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THE OFFENDER AND ADDICTION — COGNITIVE BEHAVIORAL THERAPY

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ABOUT THE INSTRUCTOR

RAND L. KANNENBERG, M.A., LAC, CCM, CCS is a Licensed Addiction Counselor, a Certified Case Manager, and a Certified Clinical Sociologist as well as an approved education provider by both NBCC and NAADAC. Kannenberg, creator of Resocial Group TM: "A Group Treatment Curriculum for Adults with Antisocial Behavior and Substance Abuse," has been executive director of Criminal Justice Addiction Services in Lakewood, Colorado since 1995, and has provided substance abuse and corrections advanced level training and continuing education workshops in 40 states, Italy, Puerto Rico and South Africa. He also has a private clinical practice specializing in forensic drug and alcohol adult assessments. Kannenberg graduated from the state department of corrections basic training academy and completed the extended prison based training program. He has worked in two correctional facilities, a halfway house, a day reporting center and at a treatment center. He is a credentialed consultant with physicians in emergency departments and on the medical units at several local hospitals. He completed his graduate program in 1984 and has been treating amphetamine and amphetamine-like substance use disorders regularly since 1999. He has been a featured speaker or trainer at nearly 300 state, regional, national, and international workshops or conferences. Kannenberg, distinguished career award nominee and Public Health Champion of the Year recipient, is author of Sociotherapy for Sociopaths ™ (2003) and Case Management Handbook for Clinicians (2004).

CBT for Offenders with Addiction: Effectiveness, Moderators, and Delivery

The cognitive-behavioral framework this course provides for treating offenders with substance use disorders and antisocial behavior, covering the application of clinical sociology, the identification and restructuring of criminal thinking patterns, and the resocialization process, has been tested through randomized controlled trials, meta-analyses, digital-delivery implementations, and nurse-led and group-based interventions. The body of research published since this course was written now spans effectiveness evidence across correctional CBT delivery, moderator analyses identifying which offender subgroups benefit most, scalability through digital platforms, integration with pharmacotherapy, gender-specific outcomes in female correctional populations, systematic review evidence on legally mandated treatment, aftercare maintenance requirements, and client-level predictors of dropout.

The broader question of whether court-mandated substance use treatment for justice-involved populations produces measurable health and well-being gains, the legal-compulsion context in which much of the CBT this course describes is actually delivered, was examined in a 2026 systematic review and meta-analysis of 11 studies, seven of them randomized controlled trials, involving 4,643 justice-involved adults across drug and alcohol courts in high-income countries. The review found that poor and inconsistent outcome reporting across the studies limited what could be concluded, so that the evidence was insufficient to establish that legally mandated non-custodial treatment orders outperform usual care on the health and well-being outcomes examined (Campbell et al., 2026). For the CBT framework this course applies to mandated offender populations, this synthesis is a clinical caution: the legal pressure that brings the client into the room does not by itself produce the outcomes the course targets. The therapeutic work, the cognitive restructuring, the resocialization process, the sustained engagement, has to carry the outcome, and the mandate alone cannot substitute for it.

The question of whether cognitive-behavioral interventions reduce recidivism in justice-involved populations with substance use and mental health disorders was directly tested in a 2022 randomized controlled trial of moral reconation therapy, a structured CBT program designed to address criminal thinking through a series of cognitive restructuring exercises. The trial enrolled 341 justice-involved patients in mental health residential treatment programs, randomizing them to either usual care alone or usual care plus two moral reconation therapy groups per week over 12 weeks. The results were sobering: the intervention was not more effective than usual care at reducing recidivism risk in the overall sample, with similar rearrest rates between groups, 20.2 percent for usual care versus 24.9 percent for the added program. However, only 37 percent of participants assigned to the program completed the minimum therapeutic dose, and subgroup analyses suggested benefits among those who fully engaged (Blonigen et al., 2022). For the CBT framework this course teaches, this trial illustrates the critical distinction between program availability and program dosage. A CBT program that most participants do not complete cannot be evaluated as a CBT program; it can only be evaluated as a referral to a program that the majority declined to finish.

The dosage-and-engagement problem this trial documented at the program level was examined at the client level in a 2022 study of 210 female offenders receiving motivational enhancement therapy combined with cognitive-behavioral therapy through a prescription drug court program. The analysis found that posttraumatic stress, at a correlation of negative 0.19, past-90-day nonmedical prescription painkiller use, at negative 0.19, and past-month substance use problems, at negative 0.25, each

negatively predicted graduation, with effect sizes for these factors ranging from 0.40 to 0.50 (Abarno et al., 2022). For the CBT framework this course teaches, this finding identifies the specific clinical factors that pull female offenders out of cognitive-behavioral programming before the cognitive restructuring work can take hold. Active substance use and untreated trauma are not only the problems CBT is meant to address; they are simultaneously the conditions that prevent CBT from being received, which means assessment for both must precede program assignment rather than waiting for the program to reveal them.

A subsequent 2024 moderator analysis of the same 341-participant trial identified which offender subgroups actually benefit when they do engage. Among veterans incarcerated in the year prior to enrollment, the intervention was associated with greater reductions in criminal associations at six months and fewer days drinking or using drugs at 12 months. Among those convicted in the prior year, it was associated with greater reductions in employment problems and in substance use. Most notably, those scoring high on psychopathic traits, the population this course specifically targets through its discussion of antisocial personality disorder, showed greater reductions in days of substance use across both follow-up periods (Blonigen et al., 2024). For the CBT model this course applies to offenders with antisocial features, this moderator finding is counterintuitive and clinically important: the clients most clinicians expect to be least responsive to cognitive-behavioral intervention, those with elevated psychopathic traits, may actually be among the more responsive when the intervention is designed to address criminal thinking specifically.

The question of whether the cognitive restructuring this course teaches operates for women in correctional settings was examined in a 2026 qualitative study of female detainees participating in a CBT-based chemical dependency program. Analyzing essays written before treatment and upon release, the researchers documented cognitive changes consistent with the Identity Theory of Desistance: the women revised their sense of self and social connectedness through the cognitive work of the program, even as they simultaneously endured what the authors described as the pains of imprisonment (Munoz-Serna et al., 2026). For the CBT model this course describes, this finding indicates that the cognitive change process does operate inside the facility, that it produces shifts in self-concept rather than only behavioral compliance, and that female detainees demonstrate the capacity for the identity revision this course's resocialization framework describes.

The scalability of CBT for incarcerated populations, which this course addresses through small-group therapy models, was demonstrated in a 2022 study of 2,187 Ohio prison residents who engaged with a digital CBT program for methamphetamine use introduced during COVID-19 lockdowns. Participants exhibited moderate to severe substance dependence along with depression, anxiety, interpersonal conflict, and aggressive behavior, and the digital program produced significant reductions in substance dependence, in depression and anxiety, and in biopsychosocial impairment, with improvements in quality of life, and a dose-response pattern in which completing specific program components was associated with better results (Elison-Davies et al., 2022). For the CBT delivery model this course describes, the digital finding represents a paradigm expansion: a single platform reached more than two thousand incarcerated people during a period when in-person group therapy was suspended, producing measurable outcomes at a scale far beyond what individual clinicians can deliver.

The specific mechanisms this course teaches, cognitive restructuring, craving management, stress coping, and relapse prevention, were tested in a 2025 randomized controlled trial of 72 incarcerated young men with methamphetamine use disorder. An eight-week nurse-delivered CBT protocol produced

a 38.5 percent reduction in craving intensity and a 26.7 percent improvement in overall stress coping, with effect sizes rated large for coping and medium for craving (Aslan et al., 2025). For the treatment model this course describes, this confirms that the four-component CBT package produces measurable change on the exact outcomes the framework predicts, and does so when delivered by a non-psychiatrist clinician, which expands the pool of providers who can deliver this work inside correctional settings. A companion 2026 feasibility trial of 33 incarcerated women with methamphetamine use disorder who received 12 group-CBT sessions over six weeks found that craving declined and Addiction Severity Index employment scores improved during and after treatment, but craving rebounded once the group ended, psychiatric symptoms rose, and quality of life declined, leading the authors to recommend structured maintenance sessions (Siste et al., 2026). This sharpens the course's emphasis on resocialization and aftercare: a time-limited in-custody group produces acute-phase gains, but without a continuation structure the gains do not hold.

The integration of CBT with pharmacotherapy for forensic populations, which this course does not address because it focuses on behavioral intervention alone, was examined in a 2026 retrospective study of a semi-structured manualized program combining motivational enhancement and cognitive-behavioral approaches with concurrent pharmacotherapy for 96 forensic psychiatric patients with substance misuse. The analysis found significant increases in recognition of substance use problems and in active steps toward change among users of cannabis, cocaine, and tobacco, while alcohol users showed a significant increase in ambivalence, the stage-of-change indicator that precedes behavioral action (Olagunju et al., 2026). For the CBT model this course describes, this demonstrates that the cognitive change process operates differently depending on the substance of use, and that medication support during CBT may enhance engagement with the cognitive work, particularly among forensic patients whose antisocial traits and involuntary treatment status might otherwise limit therapeutic alliance.

The Evidence Base for Correctional Cognitive-Behavioral Therapy

The central premise of this course, that cognitive-behavioral treatment can change the thinking and behavior of substance-abusing offenders and reduce their return to crime, rests on a research base that the counselor should understand in both its strength and its limits. Cognitive-behavioral approaches are the most widely studied and most consistently supported psychological interventions for offending, and decades of evaluation have established that programs targeting criminal thinking, problem-solving, and self-regulation can reduce recidivism when they are well designed and well delivered. A rigorous 2021 systematic review and meta-analysis restricted to randomized controlled trials of psychological interventions delivered to incarcerated adolescents and adults, and measuring recidivism after release, assembled the strongest tier of evidence in this field, converting the effects of eligible trials to a common metric to estimate whether in-prison psychological treatment reduces reoffending (Beaudry et al., 2021). The counselor delivering the approach this course teaches is therefore working within an evidence-based tradition, not an untested one, and can hold reasonable confidence that the cognitive-behavioral methods have genuine support.

That said, the evidence carries important qualifications the honest counselor must hold alongside the confidence. The randomized-trial literature is smaller and more mixed than the broader observational literature, effect sizes are generally modest rather than dramatic, and the quality of delivery matters enormously, so that a cognitive-behavioral program delivered with poor fidelity, insufficient dose, or

untrained staff may show little benefit even though the approach itself works. The moral reconation therapy trial discussed earlier, in which the program was not superior to usual care overall largely because most participants never completed a minimum dose, is a concrete illustration: the approach can work, but only when it is actually received, and the gap between a program's design and its real-world delivery is where much of the disappointing evidence originates. A direct test of integrated cognitive-behavioral treatment for substance-dependent offenders found what good delivery can accomplish, as a randomized trial of 63 substance-dependent men arrested for partner violence, comparing an integrated cognitive-behavioral substance-abuse and violence program to drug counseling, found that the integrated program produced fewer cocaine-positive toxicology screens and fewer episodes of violence at follow-up (Easton et al., 2018).

For the practitioner, the state of the evidence argues for a stance of grounded confidence paired with attention to delivery. It means recognizing that the cognitive-behavioral methods this course teaches are genuinely evidence-based and worth delivering well, while resisting the overclaim that they are a guaranteed or dramatic solution to offending, which the modest and variable effect sizes do not support. It means taking seriously that the difference between a program that works and one that does not often lies not in the model but in its delivery, the fidelity to the approach, the dose actually received, the training and skill of the counselor, and the engagement of the client, all of which the counselor can influence. And it means holding realistic expectations with clients and referral sources alike, framing cognitive-behavioral treatment as an effective approach that meaningfully improves the odds of change rather than as a certainty, which both honors the evidence and protects against the disillusionment that follows overpromising.

The Risk-Need-Responsivity Framework

Contemporary correctional treatment is organized around a framework the counselor should know by name and principle, because it structures how effective programs target their effort: the Risk-Need-Responsivity model. The framework holds that treatment reduces recidivism most when it matches the intensity of intervention to the offender's risk level, concentrating resources on higher-risk clients rather than diffusing them across low-risk ones, when it targets the criminogenic needs that actually drive offending, the dynamic risk factors such as criminal thinking, antisocial associates, and substance use, rather than needs unrelated to crime, and when it delivers the intervention in a way responsive to the client's learning style, abilities, and circumstances, which for most offenders means the structured, active, cognitive-behavioral methods this course teaches. These three principles, risk, need, and responsivity, are the organizing logic of evidence-based correctional treatment, and the cognitive-behavioral approach this course describes is the responsivity principle in action.

The evidence for the framework is substantial, though it also reveals a persistent gap between the model and its real-world use. A study of 136 community-supervised offenders found that the risk assessment instrument built on the framework strongly predicted general recidivism, with an area under the curve of 0.75 for men and 0.94 for women over an average follow-up of roughly three and a half years, confirming that the model identifies who is likely to reoffend, yet the same study found that the case management plans probation officers actually prepared showed poor adherence to the framework's principles (Dyck et al., 2018). A meta-analysis of interventions to prevent intimate partner violence, which compared programs situated within the framework against the traditional one-size-fits-all approach, found an overall pooled odds ratio of 0.52 in favor of intervention for follow-up periods of a

year or less, judged the framework-based programs to perform well against other modalities, and also found that these effects were difficult to sustain into the longer term (Travers et al., 2021). The framework works, in other words, but implementing it faithfully is harder than adopting it in principle.

For the practitioner, the framework offers a structure for allocating the cognitive-behavioral work this course teaches where it will do the most good. It means assessing risk and concentrating the most intensive intervention on higher-risk clients, resisting the intuitive but counterproductive pull to invest heavily in low-risk clients who need little and may even be harmed by over-intervention. It means targeting the criminogenic needs that actually drive offending, above all the criminal thinking this course addresses, rather than needs that, however real, do not reduce crime when treated. And it means delivering the intervention responsively, in the structured, active, skills-building cognitive-behavioral style that the evidence shows works for most offenders, and adapting it to the individual client's abilities and circumstances. The counselor who internalizes the framework has a principled way to answer the questions of whom to treat most intensively, what to target, and how to deliver, which is the difference between scattered effort and effective correctional treatment.

Criminal Thinking as a Dynamic, Changeable Risk Factor

At the heart of this course is the proposition that criminal thinking, the distinctive patterns of thought that support and rationalize offending, is both a driver of crime and a legitimate target of treatment, and the research strongly supports both halves of that proposition. Criminal thinking encompasses the cognitive distortions, attitudes, and beliefs through which offenders justify their behavior, minimize its harm, blame others, claim entitlement, and view the world in ways that make crime seem reasonable, necessary, or deserved. The cognitive-behavioral approach this course teaches rests on the premise that these thinking patterns can be identified, challenged, and changed, and that changing them reduces offending, which makes the empirical status of criminal thinking as a changeable risk factor foundational to the whole enterprise.

The evidence establishes that criminal thinking is not a fixed trait but a dynamic risk factor that changes over time and predicts offending as it changes. A large study of more than forty thousand federal probationers and supervised releasees, 35,147 men and 5,254 women, found that a one-year rise in measured general criminal thinking incrementally predicted the time until a person's first arrest, after controlling for age, criminal history, and race and ethnicity, demonstrating that changes in criminal thinking track changes in offending risk and that the effect held for both men and women (Walters and Cohen, 2016). This is precisely what a treatment target should be: something that varies, that can move in a favorable direction, and whose movement predicts the outcome that matters. A separate study of drug-involved probationers and jail inmates added an important qualification for this course's population specifically, finding that substance use disorder severity moderated the relationship between criminal thinking and recidivism, so that the link between criminal thinking and reoffending operated differently depending on the severity of the person's substance use (Caudy et al., 2015).

For the practitioner, the status of criminal thinking as a dynamic, changeable risk factor is both the justification and the target of the work. It justifies the cognitive-behavioral approach by confirming that criminal thinking genuinely drives offending and genuinely changes, so that the effort to identify and restructure it is aimed at a real mechanism rather than a clinical abstraction. It provides the target by directing the counselor's attention to the specific thinking patterns, the justifications, minimizations,

entitlements, and hostile interpretations, that support the individual client's offending, which become the concrete material of the cognitive work. And the moderating role of substance use severity reminds the counselor that for this population, criminal thinking and substance use are intertwined, so that the cognitive work on criminal thinking must proceed alongside attention to the substance use that shapes it. Helping a client recognize, question, and revise the thinking that supports both their offending and their substance use is the core of what this course teaches, and it is aimed exactly where the evidence says change is possible.

Antisocial Personality Disorder and Substance Use

This course addresses antisocial personality disorder directly, and the counselor working with substance-abusing offenders will encounter it frequently, because the two conditions co-occur at high rates and together define a substantial share of the correctional treatment population. Antisocial personality disorder is characterized by a pervasive pattern of disregard for and violation of the rights of others, including deceitfulness, impulsivity, irritability and aggression, reckless disregard for safety, consistent irresponsibility, and lack of remorse, and it is strongly associated with both criminality and substance use. Understanding its prevalence, its relationship to substance use, and the realistic prospects for treatment is part of the clinical competence this course builds, and the recent epidemiological and treatment evidence sharpens that understanding.

