had been transferred to an all-female institution after becoming enmeshed with another young male client and allegations of an inappropriate relationship.

Epilogue

This case teaches us the importance of upholding the “No eject, no reject policy” even in cases where the staff are angry at abusive youth for committing trust abuse on them. If the treatment staff had let their feelings about this youth block his readmission, he would not have had to face the staff whose trust he had abused and the issue may have never been resolved.

Appendix G

Addressing extinction burst vignette

Harley was a 15-year-old, white male perpetrator of both sexual (molestation of two elementary school aged female cousins) and physical abuse (repeated assault). His extreme violent assaults at school were always on male peers and always after minor perceived injustices. The beatings he administered to others were severe to the point of being alarming and traditional therapeutic intervention focusing on uncovering possible reasons for his behavior was unproductive. He only seemed to value his free time outside of school. He seemed to live for the weekends when he had control and could do what he wanted to do when he wanted to do it.

After his last vicious assault in school, a recommendation was made to the court that he receive 30 days detention spread across 15 weekends without informing Harley of any time limit on his weekend detention. He was under the impression that every week he was out of control and assaultive in school, he would spend the weekend in juvenile detention. Since the local detention center policy was to spend

Epilogue

This case teaches two valuable lessons. First, jail can be therapeutic. Only after being forced to stop the abusive behavior did Harley admit in therapy that around age five his father repeatedly beat and anally raped him. He disclosed memories of regularly crawling into bed bleeding from the rectum and crying

himself to sleep. This trauma was experienced as a learned helplessness depression that was relieved by Harley re-enacting the successful defense of his past victimization through the violent assault of those who acted unjustly towards him. The abusive behavior was reinforcing as it acted as relief from adverse emotions. Harley had no motivation to find another way to cope until that maladaptive, harmful behavior was prevented. The second lesson learned from this case is not to expect an immediate drop in abusive behavior just because you have implemented an intervention that uses consequences known to affect the youth. When reinforcement of abusive behavior is removed a burst of that behavior is likely before it extinguishes.

References

- Aldgate, J. and Hawley, D. (1986) Preventing Disruption in Long-term Foster care. *Adoption and Fostering*. 10:3 23-30.
- Angold, A., and Costello, E. J. (1993) Depressive Comorbidity in Children and Adolescents: Empirical, Theoretical, and Methodological Issues. *American Journal of Psychiatry*. 150: 1779-91.
- Awad, G., Saunders, E. and Levene, J. (1984) A Clinical Study of Male Adolescent Sexual Abusers. *International Journal of Abuser Therapy and Comparative Criminology*. 28: 10515.
- Bath, H., Richey, C. and Haapala, D. (1992) Child Age and Outcome Correlates in Intensive Family Preservation Services. *Children and Youth Services Review*. 14: 389-406.
- Becker, J. and Kavoussi, R. (1989) Diagnosis and Treatment of juvenile Sex Offenders. in Schwartz, H. I. and Rosner, R. (Eds.) *juvenile Psychiatry and the Law*. New York: Plenum. 133-43.
- Benton Foundation. (2000) *What you may not know about foster care*. Children and Foster Care Feature Article. Available: www.connectforkids.org.
- Cates, J. A. (1991) Residential Treatment in the 1980s: I. Characteristics of Children Served. *Residential Treatment for Children and Youth*. 9: 75-84.
- Chamberlain, P., Moreland, S. and Reid, K. (1992) Enhanced Services and Stipends for Foster Parents: Effects on Retention Rates and Outcomes for Children. *Child Welfare*. 71:5 387-401.
- Chamberlain, P. and Reid, J. (1998) Comparison of Two Community Alternatives to Incarceration for Chronic juvenile Abusers. *Journal of Consulting and Clinical Psychology*. 66:4 624-33.
- Clausen, J. M., Landsverk, J. Ganger, W. Chadwick, D. and Litrownik, A. (1998) Mental Health Problems of Children in Foster Care. *Journal of Child and Family Studies*. 7:3 283-96.
- Cole, D. A. and Carpentieri, S. (1990) Social Status and the Co-morbidity of Child Depression and Conduct Disorder. *Journal of Consulting and Clinical Psychology*. 58:748-57.
- Cooper, C. C., Peterson, N. L. and Meier, J. H. (1987) Variables Associated With Disrupted Placement in a Select Sample of Abused and Neglected Children. *Child Abuse and Neglect*. 11: 75-86.
- Cunningham, C. and MacFarlane, K. (1996) *When Children Abuse*. Brandon, Vermont: The Safer Society Press.
- Davis, G., Yokley, J. and Williams, L. (1996) *An Evaluation of Court-ordered Contact Between Child Molesters and Children: Polygraph Examination as a Child Protective Service*. 15th Annual Research and Treatment Conference of the Association for the Treatment of Sexual Abusers, Chicago, Illinois.
- Denby, R. and Rindfleisch, N. (1996) African Americans' Foster Parenting Experiences: Research Findings and Implications for Policy and Practice. *Children and Youth Services Review*. 18:6 523-52.
- Dubner, A. and Motta, R. (1999) Sexually and Physically Abused Foster Care Children and Posttraumatic Stress Disorder. *Journal of Consulting and Clinical Psychology*. 67:3 367-73.
- Etzioni, A. (2001). *The Diversity Within Unity Platform*. Available online at http://www.gwu.edu/%7Eeccps/dwu_positionpaper.html
- Fanshel, D., Finch, S. and Grundy, J. (1989) Foster Children in Life-course Perspective: The Casey Family Program Experience. *Child Welfare*. 68:5 467-78.
- Fehrenbach, P., Smith, W., Monastersky, C. and Deisher, R. (1986) Adolescent Sexual Abusers: Abuser and Offence Characteristics. *American Journal of Orthopsychiatry*. 56: 225-33.
- Feshbach, N. and Feshbach, S. (1982) Empathy Training and the Regulation of Aggression: Potentialities and Limitations. *Academic Psychology Bulletin*. 4: 399-413.
- Gabel, S. and Shindledecker, R. (1990) Parental Substance Abuse and Suspected Child Abuse/Maltreatment Predict Outcome in Children's Inpatient Treatment. *Journal of the American Academy of Child and Adolescent Psychiatry*. 29: 919-24.

