Social Responsibility Therapy: Overview and Program Evaluation

Abstract

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

Introduction

Social Responsibility Theory

According to social responsibility theory, if organizations do not uphold their social responsibility to respect the rights, needs and interests of others, government will get involved in regulating them. Social responsibility theory originated in the 1940's during World War-II after widespread public criticism of powerful publishers engaged in selfish business practices (i.e., politics for profit motive) without concern for the rights, needs or interests of the community. According to social responsibility theory, if the news media did not assume the responsibility of considering the overall needs of society, the public would demand government regulation of the media. Social responsibility theory was supported by the Commission on Freedom of the Press which noted that continued misuse of press power would necessitate regulation. Similar public criticism has occurred regarding corporations engaging in selfish business practices for profit motive without concern for the rights, needs or interests of the community. This resulted in environmental and consumer protection laws. Application of social responsibility theory to corporations has motivated implementation of corporate social responsibility policies to avoid government regulation of their organizations. When applied to individuals with unhealthy, harmful behavior, social responsibility theory has always accurately predicted that those who do not assume the social responsibility of considering the impact of their behavior on the rights and needs of others will end up being regulated by the health and human services system or governed by the legal system.

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

Social Responsibility Therapy

Social Responsibility Therapy (SRT) helps individuals with unhealthy, harmful behavior assume responsibility for the impact of their behavior on others and learn how to manage that behavior.

The present study provides a brief description and initial evaluation of Social Responsibility Therapy (SRT) in a social service treatment setting for youth with harmful, abusive behavior. Unhealthy, harmful behaviors are exhibited when an individual commits an action that is physically, socially or emotionally harmful to self or others. In this respect, SRT targets sexual abuse (including harassment), physical abuse (including cyber bullying), property abuse (including money), substance abuse (including food) and trust abuse (including cheating). In SRT harmful behavior is considered to be the primary symptom of a social-emotional maturity deficit and increasing social responsibility involves developing social-emotional maturity.

SRT combines evidence-based interventions and procedures to increase socially responsible behavior and decrease unhealthy, harmful behavior

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

Contemporary Issues in Harmful Behavior-Specific Treatment

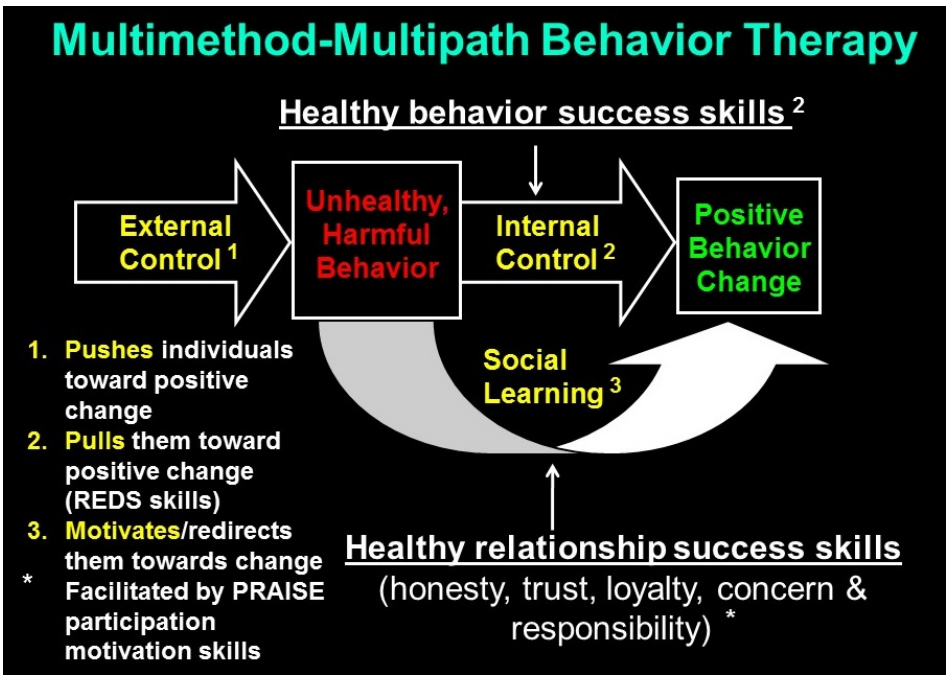
Contemporary issues that need to be addressed in harmful behavior-specific treatment include: harmful behavior comorbidity; comorbidity adverse impact; harmful behavior migration; negative social influence; intervention intensity; harmful behavior conceptualization and; multicultural recognition in treatment program design. The following is a summary of these issues which are described further in Yokley & Seeholzer (2009). *Harmful behavior comorbidity* defined as co-occurring harmful behaviors is common in harmful behavior-specific treatment. For example, when five types of unhealthy, harmful behavior (i.e., sexual abuse, physical abuse, property abuse, substance abuse, and trust abuse) were evaluated in youth referred to SRT for sexually abusive behavior, an average of 4.5 types of harmful behavior was detected at admission (Yokley, 2002). While there are many co-occurring harmful behaviors, substance abuse is a relatively prevalent co-occurring problem across harmful behaviors including sexual abuse,