The scale of the condition and its entanglement with substance use are well documented. A nationally representative survey of more than thirty-six thousand adults found that antisocial personality disorder had a prevalence of 4.3 percent, and that a broader adulthood antisocial behavioral syndrome reached 20.3 percent, with both syndromes significantly associated with substance use disorders and a range of other conditions, at odds ratios spanning from 1.2 to 7.0 (Goldstein et al., 2017). Antisocial personality, in other words, is common in the general population and far more common in the offending population, and it travels closely with the substance use that this course's clients bring to treatment. The prospects for treating the personality disorder itself, however, must be held realistically. A Cochrane systematic review of psychological interventions for antisocial personality disorder, drawing on 19 randomized trials, found the evidence base thin and inconclusive, unable to establish that any psychological intervention reliably improves the core outcomes of aggression, reconviction, and functioning (Gibbon et al., 2020).

For the practitioner, the combination of high prevalence and limited treatment evidence for the personality disorder itself points toward a specific and workable clinical stance. It means recognizing antisocial personality disorder as a common feature of the population rather than an unusual complication, and understanding its behavioral manifestations, the deceit, impulsivity, and disregard for others, as clinical features to be worked with rather than moral failings to be condemned. It means holding realistic expectations about changing the personality structure itself, which the evidence does not show to be readily treatable, while focusing the work where change is more achievable: on the criminal thinking, the substance use, and the specific behaviors that the cognitive-behavioral approach can address even in clients with antisocial features. And it means drawing encouragement from the earlier finding that clients high in psychopathic traits showed genuine reductions in substance use when engaged in criminal-thinking-focused treatment, which suggests that even this challenging population can benefit from well-targeted cognitive-behavioral work, not by curing the personality disorder but by changing the thinking and behavior that drive the offending and the substance use.

Psychopathy and Treatment Responsivity

Related to antisocial personality disorder, but narrower and more severe, is psychopathy, a constellation of interpersonal, affective, lifestyle, and antisocial features that includes superficial charm, grandiosity, manipulativeness, shallow affect, lack of empathy and remorse, impulsivity, and irresponsibility. Psychopathy has long carried a reputation as the condition that makes offenders untreatable, and clinicians frequently approach clients with psychopathic traits expecting resistance, manipulation, and therapeutic failure. The recent evidence complicates and partly overturns this pessimism in ways the counselor should understand, because the assumption of untreatability can become a self-fulfilling prophecy that denies treatment to clients who might benefit from it.

The evidence suggests that psychopathic clients present real challenges to engagement but are not simply untreatable. A study of 302 treated men in a sexual violence reduction program, followed in the community for more than seventeen years, found that men high in psychopathy had a far higher rate of treatment noncompletion, 30 percent versus 6 percent for low-psychopathy men, yet did not show significantly less therapeutic change when they did engage, and, critically, it was therapeutic change itself, the actual reduction in risk-relevant factors, rather than mere program completion, that predicted reduced recidivism (Sewall and Olver, 2019). This is a hopeful and clinically important finding: psychopathic clients are harder to retain, but those who engage can change, and the change is what matters. A separate study of the working alliance with 111 incarcerated men in sexual-offender treatment found that a large majority of high-psychopathy clients, 85 percent, completed treatment and generally formed strong working alliances with their therapists, though specific facets of psychopathy were associated with weaker bonds and lower engagement in the tasks of therapy (DeSorcy et al., 2020).

For the practitioner, the evidence on psychopathy argues for a stance of realistic engagement rather than resignation. It means recognizing that psychopathic clients are genuinely harder to retain and engage, and attending deliberately to the retention and alliance challenges the evidence documents, rather than being surprised or defeated by them. It means focusing on producing actual therapeutic change, the real reduction in criminal thinking and risk-relevant behavior, rather than settling for mere program completion, since the evidence shows that change, not attendance, is what reduces recidivism. And it means resisting the pessimism that would write off psychopathic clients as untreatable, which the evidence does not support and which becomes an excuse for not doing the work, while also avoiding naive optimism about the ease of that work. The counselor who approaches clients with psychopathic traits expecting a hard but not hopeless engagement, and who aims for genuine change rather than compliance, is positioned by the evidence to reach at least some of a population too often abandoned as beyond help.

The Therapeutic Alliance with Resistant and Mandated Clients

The clients this course addresses are frequently mandated, resistant, and interpersonally difficult, and the therapeutic relationship the counselor must build with them differs in important ways from the alliance formed with a voluntary, help-seeking client. Many offenders arrive at treatment under legal compulsion, viewing the counselor as an extension of the correctional system rather than a helper, expecting judgment and control, and bringing the manipulative, guarded, or hostile interpersonal style that antisocial features produce. Building a working alliance under these conditions is both harder and

more important than in ordinary clinical work, because the alliance is the vehicle through which the cognitive-behavioral techniques reach the client, and without it the techniques are delivered to someone who is not receiving them.

The evidence on alliance with this population offers both encouragement and useful nuance. The finding that a large majority of high-psychopathy incarcerated clients formed strong working alliances with their therapists is itself encouraging, countering the assumption that antisocial clients cannot bond in treatment, though the same research found that specific features of psychopathy, the shallow affect of the affective facet and the impulsive irresponsibility of the lifestyle facet, were associated respectively with weaker emotional bonds and lower engagement in therapeutic tasks (DeSorcy et al., 2020). Notably, that study also found that the strength of the alliance was not by itself associated with reduced recidivism, a finding that cautions against treating alliance as sufficient: the relationship matters as the vehicle for the work, but it is the cognitive and behavioral change carried by that vehicle, not the warmth of the relationship alone, that reduces offending.

For the practitioner, working with mandated and resistant clients calls for a particular relational stance that the broader motivational and correctional literature supports. It means meeting the client's resistance without either capitulating to it or matching it with counter-hostility, recognizing that a mandated client's guardedness is a reasonable response to their situation rather than a personal affront or a sign of hopelessness. It means being clear and honest about the counselor's role, including any reporting or monitoring obligations, since offenders are quick to detect and reject perceived deception, and a straightforward acknowledgment of the counselor's dual role often builds more trust than a pretense of pure helpfulness. It means finding and working from the client's own goals, the things they want that a change in their offending and substance use would serve, rather than relying on the external mandate to supply motivation. And it means holding the alliance as the necessary vehicle for the cognitive-behavioral work while remembering that the work itself, the actual change in thinking and behavior, is what produces the outcome, so that a good relationship is the beginning of effective treatment rather than its substitute.

Group Treatment, Therapeutic Communities, and Resocialization

This course emphasizes group treatment and the resocialization of the offender, and both the group format and the resocialization goal have a substantial evidence base in the therapeutic community model, one of the most widely implemented approaches for justice-involved substance users. The therapeutic community uses the treatment environment itself, the community of residents and staff, as the primary agent of change, immersing the offender in a prosocial social structure with clear expectations, mutual accountability, and graduated responsibility, and working to resocialize the person's values, thinking, and behavior through sustained participation in that community. This is resocialization in the fullest sense, and it aligns closely with the sociological and group-based framework this course develops.

The evidence for therapeutic communities is encouraging but qualified in a way the counselor should understand. A systematic review of therapeutic community treatment for inmates with substance dependence, drawing on 14 studies, found that about three-quarters of the studies reported reductions in re-incarceration, roughly 70 percent reported reductions in drug-misuse relapse, and 55 percent reported reductions in re-arrest, while also finding that the effects were generally stronger in the short term than

over the longer term (Galassi et al., 2015). The pattern, real benefit that tends to fade without continuation, echoes the aftercare finding from the group-CBT trials discussed earlier and points to a recurring lesson: intensive in-custody intervention produces gains that require post-release continuation to sustain. A mixed-methods study looking inside the mechanisms of a prison-based therapeutic community found more variation between individuals than change within individuals over time in treatment engagement, and identified selection effects and lapses in program fidelity as factors that can undermine outcomes (Davidson and Young, 2019), a reminder that the model works through genuine engagement and faithful implementation rather than mere placement.

For the practitioner, the therapeutic community evidence supports the group and resocialization emphasis this course teaches while sharpening the conditions under which it works. It means using the group and community as active agents of resocialization, not merely as an efficient way to deliver individual content to several people at once, drawing on the mutual accountability, prosocial modeling, and graduated responsibility that give the community model its power. It means attending to genuine engagement rather than mere attendance, since the evidence shows that placement without real participation produces little change, and to program fidelity, since a therapeutic community that drifts from its model loses its effect. And it means building in the continuation and aftercare that the fading of short-term gains makes essential, recognizing that resocialization begun inside the facility must be sustained after release through ongoing support, or the prosocial identity the community fostered will erode in the environment the person returns to. The counselor who understands the therapeutic community as an evidence-based resocialization method, effective through engagement and continuation, is equipped to deliver the group-based work this course describes in the way most likely to last.

Contingency Management and Behavioral Reinforcement

Alongside the cognitive restructuring this course emphasizes sits a behavioral method with strong evidence for substance use specifically, one the counselor working with offenders should know and can incorporate: contingency management, the systematic use of tangible reinforcement to reward verified abstinence and other target behaviors. Grounded in operant conditioning, contingency management provides concrete, immediate rewards, vouchers, prizes, privileges, or points, for objectively verified behavior such as a drug-negative urine test, and it has accumulated some of the strongest evidence of any behavioral approach for reducing substance use, particularly for the stimulant use disorders that dominate many correctional populations and for which no effective medication exists.

The evidence supports contingency management both for substance use generally and within criminal justice settings specifically. A network meta-analysis of psychosocial interventions for cocaine and amphetamine addiction, which clinical guidelines recommend as first-line treatment, evaluated the comparative effectiveness of the available approaches and identified contingency management, especially in combination with a community reinforcement approach, as among the best-supported for achieving abstinence (De Crescenzo et al., 2018). Within the justice system, a pilot of contingency management across four federal probation districts, using a case-controlled matched design with 128 participants matched to 128 comparison cases, found that sites using early reward strategies showed delayed recidivism relative to comparison sites (Sloas et al., 2019), demonstrating that the method can be implemented in supervision settings and can affect the outcomes that matter to the justice system. The behavioral reinforcement of prosocial and abstinent behavior, in other words, is not a departure

from the cognitive-behavioral tradition but a complementary and well-supported part of it.

For the practitioner, contingency management offers a concrete, evidence-based tool that complements the cognitive work this course emphasizes. It means recognizing that for substance use, and especially for stimulant use disorders where no medication helps, the systematic reinforcement of verified abstinence is among the most effective approaches available, and worth incorporating where the setting permits. It means understanding the principles that make contingency management work, the immediacy and certainty of reinforcement, the objective verification of the target behavior, and the escalation of rewards for sustained success, so that any reinforcement the counselor builds into treatment follows the logic that the evidence supports rather than a vague notion of encouragement. And it means seeing behavioral reinforcement and cognitive restructuring as partners rather than alternatives, since changing how a client thinks and rewarding what a client does address the problem from complementary directions, and the combination is stronger than either alone. The counselor who adds well-designed behavioral reinforcement to the cognitive work this course teaches is drawing on the full range of what cognitive-behavioral treatment, broadly understood, has to offer the substance-abusing offender.

Women Offenders and Gender-Responsive, Trauma-Informed Treatment

This course's framework, developed largely with the male offender in mind as most correctional treatment historically has been, applies to women offenders with important modifications that the evidence increasingly clarifies, and the counselor working with justice-involved women must understand how their pathways into offending and substance use, and their treatment needs, differ from men's. Women in the criminal justice system have exceptionally high rates of trauma, particularly childhood abuse and interpersonal violence, and their offending and substance use are more often bound up with that trauma, with abusive relationships, and with caregiving responsibilities than is typical for men. Treatment that ignores these differences and delivers a male-normed program to women misses much of what drives their situation.

The evidence supports gender-responsive and trauma-informed approaches while also documenting how thin the rigorous evidence base for female offenders remains. A Cochrane review of interventions for female drug-using offenders, drawing on 13 randomized trials with 2,560 women, found the evidence generally low in certainty and was unable to establish, for example, that collaborative case management reduced drug use or reincarceration relative to usual care, underscoring how much remains unproven for this population (Perry et al., 2019). At the same time, research on trauma-specific treatment for incarcerated populations offers encouragement: a study of gender-responsive, trauma-specific brief interventions delivered to 682 women and 624 men found that the greater a participant's cumulative childhood adversity, the greater their gains from treatment on mental health, aggression, and anger outcomes (Messina and Schepps, 2021). This is a striking and hopeful finding, indicating that the women and men with the most extensive trauma histories, often assumed to be the hardest to help, were the most responsive to treatment designed to address that trauma.

For the practitioner, the evidence directs specific attention to trauma and to gender-responsive adaptation in work with justice-involved women. It means recognizing the centrality of trauma in women's pathways into offending and substance use, and screening for and addressing that trauma rather than treating the offending and substance use in isolation from the abuse that so often underlies them. It means adapting the cognitive-behavioral framework this course teaches to women's circumstances,

attending to relationships, caregiving, safety, and the trauma-driven emotional and cognitive patterns that a male-normed program would miss. It means drawing encouragement from the finding that the most trauma-burdened clients can be the most responsive to trauma-specific treatment, which counters the pessimism that would write off the hardest cases. And it means holding honestly the limited state of the rigorous evidence for female offenders, delivering the best-supported gender-responsive and trauma-informed approaches while acknowledging that much about what works for this population remains to be established. The counselor who treats justice-involved women as a distinct population with trauma at the center, rather than as female versions of the male offender the standard model assumes, is working with the grain of what the evidence increasingly shows.

Trauma as Both a Driver and a Barrier

The prominence of trauma in the offending population, and especially among women, deserves emphasis as a theme that cuts across the specific interventions, because trauma operates in this population as both a driver of the substance use and offending the treatment targets and a barrier to receiving that treatment. On the driver side, the high rates of childhood adversity and interpersonal violence among offenders feed the substance use that offers escape from traumatic distress, the emotional dysregulation that fuels impulsive and aggressive behavior, and the distorted views of self and others that support both offending and continued victimization. A treatment that addresses the substance use and criminal thinking without attending to the trauma beneath them works at the surface of a deeper problem, which is why trauma-informed and, where indicated, trauma-specific treatment has become central to work with this population.

On the barrier side, the earlier finding that posttraumatic stress predicted dropout from a cognitive-behavioral drug court program for women illustrates how trauma can prevent the very treatment meant to help, as the trauma symptoms, the hypervigilance, the difficulty trusting, the emotional dysregulation, and the avoidance, interfere with engagement in a program that demands exactly the cognitive and relational capacities trauma disrupts (Abarno et al., 2022). Trauma thus creates a clinical trap: it drives the problems that bring the client to treatment, and it undermines the client's ability to use the treatment, so that the clients who most need help are among those least able to engage with it as ordinarily delivered. The encouraging counterpoint, that trauma-specific treatment produced the greatest gains in the most trauma-burdened clients, points to the way out of the trap: treatment designed to address the trauma directly, rather than treatment that demands the client set the trauma aside, can reach clients whom an unadapted program would lose.

For the practitioner, holding trauma as both driver and barrier reshapes the approach to the substance-abusing offender. It means screening for trauma routinely rather than treating it as an occasional complication, given its prevalence and its impact on both the problems and the treatment. It means understanding a client's substance use, offending, and difficulty engaging in treatment in the context of their trauma history, which changes the interpretation of behavior that might otherwise read as resistance or lack of motivation. It means incorporating trauma-informed principles, safety, trustworthiness, choice, and the avoidance of retraumatization, into cognitive-behavioral treatment that was not originally designed with trauma in view, and drawing on trauma-specific interventions where the trauma is central. And it means recognizing that addressing the trauma is often not a detour from the work on substance use and criminal thinking but a precondition of it, since the client who cannot manage their traumatic distress will struggle to do the cognitive work the course teaches. The counselor

who sees the trauma beneath the offending reaches a depth that surface-level correctional treatment cannot.

Desistance, Identity Change, and the Resocialization Goal

The ultimate aim of the treatment this course describes is not merely the reduction of specific behaviors but the transformation of the offender into a person who no longer offends, what the research literature calls desistance, and the emerging understanding of how desistance actually happens illuminates and deepens the resocialization goal at the course's heart. Desistance is increasingly understood not as a single event but as a process, often gradual and marked by setbacks, through which a person moves away from offending, and one in which change in identity, in how the person sees and understands themselves, plays a central role alongside changes in circumstances and relationships. A person desists not only by behaving differently but by becoming, in their own self-understanding, a different kind of person, one for whom offending is no longer consistent with who they are.

The evidence supports the importance of identity change while also situating it within a broader web of social factors. A study using five waves of longitudinal data found that identity changes were associated with declines in offending, confirming that the cognitive and self-conceptual shifts the resocialization process aims at genuinely matter for desistance, but the same study found that these identity changes did not by themselves guarantee sustained change, and that social experiences, including relationships with parents and movement away from antisocial peers, also shaped the trajectory (Copp et al., 2020). The earlier finding that female detainees revised their sense of self through the cognitive work of a treatment program, consistent with an identity theory of desistance, even amid the pains of imprisonment, adds that this identity change can begin inside the correctional setting itself (Munoz-Serna et al., 2026). Identity change matters, in other words, but it operates alongside and depends upon changes in the person's social world.

For the practitioner, understanding desistance as an identity-involving process gives the resocialization goal both depth and realism. It means aiming the cognitive work not only at specific thoughts and behaviors but at the client's sense of who they are, helping them develop a self-concept, a personal narrative, and a vision of their future in which offending has no place, which is the identity change that desistance research shows to matter. It means recognizing that identity change, while central, is not sufficient by itself, and attending also to the client's social world, the relationships, associates, and circumstances that either support or undermine the emerging prosocial identity, since a changed identity in an unchanged environment struggles to survive. It means holding desistance as a process rather than an event, expecting the gradualness and the setbacks that characterize it, and framing lapses as features of the process rather than proof of failure. And it means recognizing that the resocialization this course describes, at its most ambitious, is exactly this work of supporting a change in identity within a supportive change in social world, which is how the research suggests lasting desistance actually occurs. The counselor who helps a client become a person for whom crime is foreign, within a life that sustains that person, is doing the deepest work the course points toward.