- Gottesman, H., Yokley, J. and Bobek, A. (1994) *The Use of Oral Medroxyprogesterone Acetate in Adolescent Sex Abuser Treatment: A Case Study of Risk-benefit Factors*. 13th Annual Research and Treatment Conference of the Association for the Treatment of Sexual Abusers, San Francisco, California.
- Greenberg, D. and Bradford, J. (1997) Treatment of the Paraphilic Disorders: A Review of the Role of the Selective Serotonin Re-uptake Inhibitors. *Sexual Abuse: A Journal of Research and Treatment*. 9: 4 351-59.
- Heap, K. K. (1991) A Predictive and Follow-up Study of Abusive and Neglectful Families by Case Analysis. *Child Abuse and Neglect*. 15: 261-73.
- Houts, S. (1995) Explaining Alcoholism Treatment Efficacy With the Theory of Reintegrative Shaming. *Alcoholism Treatment Quarterly*. 13:4 25-38.
- Lowenstein, L. (1985) Let Them do the Rejecting: The Treating of Physically and Psychologically Abused Children. *Contemporary Review*. 247:1439 304-10.
- Miller, D. (1998) Forced Administration of Sexdrive Reducing Medications to Sex Abusers: Treatment or Punishment. *Psychology, Public Policy and Law*. 4:1/2 175-99.
- Proch, K. and Taber, M. (1985) Placement Disruption: A Review of Research. *Children and Youth Services Review*. 7:4 309-20.
- Ray, J. and Homer, W. (1990) Correlates of Effective Therapeutic Foster Parenting. *Residential Treatment for Children and Youth*. 7:4 57-69.
- Roberson, G., Yokley, J. and Zuzik, J. (1995) Developing Treatment Guidelines for Sex Offender Attendance at Religious Services: A Clergy Opinion Survey. 14th Annual Research and Treatment Conference of the Association for the Treatment of Sexual Abusers, New Orleans, Louisiana.
- Rogers, C. (1957). The Necessary and Sufficient Conditions of Personality Change. *Journal of Consulting Psychology*. 21: 95-103.
- Sanchirico, A., Lau, W. J., Jablonka, K. and Russell, S. J. (1998) Foster Parent Involvement in Service Planning: Does it Increase Job Satisfaction? *Children and Youth Services Review*. 20:4 325-46.
- Shoor, M., Speed, M. and Bartelt, C. (1966) Syndrome of the Adolescent Child Molester. *American Journal of Psychiatry*. 122:, 783-9.
- Tkachuk, G. and Martin, G. (1999) Exercise Therapy for Patients with Psychiatric Disorders: Research and Clinical Implications. *Professional Psychology: Research and Practice*. 30:3 275-82.
- Tjaden, P. G. and Thoennes, N. (1992). Predictors of Legal Intervention in Child Maltreatment Cases. *Child Abuse and Neglect*. 16: 807-21.
- Urquhart, L. (1989) Separation and Loss: Assessing the Impacts on Foster Parent Retention. *Child and Adolescent Social Work journal*. 6:3 193-209.
- Wahler, R. (1990) Who Is Driving the Interactions? A Commentary on "Child and Parent Effects in Boys" Conduct Disorder". *Developmental Psychology*. 26:5 702-4.
- Yokley, J. (1990) The Clinical Trials Model: Victim Responsibility Training. in Yokley J. (Ed.) *The Use of Victim-abuser Communication in The Treatment of Sexual Abuse: Three intervention Models*. Orwell, Vermont: The Safer Society Press. 69-110).
- Yokley, J. (1993) *Treatment for Appropriate Social Control (TASC) Program Manual*. Revised 1997. Ohio: Clinical and Research Resources.
- Yokley, J. (1996) *The Development of Abuse in Youth Sex Abusers: A Conceptual Model with Treatment Implications*. The 12th Annual Conference of the National Adolescent Perpetrator Network, Minneapolis, Minnesota.
- Yokley, J. (1999a) Using Therapeutic Community Learning Experiences with Youth Sex Abusers. in Schwartz, B. (Ed.) *The Sex Abuser: Theoretical Advances Treating Special Populations and Legal Developments*. Kingston, NJ: Civic Research institute. 3: 19.
- Yokley, J. (1999b) The Application of Therapeutic Community Learning Experiences to Adult Abusers. in Schwartz, B. (Ed.) *The Sex Abuser: Theoretical Advances Treating Special Populations and Legal Developments*. Kingston, NJ: Civic Research institute. 3:25.
- Yokley, J. and Boettner, S. (1999a) *Behavior Norms for Outpatient Youth Sex Abusers: Constructing A Database for Treatment Intervention Decisions*. Association for the Treatment of Sexual Abusers 18th Annual Research and Treatment Conference, Lake Buena Vista, Florida.
- Yokley, J. and Boettner, S. (1999b) *Youth Sex offender Treatment in Therapeutic Foster*

