3-19-2014

Acquisition of a Social Problem Solving Method by Caregivers in the Foster Care System: Evaluation and Implications

Evan Ann Skelton

University of South Florida, eskelton@mail.usf.edu

Follow this and additional works at: <https://digitalcommons.usf.edu/etd>

Part of the [Behavioral Disciplines and Activities Commons](#)

Scholar Commons Citation

Skelton, Evan Ann, "Acquisition of a Social Problem Solving Method by Caregivers in the Foster Care System: Evaluation and Implications" (2014). *USF Tampa Graduate Theses and Dissertations*.
<https://digitalcommons.usf.edu/etd/5127>

This Thesis is brought to you for free and open access by the USF Graduate Theses and Dissertations at Digital Commons @ University of South Florida. It has been accepted for inclusion in USF Tampa Graduate Theses and Dissertations by an authorized administrator of Digital Commons @ University of South Florida. For more information, please contact digitalcommons@usf.edu.

Acquisition of a Social Problem Solving Method by Caregivers in the Foster Care System:
Evaluation and Implications

by

Evan A. Skelton

A thesis submitted in partial fulfillment
of the requirements for the degree of
Master of Arts in Applied Behavior Analysis
Department of Child and Family Studies
College of Behavioral and Community Sciences

Co-Major Professor: Kimberly Crosland, Ph.D., BCBA
Co-Major Professor: Hewitt B. “Rusty” Clark, Ph.D., BCBA
Raymond G. Miltenberger, Ph.D., BCBA

Date of Approval:
March 19, 2014

Keywords: emotional, behavioral, decision-making, TIP model, SODAS

Copyright © 2014, Evan A. Skelton

TABLE OF CONTENTS

List of Tables	iii
List of Figures	iv
Abstract	v
Chapter One: Introduction	1
Chapter Two: Method	9
Participants	9
Setting	10
Materials	10
Target Behaviors and Data Collection	11
Target Behaviors	11
Data Collection	11
Researcher Role Plays	12
Youth Participant Role Play Probes	12
Experimental Design	12
Procedures	12
Youth Participant Training	12
Baseline	13
Caregiver SODAS Training	14
Post-Training Assessment	15
Inter-Observer Agreement (IOA)	15
Procedural Fidelity of Youth Participant Performance	15
Social Validity	16
Chapter Three: Results	17
Tables and Figures	18
Chapter Four: Discussion	22
References	27
Appendices	32
Appendix A: SODAS Checklist	33
Appendix B: SODAS Worksheet	34
Appendix C: SODAS Flowchart	36

Appendix D: Youth Participant Scenarios	37
Appendix E: Social Validity Survey	41
Appendix F: Youth Fidelity Checklist	42
Appendix G: Training Fidelity Checklist	43
Appendix H: SODAS Training PowerPoint	44
Appendix I: IRB Approval Letter	57

LIST OF TABLES

Table 1: Results of Social Validity Questionnaire	18
---	----

LIST OF FIGURES

Figure 1: Shows the SODAS problem solving process essential 11 steps	20
Figure 2: Qualitative features of the SODAS problem solving process	21

ABSTRACT

All youth are faced with many social issues and problems on a daily basis, and youth in foster care are often less equipped than their peers to make good decisions for themselves. The SODAS problem solving method is a component of the Transition to Independence Process (TIP) model and is intended for personnel to use with youth to help them make better decisions when faced with difficult situations. The SODAS method is designed to guide youth through a problem solving method for a current situation, and over time to acquire improved problem solving skills. Three caregivers at a group facility for youth in foster care were trained in the use of the SODAS method using Behavioral Skills Training (BST) and were evaluated by the researchers in their use of SODAS in simulated role plays with the researchers and with youth participants to test for generalization of the SODAS method to novel situations. Results showed substantial improvement of caregiver application of the steps on the SODAS method from baseline to the post-training condition when researchers simulated the youth's role. Results also showed that caregiver proficiency generalized to novel situations presented by youth participants during their role play probes.

CHAPTER ONE:

INTRODUCTION

Youth in foster care are generally dealt a bad hand when it comes to circumstances beyond their control. Between the conditions that brought them to live in a foster care setting and the lack of any stability in their home lives, these youth are left at high risk for many serious problems. Youth in foster care are more likely to suffer from emotional or behavioral disorders, lack significant social relationships, be unemployed or impoverished, be incarcerated, and engage in drug and/or alcohol abuse (Barth et al., 2007; Charles & Matheson, 1991). Youth who age out of the foster care system tend to be ill prepared for life outside the residential care walls. Improving the caregiver-youth relationship could potentially be a way to alleviate some of the difficulties these youth have encountered (Barth et al., 2007; Charles & Matheson, 1991).

Caregiver and foster youth relationships are generally strained. Residential foster care placements tend to have high caregiver turnover rates, therefore potentially allowing for inadequate care (Barth et al., 2007; Charles & Matheson, 1991). According to California Youth Connection's 2006 report of the Summary of Foster Youth Speak Outs, youth find caregivers to be unhelpful and unsupportive. Youth are heavily reliant on the caregivers to provide them with resources and support the youth feel are necessary for their lives, yet are overall doubtful of caregiver competency. Some recommendations to address these are to increase quality and quantity of training services caregivers receive, increase the frequency of caregiver evaluations and include foster youth in the hiring process when new caregivers are brought on board

(California Youth Connection, 2006). Also, general caregiver improvement techniques could be utilized such as increasing supervisor monitoring of caregivers and using motivation, via incentives, techniques to keep turnover down and to influence better caregiver performance (Reid, Parsons, & Green, 2012). However, youth would most likely benefit more from caregiver training specifically focused on techniques for improving the lives of youth in foster care.

There are several programs available to caregivers to learn the necessary skills to care for foster youth. Crosland, Cigales et al. (2008), Crosland, Dunlap et al. (2008) and Van Camp et al. (2008) used a behavioral caregiver training program that utilized basic behavior change techniques such as positive reinforcement, differential reinforcement, noncontingent reinforcement, and contracts to increase positive interactions between caregivers and youth. Crosland, Cigales et al. specifically looked at the effect training would have on the use of restrictive procedures used by caregivers in two foster care facilities. They found that following training, both facilities saw a decrease in usage of restrictive procedures with the youth and a decline in the number of restrictive procedure related injuries to caregivers. Crosland, Dunlap et al. evaluated caregiver-child interactions at two group homes for children in foster care. The researchers utilized instruction, group discussion, activities, practice, and role-plays to train caregivers in addition to providing in-home feedback (both positive and corrective). Improvements in child-caregiver interactions were observed in both homes; negative interactions and lack of interactions decreased. Van Camp et al. also evaluated the use of the same behavioral techniques to train foster parents (both relative and nonrelative) to deal with the emotional and behavioral problems that are generally exhibited by youth in long term care (Stoutimore, Williams, Neff, & Foster, 2008). Van Camp et al. found that the training increased the use of the techniques by all parent participants.

All of these parent training studies reviewed incorporated the use of Behavior Skills Training (BST); an evidence-supported way to train staff and caregivers effectively (Gross, Miltenberger, Knudson, Bosch, & Breitwieser, 2007; Hsieh, Wilder, & Abellon, 2011; Lafasakis & Sturmey, 2007; Miles & Wilder, 2009; Miltenberger et al., 2004; Sarokoff & Sturmey, 2004). BST is a treatment package that includes instructions, modeling, rehearsal and feedback. Instructions involve oral discussion of the programs being trained, modeling incorporates the trainers demonstrating to the participants what the behaviors being trained should look like, rehearsal encompasses the trainers asking the participants to practice the behaviors in a role play or simulated situation and feedback includes the trainer providing the participant with praise for the behaviors performed correctly and providing corrective feedback for incorrect responses. Follow-up rehearsals and in-situ trainings are often used until the participant masters the skill.

There are a few other techniques that have been used to increase the chances youth in the foster care system will develop positive social relationships and social problem solving skills needed to improve the likelihood of youth successfully transitioning into adulthood. Some of the techniques that have shown some success are motivational interviewing (MI) (Atkinson & Ames, 2007; Barrowclough et al., 2001; Colby et al., 1998; Kittles & Atkinson, 2009; Lane, Hood, & Rollnick, 2008), the usage of harm reduction strategies (Lee & Zerai, 2010; Ritter & Cameron, 2006; Tatarsky & Kellogg, 2010; Tatarsky & Marlatt, 2010; Tompkins, 2011; Whiteside, Crounce, Pedersen, & Larimer, 2010), and SODAS (a problem solving process extracted from the Transition to Independence Process [TIP] model; Clark & Hart, 2009; Clark, Karpur, Deschenes, Gamache, & Haber, 2008; “Overview of TIP Model”, 2011; “Theory and Research”, 2011).