Medication as an Adjunct in Correctional Settings

Although this course focuses on behavioral and cognitive intervention, the counselor working with substance-abusing offenders should understand where medication fits, particularly for opioid use disorder, because withholding effective medication from this population has become recognized as a serious and sometimes lethal gap, and because medication and the cognitive-behavioral work this course teaches are complementary rather than competing. For opioid use disorder specifically, medications such as buprenorphine and methadone are among the most effective treatments available, substantially reducing overdose death and supporting recovery, yet correctional settings have historically been slow to provide them, and the period immediately after release from incarceration is one of the highest-risk times for fatal overdose in the entire population.

The evidence for providing medication in correctional settings is strong and directly relevant to the recidivism outcomes the justice system cares about. A natural-experiment study comparing two Massachusetts jails, one of which provided buprenorphine and one of which did not at the time, followed 469 incarcerated adults with opioid use disorder and found that those with access to buprenorphine were significantly less likely to recidivate after release, 48.2 percent versus 62.5 percent, and less likely to be re-arraigned, 36.0 percent versus 47.1 percent (Evans et al., 2022). Medication for opioid use disorder, in other words, not only saves lives but reduces the reoffending that the correctional system exists to prevent, which makes the historical reluctance to provide it both a clinical and a public-safety failure. For the substance-abusing offender with opioid use disorder, the cognitive-behavioral work this course teaches and medication are not alternatives between which the client must choose but complementary components that work best together, the medication stabilizing the person and reducing overdose risk while the cognitive-behavioral treatment addresses the thinking, behavior, and circumstances that medication alone does not touch.

For the practitioner, the place of medication argues for an integrated rather than a purely behavioral stance, even within a course focused on cognitive-behavioral treatment. It means understanding that for opioid use disorder, effective medication exists and is lifesaving and recidivism-reducing, and that supporting a client's access to it, rather than viewing medication as a competitor to or a compromise of the behavioral work, is part of responsible practice. It means recognizing the acute danger of the post-release period for opioid overdose, and the corresponding importance of ensuring continuity of medication across the transition from incarceration to the community, a transition where treatment so often breaks down. And it means holding the cognitive-behavioral work and medication together as parts of a comprehensive approach, in which the medication addresses the physiology of opioid use disorder and the cognitive-behavioral treatment addresses the thinking, behavior, and resocialization that this course describes. The counselor who understands medication as a complement to rather than a competitor with the behavioral work is positioned to support the fullest and safest recovery for the opioid-using offender.

Assessment, Dosage, and Engagement

A theme running through the effectiveness evidence deserves its own focused attention, because it determines whether any of the methods this course teaches actually produce results: the questions of assessment, dosage, and engagement, of matching the right intervention to the right client and ensuring the client actually receives enough of it. The moral reconation therapy trial's central lesson, that a program most participants never completed could not outperform usual care, and the drug court finding that trauma and active substance use predicted dropout, together establish that the best-designed cognitive-behavioral program accomplishes nothing for a client who does not engage with and complete it. Assessment, dosage, and engagement are therefore not administrative details but the conditions on which effectiveness depends.

Assessment, in this framework, means more than establishing a diagnosis; it means identifying the client's risk level, criminogenic needs, and responsivity factors as the Risk-Need-Responsivity model requires, and it means identifying the specific conditions, such as the active substance use and untreated trauma that predicted dropout, that will interfere with engagement if not addressed. A client assessed thoroughly at the outset can be matched to an appropriate intensity of intervention and can have the barriers to their engagement addressed before those barriers pull them out of treatment, whereas a client assigned to a program without such assessment may be over- or under-served and may fail for reasons that assessment would have surfaced. Dosage means ensuring the client receives enough of the intervention to benefit, recognizing that cognitive-behavioral change requires sufficient exposure and practice and that a partial dose may accomplish little, which makes the retention of clients through a full course of treatment a central clinical task rather than an afterthought.

For the practitioner, attending to assessment, dosage, and engagement is often the difference between a program that works on paper and one that works in practice. It means conducting thorough initial assessment that establishes risk, need, and responsivity and identifies the barriers to engagement, rather than assigning clients to treatment generically. It means treating retention and engagement as central clinical priorities, addressing the trauma, active substance use, and other factors that drive dropout, and working actively to keep clients in treatment long enough to receive an effective dose. It means recognizing that the mandate that brings many offenders to treatment provides attendance but not engagement, and that the counselor's task is to convert compelled attendance into genuine participation through the alliance and motivational work discussed earlier. And it means measuring and monitoring engagement rather than assuming it, so that a client drifting toward dropout can be recognized and re-engaged before they are lost. The counselor who attends to these conditions delivers the cognitive-behavioral methods this course teaches in the way that gives them a chance to work, rather than delivering them into a void of non-engagement.

Cultural Competence and Individual Difference

This course addresses the application of cognitive-behavioral treatment across diverse offender populations, and cultural competence is essential to that application, because the offending population is diverse in race, ethnicity, culture, language, and circumstance, and a cognitive-behavioral approach delivered without attention to that diversity will fit some clients poorly and misread others. Cultural competence in this context means understanding how a client's cultural background shapes their

experience, their communication, their understanding of their own behavior, and their response to treatment, and adapting the delivery of the intervention accordingly, while still addressing the criminal thinking and substance use that the treatment targets. It is not a matter of lowering expectations or excusing behavior but of delivering the treatment in a way the particular client can actually receive.

The need for cultural competence is sharpened by the well-documented disparities in the justice system itself, in which some racial and ethnic groups are disproportionately arrested, convicted, and incarcerated, so that the counselor working with offenders is working with a population shaped by those disparities and must be alert to how they affect the client's situation and stance. A client who has experienced the justice system as unjust, and who has reason to view its agents with distrust, brings that history into the treatment room, and a counselor who fails to understand it may misread the client's guardedness or resistance as pathology rather than as a reasonable response to experience. Cultural competence also means recognizing that the concepts and methods of cognitive-behavioral treatment, developed largely within particular cultural frames, may need adaptation to fit clients from different backgrounds, and that what counts as a distorted or prosocial thought is not always culturally neutral.

For the practitioner, cultural competence is an ongoing discipline rather than an achieved state. It means approaching each client with humility about the counselor's own cultural assumptions and a readiness to learn the client's world rather than assuming it, since the counselor's cultural frame is as particular as the client's and can distort the work if unexamined. It means understanding the client's cultural background as it bears on their experience, their communication, and their response to treatment, and adapting the delivery of the cognitive-behavioral methods accordingly. It means holding awareness of the justice system's disparities and their effect on the client's history and stance, without either excusing genuinely harmful behavior or dismissing the client's experience of injustice. And it means treating the client as an individual shaped by, but not reducible to, their cultural background, avoiding both the blindness that ignores culture and the stereotyping that reduces the client to it. The counselor who delivers the cognitive-behavioral work this course teaches with genuine cultural competence reaches a diverse population that a culturally uniform approach would serve unevenly.

Documentation, Outcome Measurement, and Clinical Supervision

The effective delivery of the treatment this course describes depends not only on what happens in the treatment room but on the professional infrastructure around it, the documentation, outcome measurement, and clinical supervision that sustain quality over time, and the counselor working with offenders should understand these as integral to good practice rather than as bureaucratic burdens. Documentation records the assessment, the treatment plan, the interventions delivered, and the client's response, creating both a clinical record that supports continuity of care and, in the correctional context, a record that may bear on legal and supervisory decisions affecting the client. Careful, accurate documentation is part of responsible practice, and its importance is heightened in a setting where the stakes for the client, including their liberty, may turn in part on the clinical record.

Outcome measurement, the systematic tracking of whether clients are actually changing on the targets the treatment aims at, is a discipline the evidence increasingly supports as a driver of quality, because a counselor who measures outcomes can recognize when treatment is not working and adjust, whereas one who does not may continue an ineffective course unaware. Measuring criminal thinking, substance use, engagement, and the other targets of the cognitive-behavioral work, using the structured

instruments available for this population, turns treatment from a matter of impression into one of evidence, and it allows the counselor to recognize both the client drifting toward dropout and the intervention that is not producing change. Clinical supervision, in turn, sustains and develops the counselor's own skill, providing the reflection, feedback, and support that keep practice sharp and that help the counselor manage the particular demands of working with a difficult and sometimes disturbing population.

For the practitioner, attending to this professional infrastructure is part of delivering the treatment well over time. It means documenting carefully and accurately, understanding the clinical and, in the correctional context, legal significance of the record, and treating documentation as part of the care rather than as a distraction from it. It means measuring outcomes systematically, using the available instruments to track whether clients are changing on the targets that matter, and using that information to adjust treatment and to recognize both faltering engagement and ineffective intervention. It means engaging in clinical supervision as an ongoing source of skill development and support, rather than viewing it as oversight to be endured, and drawing on it particularly to manage the emotional demands and the risk of drift that working with this population entails. And it means understanding one's own continuing professional development as a responsibility, since the evidence base this course draws on continues to evolve and effective practice requires keeping current with it. The counselor who attends to documentation, measurement, and supervision sustains the quality of the cognitive-behavioral work this course teaches across a career, rather than delivering it well only at the start.

Motivation, Ambivalence, and the Stages of Change

The offender entering treatment rarely arrives eager to change, and the counselor who does not attend to motivation will find the cognitive-behavioral methods this course teaches delivered to a client who is not ready to use them. Most substance-abusing offenders come to treatment under legal compulsion, and many are ambivalent at best about changing either their substance use or their offending, seeing the costs of change as immediate and certain and its benefits as distant and uncertain. Understanding change as a process that moves through stages, from not yet considering change, through weighing it, to preparing for it, acting on it, and maintaining it, gives the counselor a way to meet clients where they actually are rather than where the treatment assumes them to be, and to match the intervention to the client's readiness.

The clinical error that this staged understanding guards against is the assumption that a client in treatment is a client ready to change, and the delivery of action-oriented cognitive-behavioral techniques to a client who has not yet decided that change is worth pursuing. A client who does not yet see their substance use or offending as a problem needs first to develop that recognition, and pressing cognitive restructuring exercises on them before they have any motivation to change typically produces resistance rather than progress. The counselor who recognizes a client's actual stage can do the work appropriate to it, building recognition and motivation with the client who has not yet decided to change, and reserving the intensive skills-building work for the client who has, which both respects the client's autonomy and delivers the intervention when it can be received.

For the practitioner, attending to motivation and stage of change is often the difference between engagement and resistance. It means assessing where each client actually stands in their readiness to change, rather than assuming that legal mandate or physical presence indicates readiness. It means doing

the motivational work, helping the client examine the costs of their substance use and offending and the benefits of change in their own terms, with clients not yet ready for action, rather than pressing action-oriented techniques prematurely. It means recognizing that motivation is not a fixed trait a client either has or lacks but a state that the counselor can help build, and that a mandated, resistant client can move toward genuine motivation through skillful engagement. And it means expecting movement to be gradual and non-linear, with clients advancing and retreating through the stages, so that a client who slips back is understood as moving within a normal process rather than as failing. The counselor who works with the client's actual motivation, rather than against an assumed readiness, converts the compelled attendance that the mandate provides into the genuine engagement that change requires.

Working with Denial, Minimization, and Criminal Thinking in the Room

The criminal thinking this course targets does not stay conveniently on the page; it shows up in the treatment room as denial, minimization, justification, blame, and the other cognitive moves through which the offender protects their offending and substance use from examination, and the counselor must know how to work with these patterns as they appear. A client may deny that they have a substance problem at all, minimize the extent or consequences of their use, justify their offending as necessary or deserved, blame their victims or circumstances, or claim an entitlement that excuses their behavior, and each of these is both a manifestation of the criminal thinking the treatment aims to change and an obstacle to the work of changing it. Confronting them clumsily produces defensiveness and rupture; ignoring them leaves the criminal thinking unchallenged.

The skillful handling of these patterns draws on the recognition that direct confrontation, the aggressive challenging of a client's denial or justification, tends to entrench rather than dissolve it, provoking the client to defend their position more firmly. The research on counselor style in addiction treatment has long shown that a confrontational approach often produces more resistance and worse outcomes, and the same dynamic operates with offenders, whose antisocial features make them particularly likely to meet confrontation with counter-resistance. The more effective approach helps the client examine their own thinking rather than having the counselor attack it, guiding them to notice the discrepancies between their behavior and their goals, to consider alternative interpretations of the situations they have justified, and to arrive at a recognition of their own distortions rather than having that recognition imposed. This is the cognitive work of the course conducted through a collaborative rather than a combative stance.

For the practitioner, working with denial and minimization is a matter of technique and stance together. It means recognizing these patterns as the criminal thinking the treatment targets, appearing in real time, and treating them as material for the work rather than as obstacles to be overpowered. It means avoiding the direct confrontation that entrenches the patterns, and instead helping the client examine their own thinking, notice its inconsistencies, and consider alternatives, so that the client does the cognitive work rather than merely resisting the counselor's. It means holding the client accountable for their behavior while not attacking their character, a distinction that allows firmness about the behavior without the personal assault that provokes defense. And it means patience with the gradualness of the change, since deeply held justifications and minimizations do not dissolve at once but erode through repeated, collaborative examination. The counselor who can work skillfully with denial and minimization addresses the criminal thinking exactly where it lives, in the client's real-time defense of their offending and substance use, and does so in the way most likely to change it.

Skills Training: The Behavioral Half of Cognitive-Behavioral Therapy

Cognitive-behavioral treatment is not only cognitive, and the counselor who attends to the restructuring of thinking while neglecting the building of behavioral skills delivers only half of what the approach offers. The behavioral half consists of teaching, modeling, and rehearsing the concrete skills the offender needs to live differently, the problem-solving, self-control, communication, refusal, and coping skills that a life without offending and substance use requires and that many offenders have never adequately developed. Changing how a client thinks is necessary but not sufficient; the client must also be able to do the things that a changed life demands, and often they cannot, because the skills were never learned, atrophied through a criminal and substance-using lifestyle, or were never modeled in the environments that shaped them.

The skills-training half of the work follows a distinct method that the counselor should deliver deliberately rather than assume the client will absorb. It involves identifying the specific skills the client lacks, explaining and demonstrating them, having the client practice them through role-play and rehearsal, providing feedback and refining the performance, and then supporting the transfer of the skills to real situations outside the treatment room. A client learning to refuse an offer of drugs, to manage a confrontation without violence, to solve a problem without resorting to crime, or to cope with distress without using, needs to practice these skills, not merely to understand them intellectually, because the capacity to perform a skill under real-world pressure is built through rehearsal rather than through explanation. This behavioral rehearsal is a core part of the cognitive-behavioral method and a central element of the group work this course describes.

For the practitioner, delivering the behavioral half of the treatment means treating skills training as a deliberate, structured activity rather than an incidental byproduct of discussion. It means assessing which specific skills each client lacks, since offenders vary in their deficits and a generic curriculum will overserve some areas and underserve others. It means using the full method of skills training, demonstration, guided practice, feedback, and rehearsal toward real-world application, rather than merely describing skills and hoping they take hold. It means recognizing that the group format this course emphasizes is particularly well suited to skills training, since the group provides multiple models, partners for role-play, and an audience whose feedback aids learning. And it means attending to the transfer of skills from the treatment room to the client's real environment, which is where the skills must ultimately function and where their absence would render the training academic. The counselor who delivers the behavioral half of cognitive-behavioral treatment, building the concrete capacities a changed life requires, complements the cognitive restructuring with the skills that make a different life not only imaginable but possible.

Group Leadership and the Management of the Difficult Group

The group format at the center of this course places particular demands on the counselor as a group leader, because a group of substance-abusing offenders can be a difficult group to lead, with members who may be resistant, manipulative, aggressive, or disengaged, and with group dynamics that can either support or sabotage the therapeutic work. Leading such a group well is a distinct skill set beyond individual counseling competence, and the counselor who understands group process and group leadership can harness the group as the powerful agent of change that the therapeutic community and

group-CBT models show it can be, while one who does not may find the group working against the treatment rather than for it.

The particular challenges of the offender group are well known to those who lead them. Members may test the leader's authority and competence, may collude to resist the work or to protect one another's criminal thinking, may attempt to dominate or manipulate the group, or may sit in passive disengagement, and the antisocial features common in the population can make these dynamics more pronounced than in other groups. At the same time, the group offers unique therapeutic resources, the capacity of members to confront one another's criminal thinking with a credibility the counselor cannot match, to model prosocial behavior and change for one another, to provide mutual support and accountability, and to create the prosocial community that resocialization requires. The leader's task is to manage the challenges while mobilizing the resources, maintaining enough safety and structure that the work can proceed while harnessing the members' influence on one another in a prosocial direction.

For the practitioner, effective group leadership with offenders combines structure, safety, and the skillful use of group process. It means establishing and maintaining clear structure and expectations, since offender groups function poorly without firm boundaries and can become unsafe or unproductive when structure is lacking. It means maintaining the group's safety, both physical and psychological, so that members can engage in the vulnerable work of examining their thinking without fear, which requires the leader to manage aggression, intimidation, and manipulation firmly. It means mobilizing the group's members as agents of change for one another, encouraging the prosocial confrontation, modeling, and support that give group treatment its distinctive power, rather than positioning the leader as the sole source of intervention. And it means reading and managing the group's dynamics, recognizing collusion, scapegoating, domination, and disengagement and intervening to keep the group working therapeutically. The counselor who can lead a difficult offender group well delivers the group-based treatment this course describes in the way that realizes its potential, turning a collection of resistant individuals into a community that supports the change in each.