physical abuse, property abuse and food abuse/overeating (e.g., Baltieri & de Andrade, 2006; Basu, Paltiel & Pollack, 2008; Conason & Sher, 2006; Stuart et. al., 2008). This makes substance abuse an important co-occurring target for many harmful behavior-specific treatment programs which do not routinely treat multiple forms of harmful behavior.

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

Combining Evidence-Based Interventions and Procedures in Social Responsibility Therapy

SRT increases *intervention intensity* by combining interventions and procedures demonstrated effective in achieving behavior change using different methods and pathways in a comprehensive Multimethod-Multipath Behavior Therapy



model. Awareness Training in SRT develops self-awareness across a broad range of internal, external and social learning events. In order to respects the rights and needs of others, our number one social responsibility is self-control. Thus, the most important responsibility in SRT is self-control and Responsibility Training in SRT involves self-control development across multiple forms of unhealthy, harmful behavior. Among other things, Tolerance Training in SRT develops both social tolerance and multicultural interaction self-efficacy as well as emotional tolerance and emotional regulation self-efficacy. Intervention methods in SRT are integrated across pathways such that the development of self-awareness and self-efficacy enables self-control success which enhances self-efficacy. Intervention pathways are categorized in SRT as primarily utilizing internal control with "Healthy behavior success skills" (e.g., cognitive restructuring, ACTS skills), external control with reinforcement and consequences (e.g., operant conditioning) and social learning (e.g., modeling) of "Healthy relationship success skills" (i.e., honesty, trust, loyalty, concern and responsibility). A summary of how SRT intervention methods in each intervention pathway address contemporary issues in harmful behavior-specific treatment (in italics) is outlined below.

Our number one social responsibility is self-control

control procedures to address *harmful behavior comorbidity, comorbidity adverse impact and, harmful behavior migration* through interventions and procedures that target primary contributing factors to multiple forms of unhealthy, harmful behavior. For example, self-awareness training on recognition of 20 irresponsible thinking types along with cognitive, social and emotional triggers of multiple forms of harmful behavior is used in self-control responsibility training involving cognitive restructuring to avoid harmful behavior relapse. Self-awareness training on relapse prevention knowledge of the three-step social responsibility plan to *Avoid trouble* is implemented. Self-awareness training on the basic cognitive processing steps involved in emotional regulation is used in emotional tolerance training to *Calm down* as follows. SRT adopts a Rational Emotive Behavior Therapy approach in "The ABC's of letting feelings go" to dissipate emotional stress below the threshold of harmful acting out while "The ABC's of holding on to feelings" are used to help clients accommodate to emotional stress and avoid acting it out. Mindfulness can be quite useful in emotional accommodation, is easily integrated into "The ABC's of holding on to feelings" and is particularly helpful when it is not possible for clients to channel feelings to the right place at the right time. Knowledge development of these tools contributes to harmful behavior change self-efficacy.

"Avoid trouble, Calm down, Think it through & Solve the problem"

Best practice in unhealthy, harmful behavior treatment requires targeting the primary contributing factors that support multiple forms of harmful behavior to prevent one harmful behavior from triggering another and behavior migration from blocking self-control development. SRT utilizes internal

Decisional balance training with three reality scales to *Think it through* along with Social Problem-Solving training to *Solve the problem* and overcome barriers to recovery are used in self-control responsibility training for relapse prevention. "ACTS speak louder than words" helps clients

remember to *Avoid trouble, Calm Down, Think it through and Solve the problem* in emotional or crisis situations that put them at risk for unhealthy, harmful behavior relapse.