MI is a process that aims to manipulate the motivation of an individual to set the occasion for him or her to consider changing ones behavior (Atkinson & Ames, 2007; Barrowclough et al., 2001; Colby et al., 1998; Kittles & Atkinson, 2009; Lane et al., 2008). The process is intended to be a therapeutic, non-coercive way to lead individuals to recognize the negative effects their actions have on their life, determine the best ways to go about changing those actions, and commit to the changes. This is accomplished via the use of reflective and open-ended questions designed to support personal change goals. MI is an evidence-based treatment process for adults involved in substance abuse but may possibly be equally effective with youth and young adults in the foster care system (Atkinson & Ames, 2007; Barrowclough et al., 2001; Colby et al., 1998; Kittles & Atkinson, 2009; Lane et al., 2008). Colby et al. (1998) tested MI versus brief advice in a sample of adolescent smokers while Barrowclough et al. (2001) evaluated MI for individuals with schizophrenia who were engaging in substance abuse. The result of these two studies were mixed with the Colby et al. study showing little affect while the Barrowclough et al. study found the treatment package that included MI to be more effective than routine care. Kittles and Atkinson (2009) found that MI was successful in decreasing behavioral problems related to school expulsion for two students. Although MI appears to be a useful treatment option for individuals of different ages and diagnoses, it has its limitations; for example, if the MI process is not effective in bringing an individual to recognize the behavior in question as a problem and he or she has little readiness for change, the likelihood that MI will result in a change in the target behavior is low (Atkinson & Ames, 2007; Barrowclough et al., 2001; Kittles & Atkinson, 2009).

Harm reduction is a framework of strategies that may be utilized to reduce the potential risk factors in the harmful behaviors individuals are engaging in by either reducing the behavior

itself, or altering the environment in which the individual is exhibiting the harmful behavior (Lee & Zerai, 2010; Ritter & Cameron, 2006; Tatarsky & Kellogg, 2010; Tatarsky & Marlatt, 2010; Tompkins, 2011; Whiteside et al., 2010). Essentially, harm reduction is the marriage of philosophical approaches and individualized treatment packages that may include processes such as MI, solution-focused therapy, single-session therapy, cognitive-behavioral therapy, among others. The appeal of harm reduction is that it is a process that encourages building rapport between the counselor and the consumer and strives to remain non-coercive (Lee & Zerai, 2010; Ritter & Cameron, 2006; Tatarsky & Kellogg, 2010; Tatarsky & Marlatt, 2010; Tompkins, 2011; Whiteside et al., 2010). Although injection-drug abuse is the highest researched “risky” behavior for harm reduction strategies, many other behaviors have been targeted as well, such as alcohol, tobacco and non-injection drug use (Ritter & Cameron, 2006; Tatarsky & Marlatt, 2010; Whiteside et al., 2010). Strategies for harm reduction are designed based on where the individual currently stands along the behavior change process instead of pressuring the individual to change (Whiteside et al., 2010). Whiteside et al. (2010) suggested that individuals who may not be ready for change, do not think there is a problem, or are just starting to consider change as an option, may benefit from the use of harm reduction strategies which may yield this strategy as more efficacious than MI. No known studies have evaluated MI or harm reduction specifically with youth in foster care.

A successful technique for improving the lives of young individuals with emotional and behavioral disorders (EBD) is called the Transition to Independence Process, or TIP, model. The TIP model is an evidence-supported practice generally used to aid youth and young adults from ages 14 to 29 years of age with EBD through the transition into adulthood. The TIP model focuses on allowing the youth to achieve his or her potential and gain progress in personal goals

in the areas of employment, education, living situations, personal effectiveness, well-being and community life (Clark et al., 2004; Clark et al., 2008; Clark & Hart, 2009; “Overview of TIP Model”, 2011; “Theory and Research”, 2011). The process utilizes seven core practices in order to aid the youth through this critical transition: 1) strength discovery and needs assessment, 2) futures planning, 3) rationales, 4) in vivo teaching, 5) social-problem solving (SODAS), 6) prevention planning for high risk behaviors, and 7) mediation with young people and other key players (SCORA). In order for caregivers to be able to provide these services they must have smaller caseloads (15 or fewer individuals) and must be able to engage with youth, involve the individual’s family or key players, and tailor supports and services to match the young person’s needs and goals (Clark & Hart, 2009).

Several studies have illustrated positive effects from the use of the TIP model. Clark et al. (2004) found the model helpful in improving postsecondary outcomes of young adults. Results indicated that 24 of the 34 participants were diverted from correctional outcomes, 21 of the 34 participants ceased to accept food stamps, 3 of the 13 participants that were receiving social security income (SSI) ceased from accepting it and 10 of the 13 reduced their SSI benefits. Karpur, Clark, Caproni, and Sterner (2005) used Steps-to-Success, a program based on the TIP model designed to provide educational, psychosocial, and vocational training and follow-up services to youth with EBD. Results showed that those youth with EBD who participated in the program had better overall outcomes than those with EBD who did not participate in the program and that the postsecondary outcomes for those who graduated from the TIP program had outcomes that closely matched the non-classified group (Karpur et al., 2005). Another study by Clark et al. (2008) tested the TIP model and found that youth participating in the model showed increases in employment, graduation, and post-secondary outcomes, and decreases in high school

drop-outs and drug/alcohol and mental health interference. Koroloff, Pullman, and Gordon (2008) found similar results when they used a rendition of the TIP model called Option with 51 youth from 14 to 19-years-old with EBD over a 9 month period. Option focused on improving education, employment, criminal justice, community living skills and housing for the youth. Koroloff et al. found that the youth involved in the program experienced more positive outcomes than negative when compared to youth not involved in the program.

As described by Clark and Hart (2009), one particularly relevant component of the TIP model is the SODAS method (Situation, Options, Disadvantages, Advantages, Solution). The first step of this process is walking through the *situation* at hand. Once the situation is defined, the facilitator can begin brainstorming the many *options* available with the youth. The key to this step is to remain non-judgmental and not rule out any options set forth by either party. The next two steps, listing the *advantages* and *disadvantages* to each of the options, can occur simultaneously (although the acronym lists “D” before “A”, advantages should be listed first). Once all of these steps are taken, the person is better equipped to make an informed decision based on objective information. The decision made is the individual’s *solution* to the situation (Clark & Hart, 2009)

In particular, the SODAS problem solving method, which has not been evaluated independently from the TIP model, seems especially appropriate for working with youth in foster care in that the majority of the issues they face tend to be socially mediated (Barth et al., 2007; Charles & Matheson, 1991). SODAS may be particularly beneficial for youth in foster care to improve their decision-making and create more positive relationships with caregivers. The SODAS method utilizes aspects of motivational interviewing (MI), harm reduction and BST making it a more comprehensive approach, tailored to the age group and circumstances of youth

in this particular study. The purpose of this study is to train the skills necessary to perform the SODAS method within a residential foster care setting using BST. This study is intended to evaluate if caregivers can independently perform the steps in the model and use them during role plays with researchers and generalization role plays with youth participants involving novel situations.

CHAPTER TWO:

METHOD

Participants

Participants were three adults who were caregivers at a local group home facility for youth in foster care. DK was the group home manager and had worked in foster care for many years. His interactions with the youth were generally limited to intervening with the youth when situations became more problematic. TG had been working as a caregiver for many years in this group home facility. She interacted directly with the youth on a daily basis. RC was relatively new to the group home, although he had previous experience in the social service field. He interacted with the youth directly on a daily basis. Eligibility requirements for caregivers included in the study were having daily interactions with the youth, having an interest in learning how to better interact with youth, and being available/willing to participate. Consent of caregivers to be video recorded was obtained prior to the caregivers' involvement in the study. Caregivers were offered an incentive of a \$20 gift card at the completion of the study. There were also three youth, ages 17-22, recruited from outside of the facility (e.g. not in foster care) who served as youth participants. The eligibility requirements for youth who volunteered for this study and participated in the role plays were that they had to have a biological parent who also consented to this arrangement, unless the youth participant was over 18, in which case, consent was obtained directly from the youth. Youth participants were provided an incentive for participation; a gift card of \$10 was given for each youth participant role play completed and a

\$25 gift card was given to each youth at the end of data collection to a store or movie theater of their choice. Youth participants were able to receive up to \$75 in gift cards for the various role plays conducted with the caregivers throughout the duration of the study.