Relapse Prevention for the Substance-Abusing Offender

The gains of treatment, whether in reduced substance use or reduced criminal thinking, are vulnerable to relapse, and the counselor must equip the offender with the specific skills of relapse prevention if the changes achieved in treatment are to survive the return to a high-risk environment. Relapse prevention teaches the client to anticipate the situations, states, and cues that threaten their recovery, to recognize the early warning signs of a return to substance use or offending, and to deploy coping strategies that interrupt the slide before it becomes a full return to old patterns. For the offender, relapse prevention must address both the substance use and the offending, since the two are intertwined and a return to either often drags the other with it, and it must contend with the particularly high-risk environments to which many offenders return.

The high-risk situations for this population are often severe and pervasive, which makes relapse prevention both more necessary and more challenging than for many other clients. The offender frequently returns to a neighborhood saturated with substances and crime, to associates who use and offend, to families that may be sources of stress or of substance use themselves, and to the unemployment, poverty, and lack of prosocial opportunity that press toward the old life. Relapse prevention that acknowledges these realities helps the client anticipate the specific high-risk situations

their environment presents, develop concrete plans for handling them, and, where possible, change the environment itself by finding new associates, new activities, and new sources of support. The aftercare findings discussed earlier, in which treatment gains faded once the intensive intervention ended, underscore that relapse prevention is not a single lesson but an ongoing structure of support that must extend into the period of greatest vulnerability.

For the practitioner, relapse prevention is a central and practical part of the work with offenders. It means helping the client identify the specific high-risk situations, both external and internal, that threaten their recovery, and developing concrete, rehearsed plans for handling each, rather than relying on general good intentions. It means teaching the client to recognize the early warning signs of relapse, the thoughts, feelings, and behaviors that precede a return to substance use or offending, so that they can intervene early while intervention is still possible. It means attending to the environment to which the client will return, helping them change what can be changed, the associates, the activities, the sources of support, and prepare for what cannot. And it means building the continuation of support into the treatment, recognizing that relapse prevention is most tested after formal treatment ends, and that the transition out of treatment and, for the incarcerated, out of custody is the period of greatest risk. The counselor who equips the offender with real relapse-prevention skills and supports gives the changes achieved in treatment their best chance of surviving the return to a difficult world.

The Reentry Transition and Continuity of Care

For the incarcerated offender, the transition from custody back to the community is a period of acute vulnerability, and the discontinuity of treatment across that transition is one of the most consequential gaps in the whole system of correctional care. A person may engage well in treatment inside the facility, develop genuine motivation and real skills, and begin the identity change that desistance requires, only to be released into an environment of overwhelming risk with no continuation of the support that fostered those gains, and the result is too often a rapid erosion of progress and a return to substance use and offending. The evidence throughout this material, the fading of therapeutic community gains, the rebound of craving after group treatment ended, the elevated post-release overdose risk, points repeatedly to the reentry transition as the point where treatment most often fails not because it did not work but because it did not continue.

The reentry period concentrates risk in several dimensions at once. The released person confronts the practical challenges of housing, employment, and basic survival, often with few resources and many barriers, at the same time as they face the temptations and pressures of the environment they left, and frequently without the medication, counseling, or support that stabilized them inside. For the opioid-using offender, the loss of tolerance during incarceration combines with the return to availability to make the post-release period one of extreme overdose risk, which is why continuity of medication for opioid use disorder across the transition is literally lifesaving. For all offenders, the discontinuity between in-custody treatment and community support means that the changes begun inside are tested immediately, under the worst conditions, without the scaffolding that helped build them.

For the practitioner, attending to the reentry transition and to continuity of care is essential to the durability of the treatment this course describes. It means recognizing the reentry period as one of acute risk and planning for it deliberately, rather than treating release as the end of the counselor's concern. It means working toward continuity of care across the transition, connecting the client to community

treatment, support, and, where relevant, medication before release rather than after, so that the scaffolding is in place when it is needed most. It means addressing the practical challenges of reentry, the housing, employment, and survival needs that can overwhelm recovery if unmet, as part of the treatment rather than as someone else's problem. And it means holding realistic awareness that the changes achieved in custody are fragile until they are established in the community, so that the work of treatment includes preparing the client for, and supporting them through, the transition where those changes are most severely tested. The counselor who attends to reentry and continuity gives the in-custody work a chance to endure, rather than watching it dissolve at the moment of release.

Co-Occurring Mental Health Disorders

The substance-abusing offender frequently carries co-occurring mental health disorders alongside the substance use and antisocial features, and the counselor who addresses the substance use and criminal thinking while ignoring the co-occurring conditions works with an incomplete picture of the client. Depression, anxiety, post-traumatic stress, bipolar disorder, and other conditions are common in the offending population, driven by the same adversity, trauma, and disadvantage that drive the substance use and offending, and they interact with the substance use in ways that complicate treatment. The moral reconation therapy trial discussed earlier was conducted specifically with justice-involved patients in mental health residential treatment, a reminder that the population this course addresses often carries significant psychiatric burden alongside the criminogenic factors.

The interaction of mental health disorders with substance use and offending has clinical implications the counselor must hold. Untreated mental health conditions can drive substance use, as clients use substances to manage the distress of depression, anxiety, or trauma, so that addressing the substance use without addressing the underlying condition leaves a powerful driver in place. Mental health symptoms can interfere with engagement in the cognitive-behavioral work, as the earlier finding on posttraumatic stress predicting dropout illustrates, so that the co-occurring condition becomes a barrier to the treatment as well as a driver of the problem. And the combination of a mental health disorder, substance use, and antisocial features presents a complexity that no single-focus treatment can adequately address, which is why integrated treatment that addresses the co-occurring conditions together has become the standard of care for co-occurring disorders generally.

For the practitioner, attending to co-occurring mental health disorders is part of treating the whole client rather than a slice of them. It means screening for and recognizing the mental health conditions that so often accompany substance use and offending, rather than treating the substance use and criminal thinking in isolation from the psychiatric picture. It means understanding how the co-occurring conditions drive the substance use and interfere with treatment, and addressing them as part of the work rather than as someone else's concern or a distraction from the criminogenic focus. It means coordinating with psychiatric care where medication or specialized treatment is needed, recognizing the limits of what cognitive-behavioral substance treatment alone can address. And it means holding the complexity of the client who carries a mental health disorder, a substance use disorder, and antisocial features together, resisting the temptation to reduce them to any single dimension and instead delivering treatment that addresses the whole. The counselor who attends to co-occurring disorders treats the substance-abusing offender as the complex person they usually are, rather than as the simpler case that single-focus treatment assumes.

Goal-Setting and Treatment Planning

The treatment this course describes proceeds most effectively when it is organized around clear goals and a deliberate plan, and the counselor who works without them risks a treatment that drifts, that fails to target the factors that matter, and that cannot recognize its own progress or lack of it. Goal-setting and treatment planning translate the general aims of reducing substance use, changing criminal thinking, and building prosocial skills into specific, concrete objectives for the individual client, matched to that client's particular risks, needs, and circumstances, and they give both counselor and client a shared map of where the work is headed and how they will know they are getting there. For the offender population, treatment planning is guided by the Risk-Need-Responsivity framework, targeting the criminogenic needs that drive the individual's offending at an intensity matched to their risk.

Effective goal-setting with offenders navigates a particular tension between the goals the system imposes and the goals the client owns. The correctional system brings its own objectives, the reduction of recidivism, compliance with supervision, completion of mandated treatment, and these are legitimate and often non-negotiable, but treatment organized solely around externally imposed goals engages the client's compliance at best rather than their genuine investment. The more effective approach connects the system's goals to the client's own, helping the client identify what they want, a life free of incarceration, restored relationships, employment, self-respect, and showing how the reduction of substance use and offending serves those wants, so that the client pursues change for their own reasons rather than merely to satisfy the mandate. Goals set collaboratively, concrete enough to be worked toward and measured, and owned by the client, drive treatment more powerfully than goals imposed from outside.

For the practitioner, goal-setting and treatment planning are the structure that gives the work direction and accountability. It means developing individualized treatment plans grounded in a thorough assessment of the client's risks, needs, and responsivity factors, targeting the specific criminogenic needs that drive that client's offending rather than applying a generic template. It means setting concrete, specific, measurable goals that both counselor and client can work toward and recognize when achieved, rather than vague aspirations that cannot guide the work or reveal progress. It means connecting the system's goals to the client's own, engaging the client's genuine investment by showing how change serves what they actually want, rather than relying on the mandate to supply motivation. And it means treating the plan as a living document, revisited and revised as the client progresses or as circumstances change, rather than a form completed once and filed away. The counselor who organizes treatment around clear, collaborative, individualized goals gives the cognitive-behavioral work this course teaches the direction and accountability that make it effective.

Ethics, Boundaries, and the Counselor's Dual Role

Work with offenders raises ethical challenges distinct from those of ordinary clinical practice, arising above all from the counselor's dual role as both a helper of the client and, often, an agent of the correctional system, and the counselor who does not navigate this dual role thoughtfully risks both ethical failure and the loss of the therapeutic relationship. The substance abuse counselor working with mandated offenders frequently owes obligations to the court, probation, or correctional authorities as well as to the client, may be required to report on the client's compliance and progress, and operates

within a system whose coercive power over the client is real and ever-present. This situation differs fundamentally from voluntary clinical work, and it generates ethical tensions the counselor must recognize and manage rather than pretend away.

The central tension is between the counselor's therapeutic role and their reporting or monitoring role, and the way it is handled shapes both the ethics and the effectiveness of the work. A counselor who conceals their reporting obligations from the client, or who blurs the line between helper and monitor, invites the client's justified distrust when the reality emerges, and undermines the honesty on which treatment depends. The more ethical and more effective approach is transparency: being clear with the client from the outset about the counselor's role, the limits of confidentiality, and the reporting obligations that apply, so that the client knows the terms of the relationship and can engage with them honestly. Offenders, attuned to deception and power, generally respond better to a counselor who is straightforward about the dual role than to one who pretends to a pure helpfulness the situation does not permit. Boundaries, too, require particular care with this population, whose antisocial features may include attempts to manipulate, test, or exploit the relationship, and the counselor must maintain clear, consistent boundaries that protect both the integrity of the work and the counselor themselves.

For the practitioner, navigating the ethics of correctional work is an ongoing discipline central to responsible practice. It means being transparent with clients about the counselor's dual role, the limits of confidentiality, and the reporting obligations that apply, rather than concealing or blurring them, so that the therapeutic relationship rests on honesty about its actual terms. It means maintaining clear, consistent professional boundaries, attending to the manipulation and boundary-testing that the population's antisocial features may produce, and protecting both the work and the counselor from exploitation. It means holding the genuine tension between the therapeutic and the monitoring roles without collapsing into either pure advocacy that ignores the client's behavior or pure enforcement that abandons the helping relationship. And it means engaging the ethical complexities through consultation and supervision rather than navigating them alone, since the dual role generates dilemmas that benefit from outside perspective. The counselor who navigates the ethics of the dual role with transparency, clear boundaries, and honest management of its tensions practices responsibly and, in doing so, builds the trust that makes the treatment possible.

Sustaining the Work: Counselor Resilience and Development

Working with substance-abusing offenders is demanding in ways that can wear on the counselor over time, and the sustainability of good practice depends on the counselor attending to their own resilience and development as deliberately as to the clients' treatment. The population is difficult, the work is often frustrating, progress is frequently slow and setbacks common, and the behavior the counselor encounters can be disturbing, including histories of serious harm to others. The risk of burnout, of cynicism, of the erosion of the hopeful and respectful stance that effective treatment requires, is real, and a counselor who does not tend to their own sustainability may find their practice deteriorating into the going-through-the-motions that helps no one, or into a hardened cynicism that writes off the clients the work is meant to serve.

The particular strains of this work deserve honest acknowledgment. Repeated exposure to clients who reoffend despite the counselor's efforts can produce a demoralizing sense of futility; the manipulation and hostility that some clients bring can wear on the counselor's goodwill; the disturbing

histories of some offenders can produce genuine emotional strain; and the systemic constraints of correctional work, the limited resources, the competing pressures, the sometimes punitive environment, can frustrate the counselor's therapeutic aims. Sustaining good practice in the face of these strains requires the counselor to attend to their own well-being, to maintain the support and perspective that keep the work in balance, and to hold onto the realistic hope that the evidence supports, that change is possible even in this difficult population, without either the naive optimism that sets up disillusionment or the cynicism that abandons the effort.

For the practitioner, sustaining the work over a career is itself a professional responsibility. It means attending to one's own resilience and well-being, recognizing the particular strains of correctional work and taking them seriously rather than dismissing them, since a depleted counselor cannot deliver the treatment well. It means drawing on clinical supervision and peer support not only for skill development but for the perspective and support that sustain the counselor through frustration and strain. It means maintaining the realistic, evidence-grounded hope that anchors effective practice, holding onto the reality that change is possible while accepting that it is often partial, slow, and hard-won, so that neither the failures nor the difficulty erodes the counselor's capacity to keep doing the work. And it means continuing to develop as a practitioner, keeping current with the evolving evidence and refining one's skills, so that the work remains alive rather than settling into rote repetition. The counselor who tends to their own resilience and development sustains across a career the quality of practice that the substance-abusing offender needs, and that only a counselor who has not burned out or hardened can provide.

Motivational Interviewing and the Collaborative Spirit

The engagement challenges that run through work with mandated, resistant offenders have a well-developed clinical answer in motivational interviewing, an approach whose collaborative, evocative, autonomy-honoring spirit is particularly suited to a population that responds poorly to confrontation and pressure. Motivational interviewing works not by persuading or coercing the client toward change but by evoking the client's own motivations for it, exploring and resolving the ambivalence that keeps them stuck, and honoring their autonomy even within the coercive frame of correctional treatment. For offenders, whose antisocial features and adversarial history with authority make them quick to resist anything that feels like being pushed, the motivational approach offers a way to build genuine motivation where confrontation would build only resistance, and the earlier evidence on drug court and forensic programs that combined motivational enhancement with cognitive-behavioral methods reflects how naturally the two fit together.

The core of the approach for this population is the recognition that motivation cannot be installed from outside but must be evoked from within, even when the external mandate is real and unavoidable. The counselor using motivational methods rolls with the client's resistance rather than opposing it, avoiding the argument that would entrench the client's position, and instead helps the client voice their own reasons for change, notice the discrepancies between their behavior and their goals, and arrive at their own decision to change. This does not mean abandoning the accountability that offender treatment requires or pretending the mandate does not exist; it means working within those realities in a way that engages the client's own agency rather than relying on compulsion, which the evidence on mandated treatment suggests cannot by itself produce lasting change.

For the practitioner, integrating the motivational spirit into the cognitive-behavioral work this course teaches strengthens engagement across the whole treatment. It means approaching clients with the collaborative, evocative, autonomy-honoring stance that motivational interviewing describes, particularly at the stages where motivation is being built, rather than defaulting to the confrontation that offender treatment has historically overused. It means evoking the client's own motivations for change and helping them resolve their ambivalence, rather than supplying the motivation from outside through pressure or persuasion. It means honoring the client's autonomy even within the coercive correctional frame, recognizing that the client's own decision to change is more powerful than any compelled compliance. And it means integrating this motivational spirit with the structured cognitive-behavioral methods, using the motivational approach to build the engagement that the skills-building work then requires. The counselor who brings the collaborative spirit of motivational interviewing to the treatment of offenders engages a resistant population in the way the evidence shows works, converting mandate into genuine participation.

Family and Social Network Involvement

The offender does not exist in isolation but within a web of family and social relationships that powerfully shape their substance use, their offending, and their prospects for change, and the counselor who attends only to the individual client, ignoring the social network, works with a fraction of what determines the outcome. The desistance research discussed earlier established that changes in relationships, movement away from antisocial peers, and shifts in family closeness, figure centrally alongside identity change in the process of leaving crime behind, which means the client's social world is not a backdrop to the treatment but a central factor in whether it succeeds. A client who changes inside the treatment room but returns to a network of using, offending associates faces conditions that press powerfully back toward the old life, while a client with prosocial support has conditions that sustain change.

The social network can function as either an obstacle or a resource, and the counselor who understands this can work with it deliberately. On the obstacle side, families may be sources of conflict, stress, or substance use themselves, and antisocial peer networks actively support and reinforce the offending and substance use the treatment aims to change, so that the client's relationships may work directly against the treatment. On the resource side, prosocial family members and associates can support recovery, provide the accountability and encouragement that sustain change, and help the client build the new life that desistance requires, and involving them in the treatment where appropriate can extend its reach into the client's daily world. The counselor's task is to assess the client's social network realistically, recognizing both its risks and its resources, and to work with it in a way that reduces its pull toward the old life and strengthens its support for the new.

For the practitioner, attending to the family and social network extends the treatment beyond the individual into the relationships that shape the outcome. It means assessing the client's social world realistically, identifying both the antisocial influences that press toward continued offending and substance use and the prosocial supports that could sustain change. It means helping the client navigate their relationships in the service of change, which may mean distancing from using and offending associates, repairing or strengthening prosocial family ties, and building new prosocial connections, all of which the desistance evidence shows to matter. It means involving family and supportive others in the treatment where appropriate and safe, extending its reach into the client's daily life and mobilizing the

network as an ally. And it means recognizing that a change achieved in the individual but unsupported by the social world is fragile, so that attention to the network is part of making change durable. The counselor who works with the client's social world, rather than treating the client in isolation from it, addresses the relationships that the evidence shows to be central to whether change lasts.