A substantial evidence base for the relapse prevention, emotional control, decision-making and social problem-solving procedures employed in SRT is provided in the research literature (e.g., Dowden & Andrews, 2007; Gonzalez et al., 2004; Lösel & Beelmann, 2005; Stein, Ives-Deliperi & Thomas, 2008; Wilson, Bouffard & Mackenzie, 2005). Three structured workbooks address the *harmful behavior conceptualization* issue by helping clients develop self-awareness of how they acquired, maintained and generalized their unhealthy, harmful behavior to other problem areas. *Multicultural recognition* is addressed in self-awareness training on multicultural prosocial values along with motivational enhancement to actualize them.

Three structured workbooks help clients understand how they acquired, maintained and generalized their unhealthy, harmful behavior to other problem areas

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

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

behavior migration through interventions and procedures that target multiple forms of harmful behavior with reinforced modeling. SRT implements a number of social learning experiences in Structured Discovery social learning groups that are structured to help clients discover self-efficacy in managing harmful behavior and engaging in prosocial behavior. A simple "PRAISE" acronym helps SRT therapists remember the social learning procedures used to facilitate Structured Discovery groups by Pulling people into the group process, Responsible reinforcement, Acknowledgement of contributions, Instant identification, Social mathematics to discover common participant denominators and Enabling responsibility. Positive modeling is reinforced in group with therapist acknowledgement, calls for "instant identification" support through a show of hands and responsible reinforcement applause which further enhances self-efficacy. Written accomplishment awards for client modeling of multicultural prosocial values and relapse prevention skills are also provided. Participant modeling and covert modeling are used to correct *negative social influence* that occurs when clients exhibit social maturity problems and to help clients develop self-efficacy in emotional regulation skills. Client presentation of their *harmful behavior conceptualization* is a personal self-awareness benchmark and a self-efficacy developing demonstration that understanding how unhealthy, harmful behavior was acquired, maintained and generalized can be mastered. The culturally diverse social learning group addresses *multicultural recognition* by identifying shared values in a therapeutic setting that develops multicultural interaction self-efficacy. All of the basic types of social learning experiences employed in SRT (i.e., positive peer modeling, social behavior feedback, structured groups where clients encounter their feelings and attitudes) are utilized in the residential Therapeutic Community social learning model which has meta-analytic research support in the literature (e.g., Lees, Manning & Rawlings, 2004). Although there appear to be no deconstruction studies on the components of the Therapeutic Community social learning model, meta-analytic support is provided in the research literature for modeling and cognitive-behavioral group therapy along with group therapy with offenders (e.g., Morgan & Flora, David, 2001; Petrocelli, 2002; Taylor, Russ-Eft & Chan, 2005). Further review of the behavior change evidence base for internal control, external control and social learning procedures combined in SRT is provided in Yokley (2008).

PRAISE participation motivation skills involve: Pulling people in; Responsible reinforcement; Acknowledgement; Instant identification; Social mathematics and; Enabling responsibility

The Strength-Based Aspect of Social Responsibility Therapy

Social maturity and emotional maturity are considered important personal strengths developed in SRT to support positive change. Social maturity development in SRT draws on multicultural values theory (e.g., Schwartz et al., 2001) to select basic prosocial values accepted by multiple cultural groups. Consumer preference for the multicultural prosocial values selected for development in SRT has been validated in structured clinical exercise surveys of multicultural population youth, their