Setting

The study was conducted within a local group home facility for youth in the foster care system. Youth living at the group home attended local county schools and had some access to community activities outside of the facility. There were five individual homes on the campus, each housing a different age range, and sorted by gender. There were 15 girls and 9 boys living on the campus. The particular home that all three caregivers worked in housed only girls ages 16 and 17. There were seven girls living in the home at the time of the study. The role-play sessions were conducted in either a small, empty room within the home in which the caregiver worked, or in an empty home across the courtyard.

Materials

Materials used for training caregivers included a power-point presentation on the SODAS method (Deschênes, Clark, & Huntsman, 2005; see Appendix H), the checklist (adapted from Streetman, 2013; see Appendix A), and the SODAS worksheet (Streetman, 2013; see Appendix B). The scenarios of problem situations (see Appendix D) were used during training and during the role play sessions. Also, a training fidelity checklist was used to collect fidelity on the training of the caregivers to ensure caregivers received adequate training (see Appendix G).

A video camera was utilized during the role plays between the researcher and the caregiver and the caregiver and youth participants in order to score for inter-observer agreement (IOA) and fidelity measures. Data collection materials included a SODAS checklist created in collaboration with another researcher (Streetman, 2013) based on the task analysis of the

SODAS method (see Appendix A). During training, caregivers were provided with this checklist. A fidelity checklist on youth responses was used to determine if the youth performed the steps trained (see Appendix F). Youth participants and caregivers were both also provided with a SODAS flowchart created by the researchers based on the SODAS checklist to map out the responses expected by both parties (see Appendix C). At the end of data collection, caregivers were offered a survey to provide his or her opinions on the study and its implications (see Appendix E).

Target Behaviors and Data Collection

Target Behaviors. The target behavior measured for the caregivers was the use of each of the components/steps of the SODAS method with researchers and youth participants during role play sessions and youth participant probes (Appendix A).

Data Collection. A caregiver was provided different role plays that covered a variety of different problem situations during baseline and the post-training conditions. The same scenarios were used for each caregiver, but no scenarios were repeated. Researchers simulated the youth role for all sessions, while youth participants conducted periodic generalization probe sessions. Data were collected by the observers using the SODAS checklist (see Appendix A) where they recorded if a caregiver used the steps of the process. If the caregiver completed a step, it was scored as a “Y.” If the caregiver skipped a step, performed a step incorrectly, or offered a solution the step was scored as a “N.” In the case of the caregiver skipping a step or performing a particular step incorrectly, the session continued and following steps were still scored. In the case of the caregiver offering a solution, for example telling the youth “you need to...”, the session was terminated and all following steps were scored as “N.” One-third (33%) of all role

plays between caregivers and researchers and all role plays between caregivers and youth participants were videotaped in baseline, during training, and in the post-training condition.

Researcher Role Plays. The caregivers were evaluated through role plays from a pool of thirteen scenarios conducted by the researchers acting as the youth in the situation. Data were collected in the manner discussed above in both baseline and the post-training conditions.

Youth Participant Role Play Probes. Throughout baseline and the post-training condition, the youth participants presented caregivers with problem situations to play out during the probes. There were at least two probes presented by youth participants during baseline and at least one in the post-training condition. The youth checklist (see Appendix F) was used to determine whether the youth were performing the steps they were be trained to use; the youth were scored in the same manner as the caregivers. Each youth participant ran probes with all caregivers and was determined based on mutual availability.

Experimental Design

The study was conducted with role plays between the researcher and caregiver involving a multiple baseline across caregivers design. Youth participant role play probes were conducted periodically throughout baseline and post-training phases.

Procedures

Youth participants were trained in the procedures prior to baseline and post-training conditions. Caregivers were evaluated in baseline prior to receiving training. The post-training condition immediately followed caregiver training.

Youth Participant Training. Each youth participant received training individually by the researchers on how to present a problem situation, to react to the caregiver's use of various steps of the SODAS method, and how to end the interaction. Each youth participant was trained

on the scenarios for use in their role play probes under both baseline and post-training conditions. BST was used by the researchers to train the youth participants -- starting with instructions describing what the youth participant should do in presenting a problem situation and possible reactions to the caregiver for each step of the SODAS method, followed by modeling what the interactions should look like on the part of the youth, and ended with role plays done with the youth participants to prepare him or her for approaching the caregiver. Researchers role played with the youth participant at least three times, changing when the role played situation ended and how the researchers responded. Youth participants were also trained on when to discontinue the interaction with the caregiver. For example, if the caregiver at any point told or suggested to the youth participant what the solution should be in that particular situation, the session was to be terminated by the youth participant. The flowchart (see Appendix C) was provided to the youth participant during training to map out how he or she was expected to respond and to know when to discontinue the conversation with the caregiver. Youth training was relatively brief and took on average about 30 minutes.

Baseline. Out of a pool of 13 problem scenarios, three to five were chosen for baseline use for a given caregiver. Baseline role plays were conducted to determine what, if any, steps in the SODAS method are already being used by each caregiver. Baseline was collected by pairing a participating caregiver with a researcher who simulated a youth concerned about a problem situation (see scenarios in Appendix D). During baseline, there were at least two youth participant role play probes to determine how the caregiver responded to youth presenting a difficult situation. When caregivers failed to use a SODAS step, the researcher or the youth participant responded following the lead of the caregiver. Youth participants were trained on how to end the conversations based on the performance of the caregiver. If a caregiver simply

told the youth participant or researcher what to do verses using the problem solving process, he or she responded to the caregiver with a statement of acceptance such as “ok, I will do that,” and terminated the session.

Caregiver SODAS Training. After baseline, training was conducted in the same facility by the researchers using BST procedures (instructions, modeling, role play, and feedback). This training also provided the caregivers with background information on the TIP model and the SODAS method. Specifically, the SODAS method was described along with its components and the possible benefits to youth and to caregivers. The researchers instructed the caregiver on the use of SODAS and then conducted a trainer role play to model for the caregiver how one would complete the practice in a real-life situation with a youth. After the modeling session, the researcher set up trainer role plays for the caregiver to perform using the skills he or she had been taught and immediately following his or her rehearsal of the skills, the researcher provided feedback. In training, the researcher responded as a cooperative youth would respond during a SODAS session. If a caregiver’s score fell below 100%, additional training would have been provided until he or she was capable of performing all of the steps in the SODAS method. Retraining would have consisted of briefly reviewing the SODAS slides and running through the role plays again, however, retraining was not needed and did not occur with any participants. Generally during training, researchers would prepare caregivers for the challenging ways in which youth might respond to various situations, however, for the purposes of this study, researchers as well as youth participants remained cooperative. Caregivers were, nevertheless, made aware during training of the challenges he or she may encounter in real life situations. Due to the limited availability of the caregivers, training was conducted in about one hour.

Post-Training Assessment. After training, caregivers were presented with all novel scenarios; there were no repeated scenarios from baseline. The same criteria for terminating the session discussed in the training applied in this condition as well. If a caregiver's score fell below 90%, the researcher provided comprehensive corrective feedback immediately following the session by going over the essential and qualitative features of the process again and going step-by-step through their performance.

Inter-Observer Agreement (IOA)

IOA data was collected for approximately 33% of all sessions in baseline, all sessions in post-training condition, and all youth probes by two observers viewing the role plays in baseline and in the post-training condition via either direct observation or video recording. The observers separately scored the caregivers on the steps he or she completed using the SODAS checklist. IOA was also collected for the youth participant role play probes in the same manner as described above. IOA was calculated by dividing agreements by the total number of steps and multiplying the result by 100. An agreement was scored when both observers scored a particular step as a "Y" or an "N," therefore agreeing about the caregiver response. A disagreement was scored when one observer scored a particular step as "N" while the other scored it as a "Y," therefore disagreeing about the caregiver response. IOA was collected on an item-by-item basis. For baseline role plays, IOA was 95% (88%-100%). For role plays in the post-training condition, IOA was 100%. For all youth probes, IOA was 94% (88%-100%).

Procedural Fidelity of Youth Participant Performance

Procedural fidelity was measured for all youth participant role play probes (see Appendix F) to determine how well youth participants followed their part of the flowchart based on the caregivers' initiation of each step of the SODAS method. Using the video recordings, the

observers scored the youth responses following each probe session and generated a percentage of the steps performed correctly. If youth fell below the mastery criterion of 90% accuracy, retraining was provided until they performed at criterion level. Procedural fidelity for youth participants never fell below 90% and across all probes averaged 92%.

Social Validity

Following the completion of the study, caregivers were asked to fill out a social validity questionnaire. The questionnaire aimed to collect caregiver opinion on the effectiveness of training and the use of the SODAS step of the TIP model when working with youth, particularly its potential for success with youth in the foster care system (see Appendix E). The survey contained 12 positive statements and asked the caregivers to rate each statement on a scale of 1 to 5 with 1 being strongly disagree and 5 being strongly agree. Social validity was only collected on two caregivers; RC's last role play session was his last day at the group home and he was unavailable at the completion of the study to complete the questionnaire. Please refer to Table 1.