Experiential Methods: Role-Play, Sociodrama, and Rehearsal

This course describes experiential group methods, including sociodrama and role-play, as vehicles for the cognitive and behavioral change it aims at, and these action-based methods have a distinctive power that the counselor should understand and use deliberately. Where verbal discussion engages the client's intellect, experiential methods engage the whole person in enacting, practicing, and feeling their way through situations, which can reach clients that talk alone does not and can produce learning that verbal instruction cannot. For a population that often includes clients who are not verbally oriented, who have limited insight, or who resist the abstract discussion of their behavior, the chance to enact a situation, to practice a new response, or to see their own patterns played out can open a door that words leave closed, and the broader evidence on action-based and experiential group methods reflects their distinctive power for this kind of work.

The particular value of experiential methods lies in their capacity to make the abstract concrete and the intellectual behavioral. Role-play lets a client practice a new skill, refusing an offer of drugs, handling a confrontation without violence, responding to a provocation with words rather than aggression, in a way that builds the behavioral capacity rehearsal develops, rather than merely understanding the skill in principle. Sociodrama and related methods let the group enact and examine the situations, roles, and patterns that characterize the members' lives, surfacing the criminal thinking and the behavioral habits in a form that can be seen, felt, and worked with directly. These methods also engage the group as a whole, drawing on the members' participation as actors, observers, and sources of feedback, which mobilizes the group's therapeutic resources in the way the group-treatment emphasis of this course describes.

For the practitioner, using experiential methods well means deploying them deliberately as vehicles for specific change rather than as mere activity. It means using role-play and rehearsal to build behavioral skills, giving clients the practice that turns understanding into capacity, and structuring the rehearsal with the demonstration, practice, and feedback that skills training requires. It means using sociodrama and enactment to surface and examine the criminal thinking and behavioral patterns that verbal discussion might not reach, making the abstract concrete and the pattern visible. It means managing these methods with the skill they require, since experiential work can raise strong emotion and must be conducted with attention to safety and containment, particularly with a volatile population. And it means integrating the experiential methods with the cognitive work, using the enactment and rehearsal to reinforce and apply the cognitive change rather than as a separate activity disconnected from the treatment's aims. The counselor who uses experiential methods skillfully reaches clients and produces learning that verbal methods alone cannot, realizing the distinctive power of the action-based group work this course describes.

Settings of Care and the Adaptation of Treatment

Cognitive-behavioral treatment of the offender is delivered across a range of settings, from prison and jail to boot camp, halfway house, residential, and outpatient programs, and the counselor should understand how the setting shapes the treatment and how the approach must adapt to each. The settings differ in their level of control and restriction, in the length and stability of the client's stay, in the population they serve, and in their relationship to the community, and these differences affect what the treatment can accomplish and how it must be delivered. A treatment designed for one setting may fit another poorly, and the counselor who understands the setting can adapt the approach to its constraints and opportunities rather than delivering a uniform program regardless of context.

The settings present distinct conditions that shape the work. In prison and jail, the counselor works within a controlled, often punitive environment, with a captive but sometimes transient population, and must contend with the tension between the correctional and therapeutic aims of the institution, while also confronting the reentry challenge of connecting in-custody treatment to community continuation. In residential and halfway-house settings, the counselor has the advantage of an immersive, structured environment that can function as a therapeutic community, along with the challenge of preparing clients for the transition back to less structured living. In outpatient settings, the counselor works with clients living in the community, which offers the advantage of real-world application and the challenge of the high-risk environment the client returns to daily. Each setting, in short, offers particular opportunities and imposes particular constraints, and the effective delivery of cognitive-behavioral treatment adapts to them.

For the practitioner, understanding the setting is part of delivering the treatment well within it. It means recognizing how the particular setting shapes what the treatment can accomplish, the level of control, the stability of the population, the relationship to the community, and adapting the approach to fit rather than delivering a uniform program regardless of context. It means attending to the particular challenges each setting presents, the reentry gap in custodial settings, the transition to independence in residential ones, the daily high-risk environment in outpatient ones, and addressing them as part of the work. It means drawing on the particular opportunities each setting offers, the immersive structure of residential care, the real-world application of outpatient work, the concentrated time of custody, to strengthen the treatment. And it means holding continuity across settings in view, since clients often move among them, and the treatment is most effective when it connects across the transitions rather than starting over or breaking off at each move. The counselor who adapts the cognitive-behavioral approach to the setting delivers it in the form that setting makes possible, rather than forcing a single template onto varied contexts.

Recognizing Progress and Managing Setbacks

Change in the substance-abusing offender is typically partial, gradual, and marked by setbacks, and the counselor who expects a clean linear progression toward recovery will misread the normal course of the work as failure, while the counselor who understands the realistic shape of change can recognize genuine progress and respond to setbacks constructively. The desistance research established that leaving crime behind is a process rather than an event, often stretching over years and punctuated by relapses and returns, and the same is true of recovery from substance use, which is likewise

characterized by progress and setback rather than a single decisive turn. Holding this realistic understanding matters both for the counselor's own sustainability and for the client, because how a setback is understood and handled shapes whether it becomes a temporary lapse or a full return to the old life.

Recognizing progress in this population requires attending to the incremental and the internal, not only the dramatic and the behavioral. A client who has not yet stopped using but who has begun to question their criminal thinking, who has developed some motivation for change, who has built a skill or two, or who has begun to see themselves differently, has made real progress even though the ultimate behavioral change has not yet arrived, and a counselor attuned only to the final outcome may miss these genuine gains. Measuring the intermediate targets, the criminal thinking, the motivation, the skills, the emerging identity change, allows the counselor to recognize progress that the presence or absence of reoffending alone would not reveal, and to sustain both their own and the client's engagement through the long process that change requires.

Setbacks, when they come, are occasions for learning rather than proof of failure, and the counselor's response to them can determine their meaning. A lapse into substance use or a return to old thinking, understood within a process view of change, is information about the situations and vulnerabilities that threaten the client's recovery, and it can be used to strengthen the relapse-prevention work rather than to condemn the client or abandon the effort. The counselor who responds to a setback with the message that the client has failed, or who withdraws in discouragement, risks turning a lapse into a full relapse, while the counselor who responds with the message that the setback is a normal and workable part of the process, to be learned from and moved past, helps the client recover their footing. This does not mean excusing the behavior or ignoring its consequences, which the correctional context makes real, but understanding the setback within the process of change rather than as its negation.

For the practitioner, holding a realistic understanding of the shape of change is essential to both effectiveness and endurance. It means expecting change to be partial, gradual, and non-linear, and reading the setbacks and slow progress that characterize the work as normal features of the process rather than as failure. It means recognizing and valuing the incremental and internal gains, the shifts in thinking, motivation, skill, and identity, that precede and accompany the behavioral change, rather than attending only to the ultimate outcome. It means responding to setbacks as occasions for learning and re-engagement rather than as proof of failure, helping the client recover from a lapse rather than allowing it to become a relapse. And it means holding this realistic understanding for the counselor's own sake as well as the client's, since a counselor who expects clean success will burn out on the reality of the work, while one who understands its true shape can sustain the hope and effort that the long process requires. The counselor who recognizes progress accurately and manages setbacks constructively works with the actual grain of change in this population, rather than against an idealized expectation that the reality would defeat.

Treatment Versus Punishment: The Rehabilitative Premise

Underlying the entire enterprise this course describes is a premise worth making explicit, because it is contested in the wider world and shapes the counselor's work: the premise that offenders can change, and that treatment aimed at producing that change is a legitimate and effective response to offending, alongside or in place of punishment alone. The justice system has long been pulled between punitive and rehabilitative impulses, between the aim of punishing offenders for what they have done and the aim of changing them so they do not do it again, and the cognitive-behavioral treatment this course teaches sits squarely within the rehabilitative tradition, resting on the conviction that offending behavior can be altered through treatment rather than only deterred through sanction. The counselor working in this field is, in effect, an agent of the rehabilitative premise, and understanding it helps the counselor hold their purpose clearly within a system that does not always share it.

The evidence assembled throughout this material supports the rehabilitative premise while defining its realistic scope. Cognitive-behavioral treatment genuinely reduces the thinking and behavior that drive offending, the risk-need-responsivity framework identifies how to target it effectively, and even challenging clients with antisocial and psychopathic features can change when well-treated, which together establish that rehabilitation is not a naive hope but an evidence-based reality. At the same time, the modest effect sizes, the importance of engagement and dose, and the difficulty of sustaining change all define the limits within which rehabilitation works, cautioning against the overclaim that treatment can transform any offender or that it makes punishment and public safety irrelevant. The realistic position the evidence supports is that treatment meaningfully increases the odds of change for many offenders, that this both serves the offenders and protects the public, and that it works best not in opposition to accountability but alongside it, within a system that holds offenders responsible while offering them the genuine possibility of change.

For the practitioner, holding the rehabilitative premise clearly matters both for purpose and for practice. It means understanding the counselor's own role as an agent of change within a system often oriented toward punishment, and holding onto the rehabilitative purpose that gives the work its meaning, without either naivety about the difficulty or cynicism about the possibility. It means grounding that purpose in the evidence, which supports rehabilitation as a real and effective response to offending while defining its realistic scope, so that the counselor's hope is evidence-based rather than sentimental. It means recognizing that treatment and accountability are not opposed but complementary, so that holding a client responsible for their behavior and offering them the means to change it are parts of a single coherent response rather than competing philosophies. And it means articulating, when the occasion requires, the case for rehabilitation to a system and a public that may doubt it, drawing on the evidence that offenders can and do change when well-treated, and that changing them serves public safety more durably than punishment alone. The counselor who holds the rehabilitative premise clearly, grounded in evidence and realistic about its scope, brings to the difficult work with substance-abusing offenders a purpose that sustains it and a case that justifies it.

Integration and the Counselor's Stance

The unifying lesson of the evidence assembled here is that cognitive-behavioral treatment of the substance-abusing offender genuinely works, but that its effectiveness depends on a set of conditions the counselor must actively secure: the right intervention matched to the right client, delivered with fidelity and in sufficient dose, to a client actually engaged in the work, within a supportive structure that extends beyond the treatment room and continues after release. The approach this course teaches is not a magic key that opens every offender to change, but a well-supported set of methods that meaningfully improve the odds of change when the conditions for their effectiveness are met, and much of the counselor's skill lies precisely in securing those conditions.

The counselor's stance toward the substance-abusing offender shapes the work as much as any technique. The population is difficult, often mandated, resistant, interpersonally challenging, and marked by the antisocial features and criminal thinking that can evoke in the counselor the very judgment, distrust, or hopelessness that undermines treatment. A stance of realistic engagement, taking the difficulty seriously without being defeated by it, holding the client accountable for their behavior while treating them with the respect that makes change possible, and maintaining a grounded hope supported by the evidence that even challenging clients can change, is what allows the methods to reach the client. The evidence that psychopathic clients can change when they engage, that the most trauma-burdened women can be the most responsive to trauma-specific treatment, and that identity change toward desistance can begin even inside the correctional setting, together rebut the pessimism that would write off this population and ground an attitude of expectation rather than resignation.

Ultimately, the work this course describes is a matter of both public safety and human change, and the two are joined rather than opposed. Reducing offending protects the community, and it is accomplished not by containment alone but by helping the offender become a person who no longer offends, through the change in thinking, behavior, and identity that the cognitive-behavioral and resocialization methods aim at. The counselor who delivers those methods well, securing the conditions for their effectiveness and bringing to the work a stance of realistic, respectful, evidence-grounded engagement, contributes to both aims at once, extending to a difficult and often written-off population the genuine possibility of change that the evidence shows to be real. The competencies this course builds are the concrete means of that contribution, and the counselor who masters them serves both the clients and the community that the treatment of the substance-abusing offender is meant to protect.

The Offender and Addiction - Cognitive Behavioral Therapy

Community Mental Health: Applying Sociology to the Clinical Setting - Sociotherapy for Sociopaths

(Rand L. Kannenberg, Southwestern Sociological Association Annual Meeting in conjunction with the Southwestern Social Science Annual Meeting, Dallas, Texas, March, 1987; Colorado Mental Health Association Conference, Breckenridge, Colorado, September, 1987)

For a variety of reasons, more M.A. and Ph.D. level sociologists, like many other social scientists with advanced degrees, are employed outside of academia. For some it is a simple matter of economics: business pays better than what can be made in most classrooms or laboratories. Others prefer occupations off campus. And for those who do lean toward teaching and research, there are too few jobs for everyone. Luckily, sociology is a behavioral science, which can be successfully practiced, in other applied or clinical settings. One important example is mental health. Historically, the field of adult mental health, even in low paying community centers, has been occupied predominantly by registered or licensed professionals from psychiatry, psychology and social work. Nonetheless, clinical sociologists along with applied sociologists have organized. The result is a professional association[1], which provides the opportunity for certification as a clinical sociologist in one or more specialty areas, political power has been increased, and members are more attractive to the potential employer, in the mental health field and others. Accordingly, there is an improved recognition of sociological counseling or sociotherapy, and clinical sociologists are often seen by colleagues from the different disciplines named above (disciplines which it must be noted are conceptually interrelated with sociology) as the experts of certain techniques or modalities for treatment. Sociodrama or role-playing, sociometry or the diagramming of relationships within groups, and group therapy are just a few examples.

Clinical sociologists are also effective criminologists. Using paradigms that vary from Functionalism to Conflict Theory and somewhere in between the two extremes, sociologists have done impressive work inside of prisons and in community based clinics with probationers and adults paroled from penal institutions. Because crime is a major social problem in contemporary American society, sociologists are no longer being asked to only explain the causes of

[1] Sociological Practice Association: A Professional Organization of Clinical and Applied Sociologists (formerly known as the Clinical Sociology Association, which was established in 1978).

social deviance by different theories, but also to work directly with the deviants themselves. Utilizing the concepts of social groups, norms, deinstitutionalization, and resocialization, a clinical sociologist is capable of playing an active role in the process of reintegrating convicted criminals back into society.

This course will address the value of applying clinical sociology as an intervention for positive change in community mental health. More specifically, the significance of sociological counseling for felons with mental disorders will be discussed by studying an actual therapy group in progress which was designed for clients with the diagnosis of Antisocial Personality Disorder. An arbitrarily chosen member of the group will be anonymously presented in an attempt to identify a few of the social characteristics of such clients.

Community Mental Health

This author is currently employed as a clinician in an adult outpatient clinic at one of four community mental health centers in the city and county of Denver[2], all of which contract for services with the state of Colorado. Duties include the provision of ongoing individual, couple and group therapy as well as telephone and walk-in screenings, face-to-face intake evaluations; and the shared responsibility of emergency coverage. In addition to the author who has a Master of Arts degree in Sociology, the adult outpatient team consists of two licensed social workers, two unlicensed masters' level social workers, a registered nurse with a bachelors degree and certification in psychiatric nursing, an M.A. level psychologist and a part-time psychiatrist. Specialties are varied but none of the clinical staff members have extensive education, training or prior work experience in criminology.

All therapists have the right as a supervised yet mostly autonomous professional to refuse treatment to any client if the reason is clinically justifiable. A potential client's high level of risk for danger to others exemplifies such decision-making. The policies and procedures clearly reflect the administration and management's concern for the safety of both staff and other clients alike. In accordance with this arrangement, a history of violence is listed as suitable grounds for the denial of services.

Violent clients may be referred to other outside agencies such as private nonprofit clinics, which specialize in working with people involved in the criminal justice system. However, the reason that most parolees, probationers, individuals involved with Social Services[3] by court order, and inmates at the county jail on work and therapy release are initially referred to the community mental health center in their area, is financially motivated. A sliding fee scale

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[2] Shortly after this paper was first published, the four mental health centers merged and became a single agency serving the city and county of Denver.

[3] Now called "Human Services" in Colorado.

based on family size and income is used. Many clients pay as little as $1.50 an hour (the full rate is $60 for individual treatment and half that for groups) and the other agencies charge much more than the average involuntary client is able to afford. Therefore, someone has to provide mental health treatment to this population at a realistic cost. (In Colorado, parolees are given $100 cash upon release from prison and expected to pay for their own transportation, room, board and other expenses including therapy if such is a condition of their parole agreement.)

This therapist inherited involuntary clients as described earlier from his predecessor. The existing caseload included a convicted murderer, several rapists and other violent offenders. In reviewing cases and planning a schedule it was decided that the parolees and probationers (those already admitted to the program as well as future referrals) could best be served by remaining at the outpatient clinic but in a group that would meet regularly. Before this time these difficult to work with clients were seen individually, however, appointments were sporadic, mainly because of other priorities. Clients who required crisis intervention or even the more stable individuals who were in treatment voluntarily received precedence. The client who sees himself as being "forced" to attend and participate is clearly not motivated to be there. The brief sessions once monthly, for example, is something that the client may have preferred, but it was not necessarily therapeutic. For this reason, a group which meets for fifty minutes (or one clinical hour) on the same day and time every week was developed. What follows is a description of the group.

Sociotherapy for Sociopaths™[4]

In September 1986 when the group was started by the author, five clients were enrolled. The current number is eight (this is the maximum because of room size and basic concerns of manageability). At present time there is also a waiting list of additional referrals.