- Care: Lessons from Five Years of Treatment Program Experience.* 18th Annual Research and Treatment Conference of the Association for the Treatment of Sexual Abusers, Lake Buena Vista, Florida.
- Yokley, J., Laraway, C. and Clough, A. (1997) *Behavior Therapy and Criminal justice: The Controversy over Boot Camp Treatments.* 31st Annual Convention of the Association for the Advancement of Behavior Therapy, Miami Beach, Florida.
- Yokley, J. and McGuire, D. (1990) introduction to the therapeutic use of victim-abuser communication. in Yokley, J. (Ed.) *The Use of Victim-abuser Communication in The Treatment of Sexual Abuse: Three Intervention Models.* Orwell, Vermont: The Safer Society Press. 7-22.
- Yokley, J. and McGuire, D. (1991) *Emotional Restitution: The Therapeutic use of Sex Abuser Communication with Victims.* Association for the Treatment of Sexual Abusers 10th Annual Research and Treatment Conference, Fort Worth, Texas.
- Yokley, J. (2008). *Social Responsibility Therapy for Adolescents & Young Adults: A Multicultural Treatment Manual for Harmful Behavior,* New York, NY, US: Routledge/Taylor & Francis Group. ISBN: 978-0-7890-3121-1, 357 pp.
- Yokley, J. (2011). Emotional Restitution Training in Social Responsibility Therapy for Sex Offender Referrals. In B. Schwartz (Ed.), *Handbook of Sex Offender Treatment* (Chapter 56). Kingston, NJ: Civic Research Institute. ISBN: 978-1-887554-03-9.
- Yokley, J. (2016). *The Clinician's Guide to Social Responsibility Therapy: Practical Applications, Theory and Research Support for Unhealthy, Harmful Behavior Treatment.* N. Myrtle Beach SC US: Social Solutions Press. ISBN: 978-0-9832449-4-3, 301 pp.