CHAPTER THREE:

RESULTS

Figure 1 displays the results for the essential steps of the SODAS method for each participant. The essential steps are the main 11 steps that comprise the SODAS method. Each data point represents a role play between researchers and caregivers while the triangles represent youth participant probes. The phase change line signifies when training took place. In baseline, TG performed zero steps in role plays and youth probes. After training, her performance increased to 11. Following her first post-training role play, TG scored an 8 on her youth probe; she immediately received a comprehensive corrective feedback session. TG's second youth probe was scored as a 4; she received another corrective feedback session. Consequently, researchers required TG to use the SODAS worksheet provided in training in all role plays and youth probes thereafter. After the worksheet was utilized, her final role plays were scored as a 10 and 10, and her final youth probe scored as an 11. In baseline, TG performed at 0% in role play sessions and youth probes. In the post-training condition, TG performed with 94% accuracy in role play sessions and 70% in youth probes. In baseline, DK performed at 0% in role play sessions and 0% in youth probes. In the post-training condition, DK performed at 100% in role play sessions and 95% in youth probes. In baseline, RC performed at 6% in the role play sessions and 6% in the youth probes. After training, RC performed at 100% in role play sessions and 100% in the youth probe. All participants eventually reached 90-100% implementation of the essential SODAS steps (see Figure 1 on page 20).

Figure 2 displays qualitative features of the SODAS method. Qualitative features are the components of the SODAS method that are not necessarily essential, but are still recommended to provide a complete SODAS experience. Five features were measured. In baseline TG performed at 27% accuracy for role play sessions and 10% in youth probes. In the post-training condition, TG performed at 87% for role play sessions and 73% in youth probes. On average, DK performed at 40% accuracy in baseline for role play sessions and 40% for youth probes. In the post-training condition, DK performed at 100% for role play sessions and 70% for youth probes. In baseline, RC performed at 30% in role play sessions and 50% in youth probes. In the post-training condition, RC performed at 87% in role play sessions and 100% on the youth probe (see Figure 2 on page 21).

The social validity questionnaire for DK reportedly agreed with most statements with the exception of three receiving a 3, meaning he neither agreed nor disagreed, for an average rating of 3.8. TG reportedly agreed with all statements except one, “I believe using the SODAS method will promote more positive interactions between staff and youth.” TG’s average rating was a 3.75 (see Table 1).

Tables and Figures

Table 1. Results of Social Validity Questionnaire.*

Items	Participants	
	DK	TG
Positive Statements on SODAS		
1. I found the training to be instructive and helpful	4	4
2. I feel I learned a lot about interacting with youth from the training I received	3	4

Table 1. (Continued)

3. I believe the skills I was taught will be effective in interacting with youth	4	4
4. I believe utilizing the skills I learned will significantly help youth in the long term	4	4
5. Youth seem to respond well when I utilize the steps of SODAS	4	4
6. I think the SODAS process will encourage youth to make better decisions	4	4
7. I believe youth will follow through with their "solutions" from SODAS	3	4
8. I believe using the SODAS process will promote more positive interactions between staff and youth	4	2
9. I think all staff should utilize the SODAS process	4	4
10. The SODAS process made it easier to talk to youth about their problems	3	4
11. I believe the SODAS process is easy to do with youth	4	4
12 Overall, I believe SODAS is a helpful and effective technique for youth	4	4

**Given to caregivers to rate each positive statement regarding SODAS. On a scale of 1-5; 1- strongly disagree, 2- disagree, 3- neither agree nor disagree, 4- agree, 5- strongly agree. Average rating for both caregivers was 3.75.*

Figure 1. Shows the SODAS problem solving process essential 11 steps. The y axis displays the number of steps required to perform. The x axis displays sessions. Blue diamonds represent role play sessions. Black triangles represent youth participant probes.

Figure 2. Qualitative features of the SODAS problem solving process. The y axis represents the qualitative features of the SODAS method. The x axis represents sessions. The blue diamonds represent role play sessions. Black triangles represent youth participant probes.

CHAPTER FOUR:

DISCUSSION

These results suggest that caregivers in the foster care system were able to acquire the necessary skills needed to conduct a SODAS session with youth and young adults. This is important for caregivers to have in the foster care setting because it could potentially improve the decision-making abilities of the youth as well as the relationships between the youth and caregivers. According to previous research on the TIP model, improvement in these areas could lead to less correctional consequences, less reliance on government assistance, an increase in graduation and employment, and a decrease in high school drops outs (Clark et al., 2004; Clark et al., 2008; Karpur et al., 2005). Results also show that not only did caregivers acquire the skills, they maintained the skills over several weeks/months during data collection.

While the study showed positive results, it was not without its difficulties. The single most prevalent problem that occurred throughout the study was caregiver scheduling. This particular home in this local foster care setting generally kept only one or two caregivers on staff at any given time. Because of this, it was difficult to conduct individual trainings and sessions without interruptions and delays. The study started out with four caregivers from the group home, but due to scheduling conflicts with researchers and youth participants, one participant had to be dropped. Some of the trouble with scheduling was due to the fact that each caregiver had a different schedule. With the exception of one caregiver, there was no overlap in schedules, making it very difficult to schedule more than one session at a time. While DK did have some

overlap with other caregivers, he was often unavailable because he was the supervisor of the house and generally had obligations outside of the home such as meetings and trainings. Other issues we came into contact with scheduling was the lack of a second caregiver to stay with the girls while the session took place, caregivers needing to leave campus to take one of the girls to school, an extracurricular activity, etc., incidents with the girls such as runaways or fights, and being unable to get in contact with any given caregiver to make arrangements as all sessions were scheduled over the phone. Cancelled sessions also occurred at the last minute, usually for one of the reasons listed above. This thinning of the caregiver's attention could also inhibit them from conducting a SODAS session with a young person needing help with a difficult problem. These availability issues also made training difficult. During training, there were always several interruptions and distractions. Because scheduling was an issue, at times there were weeks between sessions. There was a span of five months between the date of training and the last data point collected for both TG and DK; there was a span of 2 weeks between training and the last data point for RC. In spite of the lapse of time, caregivers maintained the skills they learned in training showing strong acquisition.

The second biggest issue faced was the nervousness spawned by participating in role plays. Both caregivers and youth participants expressed feeling uncomfortable doing role plays. Three youth participants dropped out of the study because they felt uncomfortable doing role plays with the caregivers. It is also believed that some of the difficulty scheduling sessions with one particular caregiver could potentially be due to apprehension over the role plays.

Unfortunately, this is a necessary component of this project and no accommodations could have been offered to alleviate this other than an attempt to make the session as positive as possible by providing positive feedback after the session and reminding the caregiver of the gift card

incentive. It should be noted that it is also possible that being videotaped caused some of the discomfort reported. While caregivers may have voiced complaints over role plays, the results show this did not affect caregiver performance suggesting the aversion was minimal/insignificant.

Another issue that surfaced during data collection in the post-training phase was remaining neutral. TG had a difficult time not making negative comments about options she found to be unhealthy (seen in the fourth session and fourth youth probe). Along with remaining neutral or non-coercive, TG may have had difficulty maintaining the skills she learned in training as previously mentioned. It could not be determined whether TG had difficulty maintaining the skills she learned or if her skills did not generalize to youth participants, however, after a decline in her youth participant probe scores was seen, in spite of comprehensive corrective feedback, she was required to use the worksheet provided during training. The worksheet acts as a visual prompt to lead the caregiver through the process; an acceptable practice in the use of the SODAS method. The other caregivers were encouraged to use the worksheet or notebook paper as well but declined because they felt comfortable enough to do it without an aid.

Another limitation was possible lack of generalization to youth participants. As stated above, it was unclear if TG's skills did not generalize to youth participants or if she was not maintaining the skills. A potential lack of generalization to youth participants was also seen in the qualitative features for DK; this was not as concerning because his skills showed generalization in the essential steps. Along with this, youth participants and researchers remained cooperative with the caregivers during role plays. It was only briefly discussed during training what difficulties caregivers may encounter with uncooperative youth while using the SODAS

method. Because of this, it cannot be known whether or not the skills will truly generalize to the youth in foster care.