Referral criteria are that the client be a male[5] probationer or parolee between the ages of 18 to 59 years who resides in the catchment area of this community mental health center. (Geographically, the area covers most of east Denver which includes the airport[6], an airforce base, a section immediately adjacent to the downtown district, low income housing, as well as historic neighborhoods.)

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[4] The first name of the treatment program was "Parolee/Probationer Group." It was changed to "Resocial Group"™ about five years ago. The training is known as "Sociotherapy for Sociopaths."™

[5] Resocial Group™ has been coed for years. Training discusses the minimum number of female members to minimize retraumatizing clients as well as some issues more likely to be female specific.

[6] Stapleton International Airport (now closed).

Antisocial Personality Disorder must be the primary mental health diagnosis. As defined in the Diagnostic and Statistical Manual of Mental Disorders (Fourth Edition, Text Revision) (this widely used guidebook is more commonly known as the "DSM IV-TR"), the onset had to occur before age 15 years and there must be a pattern of continuous antisocial behavior in which the rights of others are violated. Citing directly from the DSM IV-TR this diagnosis also requires at least three or more of the following manifestations of the disorder since age 18 years:

(1) failure to conform to social norms with respect to lawful behaviors as indicated by repeatedly performing acts that are grounds for arrest
(2) deceitfulness, as indicated by repeated lying, use of aliases, or conning others for personal profit or pleasure
(3) impulsivity or failure to plan ahead
(4) irritability and aggressiveness, as indicated by repeated physical fights or assaults
(5) reckless disregard for safety of self or others
(6) consistent irresponsibility, as indicated by repeated failure to sustain consistent work behavior or honor financial obligations
(7) lack of remorse, as indicated by being indifferent to or rationalizing having hurt, mistreated, or stolen from another

Potential clients who have a primary problem of substance abuse or dependence[7], a diagnosis of Schizophrenia or Severe Mental Retardation, or are deemed at high risk for violence in the clinical setting specifically, will not be admitted. Potential clients who have a history of adult antisocial behavior which is not due to this specific personality disorder will also be refused enrollment in the group but might be appropriate for individual treatment (this author has offered therapy outside of the group to a former drug dealer, several child molesters, and an individual on federal probation for racketeering).

A completed referral form along with a release of information form signed and dated by the potential client, allowing disclosure of this confidential record information as well as future exchanges of information between the two agencies, must be sent by the referral source (i.e., parole officer, probation officer, or Department of Corrections mental health staff, etc.) prior to a scheduled intake evaluation appointment. Besides basic identifying information, the referral form requests criminal history and details regarding any violent behavior even if not convicted of these crimes; current level of risk for danger to self and others; information regarding all incarcerations; and dates and locations of prior mental health and drug/alcohol treatment including hospitalizations (if any). A mental health diagnosis, if available and names and dosages of prescribed medications, if applicable are also requested as is a summary of

[7] Currently, Resocial Group™ members must have co-occurring diagnoses of Antisocial Personality Disorder (APD) and a Substance Use Disorder (SUD).

social history (e.g., family background, employment, and education) and treatment recommendations. Word-of-mouth has been the primary source of publicity for the group although two inservice seminars have been provided to date – one at the Denver Field Office of Parole, the other at the state penitentiary with mental health staff.

The duration of treatment is at least six months. In addition to therapy, case management, namely coordination of services with the parole/probation officer[8], is provided as needed. Again, the problem is stated as a history of continuous and chronic antisocial behavior in which the rights of others are violated, resulting in incarceration for those clients on parole (the average length of stay in prison for parolees in the group was seven years).

The goal of the group is that its members become deinstitutionalized (if on parole) and/or that they learn how to function responsibly in society. Objectives include regular attendance and participation in the group therapy sessions once weekly for at least six months as mentioned earlier. Payment for services rendered must be paid at the time of every appointment. Only after attending three consecutive sessions, and preferably with one week's advance notice, may one session per month be missed.[9] If a client "no shows" (i.e., does not call to cancel and reschedule) a form letter is sent to him with a copy going to the parole or probation officer documenting which scheduled appointment was not kept and giving the date, day and time of the next group meeting. The same letter also states how many unexcused absences the client has to date and will be allowed in the future.[10] Noncompliance with treatment is defined as three no shows.[11] Clients terminated from the group for the reason of nonattendance are not re-enrolled. A referral to another agency is provided if such is desired.

Other objectives are that the client will report improved interpersonal relationships and on-the-job performance (if employed); an increase in awareness of social norms; and a decrease in problems of impulsiveness and irritability. In addition, it is desired that in six months the client will have

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[8] The author is now a Certified Case Manager and has a better understanding of clinical case management. He borrows the definition from the BSS Model (Balanced Service Systems) by the Joint Commission on Accreditation of Healthcare Organizations and the Community Mental Health Center Act. Instead of simply seeing case management as the function of coordination of services, the BSS Model defines case management as including "assessment, planning, linking, monitoring and advocacy."

[9] The current attendance policy simply allows for three absences as long as the client attends at least 24 sessions.

[10] There is no longer a difference between "excused" and "unexcused."

[11] At this time, no more than three missed visits of any kind are tolerated. The client is automatically terminated on the fourth absence.

demonstrated an improved ability and willingness to function as a responsible spouse, romantic partner, and/or parent as well as an increase in motivation to honor financial obligations and to be truthful.[12]

Even though some informal education/socialization regarding society's expectations around lawful behavior is provided, for the most part, the group is talk therapy. Clients are encouraged to speak freely about situations at home and work (or during job search efforts).[13] Clients are supported interpersonally and also helped to improve their own insight into problem areas by utilizing the cognitive approach to treatment. They are assisted in problem solving and planning for the future. Role-playing is used to explore appropriate ways that anger and other strong emotions might be dealt with both effectively and efficiently. Relationships in families and social groups are studied and explained if possible. Clients are confronted about the seriousness of providing for children (if applicable) and maintaining legal or moral commitments to spouse/romantic partners and others (this includes financial obligations). A premise of the therapist is that even if these clients have seemingly learned little if anything from punishment and seen nothing wrong with their behavior in the past, all of them know right from wrong and some have feelings of guilt and can conform. A stable social support system such as this treatment group may provide the motivation they need to comply with the rules of society.

Services are denied to a client if he appears intoxicated/under the influence of alcohol or other nonprescribed drugs. Any act of violence would result in immediate notification to the appropriate law enforcement agency and automatic termination from the group.

A Case Study

John Doe is an original member of the group. He was also terminated for nonattendance and readmitted before the group rule allowing this practice was changed (actually, it was implemented because of him and his behavior). John is 39 years-old, has never been legally married, is unemployed, was referred by Colorado Department of Corrections and is on parole for sexual assault which expires later this month. Outpatient mental health treatment is a condition of his parole agreement as fixed by the state Board of Parole.

As an adult, John has had more than thirty arrests which include the charges of Aggravated Assaults, Carrying a Concealed Weapon, Rape, Aggravated Robbery and other violent crimes. He has also been convicted of Assault with a

[12] Abstinence and sobriety are also goals of Resocial Group™.

[13] This is a major change. Resocial Group™ now is a very structured cognitive behavioral treatment program that has three activities that are repeated for each of the eight topics.

Deadly Weapon. As a juvenile he was arrested for Larceny from a Motor Vehicle and Accessory After the Fact. He was placed on probation with juvenile court until the petition was later dismissed.

After the age of 18 John has been placed on probation twice, fined approximately four times, sentenced to county jail two times and in the state penitentiary twice. His most recent incarceration was in a medium security prison. He only served three of his seven-year sentence. On a scale of "1 to 10" (with 10 being the most serious), the Diagnostic Center at the state penitentiary assigned John with a rating of "9" for "Violence Potential," a '9" for "Recidivism Based on Unfavorable Habits," and a "9" for "Recidivism Based on Compulsive Self Hatred."

John has a very limited and unstable work history. He has been unemployed for about one year after release from prison. Because he is currently unable or unwilling to secure and maintain employment, this author has referred him to the state Division of Rehabilitation for vocational testing, assessment, counseling and placement.

John has seven children ages eight to seventeen years old by three different women, is currently involved with another woman and admits to sexual promiscuity. He fails to provide any financial support to his children or their mothers.

John is very dishonest. For example, he would only admit to a single felony offense until confronted about the other multiple arrests and convictions once confirmed by official records. He is also resistive to treatment and has been belligerent at times. He claims to have no real plans for the future either.

John is neither the most nor the least successful group member, but he now attends and participates actively in the discussions benefiting from and contributing to the group process. Several others have been terminated and referred elsewhere for noncompliance with treatment. As a result, they face the possibility of a parole revocation hearing and return to prison.

One member is currently in county jail for possession of stolen goods; another is to be sentenced in two months for a DUI arrest and conviction (he pled guilty) while on parole.[14]

However, after spending eleven years in prison (where he went when only 17 years-old), one client was recently named "Employee of the Month" at a local franchise of a nationally known fast food restaurant for outstanding job

[14] The next section in this text on parole clarifies the author's point of view regarding when parole should be revoked.

performance. He has also decided to "do the right thing" and marry his pregnant girlfriend who he says he "loves." Another client can finally use the telephone to call and cancel appointments instead of simply not showing. This is a small yet important example of learned responsible behavior.

A different client can now better recognize the needs of his young children and his duty to meet them. This is an accomplishment for the parent of another child who died of malnutrition not too long ago. This same individual has also received a better paying job with added responsibilities that make him "proud," a feeling he is able to identify in the group setting.

A new member of the group will probably be admitted to a corporate sponsored job-training program next week. To avoid a potential parole violation, he has already decided to make the necessary arrangements to adjust his work schedule so he does not have to miss therapy sessions. Finally, a former group member with a history of violent crimes and great difficulty controlling his anger wrote a five stanza poem entitled, "Inspiration" and dedicated it to this therapist. Four lines of the composition read as follows:

> "When you see someone who is down-and-out,
> STOP! And see what's the hurt all about.
> Letting your heart be your guide,
> While showing some decency, pulling his coat on the side!"

Conclusion

Along with the provision of work orientation training and personal/social adjustment training (especially independent living skills instruction), mental health treatment is an essential need for some but not all parolees and probationers, that should be provided as soon as possible upon disposition in court or release from prison. Clinical sociologists and other practitioners using group therapy as discussed in this paper, whether at community mental health centers or in other settings, may make a real difference in keeping criminals from repeating their crimes and staying out of prison.

Test of Parole is Protection of Lawful Citizens

(Rand L. Kannenberg, Guest Column, Rocky Mountain News, Sunday, February 22, 1987. After this article was first published, the author was nominated to the Colorado Parole Board. He was the youngest person ever nominated. He was not appointed.)

At first glance, the idea of releasing a convicted criminal from prison before the full sentence is served may not appear reasonable to everyone. However, as long as strict conditions are set and close supervision in the community is provided, parole is logical. In theory, parole is less expensive than institutionalization, bed space is made available to violent offenders who are likely to repeat their crimes and therefore must remain incarcerated, and it allows for a transitional and trial period outside of prison – a gradual reintegration back into society and an easier process of return to prison if unsuccessful.

Unfortunately though, in recent practices, parolees have been charged with murder, rape and other violent crimes. In fear of their safety, people are questioning the system and, in some cases, rightly so. Confidence in the parole board and individual parole officers has diminished. Granted, there are some serious problems in Colorado's adult parole system, but it can work. Whereas many changes may be needed to correct these problems, none of the changes are drastic.

It is wrong to pressure the parole board to release inmates simply because of a decrease in prison space and then turn around and blame them for granting parole inappropriately or hesitating to revoke parole for the same reason. A new prison is definitely needed. So are additional alternatives, such as halfway houses and other medium to low-security correctional facilities for non-violent offenders. Very simply, parole, if to be used correctly, cannot replace the need for building new prisons.

Because of the difficult decisions involved in granting and revoking parole, fixing conditions of parole agreements, and hearing requests for transfers between facilities – as well as considering the impact on the community, parole board members should be required to demonstrate certain qualifications.

Ideally, members would be professionals from the various fields of criminal justice/law enforcement (including parole officers), mental health, social work and vocational rehabilitation. An informed and open-minded citizen representative, possibly a crime victim or a victim's relative, could also be an asset because of personal exposure to crime and its effects. In accordance with these recommendations, the model four-member board soon to be appointed by the governor would be well balanced professionally and include no more than one non-professional member.

Indeed, parolees have the rights to due process of law and these should be protected. Nonetheless, because of their criminal conviction and supervision by the court they also forfeit some privileges. Automatically allowing a parolee to appeal the parole board's revocation of parole is both costly and time consuming. This is not a procedure that has to be eliminated but can be restricted in use.

If a parole officer requests a revocation hearing because of a carefully documented parole violation and the parole board chooses to revoke parole that decision should stand. Parole is a conditional release from prison. When conditions meant to rehabilitate - not punish - the parolee and also to protect society cannot be met, the parole violator will have to demonstrate good behavior back in prison and await his or her next parole hearing when again eligible. The laws should be changed to allow an appeal of parole revocation only when a parolee or an advocate can prove without a doubt that a mistake was made by the parole officer and/or parole board and parole was revoked without just cause.

On the other hand, parole revocation hearings should be automatic when a subsequent crime is committed and a parolee is arrested while on parole. Detaining a parolee during an investigation is a good idea. So is another related plan, a statewide computer system to track parolees and provide local law enforcement officials with names, finger prints, photographs and other identifying information. Without a system, it is all too likely that there will be another incident of a parolee being arrested and released 17 times before finally murdering someone, as happened in Arapahoe County last year.

Statutes dealing with parole should benefit the law-abiding citizen. If they do not, parole will not be supported by the people of this state.

Other RESOCIAL GROUP™ Case Studies

Bob[15]

Bob is a thirty-eight year old White male. He is employed as a truck and diesel mechanic for a company owned by his brother. He dropped out of school in the ninth grade. As a teenager he had multiple arrests for theft of auto parts and was placed on probation. He was also assaultive against peers. He is one of seven children. Both parents had problems with alcohol and domestic abuse. His father would regularly drink and drive. Bob has been married four times. He has not been a responsible parent with regards to consistent financial support or visitation with the two children from two of the relationships.

[15] Not the client's real name.

He has been arrested for DWAI (twice), Second Degree Assault, Shoplifting, Disturbing the Peace, First Degree Criminal Trespass, Larceny, Driving after Revocation Prohibited (four times), DUI (three times), Eluding a Police Officer, First Degree Sexual Assault, Disturbing the Peace (two times), Threat to Injure Person/Property, Assault, Wrongs to Minors, Intimidating a Witness, Third Degree Assault (twice), Sexual Assault on a Child, Third Degree Sexual Assault, Driving while Habitual Drug User, Driving under Restraint, Domestic Violence (three times), Menacing, Criminal Mischief, Failure to Display Insurance, Reckless Driving and Speeding. As an adult he has used several aliases. He has been repeatedly indifferent to hurting others. He does not have Schizophrenia, or Bipolar Disorder; however, he has been treated for depression and anxiety in the past. He did not attend mental health counseling and stopped taking the medications when he went to jail but "did not notice a difference."

Bob is a chronic alcoholic. He has increased tolerance, quantity and duration; he has been unable to discontinue drinking; he has had legal and social impairments related to the alcohol; and he continued to drink despite the depressive episodes. He has been non-compliant with substance abuse treatment and did not take Antabuse as directed on a regular basis while on probation. Most recently he has been given a direct sentence to community corrections after his fourth conviction for Driving after Revocation Prohibited and has been referred to Resocial Group™ for cognitive behavioral treatment that deals with co-occurrence of Antisocial Personality Disorder and Alcohol Dependence. He is also attending "offense specific" (sex offender) treatment and AA meetings.

Session 1. Quiet at first but with help was able to complete activity. Told group that he wants to be a better father to his son "starting now."

Session 2. Involved in role training about being responsible on the job. Nervous at first but able to participate and show the group how someone is more likely to be a good worker without alcohol and/or other drugs.

Session 3. Wrote a goal on short-term, criminal behavior. "I will find a ride, take the bus or even walk while I am in the program so I won't go to prison starting now."

Session 4. Admitted to having a difficult time understanding the exercises tonight even though he used the same technique a few weeks ago. Was willing to re-do them. Presented at the end of group and talked about a goal of feeling and showing remorse when appropriate.

Absence 1. No-show to group. Case manager notified. Per other clients, was at work.

Session 5. Apologized for missing last week. Said his case manager would explain why he missed. His goal was long-term, substance abuse and talked about attending church with a friend on a weekly basis after leaving the program.

Session 6. Written activity was somewhat difficult for him. At first he struggled with how to do the assignment. He then talked about how his alcohol use and anger with his son caused feelings of anger and rejection.

Session 7. Animated this evening. Did not hesitate to get involved in role training exercises. Defined impulsivity as "not being ready or prepared."

Session 8. Wrote a short-term substance abuse goal about continuing to take Antabuse three times a week "to help me maintain my sobriety." Active in session. Willing to take a risk by giving feedback to another peer. Did well.

Session 9. Made a mistake on assignment. Became a little defensive. Then came to the rescue of two other clients when they were given direct feedback. Asked him to talk about this. No insight into why he feels uncomfortable with the conflict or criticism (with self or others).

Session 10. Very involved. Helped facilitate an activity. Positive.

Session 11. Approximately halfway through treatment. Reviewed three goals he has written so far. Group agreed he is doing very well with Antabuse, finding rides/taking bus/walking and planning on going to church once allowed by case manager/program.