caretakers and clinical staff (Yokley, 2008). In addition to increasing socially responsible behavior while decreasing unhealthy, harmful behavior, SRT develops social maturity (i.e., multicultural prosocial values) to improve interpersonal and occupational relationships and develop community unity (i.e., a position referred to as "Diversity within Unity"- Etzioni, 2001 in Yokley, 2008). With respect to emotional maturity development in SRT, self-awareness of internal and external influences on affect and behavior are prerequisite to the cognitive restructuring and emotional regulation important in harmful behavior treatment. Developing emotional self-awareness has been an important treatment objective in multiple forms of unhealthy, harmful behavior including sexual abuse, physical abuse, substance abuse and food abuse/overeating (e.g., Bowen et al., 2006; Moriarty et al., 2001; Proulx, 2008; Rathus, Cavuoto & Passarelli, 2006). Self-efficacy, empowers clients to persist in efforts to control harmful behavior and be more resistant to pressures or temptations to re-engage in harmful behavior. This makes it important in the treatment of multiple forms of harmful behavior including sexual abuse, physical abuse, substance abuse, smoking and food abuse/overeating (e.g., Bogenschutz et al., 2006; Marshall et al., 2008; Morrel et al., 2003; Patten et al., 2008; Wolff & Clark, 2001). Self-control is a critical strength to target for development in harmful behavior treatment and a key treatment focus in multiple forms of harmful behavior including sexual abuse, physical abuse, property abuse, substance abuse, smoking and food abuse/overeating (e.g., Chapple & Hope, 2003; Feng, 2005; Harris, Mazorelle & Knight, 2008; Higgins, 2005; van den Bos & de Ridder, 2006; Wills et al., 2008). Targeting both social and emotional maturity for development is important as self-control appears to be bolstered by the presence of prosocial moral values (e.g., Schoepfer & Piquero, 2006).

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

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

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

Subjects

Subjects in the present study were 148 youth who were removed from their homes and referred to the same social services agency for group home or foster care placement. Those referred for sexually abusive behavior along with other co-occurring forms of harmful behavior were assigned to SRT. The rest received TAU involving regular foster care placement with a referral to counseling on an as needed case by case basis. TAU

counseling referrals typically involved weekly individual counseling often for pre-placement behavioral issues compounded by post-placement adjustment issues. Since almost all of the youth referred for SRT were male, gender was controlled by removing females from the study. This left 80 male subjects, 26 assigned to SRT and 54 receiving TAU. SRT subjects had a mean age of 15.8 (SD= 1.6) and 69% were Caucasian. TAU subjects had a mean age of 13.7 (SD= 3.3) and 51% were Caucasian.

Quasi-experimental Method

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

The database for the TAU group involved incident reports that related to both youth behavioral and non-behavioral issues recorded by a passive incident report system. The passive incident report systems typically required by state statutes in social service and mental health agencies to monitor adverse incidents do not actively seek input data through assigned individuals looking for target behaviors to confront, do not reward positive behaviors and typically are limited to documenting behaviors that are discovered, not actively sought out. In the treatment evaluation agency, these reports were filed under two basic categories, major unusual incident reports which included behaviors that pose harm to self or others, requiring corrective action for consumer safety (e.g., sexual abuse, physical abuse, run away or emergency room visits) and regular incident reports documenting the less serious problems and rule infractions. For the purposes of the present study, TAU incident reports relating to non-behavioral issues (i.e., medical problems, abuse allegations and past abuse reports) along with incident reports from group home programs were removed. In summary, the present comparison procedure evaluated only the behavioral issue incident reports of youth in the SRT and TAU groups.

As with all quasi-experimental evaluations, discussion of potential sources of expected bias is warranted. The utility of examining youth behavior incident reports as a measure of treatment effectiveness is directly dependent on the accuracy of the caretakers making these reports. Caretaker report has a long history of research support as a useful and accurate source of child and adolescent behavior observation in behavior checklists with meta-analytic support for the use of caretaker report in clinical and community samples (e.g., Warnick, Bracken & Kasl, 2008). An argument can be made that in harmful, abusive behavior which can result in incarceration or other substantial consequences, caregivers may be expected to provide more frequent and more accurate

incident reports than would be expected from youth self-report. Furthermore, the SRT active incident report system with its caretaker training in supervision, confrontation and documentation of harmful behaviors can be expected to generate a conservative bias against the SRT group with more frequent and severe behavior reports expected than from the passive incident report system used in TAU. Finally, the behavior problem severity level of the SRT treatment development population of youth referred for sexually abusive behavior made them a community safety risk and ruled out being able to remain in the community on a treatment waiting list or even being able to receive a referral to the less intense TAU condition. This differential treatment population severity level can be considered another source of conservative bias against the SRT group which would predict more frequent and severe behavior reports than generated by those youth whose lower behavior severity level allowed placement in less the intense TAU control group.