Results of the social validity questionnaire suggest the caregivers are open to using the SODAS method and believe it could be beneficial to use with the youth in their group home. The lowest rating given was by TG for statement 8, “I believe using the SODAS method will promote more positive interactions between staff and youth.” It was unclear as to why TG disagreed with the statement and it was inconsistent with her ratings of all other statements regarding the potential positive impact the SODAS method could have on youth in foster care. It was also inconsistent with DK’s rating of that statement. However, as group home manager, DK’s interactions with the youth in the home may differ from TG’s interactions as a caregiver. Overall, the results from the questionnaire were positive. It’s worth noting that while social validity results showed that caregivers may find the SODAS method to be a useful tool in working with youth and young adults, it may not be appropriate for all situations. TG verbally reported she believed it was unlikely that many youth in the foster care system would cooperate with the caregivers in a SODAS session, but that they could use individual components, such as remaining neutral/non-coercive and encouraging the youth to generate healthy solutions, in most interactions.

The implications of the results of this study are encouraging because they show that SODAS is a socially acceptable and acquirable process for caregivers to implement, even if it needs to be modified to fit within their stressed and heavy workloads. Ideally, this study would have used youth in the foster care system rather than youth participants, but for its purposes, it was not necessary and may have resulted in complications if youth at this facility had been used. In the future, researchers could test the SODAS method with youth actually in the foster care

setting, compare the difference in individual performance between group training and individual training of caregivers, evaluating the difference in caregiver performance using the SODAS worksheet with vs. without training, replicate this or other studies evaluating the TIP model to see if results generalize, or further the research by including other components of the TIP model.

Developing social problem solving skills is a necessary skill one must learn in order to make healthy, appropriate decisions in life. Training caregivers to use these skills with a population of youth that would otherwise have little practice in this area is crucial in improving the way they make decisions, and therefore, improving their quality of life. The ultimate goal of this research is to improve the relationships between caregivers and youth in the foster care system, and to therefore improve the lives of the youth by aiding them in making better life choices. While caregivers were skeptical about the feasibility of implementing SODAS, they showed that they were capable of learning the skills to do so and were positive about the impact SODAS could potentially have on youth such as encouraging the youth to make better decisions and having a long-term, positive influence on their decision-making skills.

REFERENCES

- Atkinson, C. & Ames, M. (2007). Using solution-focused approaches in motivational interviewing with young people. *Pastoral Care in Education: An International Journal of Personal, Social and Emotional Development*, 25 (2), 31-37.
- Barrowclough, C., Haddock, G., Tarrier, N., Lewis, S.W., Moring, J., O'Brien, R., Schofield, N., & McGovern, J. (2001). Randomized controlled trial of motivational interviewing, cognitive behavior therapy, and family intervention for patients with comorbid schizophrenia and substance use disorder. *American Journal of Psychiatry*, 158, 1706-1713.
- Barth, R.P., Lloyd, E.C., Green, R.L., James, S., Leslie, L.K., & Landsverk, J. (2007). Predictors of placement moves among children with and without emotional and behavioral disorders. *Journal of Emotional and Behavioral Disorders*, 15, 46-55.
- California Youth Connection. (2006). *Summary of Foster Youth Speak Outs*. San Francisco, CA: Author Unknown.
- Charles, G. & Matheson, J. (1991). Suicide prevention and intervention with young people in foster care in Canada. *Child Welfare*, 70, 185-191.
- Clark, H.B. & Hart, K. (2009). Navigating the obstacle course an evidence-supported community transition system. In H.B. Clark & D.K. Unruh (Eds.), *Transition of Youth & Young Adults with Emotional or Behavioral Difficulties* (pp. 47-113). Baltimore, MD: Paul H. Brookes Publishing Co.

- Clark, H.B., Karpur, A., Deschenes, N., Gamache, P., & Haber, M. (2008). Partnerships for youth transition (PYT): overview of community initiatives and preliminary findings on transition to adulthood for youth and young adults with mental health challenges. *National Center on Youth Transition for Behavioral Health (NCYT)*, 1-9.
- Clark, H.B., Pschorr, O., Wells, P., Curtis, M., & Tighe, T. (2004). Transition into community roles for young people with emotional or behavioral disorders: collaborative systems and program outcomes. *Collaborative Systems and Program Outcomes* (201-225). Arlington, VA: Council for Children with Behavioral Disorders and the Division of Career Development and Transition.
- Colby, S.M., Monti, P.M., Barnett, N.P., Rohsenow, D.J., Weissman, K., Spirito, A., Woolard, R.H., & Lewander, W.J. (1998). Brief motivational interviewing in a hospital setting for adolescent smoking: a preliminary study. *Journal of Consulting and Clinical Psychology*, 66, 574-578.
- Crosland, K.A., Cigales, M., Dunlap, G., Neff, B., Clark, H.B., Giddings, T., & Blanco, A. (2008). Using caregiver training to decrease the use of restrictive procedures at two facilities for foster care children. *Research on Social Work Practice*, 18, 401-409.
- Crosland, K.A., Dunlap, G., Sager, W., Neff, B., Wilcox, C., Blanco, A., & Giddings, T. (2008). The effects of caregiver training on the types of interactions observed at two group homes for foster care children. *Research on Social Work Practice*, 18, 410-420.
- Deschênes, N., Clark, H., B., Herrygers, J., Blase, K., Wagner, R. (2007). TIP Model Orientation Modules (Module 1). Retrieved from <http://www.tipstars.org/TIPModelOrientationTraining.aspx>

- Gross, A., Miltenberger, R., Knudson, P., Bosch, A., & Breitwieser, C.B. (2007). Preliminary evaluation of a parent training program to prevent gun play. *Journal of Applied Behavior Analysis, 40*, 691-695.
- Hsieh, H.H., Wilder, D.A., & Abellon, O.E. (2011). The effects of training on caregiver implementation of incidental teaching. *Journal of Applied Behavior Analysis, 44*, 199-203.
- Karpur, A., Clark, H.B., Caproni, P., & Sterner, H. (2005). Transition to adult roles for students with emotional/behavioral disturbances: a follow-up study of student exiters from steps-to-success. *Career Development for Exceptional Individuals, 28*, 36-46.
- Kittles, M., & Atkinson, C. (2009). The usefulness of motivational interviewing as a consultation and assessment tool for working with young people. *Pastoral Care in Education, 27*, 241-254.
- Lafasakis, M. & Sturmey, P. (2007). Training parent implementation of discrete-trial teaching: effects on generalization of parent teaching and child correct responding. *Journal of Applied Behavior Analysis, 40*, 685-689.
- Lane, C., Hood, K., & Rollnick, S. (2008). Teaching motivational interviewing: using role play is as effective as using simulated patients. *Medical Education, 42*, 637-644.
- Lee, H.S. & Zerai, A. (2010). "Everyone deserves services no matter what": defining success in harm-reduction-based substance user treatment. *Substance Use and Misuse, 45*, 2411-2427.
- Miles, N.I. & Wilder, D.A. (2009). The effects of behavioral skills training on caregiver implementation of guided compliance. *Journal of Applied Behavior Analysis, 42*, 405-410.

- Miltenberger, R.G., Flessner, C., Gatheridge, B., Johnson, B., Satterlund, M., & Egemo, K. (2004). Evaluation of behavioral skills training to prevent gun play in children. *Journal of Applied Behavior Analysis, 37*, 513-516.
- Overview of TIP Model. *Transition to Independence Process (TIP) Model*. (2011). Retrieved March 1, 2011, from tipstars.org/OverviewofTIPModel.aspx.
- Reid, D.H., Parsons, M.B., & Green, C.W. (2012). *The Supervisor's Guidebook: Evidence-Based Strategies for Promoting Work Quality and Enjoyment Among Human Service Caregiver*. Morganton, NC: Habilitative Management Consultants, Inc.
- Ritter, A. & Cameron, J. (2006). A review of the efficacy and effectiveness of harm reduction strategies for alcohol, tobacco and illicit drugs. *Drugs and Alcohol Review, 25*, 611-624.
- Sarokoff, R.A. & Sturmey, P. (2004). The effects of behavioral skills training on caregiver implementation of discrete-trial teaching. *Journal of Applied Behavior Analysis, 37*, 535-538.
- Stoutimore, M.R., Williams, C.E., Neff, B., & Foster, M. (2008). The Florida child welfare behavior analysis services program. *Research on Social Work in Practice, 18*, 367-376.
- Streetman, C. (2013). *The acquisition and usage of the SODAS problem solving method among adults at-risk for homelessness*. Unpublished master's thesis, University of South Florida, Tampa, Florida.
- Tatarsky, A. & Kellogg, S. (2010). Integrative Harm Reduction Psychotherapy: A case of substance use, multiple trauma, and suicidality. *Journal of Clinical Psychology: In Session, 66*, 123-135.