Session 12. Did not want to be on camera during videotaping of group session or ask questions off camera (even though he previously signed informed consent form volunteering to participate), but agreed to assist setting up equipment and room. Helpful.

Session 13. Very positive about how video turned out. Laughed and smiled.

Session 14. Compared his relationship to his son with what it was like growing up with his own father. Blames alcohol on the problems he has had with rule breaking. Says he knows he will not use in the future and that he can make this promise to and for his son.

Session 15. Talked openly about how he cannot drink at all because if he starts he cannot stop and he doesn't want to go to prison.

Session 16. His goal was long-term/criminal behavior. Says that only after gone from program and allowed to drive he will go to Department of Motor Vehicles to make certain he has a valid driver's license so that he doesn't get in trouble driving.

Session 17. Said his son has been afraid of his driving under the influence like he was with his own father. Optimistic that if he continues to work his program, he can stay sober and reduce his chances of getting involved in dangerous situations and settings.

Session 18. Participated on his own before being asked. Did well.

Session 19. Used over-the-counter eye drops in group. Has a very red right eye he said was injured at work. Told him to please turn in or discuss eye drops with security and housing staff. Staff notified. Client wrote a goal regarding safety and preventing future injuries on-the-job.

Session 20. Discussed growing up being forced to fight his best friend by his brother and more recently (before coming to this agency) how he made his own son cry. Thinks he can be assertive versus aggressive if he remains sober.

Session 21. Involved in defining topic and in doing activities.

Session 22. Graduates after two more sessions. Case manager notified. Wrote sixth and final goal this meeting regarding thinking about what he says before he says it at work to avoid being aggressive.

Session 23. Had some difficulty with activity but able to make the corrections. Graduates next session. Will invite case manager, have refreshments and prepare certificate of completion.

Session 24. Final meeting. Had refreshments. Presented certificate. Congratulated by peers. Case manager unable to attend. Three short-term goals accomplished or still being addressed. Three long-term goals still apply.

Gene[16]

Gene is a twenty-one year old White male. He dropped out of school in the eighth grade. He does not have a G.E.D. His parents divorced when he was thirteen. He has lived with his father, stepmother and sister where he continued to reside rent-free until his most recent arrest. He has also worked sporadically as a roofer for his father's business. Gene has never been married and has no children. He denies gang involvement but says all of his friends drink alcohol excessively and use illegal drugs.

[16] Not the client's real name.

Gene was adjudicated as a juvenile delinquent for Misdemeanor Theft, Underage Possession of Alcohol, Minor in Possession of Alcohol (twice), and Third Degree Assault. He admits to starting drinking and using drugs when he was fifteen and that before being sentenced for the current charge of Criminal Trespass he used both alcohol and marijuana daily. He states that he was intoxicated at the time of his recent arrest and all he knows is that when he woke up he was in jail. He is diagnosed with Alcohol Dependence and Cannabis Abuse.

Adult criminal history includes the following: Harassment, Burglary Two-of a Dwelling, Theft, Second-Degree Burglary, Child Abuse/No Injury/Neglect, and Possession of Paraphernalia. He has been on probation several times and violated the terms and conditions of probation at least twice. He has also served time in county jail. He is now sentenced to a private halfway house and has been placed in Resocial Group™ for the treatment of his substance use disorders and Antisocial Personality Disorder (repeated arrests, fighting, impulsivity, carelessness, and lack of remorse).

Session 1. First one to present. Talked openly regarding dishonesty and drugs.
Session 2. Very involved. Took exercise seriously. Well received.
Session 3. Took this activity seriously too. Able to help others as well.
Session 4. Learned violence in Kindergarten. Feelings: fear/rejection.
Session 5. Less energetic than usual. Looked/sounded tired tonight.
Session 6. Wrote long-term goal regarding Big Book. More involved than last week.
Session 7. Admitted to being careless and using in the past and talked about how carelessness related to using drugs. Great effort in group.
Session 8. Excellent effort. Talked about drugs and being careless again.
Session 9. Confused. Unable to concentrate to write a goal. Apologized.
Session 10. Able to participate. Said he learned aggressiveness from dad.
Absence 1. No-showed to group.
Session 11. Wrote short-term goal on criminal behavior saying he will save money and decrease spending to help avoid stealing from others in the future.
Session 12. Mostly quiet but did complete written and verbal exercises. Talked about pattern of substance abuse/irritability he learned from his dad.

Session 13. More involved tonight. Even helped direct an activity. Did well. Helped group understand that opposite of irritable for him is “relaxed.”

Session 14. Quiet. “Tired.” Midpoint through his treatment program so reviewed all three goals written. Group agreed they still apply/doing well.

Session 15. Related to learning irresponsibility, told group that he remembers his parents being late to a conference with teacher at school and how he reacted with anger.

Session 16. Talkative. Active. Helped new clients understand terms and techniques. Good examples of relationship between irresponsibility and substance abuse.

Absence 2. No show. Case manager notified.

Session 17. Apologized for missing group last week. Took activities seriously tonight. Talked regarding learning about not feeling guilty from a
drunk uncle and that he wants to assume responsibility for his own actions.

Session 18. Had to be redirected once about distracting the group with repeated laughing. Able to talk with good understanding about the topics.

Absence 3. No showed. Was in facility at the time. Will automatically be terminated if he misses again. Case manager notified.

Session 19. Told group he is less tired now off Antabuse. Talked about learning how to be reactionary from his older brother and how he has repeated pattern. Wants to work on thinking before acting.

Session 20. Involved with giving definitions, explaining techniques and then actually doing enactments. Positive. Alert and active entire group.

Session 21. Wrote a goal about buying a daily planner next week and using on a regular basis to “be more prepared and ready for future plans.” Successfully completes group if he attends three more times with no more absences.

Session 22. Fell asleep during session. Told that to graduate in a few sessions he needs to actively participate. If he is asked to leave a meeting he will be terminated from the group because he has already had the maximum of three absences.

Session 23. Wide-awake. Graduates after one more group. Did very well defining topic and explaining exercises. Also involved in activities.

Session 24. Graduated. Former case manager in attendance to celebrate and support. Gave client certificate. He received positive feedback from staff and fellow clients. Reviewed all three short-term goals. Successful with them. Also went over all three long-term goals. They still apply.

Susan[17]

Susan is a thirty-two year old Hispanic female. She is currently separated. In the past she has worked as a waitress. She completed the eleventh grade. She got in trouble in school, was aggressive to people her own age and deceitful with family and friends. Susan has two sisters and one brother. Her brother has a history of domestic violence. One of her sisters has also been involved in the criminal justice system. Her parents divorced when Susan was nineteen years old. She blames the divorce on her father's problems with violence and alcohol abuse. She had her first child when she was twenty and another child by a different boyfriend four years later.

Her current crimes involve stealing money from a cash register and new clothing items from her place of employment; as well as stealing and cashing checks from a housecleaning customer, and stealing the wallet from one of her children's teachers. Susan pretended to have a seizure when arrested for the last incident described above. She blames the drinking and domestic violence of her ex husband and past boyfriend for her behavior.

She has been convicted of Forgery (three counts), Criminal Impersonation, Shoplifting (twice), and Conspiracy to Commit Theft. She has repeatedly lied and used aliases and been unable or unwilling to sustain consistent employment and honor her financial obligations. Susan has Antisocial Personality Disorder, and Alcohol Abuse, Cocaine Abuse and Cannabis Abuse diagnoses. After being sentenced to community corrections her case manager referred her to Resocial Group™.

Absence 1. New client who called saying she couldn't make it. Will get a write-up for not following individual program plan. 1:1 tomorrow.

Session 1. Introduced self to group. Explained that she had done similar activities in another cog group elsewhere. Enjoyed session.

[17] Not the client's real name.

Session 2. Her goals on being more patient and attending in-house groups assigned by case manager were approved by clients/facilitator.

Session 3. Said her dad had an alcohol problem and she could not count on him when she was a child. Experienced anger and rejection. Told group she has had problems with drugs causing same kinds of difficulties at home.

Session 4. Excellent participation. Told group previously that she did "role playing" with a probation department cognitive behavioral treatment program before. Focus was on family relationships and spouses tolerating behavior that affects children.

Session 5. Wrote goal regarding attending two AA meetings a week "to help with my sobriety" . . . "and reporting to my case manager about my progress."

Session 6. Told group that she learned lack of remorse related to drinking and not being a responsible parent from her dad and that she repeated the pattern as an adult.

Session 7. Not as talkative as usual. Did get involved in assigned activities but said she wasn't feeling well. Complained of upset stomach.

Session 8. More quiet than usual. Wrote a goal (long-term, substance abuse) regarding AA and sponsor. Denied any problems when asked why not as talkative tonight.

Session 9. Very positive. Talked about doing well at facility because she is organized and planning more. Admits that she has repeated behaviors similar to her own parents. Wants to learn about being less impulsive, not using drugs and being happy.

Session 10. Helped new group member. Mostly quiet otherwise. Not feeling well physically. Complained of having a cold.

Session 11. Also at midpoint (with one absence). Reviewed her two short-term goals and one long-term goal. Working on them. No changes made.

Session 12. Involved but not feeling well. Told group she went to hospital yesterday for infection but is on medications. Also announced that case manager may pull her out of group. She said this is a group she would like to stay in. Reports that she is attending "six groups a week."

Session 13. Said she was feeling well. Told to talk to her case manager because it is the understanding of this facilitator that she is not being pulled out of group as she thought. Did well in defining and talking about topics.

Session 14. Helped others with exercise. Wrote a long-term antisocial goal regarding opening a bank account once no longer in halfway house to "make it easier to pay bills."

Session 15. Asked questions off camera but did not want to be videotaped. Coffee spilled on her pant leg by accident. She denied injury.

Session 16. Viewed videotape made previous week.

Session 17. Talked for the first time in group about how future might not include her husband and that changing relationships like this might be necessary to avoid substance abuse and breaking rules and laws. Drew a picture of her and her daughters only.

Session 18. Participated in a couple of activities with no problems.

Session 19. Somewhat silly. Said she was "happy" because had a great day at work. Wrote a short-term criminal behavior goal regarding keeping job, saving money, being on time, not calling in sick, "to keep me from going back to jail for theft."

Session 20. Discussed witnessing/experiencing carelessness and substance abuse and how she has had the same problems and exposed her children to unsafe situations (by her drinking and driving). Noticing a slight decrease in client's overall involvement recently.

Session 21. Told group that carelessness related to substance abuse can also be described as being negligent or unhealthy.

Session 22. Her goal is to go to a medical/technical college within six months. Will successfully complete group after two more sessions if she continues to participate.

Session 23. Will graduate next session. Actively involved with reviewing directions and cleaning up after meeting tonight. Talked openly about violence growing up as well as how she and husband have been aggressive with each other and their children. Thinks husband is "getting better" from counseling and now sees the possibility of them getting back together soon after all.

Session 24. Final session. Her case manager in attendance as invited. Had refreshments. Gave her certificate of completion. Reviewed three short-term goals. All achieved. Reviewed three long-term goals. All still apply. She received positive feedback from peers. Allowed to leave early.

Clinton[18]

Clinton is a twenty-two year old Hispanic male. He is single. His only employment history is doing a variety of jobs that his grandfather paid him for. He stopped going to school in the tenth grade. He is working on his GED currently. He was adjudicated as a juvenile (starting at the age of 14) for Criminal Mischief (twice), Second Degree Burglary, Criminal Conspiracy, Third Degree Assault, and Possession of Marijuana under Eight Ounces.

His father moved out of the family home when Clinton was thirteen and even though his mother had custody, he lived with his maternal grandmother. Three years later (when Clinton was sixteen), his father was stabbed and killed by the woman he was living with at the time. Clinton also started using marijuana when he was sixteen (about three times a week per self-report). Marijuana continues to be his current drug of choice.

As an adult he has been arrested for Making a False Report, Conspiracy, Possession of Drug Paraphernalia, Criminal Mischief and Auto Theft. He has been sentenced to community corrections for his Auto Theft conviction. He has been referred to Resocial Group™ for the Cannabis Abuse and Antisocial Personality Disorder (primary problem areas have been identified as chronic and continuous lying, carelessness, irresponsibility and lack of remorse).

Session 1. Learned about violence and THC in school. Says he can change.
Session 2. Helped group with definitions and examples. Creative, bright.
Session 3. Actively involved. Positive. Wrote short-term goal about sobriety/rules.
Session 4. Disruptive at end of group. Apologized. Overall, did well.
Session 5. Helpful member of a couple of activities, took them seriously.
Session 6. Initially silly but then actively involved and positive.
Session 7. Talked regarding learning aggressiveness in family and repeating pattern.
Absence 1. Ten minutes late. Told he could not stay/zero tolerance.
Session 8. Wrote long-term criminal behavior goal addressing staying employed to save money "to buy my own car," versus stealing a car (his crime) once allowed to drive.

[18] Not the client's real name.

Session 9. Silly and inappropriate. Given last warning. Almost asked to leave group due to distracting behavior with Victoria[19]. Made him move.

Session 10. Sat away from Victoria without having to be asked but several times was disruptive by being loud, laughing and talking out of turn.

Session 11. More appropriate. Also halfway through program. Reviewed three goals written so far. Positive feedback from peers and facilitator.

Session 12. His focus was on a future without alcohol and other drugs. Wants to "raise a son and teach him how to be responsible in this world."

Session 13. Said he's glad that "I get to stay in this group." Somewhat silly at beginning but did well when redirected. Talked about how drinking and drug use can be related to not being trustworthy or dependable.

Session 14. Goal he presented to group was to "keep myself occupied in the future with work and family activities so I will no longer steal anything."

Session 15. Had to be confronted about silly behavior twice. Otherwise did well with assignments. Shared information about cousin stealing and the cousin not feeling guilty about this. Said indifference has become a problem for him too.

Session 16. A small flashlight attached to key ring taken from client and then returned to him at the end of group. He used it to shine in Victoria's face. Given a verbal warning. Did well in session in other ways. Apologized. Seemingly sincere and related to tonight's discussion.

Session 17. Wrote a short-term antisocial behavior goal on feeling guilty and
". . . reminding myself once a week to apologize . . ." No behavior problems in group this evening.

Session 18. Disruptive at beginning of group but stopped immediately when gave him final warning. Ended up giving excellent presentation regarding first experiences seeing physical fighting and how his own violence against others was demonstrated.

Session 19. Appropriate. Helpful with group members who had not used this technique yet.

Session 20. His long-term goal regarding impulsivity is to "use a condom. . . so I don't harm myself or others." Well presented. Serious and appropriate. Related to topics. Approved by group.

[19] Not the client's real name.

Session 21. "Tired" tonight. Complained of working hard and not sleeping well. Did make presentation to the group about learning dishonesty from his father and how he repeated the pattern with his grandmother (lying to her about his drug use).

Session 22. Appropriate. Did a role training and took it seriously. Helped demonstrate dishonesty (especially denial) related to substance abuse. Graduates after two more sessions.

Session 23. Completes group after one more session. Reviewed all of his goals as well. No changes. Still appropriate. He facilitated the activity tonight.

Session 24. Not allowed to graduate tonight because received incident report for being out of location last weekend while on pleasure pass. Agrees that postponing graduation by one week is an appropriate consequence. Participated in both videotaped segments this evening. Did very well.

Session 25. Graduated. Reviewed three long-term goals. Sheet given to case manager. Presented with certificate. Wished well by peers and facilitator.

Steve[20]

Steve is a thirty-six year old White common law married male with two children who is employed as a union ironworker. He has a third child from a previous relationship as well. He has no contact with that former girlfriend or their young son. He completed the ninth grade and is enrolled in a GED preparation class at this time. He said he "lost interest" in the tenth grade and simply stopped going to school.

He has five siblings. His parents were divorced when he was sixteen. His father was an alcoholic and drug addict with a legal history of domestic violence against Steve's mother, himself and his brothers and sisters. His father died in an alcohol related motor vehicle accident when Steve was twenty-one.

As a juvenile, Steve was adjudicated for Second Degree Burglary. Adult arrests are for Second Degree Forgery (two times), Menacing, Theft, Making False Report, Possession of Under One Ounce of Marijuana (five times), Larceny, Disturbing the Peace (four times), Assault (four times), Evasion of Admission Fee, Damage/Deface/Destroy Property (three times), Second Degree Assault, Criminal Mischief, Carrying a Dangerous Weapon, Threat to Injure Person/Property (twice), DUI, Driving under

[20] Not the client's real name.

Suspension, Driving under Restraint (two times), No Operators License, Failure to Present Proof of Insurance, Violation of Restraining Order (twice), Disturbance by Use of Phone. He was convicted of Possession with Intent to Distribute Marijuana most recently; sentenced to a community-based halfway house and placed in Resocial Group™. In addition to having Alcohol Abuse and Cannabis Dependence diagnoses, and his chronic legal problems, Steve has repeatedly used aliases and different birth dates, repeatedly been involved in assaults, and repeatedly been indifferent to disregarding and violating the rights of others. His only mental health diagnosis is Antisocial Personality Disorder.