Results

The overall incident report frequency rates of about six behavior incident reports per month for the SRT group and one every other month in the TAU group reflects the nature of the active vs passive incident report systems used to capture the incident report data on these two groups. Attributing the higher frequency of incident reports in the SRT group to the active incident report system used (as opposed to the alternative hypotheses of the more severe population being treated) was supported during the first agency quarter of the fiscal year. At that time one employee from regular foster care transferred to the SRT forensic foster care program but continued to use the regular foster care passive incident report system on the forensic foster care youth receiving SRT. Although, the number of incident reports and time period was relatively limited, the results revealed no significant differences between the number of behavior incident reports recorded by the passive incident report system on youth in the SRT group and those receiving TAU during that three month period, $t(16)= 1.3$, $p= .206$. These results tend to indicate that the active incident report system used in SRT detects more incidents. This means that statistical tests comparing the frequency of behavior incident reports on youth in SRT vs TAU cannot be utilized without addressing the expected bias against SRT as a result of its use of an active incident report system that is more sensitive, powerful and routinely captures more incident reports than the TAU passive incident report system. One way to address this incident report system bias is to compare the ratio of positive to negative outcome indicators within each population measured by each incident report system.

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

When type of unhealthy, harmful behavior was examined, a significant difference between the SRT and TAU control group was revealed on the relative frequency of behavior incident reports involving trust abuse, substance abuse, property abuse, physical abuse and sexual abuse, $x^2(4, N=$

1933)= 276.6, p<.001. Examination of the relatively large trust abuse category revealed that 7% of the SRT trust abuse incident reports were for run away while 61% of the TAU trust abuse incident reports involved run away. When the ratio of less severe abusive behavior (i.e., incident reports on trust abuse, substance abuse and property abuse) to more severe abusive behavior (i.e., incident reports on physical abuse and sexual abuse) was examined, the SRT group exhibited 92% less severe abusive behavior incident reports compared to 8% more severe abusive behavior reports (i.e., about a 11:1 positive to negative outcome ratio) while the TAU group exhibited 56% less severe abusive behavior reports compared to 44% more severe abusive behavior reports (i.e., about a 1.3:1 positive to negative outcome ratio), representing a significant outcome improvement of the SRT group over the TAU control group on abuse behavior severity, $x^2(1, N= 1933)= 213.9$ p<.001.

A significant improvement of SRT over the treatment as usual control group was revealed on:
1) less severe program rule vs more severe legal violations;
2) less severe vs more severe abusive behaviors;
3) less severe responsibility problems vs more severe concern problems;
4) less problem behaviors in the home vs community and;
5) dramatically less run-away reports

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

When behavior problem location was examined, a significant difference between the SRT and TAU control group behavior incident reports was revealed in the relative frequency of behavior problem locations (i.e., foster home, treatment setting, school or work and community), $x^2(3, N= 1933)= 40.5$, p<.001. Pronounced differences were observed on behavior problems in the home vs community where the SRT group exhibited 41% of their behavior problem incident reports in the foster home compared to 59% in the community while the TAU group again produced almost mirror image opposite results exhibiting 58% of their behavior problem incident reports in the home compared to 42% in the community. This

difference represents a significant outcome improvement of the SRT group over the TAU control group on this measure of foster family adjustment, $x^2(1, N= 1933)= 19.9$, $p<.001$. This finding tends to indicate better foster family adjustment by the SRT group and is supported by the breakdown of trust abuse incident reports which revealed almost 9 times less run-away reports from foster homes by the SRT group than the TAU control group. A summary of the relative frequency of behavior incident reports in the SRT and TAU control group appears in Table 1.

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

SRT in Forensic Foster Care decreases rule violation and abuse behavior severity by increasing social maturity, particularly concern for others resulting in better foster family adjustment

Summary of Findings

In summary, a significant improvement of Social Responsibility Therapy over the Treatment as Usual control group was revealed across all of the outcome measures evaluated in the present study. Specifically, regarding rule violation severity, the SRT group exhibited a significantly higher positive to negative outcome ratio than the TAU control group on: program rule vs legal violations; less severe vs more severe abusive behaviors and; less severe responsibility problem reports vs more severe concern problem incident reports. With respect to behavior problem location, the SRT group exhibited a significantly higher positive to negative outcome ratio of behavior problems occurring in the home vs community than the TAU control group. This finding in conjunction with the dramatically reduced AWOL rate, tends to indicate better foster family adjustment in SRT which is considered critical for family reunification, a major treatment goal and desired outcome in this population.