- Tatarsky, A. & Marlatt, G.A. (2010). State of the art in harm reduction psychotherapy: an emerging treatment for substance misuse. *Journal of Clinical Psychology: In Session*, 66, 117-122.
- Theory and Research Underpinnings Supporting the Transition to Independence Process (TIP) Model. *Transition to Independence Process (TIP) Model*. (2011). Retrieved March 1, 2011, from tipstars.org/Portals/0/pdf/tip_model_theory_research.pdf.
- Tompkins, M. (2011). Working with families of people who hoard: a harm reduction approach. *Journal of Clinical Psychology: In Session*, 67, 497-506.
- Van Camp, C.M., Vollmer, T.R., Goh, H.L., Whitehouse, C.M., Reyes, J., Montgomery, J.L., & Borrero, J.C. (2008). Behavioral parent training in child welfare: evaluations of skills acquisition. *Research on Social Work in Practice*, 18, 377-391.
- Whiteside, U., Cronic, J.M., Pedersen, E.R., & Larimer, M.E. (2010). Brief motivational feedback for college students and adolescents: a harm reduction approach. *Journal of Clinical Psychology: In Session*, 66, 150-163.

APPENDICES

Appendix A: SODAS Checklist

Components Performed by the Participant Guiding the SODAS Process		
1. Participant (P) asks the Role-player (RP) to define the Situation as clearly and behaviorally specific as possible. S	Y	N
2. P guides the RP to generate at least 3 Options related to the problem situation. A. Option 1 B. Option 2 C. Option 3 O	Y Y Y	N N N
P prompts and assists the RP in listing Advantages and Disadvantages for each Option. P is to guide RP to proceed in this order. Option 1 A. Advantages (at least one is generated for each A and D) B. Disadvantages Option 2 C. Advantages D. Disadvantages Option 3 E. Advantages F. Disadvantages D A	Y Y Y Y Y Y	N N N N N N
3. P guides the RP to select an Option, modify Options, or combine Options to create a “Solution” to the situation. S	Y	N
Total Essential Steps of SODAS		11
Qualitative Interactional Features: A. P solicits input from the RP at least once. B. P summarizes the RP’s Situation at least once. C. P summarizes RP’s Options at least once. D. P summarizes RP’s Advantages/Disadvantages at least once. E. P remains open to all Options (e.g. does not comment negatively about an Option, or make negative facial expressions).	Y Y Y Y Y	N N N N N
Total		5

Appendix B: SODAS Worksheet

SODAS Worksheet

Name of Adult: _____ Date: _____

Person conducting SODAS with Adult _____

Define the Situation (who, what, where, when, how):

Brainstorm the Options:

Option 1: _____

Option 2: _____

Option 3: _____

List the Advantages and Disadvantages associated with each:

Option 1	
Advantages	Disadvantages
1.	1.
2.	2.
3.	3.
4.	4.

Option 2	
Advantages	Disadvantages

1.	1.
2.	2.
3.	3.
4.	4.

Option 3	
Advantages	Disadvantages
1.	1.
2.	2.
3.	3.
4.	4.

Select a Solution:

Follow-up:

Appendix C: SODAS Flowchart

SODAS Flowchart

Confederate Youth approaches staff...

NOTES:

- If staff skips or misses a step, but proceeds with following step correctly, continue process.
- Staff members are permitted to contribute to the development of options and advantages/disadvantages.
- Staff members must provide descriptive praise, remain non-judgmental throughout session and solicit confederate for information at least once.

Appendix D: Youth Participant Scenarios

Scenario 1: Today, a friend approached you at school and said they heard a rumor that you supposedly had spread about them (which in actuality, you did not). Due to the severity of the rumor, they not only no longer want to be your friend, they begin spreading horrible, untrue rumors about you in retaliation. You confront your friend about it to try to discuss the situation reasonably, but instead they tell you they want to settle it by fighting tomorrow after school in the school caregiver's parking lot.

Option 1: Go to the parking lot and refuse fight your friend, try to talk instead.

Option 2: Don't show up to the parking lot at all.

Option 3: Go to the parking lot and fight your friend.

Scenario 2: A couple of months ago you decided to take up smoking after being offered a cigarette by a close friend. However, today you were caught smoking on school grounds by your favorite teacher. The teacher, being the nice person he is, decided to cut you a deal. If you promised to quit smoking completely, he would not report you to the principle, who would in turn, suspend you. Your teacher expects you to report to him every day for two weeks on the matter or he plans to take the situation to the principle. You, on the other hand, believe you are addicted to cigarettes and really do not want to quit.

Option 1: Try to slowly wean yourself off of cigarettes.

Option 2: Buy nicotine gum and quit smoking.

Option 3: Lie to your teacher and tell him you quit, but keep smoking.

Scenario 3: Your best friend approached you the other day, offering to sell you a really nice pair of shoes for a ridiculously low price you couldn't pass up. Your friend told you they were given to them by a family member and they weren't their style. You happily gave your friend the money, and accepted the shoes. Today, you saw your best friend offering another pair of the same exact shoes to someone else at school; you decided to confront them and ask why they have more than one pair. Your friend took you aside and quietly told you they stole them from the department store at the mall to sell them because they needed some extra cash.

Option 1: Take the shoes back to the department store and explain what happened.

Option 2: Keep the shoes, but never trust your friend to sell you something again.

Option 3: Sit down with your friend and try to come up with more honest ways of earning money.

Scenario 4: For the last several months, there has been a caregiver at the foster home facility that has been giving you a hard time. The caregiver teases you about your appearance, gets you

in trouble every opportunity they can, and you are starting to suspect (although have no proof) that they are stealing from your bedroom when you are not there. You're fed up with the way you're being treated and decide you really want to run away.

Option 1: Run away.

Option 2: Report caregiver to her supervisor.

Option 3: Confront caregiver about the issue.

Scenario 5: There is this kid at school that has been harassing you for a few weeks now. At lunch time, they drop or spill food on you, they take things without asking, they call you names and tease you, and they hit, kick and trip you when others aren't looking. You have been trying for a while, but can't seem to get them caught and don't feel confident enough to stand up for yourself because they are much bigger than you are.

Option 1: Tell the principle about the kid.

Option 2: Start bullying the kid back.

Option 3: Confront the kid and ask why he harasses you.

Scenario 6: You've been having trouble in your math class this semester. You do all of your homework but it doesn't seem to help you to understand the material enough to take a test. You've been aware of your poor performance in class, but today your math teacher told you that you are failing the class at this point. The teacher told you there may be some extra work you could do to try to bump up your grade some, but you think there is no point because you don't understand the work and feel completely hopeless.

Option 1: Take the extra credit work and hope for the best.

Option 2: Ask for tutoring.

Option 3: Fail math. Who cares about school anyways?

Scenario 7: Lately you have been skipping class a lot to hang out with your friends at their house when their parents are not home. You and all of your friends start doing poorly in your classes due to absences and one of your friends has decided to completely drop out. They tell you that they can get a job without a high school diploma so there is no point in going. Even though the job you've always wanted requires a diploma, you start feeling persuaded to drop out too. After all, you're already on the verge of failing and hanging out with your friends is so much better than being in school.

Option 1: Realize that you need to stay in school and graduate to do what you want and start going back to class.

Option 2: Don't drop out, but don't worry about passing classes this semester.

Option 3: Drop out.

Scenario 8: You started a job about 6 months ago that pays well enough to provide you with the money to do what you like to do, but you're unsure if you want to keep it because one of your supervisors is really mean. They seem to be holding a grudge against you for being late to work during your very first week, even though you've been on time ever since. They stick you with the worst tasks, give you minimal hours and the worst shifts on the schedule. Overall, you like your job and your coworkers, but your supervisor is pushing you to the point of quitting.

Option 1: Confront your supervisor and ask what you can do to be a better employee.

Option 2: Don't quit, but start looking for a job elsewhere.

Option 3: Quit and look for another job.

Scenario 9: You have become pretty close friends with a coworker that tends to work the same shifts that you do. You hang out with her outside work often and really enjoy her company. A couple of days ago, you caught her stealing a \$20 bill out of the cash register at work. You don't want her to get in trouble and possibly lose her job, but you know stealing is wrong and you don't want to get blamed if the register comes up short.

Option 1: Confront her outside of work and try to convince her to put the money back.

Option 2: Tell your supervisor that there is an employee that has possibly been stealing.

Option 3: Completely ignore the situation.

Scenario 10: You have been struggling in one of your harder classes this semester and you have been getting really frustrated that this one particular girl has done surprisingly well so far. She annoys you because she brags about her scores and puts others down for their lower scores. However, during a recent test, you saw her looking at answers she wrote on a cheat sheet. You can't really prove she's been cheating the whole time, and she would never admit to it.