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

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

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

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

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

recommendation to remove trust and loyalty from the multicultural prosocial values and behaviors being developed in SRT. Trust is particularly important in therapeutic relationship development and loyalty to positive friends along with prosocial values

is particularly important in positive behavior maintenance.

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

SRT decreases unhealthy, harmful behavior with a comprehensive Multimethod-Multipath Behavior therapy model and increases socially responsible behavior by developing honesty, trust, loyalty, concern and responsibility. These characteristics are the commodities needed to develop the relationships we want and avoid the unhealthy, harmful behavior we don't want.

Recommendations for future research include replication on a less severe abuse-specific population in a more controlled setting that does not impose research limitations for community safety. Extension to other populations on the harmful behavior continuum requires initial application potential studies to confirm harmful behavior comorbidity treatment needs. SRT application potential studies measuring five types of harmful behavior (i.e., sexual abuse, physical abuse, property abuse, substance abuse and trust abuse) have thus far been consistent with prior research in revealing harmful behavior comorbidity. For example, regarding behavior considered both harmful to self and others, population study of male youth substance abuse referrals revealed that of the five types of unhealthy, harmful behavior evaluated, the average number reported was 3.7. The top three types of unhealthy, harmful behavior in this referral population was trust abuse, property abuse and physical abuse. With respect to behavior considered primarily harmful to self, population study of adult female food abuse/overeater referrals with morbid obesity revealed that of the five types of unhealthy, harmful behavior evaluated, the average number reported was 4.0. The top three types of unhealthy, harmful behavior in this referral population was trust abuse, substance abuse and property abuse.

Conclusion

SRT adds to the harmful behavior treatment literature by identifying and addressing the contemporary issues that plague harmful behavior treatment with a comprehensive Multimethod-Multipath Behavior Therapy model. SRT also contributes to the literature by focusing directly on increasing social responsibility through the development of multicultural prosocial values as healthy

relationship success skills and competing factors to unhealthy, harmful behavior. Honesty, trust, loyalty, concern and responsibility are what we want from peers, partners, parents and employers who also want these characteristics from us. The value of these characteristics cannot be underestimated. They are the commodities needed to develop the relationships we want, avoid the unhealthy, harmful behavior we don't want and establish the self-esteem we need to succeed in life. While further research is needed, the results of the present study are encouraging for the target referral problem considered primarily harmful to others. SRT application potential studies reveal harmful behavior comorbidity treatment needs in substance abusers with behavior considered harmful to both self and others as well as food abusers/overeaters with behavior considered primarily harmful to self. While research is needed to determine efficacy, clinical practice application of SRT to these other populations on the harmful behavior continuum has thus far revealed a relatively good treatment fit, requiring no significant modifications. The number one responsibility in SRT is self-control. Responsibility involves a willingness to assume self-control over one's behavior; clients are more likely to benefit from treatment when they are willing to assume responsibility and should be held responsible for their own behavior which makes promoting responsibility an important contemporary psychotherapy focus (Overholser, 2005).

References

Baltieri, D. A., & de Andrade, A. G. (2006). Alcohol and drug consumption and sexual impulsivity among sexual offenders. In Brozner, Elaine Y. (Ed), *New research on alcohol abuse and alcoholism.* (pp. 133-154). Hauppauge, NY, US: Nova Science Publishers.

Barnes, G. M., Welte, J. W., Hoffman, J. H., & Dintcheff, B. A. (2005). Shared Predictors of Youthful Gambling, Substance Use, and Delinquency. *Psychology of Addictive Behaviors*, *19*, 165-174.

Basu, A., Paltiel, A. D., & Pollack, H. A. (2008). Social costs of robbery and the cost- effectiveness of substance abuse treatment. *Health Economics*, *17*, 927-946.

Bogenschutz, M. P., Tonigan, J. S., & Miller, W. R. (2006). Examining the Effects of Alcoholism Typology and AA Attendance on Self-Efficacy as a Mechanism of Change. *Journal of Studies on Alcohol*, *67*, 562-567.

Bowen, S., Witkiewitz, K., Dillworth, T. M., Chawla, N., Simpson, T. L., Ostafin, B. D., Larimer, M. E., Blume, A. W., Parks, G. A., & Marlatt, G. A. (2006). Mindfulness meditation and substance use in an incarcerated population. *Psychology of Addictive Behaviors*, *20*, 343-347.

Chapple, C. L., & Hope, T. L. (2003). An Analysis of the Self-Control and Criminal Versatility of Gang and Dating Violence Offenders. *Violence and Victims, 18, 671-690.*

Conason, A. H., & Sher, L. (2006). Alcohol use in adolescents with eating disorders. *International Journal of Adolescent Medicine and Health*, *18*, 31-36.

Dowden, C., & Andrews, D. A. (2007). Utilizing relapse prevention with offender populations: What works. In Witkiewitz, Katie A. (Ed); Marlatt, G. Alan (Ed), *Therapist's guide to evidence-based relapse prevention.* (pp. 339-352). San Diego, CA, US: Elsevier Academic Press

Feng, S. (2005). Rationality and self-control: The implications for smoking cessation. *The Journal of Socio-Economics*, *34*, 211-222.

Field, C. E., Nash, H. M., Handwerk, M. L., and Friman, P. C. (2004). A modification of the token economy for nonresponsive youth in family-style residential care. *Behavior Modification*, 28, 438-457.

Foster, S. L., & Mash, E. J. (1999). Assessing social validity in clinical treatment research: Issues and procedures. *Journal of Consulting and Clinical Psychology, 67, 308-319.*

Gonzalez, J. E., Nelson, J. R., Gutkin, T. B., Saunders, A., Galloway, A., and Shwery, C. S. (2004). Rational emotive therapy with children and adolescents: A meta-analysis. *Journal of Emotional and Behavioral Disorders*, 12, 222-235.

Harris, D., Mazorelle, P. & Knight, R. (2008). The relevance of the general theory of crime for sexual offenders. 27th Annual Research and Treatment Conference of the Association for the Treatment of Sexual Abusers, Atlanta, Georgia.

Higgins, G. E. (2005). Can low self-control help with the understanding of the software piracy problem?. *Deviant Behavior*, *26*, 1-24.

Kluger, A. N., & DeNisi, A. (1996). Effects of feedback intervention on performance: A historical review, a meta-analysis, and a preliminary feedback intervention theory. *Psychological Bulletin*, *119*, 254-284.

Lees, J., Manning, N., & Rawlings, B. (2004). A culture of enquiry: Research evidence and the therapeutic community. *Psychiatric Quarterly, 75, 279-293.*

Lösel, F., & Beelmann, A. (2005). Social Problem-Solving Programs for Preventing Antisocial Behavior in Children and Youth. In McMurran, Mary (Ed); McGuire, James (Ed), *Social problem solving and offending: Evidence, evaluation and evolution.* (pp. 127-143). New York, NY, US: John Wiley & Sons Ltd.

Maramba, G. G., and Hall, G. C. N. (2002). Meta-analyses of ethnic match as a predictor of dropout, utilization, and level of functioning. *Cultural Diversity and Ethnic Minority Psychology*, 8, 290-297.

Marshall, L. E., Marshall, W. L., Fernandez, Y. M., Malcolm, P. B., & Moulden, H. M. (2008). The Rockwood Preparatory Program for sexual offenders: Description and preliminary appraisal. *Sexual Abuse: Journal of Research and Treatment*, *20*, 25-42.

Morgan, Robert D.; Flora, David B. (2001). Convention coverage APA conference August 2000. Poster session: Group dynamics: process, performance, and therapy. Group psychotherapy with incarcerated offenders: A meta-analysis.

Moriarty, N., Stough, C., Tidmarsh, P., Eger, D., & Dennison, S. (2001). Deficits in emotional intelligence underlying adolescent sex offending. *Journal of Adolescence*, *24*, 743-751.

Morrel, T. M., Elliott, J. D., Murphy, C. M., & Taft, C. T. (2003). Cognitive behavioral and supportive group treatments for partner-violent men. *Behavior Therapy*, *34*, 77-95.

Overholser, J. (2005). Contemporary Psychotherapy: Promoting Personal Responsibility for Therapeutic Change. *Journal of Contemporary Psychotherapy*, 35, 369- 376.