Option 1: Tell your teacher she's been cheating.

Option 2: Wait until the next test and watch for her cheat sheet again and call her out if you see it.

Option 3: Make your own cheat sheet for the next test.

Scenario 11: Two of your close friends recently started dating each other and things seem to be getting pretty serious between the two. At first, you were happy for them; they know each other really well and they are cute together. But yesterday you overheard a rumor that your friend was cheating on the other. You're not sure if the rumor is true, but you're worried.

Option 1: Talk to the accused friend to find out what he/she has to say.

Option 2: Tell your possibly wronged friend that he/she is being cheated on.

Option 3: Try to trace the rumor back to the source and try to get the truth before confronting anyone.

Scenario 12: Two friends that you spend a lot of time with are currently fighting. You have been trying to stay out of the situation but, naturally, you are having trouble avoiding it. Both of your friends are independently dragging you in the middle of the situation and, subsequently, fighting over you. You really don't want to be involved, but they are asking you to choose sides.

Option 1: Tell them both you cannot hang out with either one until they have resolved their differences because you refuse to get involved.

Option 2: Hear them both out and try to see both perspectives while remaining impartial.

Option 3: Bring them both together and force them to work things out.

Scenario 13: For the longest time, you have had a crush on this guy at school. Your friends have all known about it since the beginning, but you are too afraid to tell him. You have no idea how he feels about you and cannot stand the thought of rejection. You have waited too long and now he's dating someone else; one of your friends. You're so angry at her, but at the same time feel like it's unfair to be angry because you haven't made a move.

Option 1: Confront your friend and tell her how you feel about the situation.

Option 2: Steal the guy out from under your friend.

Option 3: Try to move on.

Appendix E: Social Validity Survey

Caregiver Survey

Instructions: On a scale of 1 to 5, please rate your opinion of each question.

1 = strongly disagree 2= disagree 3= neither agree nor disagree 4= agree 5= strongly agree

1. I found the training to be instructive and helpful.	1	2	3	4	5
2. I feel I learned a lot about interacting with youth from the training I received.	1	2	3	4	5
3. I believe the skills I was taught will be effective in interacting with youth.	1	2	3	4	5
4. I believe utilizing the skills I learned will significantly help youth in the long run.	1	2	3	4	5
5. Youth seem to respond well when I utilize the steps of SODAS.	1	2	3	4	5
6. I think the SODAS process will encourage youth to make better decisions.	1	2	3	4	5
7. I believe youth will follow through with their “solutions” from SODAS.	1	2	3	4	5
8. I believe using the SODAS process will promote more positive interactions between caregiver and youth.	1	2	3	4	5
9. I think all caregiver should utilize the SODAS process.	1	2	3	4	5
10. The SODAS process made it easier to talk to youth about their problems.	1	2	3	4	5
11. I believe the SODAS process is easy to do with youth.	1	2	3	4	5
12. Overall, I believe SODAS is a helpful and effective technique for youth.	1	2	3	4	5

Appendix F: Youth Fidelity Checklist

S.O.D.A.S. (Youth)

<u>STEP TO PERFORM</u>		
1. Approach staff with a problem situation	Y	N
2. Define the situation as clearly and behaviorally as possible	Y	N
3. Allow caregiver to introduce SODAS	Y	N
4. Brainstorm with caregiver to identify as many options to address the situation as possible (2-4 options ideally)	Y	N
5. Allow caregiver to summarize options; if caregiver summary is correct provide confirmation, if not, correct caregiver	Y	N
6. List, with the caregiver, the advantages for each option provided	Y	N
7. List, with the caregiver, the disadvantages for each option provided	Y	N
8. Summarize, with the caregiver, each option and the associated advantages and disadvantages	Y	N
9. Select the most appealing option based on the advantages and disadvantages provided.	Y	N

Notes: _____

Appendix G: Training Fidelity Checklist

Training Fidelity Checklist		
1. Briefly describe and provide background of training process and SODAS	Y	N
2. Define SODAS	Y	N
3. Use SODAS PowerPoint to supplement training	Y	N
4. Provide model for participant of what interaction should look like	Y	N
5. Follow up with any questions	Y	N
6. Have participant perform role play	Y	N
7. Provide feedback	Y	N
8. Score and repeat role plays & feedback until participant is performing at 100% of Essential SODAS steps	Y	N
Participant Name:	Score:	

Appendix H: SODAS Training PowerPoint

- Problem-Solving & Decision-Making

Integral part of daily life

What are some decisions we face on a daily basis?

Easy Decisions...

Hard Decisions...

Social and Non-Social decisions

- Teaching Adults to make better decisions & resolve problems helps them to...

Get along with others better.

↑ **Ability to develop and maintain close relationships.**

↑ **Control over outcomes of situations.**

Feel more control over situations.

Improve their quality of life.

- Preparation of Adult for SODAS

Facilitator introduces the person to the SODAS process.

Explain benefits of problem-solving.

Uses *clear, specific, relevant* Rationales.

- O = Options

Help person generate possible options

Accept all options – evaluate later

Reinforce person for options – even if you don't like them

Rules of Brainstorming

- O = Options

Types of Questions that can assist in generating options:

- What might be done to solve the problem?

- How might you achieve your goal?

- What do you want to do?

- What else might you do? What about...?

- We have _____ on the list, might you want to considering putting _____ on the list?

- A = Advantages

D = Disadvantages

Help the adult explore the realistic A & D of each option

May involve revising or combining aspects of options

How does exploring

the A & D of each

Option assist the person?

- S = Solution

Guide the adult in selecting an option that is safe.

Choice must be **owned** by the person.

Will the solution resolve the situation described initially?

How will you pull it off?

Does the solution involve interaction w/another person?

•Follow-up:

Asking & Discovering

•Possible Questions for Defining the Situation

•“What is the problem?”

•“What are the feelings involved with the situation?”

–“ What do you feel?”

–“ What do family members feel when the problem occurs?”

–“How do others feel such as friends, employers, teachers etc.?”

•“What stops you from...?”

•“How do you feel when...?”

•“What happens after you...?”

•” What exactly was said when...?”

•Follow-up: Solution Did Not Resolve Situation

Normalize multiple tries for a solution

Learning opportunity for person, instead of a failure

Get new info for further problem-solving/decision-making

Give descriptive praise for effort & persistence

- Benefits to Adult Using SODAS

- Action:

SODAS Training – Read From Examples in Appendix C

- What challenges may occur when applying SODAS with a person?

- Challenge 1: Participation

Goal = get person contributing to brainstorming

Remind person that all options can be listed

Praise any attempts to participate

Foster interest though rationales or direct open-ended questions

May need to elicit options by modeling some

- Challenge 2: Facilitator Stays Non-judgmental

person may list options that are dangerous, silly, extreme, or impossible

Avoid saying: “That’s a good one, but I don’t know about this? Do you really think this is a good idea?”

- Challenge 3: Validating *all* Disadvantages

Don’t ignore **Disadvantages** of your “favored” option

person will only implement an Option if:\

person has ownership of it.

If the option holds reinforcers for the person.

- Challenge 4: person Selects Harmful Solution

Discuss potential consequences – don't ignore advantages

Use Rationales & care statements

Refer to "Prevention Plan"

Follow-up as required

- "The Righting Reflex"**

We helpers have a powerful desire to set things right, to heal, to prevent harm, and to promote well-being.

This is the "Righting Reflex."

- "The Righting Reflex"**

When we voice the arguments for change, persons naturally respond by defending the other side.

The more person verbalizes the

disadvantages of change, the

more *committed* they become

to *avoiding change*.

- Resist "The Righting Reflex"**

- Effective Usage of SODAS Exercise***

•Rating Effectiveness of Usage

•*Antonio, a facilitator, is using SODAS to help Sandra solve a problem situation that arose at work. Do you think his actions are effective or not effective facilitation of SODAS?*

•**The problem at work is causing Sandra to worry about losing her job. Antonio includes Sandra's feelings in the description of the Situation.**

•Effective _____

•Not Effective _____

•**Sandra suggests that one option is to quit her job and move back home. Antonio reminds her that this option is not in line with her dreams and would make it less likely for her to meet her transition goals.**

•Effective _____

•Not Effective _____

•Rating Effectiveness of Usage

•**While brainstorming options, Antonio and Sandra begin to discuss the effects of implementing one of the options.**

•Effective _____

•Not Effective _____

•**After Sandra offers one Option, she claims to have run out of ideas. Antonio suggests an Option to add to the list and encourages Sandra to continue brainstorming.**

•Effective _____

•Not Effective _____

•**Antonio discusses Disadvantages before Advantages because he wants to get the negatives out of the way so he and Sandra can focus on the positives.**

•Effective _____

•Not Effective _____

•Rating Effectiveness of Usage

•**When reviewing the Options to select the Solution, Antonio asks Sandra how feasible the Option is for her to do.**

•Effective _____

•Not Effective _____

•**When following up, Antonio discovers that Sandra has not implemented the Solution because she is not comfortable with interacting with her supervisor, a necessary action to implement the Solution. Antonio suggests that they role-play the interaction until Sandra is comfortable. Antonio encourages her to not give up on her solution.**

•Effective _____

•Not Effective _____

•**Effective.** The Situation description includes “who, what, where, when, and how” of the problem.