Patten, C. A., Decker, P. A., Dornelas, E. A., Barbagallo, J., Rock, E., Offord, K. P., Hurt, R. D., & Pingree, S. (2008). Changes in readiness to quit and self-efficacy among adolescents receiving a brief office intervention for smoking cessation. *Psychology, Health & Medicine, 13*, 326-336.

Petrocelli, J. V. (2002). Effectiveness of group cognitive-behavioral therapy for general symptomatology: A meta-analysis. *Journal for Specialists in Group Work, 27*, 92-115.

Proulx, K. (2008). Experiences of women with bulimia nervosa in a mindfulness-based eating disorder treatment group. *Eating Disorders: The Journal of Treatment & Prevention*, *16*, 52-72.

Rathus, J., Cavuoto, N., and Passarelli, V. (2006). Dialectical behavior therapy (DBT): A mindfulness-based treatment for intimate partner violence. In R. Baer (Ed.), *Mindfulness-Based Treatment Approaches: Clinician's Guide to Evidence Base and Applications* (pp. 333-358). San Diego, CA: Elsevier Academic Press.

Schoepfer, A., & Piquero, A. R. (2006). Self-control, moral beliefs, and criminal activity. *Deviant Behavior*, *27*, 51-71.

Schwartz, S. H., Melech, G., Lehmann, A., Burgess, S., Harris, M., and Owens, V. (2001). Extending the cross-cultural validity of the theory of basic human values with a different method of measurement. *Journal of Cross-Cultural Psychology*, 32(5), 519-542.

Smith, E. P., Wolf, A. M., Cantillon, D. M., Thomas, O., & Davidson, W. S. (2004). The Adolescent Diversion Project: 25 Years of Research on an Ecological Model of Intervention. *Journal of Prevention & Intervention in the Community*, *27*, 29-47.

Stein, D. J., Ives-Deliperi, V., & Thomas, K. G. F. (2008). Psychobiology of mindfulness. *CNS Spectrums*, *13*, 752-756.

Stuart, G. L., Temple, J. R., Follansbee, K. W., Bucossi, M. M., Hellmuth, J. C., & Moore, T. M. (2008). The role of drug use in a conceptual model of intimate partner violence in men and women arrested for domestic violence. *Psychology of Addictive Behaviors*, *22*, 12-24.

Taylor, P. J., Russ-Eft, D. F., & Chan, D. W. L. (2005). A Meta-Analytic Review of Behavior Modeling Training. *Journal of Applied Psychology*, *90*, 692-709.

van den Bos, R., & de Ridder, D. (2006). Evolved to satisfy our immediate needs: Self-control and the rewarding properties of food. *Appetite, 47*, 24-29.

Warnick, E. M., Bracken, M. B., & Kasl, S. (2008). Screening efficiency of the Child Behavior Checklist and Strengths and Difficulties Questionnaire: A systematic review. *Child & Adolescent Mental Health*, *13*, 140-147

Wills, T. A., Ainette, M. G., Stoolmiller, M., Gibbons, F. X., & Shinar, O. (2008). Good self-control as a buffering agent for adolescent substance use: An investigation in early adolescence with time-varying covariates. *Psychology of Addictive Behaviors, 22*, 459-471.

Wilson, D. B., Bouffard, L. A., & Mackenzie, D. L. (2005). A Quantitative Review of Structured, Group-Oriented, Cognitive-Behavioral Programs for Offenders. *Criminal Justice and Behavior*, *32*, 172-204.

Wolff, G. E., & Clark, M. M. (2001). Changes in eating self-efficacy and body image following cognitive-behavioral group therapy for binge eating disorder: A clinical study. *Eating Behaviors*, *2*, 97-104.

Yokley, J. (2002). The treatment of multiple abuser youth in forensic foster care: A social responsibility therapy program description. In B. Schwartz (Ed.), *The Sex Offender, Volume 4*, Chapter 21. Kingston, NJ: Civic Research Institute.

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.

Yokley, J. (2009, August). Multicultural Recognition in Treatment Program Design: Another Path to Explore. 117th Annual Convention of the American Psychological Association, Toronto, ON, Canada.

Yokley, J. & Seeholzer, E. (2009, August). Developing A Comprehensive Treatment for Harmful, Abusive Behavior. 117th Annual Convention of the American Psychological Association, Toronto, Ontario, Canada.

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.