•**Not Effective.** When brainstorming Options, all ideas are accepted for later discussion.

•**Not Effective.** Michael's actions are not in concert with the rules of brainstorming. Michael and Sandra should review the rules of brainstorming before beginning this activity. When tempted to discuss the merits of ideas, Michael can remind Sandra (and himself) that the merits will be discussed after all options have been identified.

•**Effective.** Michael encourages Sandra to come up with Options. Only after she appears to be out of ideas does he offer one of his own ideas to spur her thinking.

•**Not Effective.** By starting with Advantages, Michael would start the discussion on a positive note which might minimize the negativity of the Disadvantages.

•**Effective.** By asking how feasible an Option is to do, Michael encourages Sandra to think about the ease of implementation as a criteria for selecting a Solution.

•**Effective.** Michael found out why Sandra had not implemented the Solution and offered assistance to address the reason why.

•Help person Use SODAS on their Own

Remind person of a situation where SODAS could be useful

Ask person to practice – commit to reviewing at next meeting

Review rationales for learning & using SODAS

Provide encouragement & descriptive praise

Remind person – we all need help at times thinking through tough problems

•Additional Useful Qualities of **SODAS**

•SODAS links thought with action.

–In order to help Adult (or Adult) with this, it is necessary to be both *thorough* and *efficient*

- Facilitator must help person (and self!) to stay *organized* in process

- Summarize* and record *each component of process* or, when appropriate, have person do these things.

•Preparation of Adult for SODAS

- The Facilitator makes the Adult feel comfortable

- Introduces the person to the SODAS process

- Explains how using problem-solving and decision-making can benefit the person

•S = Situation

- Facilitator gets a clear and complete picture of the situation

- What is the problem?

- Who, what, where, when, & how.

- As clear and behaviorally specific as possible.

- What are the feelings involved with the situation

- person's feelings?

- What do family members feel when the problem occurs?

- How do others feel, e.g., friends, employer, teacher?

- Sample questions

- What happened after you...?

- What exactly was said when...?

- How do you/others feel when...?

•O = Options

- Assist Adult in generating possible options
- Accept all of the options – evaluate later
- Reinforce Adult for ideas and options – no matter what you think of the specific items
- Questions that can assist in generating options...
 - How can you achieve your goal?
 - What can be done to solve the problem?
 - What do you want to do?
 - What else could you do? What about...?
 - We have _____ on the list, might you want to consider _____?

•A = Advantages

D = Disadvantages

- Help the Adult explore the realistic **A & D** of **each option**
- May involve revising or combining aspects of options
 - What are the possible benefits? Why are those things important to you?
 - What are the negatives or costs? What potential danger or harm could come of this option?
- Why are those things important to you?
 - How might family members and others who support you feel or be affected? What might happen for you as a result of their feelings or the impact on them? How about other people (e.g., employers, friends, teachers)?

–What might happen right away? How about a week or a month from now? What if you changed the option a little?

•**S = Solution**

•Guide the Adult in selecting an option that is safe & can use

•Choice must be **owned** by the Adult

–Ask the person to remember the situation identified in the beginning. Will the selected option help resolve the situation?

–How feasible is the option? Can the person and his/her support system “pull it off”?

–How to do it? Get at the specifics of who, what, when, where, etc. Again, options and strategies may be refined as you go.

•Practice? Options involving human interaction may need to be role-played. What if the person does or says X or Y? Help person practice, reinforce appropriate behavior, and plan ahead for possible outcomes.

•**Challenge 1: Participation**

•Getting the Adult to participate in generating options

–Goal is to get Adult contributing to the brainstorming

–May need to remind Adult that all options can be listed

–Praise any attempts to participate

–Foster interest through rationales or direct questions

•If Adult is still not on board

- May need to elicit options by modeling some
- Make sure these are person-centered and strength-based

•**Challenge 2: Non-Judgmental**

- Facilitator stay open, objective, and non-judgmental
- Adult may list options that are dangerous, silly, extreme, or impossible to implement
- Avoid saying: “That’s a good one, but I don’t know about this? Do you really think this is a good idea?”
- The Option component is to generate as many options as possible
- The Advantages and Disadvantages component is more evaluative

•**Challenge 3:**

Validating *all* Advantages

- Advantages shared by person to explain “negative” behavior should be validated. For example:
 - Adult lists “getting high” helps me relax.
 - Invalidating responses:
 - “Well it may, but drugs are really bad for you.” OR
 - “Well, yes I suppose that is an advantage.”
 - Better:* Facilitator “Okay, that could be an advantage.”

•**Challenge 4:**

Validating *all* Disadvantages

- Don’t ignore **disadvantages** of your “favored” option.

- Option favored by Facilitator: Don’t hang out with friends as a way to avoid shoplifting.
- Adult sees **disadvantage** of not having time with friends.
- Facilitator glosses over Adult’s concerns and emphasizes advantages of option.
- Adult will not implement Facilitator favored options if:
 - They do not feel ownership of them.
 - If they hold no reinforcers for the Adult.

•**Challenge 5:**

Person Selects Harmful Solution

- Discuss potential harmful consequences – but don’t ignore advantages (though you may respectfully disagree).
 - Encourage person to avoid harmful behavior.
 - Using SODAS with Person
 - Facilitator applies SODAS with person to address several “real life” problems
 - Facilitator teaches the process to person
 - person learns to apply SODAS on his/her own
 - Time to Role Play!
-

Appendix I: IRB Approval Letter

RESEARCH INTEGRITY AND COMPLIANCE
Institutional Review Boards, FWA No. 00001669
12901 Bruce B. Downs Blvd., MDC035 • Tampa, FL 33612-4799
(813) 974-5638 • FAX (813) 974-7091

3/7/2013

Evan Skelton, B.A.
ABA-Applied Behavior Analysis
4202 E. Fowler Ave.
Tampa, FL 33620

RE: **Expedited Approval for Initial Review**

IRB#: Pro00008333

Title: Acquisition of a Social Problem Solving Method by Caregivers in the Foster Care
System: Evaluation and Implications

Study Approval Period: 3/6/2013 to 3/6/2014

Dear Ms. Skelton:

On 3/6/2013, the Institutional Review Board (IRB) reviewed and **APPROVED** the above application and all documents outlined below.

Approved Item(s):

Protocol Document(s):

[Social Problem Solving](#)

Consent/Assent Document(s)*:

[Adult Informed Consent.docx.pdf](#)

[Child assent 13-17 - minimal risk.docx.pdf](#)

[Parental Consent - minimal risk.docx.pdf](#)

*Please use only the official IRB stamped informed consent/assent document(s) found under the "Attachments" tab. Please note, these consent/assent document(s) are only valid during the approval period indicated at the top of the form(s).

It was the determination of the IRB that your study qualified for expedited review which includes activities that (1) present no more than minimal risk to human subjects, and (2) involve only procedures listed in one or more of the categories outlined below. The IRB may review

research through the expedited review procedure authorized by 45CFR46.110 and 21 CFR 56.110. The research proposed in this study is categorized under the following expedited review category:

(6) Collection of data from voice, video, digital, or image recordings made for research purposes.

(7) Research on individual or group characteristics or behavior (including, but not limited to, research on perception, cognition, motivation, identity, language, communication, cultural beliefs or practices, and social behavior) or research employing survey, interview, oral history, focus group, program evaluation, human factors evaluation, or quality assurance methodologies.

As the principal investigator of this study, it is your responsibility to conduct this study in accordance with IRB policies and procedures and as approved by the IRB. Any changes to the approved research must be submitted to the IRB for review and approval by an amendment.

We appreciate your dedication to the ethical conduct of human subject research at the University of South Florida and your continued commitment to human research protections. If you have any questions regarding this matter, please call 813-974-5638.

Sincerely,

A handwritten signature in black ink, appearing to read 'Kristen Salomon', followed by a horizontal line.

Kristen Salomon, Ph.D., Vice Chairperson
USF Institutional Review Board