Session 1. First session. Allowed to start in middle of series. Did well.
Session 2. With feedback was able to write a positive goal regarding family.
Session 3. Told group he had a positive UA for THC before starting in program but denied using recently (said it always takes a long time to get out of his system because of his weight and heavy use).
Session 4. Did two enactments. Demonstrated examples of hostility/substance abuse for the group.
Absence 1. Away from the facility at another program (short-term residential treatment) at this time.
Absence 2. Still away from the facility.
Session 5. Welcomed back into the group after being gone at another program for two weeks. Actively involved in all exercises tonight.
Session 6. Wrote short-term substance abuse goal about using "decision making, choices and true honesty" (three skills learned at the residential treatment center).
Session 7. Said that like his own father, alcohol and other drugs have caused him to not be a responsible parent or husband. Sees a future without substance abuse and legal problems.
Session 8. Outstanding effort. Had several definitions and examples of topics. Involved in two different exercises. Said that he cannot be a responsible parent or employee when using drugs.
Session 9. Told group that he is facing a write-up from staff for not calling when changing locations. Admitted that this was an example of not being responsible. Wrote a goal about "keeping all appointments, meetings, and groups posted for constant reminding."

Session 10. Said he witnessed father's problems with alcohol and not taking ownership for his actions. Admits he has a similar relationship with his wife and children but sees a future without drugs. Wants to feel guilty when he has done something that hurts others.

Session 11. Did excellent job explaining that people get hurt by our actions and that we have a responsibility to say that we are sorry. Also talked about how we can have goals of feeling remorse and not using drugs.

Session 12. Halfway through treatment program here. Reviewed the three goals he has written so far. Somewhat hard to measure. Will be more specific for remaining three goals. Doing well overall. Very active in this session. Positive.

Session 13. Looked at how his parents were impulsive and how related to alcohol, and his own behavior with his wife and children. Asked permission to leave at 8:30 when group was running late because mother is in the hospital. Allowed to do so.

Session 14. Told peers and facilitator he defines impulsivity as "acting before thinking" and helped others see connection between this and substance abuse or dependence.

Session 15. Wrote long-term substance abuse goal. Positive. Told group he is now allowed to be a steel worker again. Very pleased.

Session 16. Did well helping to define topic. Explained how he first witnessed dishonesty and substance abuse growing up as well as how he has had problems in both areas as an adult. Sees a future without either. Hyper-religious but backed off discussion regarding "God's peace and love" when obvious that some people in group not interested.

Session 17. Did not hesitate to give a peer feedback about how his relapse was "disappointing." Critical, but supportive and caring.

Session 18. Wrote a short-term goal regarding not breaking rules or laws. Says he will keep same job as long as at facility and "not getting involved in any criminal activities or behaviors."

Session 19. Told group that he recently had a positive B.A. Wants to stay in group. Allowed to do so as long as no more alcohol/other drugs. Also participated in both segments that were videotaped and did well.

Session 20. Viewed videotape.

Session 21. Has previously identified this as his least favorite part of group (diagramming of relationships) but tonight he explained the assignment and helped new group members.

Session 22. Did a future projection exercise and was able and willing to refuse the beer during the enactment this time "because I am thinking about my kids now."

Session 23. More quiet than usual. Graduates next week. Discussed this briefly. His case manager will be invited to attend. Certificate and refreshments planned. Had a difficult time writing his goal. Defensive when group offered suggestions. Goal was too vague. It is due when group starts next week. Will help upon request.

Session 24. Final session. Presented/turned in homework as requested. Group accepted his goal because it was more specific. He also went over other five goals. Positive about how program has helped him. Pleased that his case manager attended graduation. Given certificate and allowed to leave early.

Feedback from Clients about RESOCIAL GROUP™

During a regular weekly meeting of Resocial Group™ on May 10, 2000, the following thirty (30) questions were asked on videotape (the primary purpose of taping the session was to prepare a demonstration of a role training activity for facilitator workshops). The session was full with perfect attendance. Three new clients chose not to participate. One client set up the camera and lights. Eight clients who had been in group for awhile agreed to participate in the feedback session. Four clients wanted to take turns reading the questions out loud (they were allowed to see the list of prepared questions a few minutes before the taping began). Four clients wanted to answer the questions. They were not allowed to see the questions. The only directives given were to please be honest and answer any question that they wanted to. What follows is the verbatim text of their responses. Supervisory approval was obtained. Informed consent forms were signed by everyone in attendance several weeks in advance. Participation was voluntary. Anonymity was guaranteed (with this and any other writing and research about the group, though some of the clients voluntarily used their first names during the actual taping).

Question 1. *What does "Resocial Group™" stand for or mean?*

Client 1[21] "It's a cognitive behavioral curriculum for adults."

[21] In his nineteenth session of Resocial Group™ at this time. Graduated five sessions later.

Question 2. *What is "socialization?"*

Client 2[22] "Talking with other people about stuff."
Client 3[23] "Sharing, sharing what you think and what you, what makes you do the, what makes you make the decisions you do."

Question 3. *What is "resocialization?"*

Client 4[24] "I got that one. I think resocialization, um, the meaning of this class, is to basically evaluate our decisions and behaviors, the way that we used to do things and learning new tools and thinking behaviors to, uh, be sociable in society."

Question 4. *Who is appropriate for this group?*

Client 2 "Drug addicts, convicted felons."
Client 3 "Anybody really, who has a problem, any type."
Client 1 "Any substances or a substance abuse problem."

Question 5. *What are the behaviors and experiences discussed?*

Client 2 "Dishonesty, carelessness."
Client 1 "Indifference."
Client 3 "Breaking rules and laws."
Client 2 "Relapse."
Client 1 "Did you say 'impulsivity?' Impulsivity."

Question 6. *How does this group also address substance abuse or dependence problems?*

Client 4 "It kind of looks at it by, um, looking at your past when you were first subjected to it to see where, um, you know, you learned certain things as they were introduced into your lives."

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[22] In his last session of Resocial Group™ before successful termination due to sentence completed/expired.
[23] In his second to last session of Resocial Group™ . Graduated next session.
[24] In his fourth session of Resocial Group™. Terminated unsuccessfully after escape from agency seven sessions later.

Question 7. *In what ways does Resocial Group™ help?*

Client 1 "It helps you to take a paused moment to stop and think about your actions before you act on your decisions or your choices that you've made."

Client 3 "Pretty much just act, to think before you make decisions instead of just doing something, that you might pay for later on."

Question 8. *What does "COG" or "cognitive behavioral treatment" really mean?*

Client 2 "It means focusing on the problems you have, in your life, that get you in trouble and how to stay out of trouble, basically."

Question 9. *What are the advantages to having men and women in the same group?*

Client 2 "Because everybody's got a different story, and some, some stories are different than others. And we can see where other people are coming from, cause not only you are as messed up as you think you are because other people out there are just as messed up if not worse."

Client 3 "And men and women have to deal with things in different ways, differently, yea, because they don't function the same, like exactly the same, everyone has different, differences, especially men and women."

Client 4 "Different points of view, yea."

Question 10. *What are the disadvantages to having men and women in the same group?*

Client 2 "I don't think there are no disadvantages at all."
Client 1 "I would agree."
Client 4 "Me too."

Question 11. *Why can't group members automatically graduate when they have completed the required number of groups?*

Client 3 "Because they don't always follow the rules and sometimes you break a rule but you just got to keep going, try, try harder to stay, stay strong, to stay straight, to follow the rules and laws."

Question 12. *Why are clients given certificates when they do graduate?*

Client 2 "To show, so that they let themselves know that they completed something, that they actually got something out of this class."
Client 1 "A formal document that will probably help them feel good."
Client 2 "They earned this, you know, they earned this, you know, do you know what I am saying? It's like, be proud of it."
Client 1 "Feeling the satisfaction."
Client 2 "I made it through this class. If I can do this I can do a lot of other things. You know? Because I know a lot of people when they first come, they don't want to be here. When I first started, I didn't want to be here. Look, I didn't have to be here tonight but I'm here. Because I wanted to come."
Client 1 "It gives you satisfaction of completion."
Client 2 "Yea."

Question 13. *What are the refreshments during groups when someone graduates?*

(The question was actually, "Why are there refreshments during groups when someone graduates?" but the client asking the question misread it.)

Client 2 "They're very expensive, um, cookies that Rand buys."
Client 4 "Snackwells®."
Client 2 "Yea. And his gourmet coffee."

Question 14. *Why is coffee served during all groups?*

Client 2 "So you're aware of what's going on, some people..."
Client 3 "To keep everyone motivated, really."
Client 2 "Yea."
Client 4 "No, I think it might be the kind of thing that coffee is viewed as more as a…"
Client 2 "social"
Client 4 "…social, social type thing. I mean when you go out to the bar you sit there and you drink, you know, and start talking. That's social behavior, I think, that's, you know, coffee, it's, it's a social activity."
Client 3 "Yea, but a lot of times people come here straight from work and a lot of people are kinda…"
Client 1 "tired"
Client 3 "…tired, you know, I mean."
Client 4 "Maybe that's a dual benefit."
Client 3 "Yea, it helps keep people goin."

Question 15. *Why do people have to stand when they make their presentations?*

Client 4 "Accountability."
Client 2 "Yea, focusing on one person, I mean if they're standing, you know what I mean, it's like, you got a row of some people and then something sticking out, you know what I mean? You are going to notice it. If you're standing up you are able to get focused on by the following people in the group."
Client 1 "It's an attention getter."

Question 16. Why are there written assignments?

Client 1 "I believe so that you have to participate and really pay close attention to what you write and what you're thinking and what, what you plan on answering for your goal topics and things that have to really get a hold on."
Client 2 "Yea, because if you like say something, you know what I mean, two weeks from now, chances are you ain't going to remember it but if it's down in writing then it would be like, I wrote that, you know what I mean?"
Client 3 "It sticks."
Client 2 "Why do people have contracts, do you know what I mean?"

Question 17. *Why do people have to use crayons to draw where they learned behaviors, how they are behaving currently or recently and what relationships might look like in the future?*

Client 3 "Different colors for different emotions, the way you feel, the way other people feel toward you, the way you feel towards other people."
Client 1 "Emotions."
Client 4 "I think the colors also help, to ah, identify or signify the moods that go along with, excuse me, the ah, behaviors that are going on. Red is typically characteristic of anger, and so on. So that, I think, a visual representation of colors helps identify the emotions a lot better."

Question 18. *Why do clients have to write their own goals?*

Client 3 "So you know what you are pushing for and what you want to achieve."
Client 2 "Because if somebody else sets your goals, it's like, you know, how do they know what I need, I mean, you know yourself more about what you need to do. That's why you need to set your own goals."
Client 4 "Exactly."
Client 1 "So it's measurable as well."
Client 2 "Yea."
Client 4 "It's more personable that way, if we do it."
Client 2 "Yea, cause if like, some people have a problem, you know, with authority, you know and it's like, well this is like we have a probation officer and this is what you don't want to do, but

you do it anyways. I think you feel like, more sense of *control when you set your own goals. More honest with yourself than somebody else, type of thing, I am."*

Question 19. *Why do goals have to be so detailed?*

Client 3 "So you can know what you are pushing and striving for."
Client 1 "It's realistic to see if you can achieve it, if it's even achievable instead of setting yourself up for something that you can't really even accomplish."
Client 2 "Yea, setting yourself up for failure. It's like a couple people have written goals in here before, and I mean, like, you know, it's like, I know you are not going to do that every night, you are lying. Why are you going to write it down like that?"

Question 20. *Why do we do the role training or role rehearsals?*

Client 2 "So we can get a visual idea of, you know, the type of situations that people are in sometimes, and so people like Rand can say, 'I've been there, or I've seen that,' you know."
Client 1 "To get the hands on training of role playing to act out the different behaviors and situations."
Client 3 "To see what it's like to be in another person's shoes."
Client 2 "Yea."

Question 21. *How does this group compare with other counseling or therapy?*

Client 1 "I believe it's really good because it is full participation, that you have to participate. It's a strict group that you have to be able to do the assignments, do the topics and be able to, ah, complete it so you get the best out of it for yourself."

Question 22. *Why are there so many rules for Resocial Group™?*

Client 2 "Cause it's a very strict class and it's focusing on one subject."
Client 1 "The guidelines have to be applied."
Client 3 "Part of the group is breaking rules and laws and substance abuse."
Client 2 "Well, if you are going to be in class, you are here to learn not to socialize. Socializing you can do another time."

Question 23. *Why do people have to be exactly on time for every meeting?*

Client 4 "Responsibility, and interactions."
Client 2 "Yea, exactly."
Client 1 "There's almost no room for error."
Client 3 "Because if you make errors in a group like this, you are going to make them out in the real world too, so."
Client 1 "Bottom line, responsibility."

Question 24. *Why can clients only miss three groups before being terminated?*

Client 1 "Again, it's responsibility. It's like, no tolerance."
Client 2 "If you miss three classes, obviously you don't want to be in this class, you know what I mean? If you're late, know what I mean, obviously it ain't that important for you to be on time or to learn something in each class. It's like I said, or I wouldn't be here right now."
Client 1 "It's strict rules, but it's accomplishable. You can do it."
Client 2 "Yep. I had a problem with the class when I first came because I was late. And I was mad about it because I got kicked out; you know what I mean? And, and the next few classes, you know, I learned that it was a real strict class and you got to do it."

Question 25. *What is your favorite aspect of Resocial Group™ and why?*

Client 2 "Feedback, I think, from other people."
Client 3 "Seeing how different people cope with their responsibilities and the different emotions that they have."
Client 1 "My personal favorite is the goal topics that gives you a chance to really think things through."

Client 4 "I kind of like the role playing myself."
Client 2 "Yea, I like the role playing. It's cool."

Question 26. *What is your least favorite aspect of Resocial Group™ and why?*

Client 3 "Being out of coffee."
Client 2 "Yea."
Client 1 "Mine would be the diagramming of relationships. I always have a hard time trying to pinpoint exactly when I first identified the problem that I am dealing with for that night."
Client 2 "The problem I have is that I have started it but I can't complete it, because, you know what I mean, I'm, I am leaving."

Question 27. *How could Resocial Group™ be improved?*

Client 4 "Go outside once in awhile."
Client 3 "Just if more people participate, just if people tried harder."
Client 2 "Yea, we get new people in and they are not as outgoing and they really do not want to, you know, say much. It's like an egg. You got to crack their shell and finally let them out."
Client 1 "Just wholehearted group involvement with everybody."
Client 2 "Some people probably feel a little embarrassed, but you know, everybody's got problems, that's when you realize it, when everybody talks about their problems, you know what I mean. When you do it as a group, it's like, you know, everyone comes closer and you know a bit more about each other. We are all in here with each other; you know what I mean? We might as well know a little bit about each other."

Question 28. *Would you ever recommend Resocial Group™ to someone else?*

Client 1 "Yea, I would. I talk to my significant other about it, things I've learned and the things I do, and it helps me to reflect on pretty much every day."
Client 2 "I think any kind of cognitive class is positive. I have been to cognitive education before, and, you know, it's like just a brainwash from your family, you know? You have got to wash all of those bad things out of your head, you know, that you should not be thinking."
Client 1 "It's like unlearning behavior."

Client 2 "Yea, like unlearning bad, bad things, but it's good. I mean, to get it straight, it's like conditioning your mind. We learn bad things. All we're doing is unlearning them and what to do to keep unlearning and stuff like that."

Client 4 "And, I have got to agree with (name of Client 1). I shared something that I had learned with my significant other and it was ah, strange. It was definitely strange, because I implemented that I knew that there was a trust issue there. Even after I go through all of this there will be that underlying fear that I will drink. You know, but it's um, okay today, you know, because I haven't today and she knows I haven't today. So, every day, I mean, I am not saying that I can snap my fingers and it's gone, because (name of Client 4) is not God, you know, but, you know, slowly and surely, you know, I mean, I learned things in this class and other classes and it, ah, it helps."

Client 1 "Yes, that's the truth, yea."

Question 29. *What do other clients here think about Resocial Group™?*

Client 1 *"I think the clients that haven't been participating or, or involved in the group, probably don't think so much of it. But other people who have been in the group, there are some positives that they come out with, even if they don't want to attend, if they feel they don't have to go to this group because they're forced to or whatever. There's no hiding the fact that you get some positive out of it no matter who you are."*

Question 30. *What else would you like to say about Resocial Group™?*

Client 1 "I would like to say it's helped me with a lot of thinking and taking time to stop before I make an action, not always in every case, I am not perfect, I make mistakes. And I am fortunate to still be involved. But give yourself time to think about things, especially if you have a family and children."

Client 2 "It helps you, you know, communicate with other people about your drug addictions or your alcohol addictions, you know."

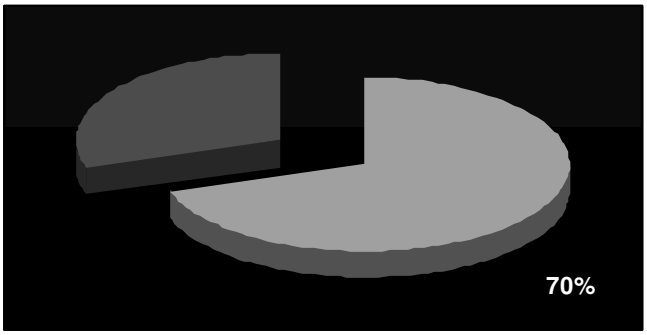
Client 1 "And criminal behavior."

Client 2	"Yea, criminal behavior. It's not easy to just sit here in front of a bunch of people and say, 'Well, I did this, I did that, I did this. Resocial Group™ you know, it's not like someone is always picking on me, I want to know this, I want to know that, you just ease into it."
Client 1	"And there is this trust between each other with confidentiality which I think is important."
Client 4	"I think it's good that there's this class because, I mean, like (name of Client 1) was saying, the drugs and the alcohol. The drugs and the alcohol are the end result, you know, we got to get back to the behaviors that drove us to use drugs and alcohol, you know, that's where this stops at."

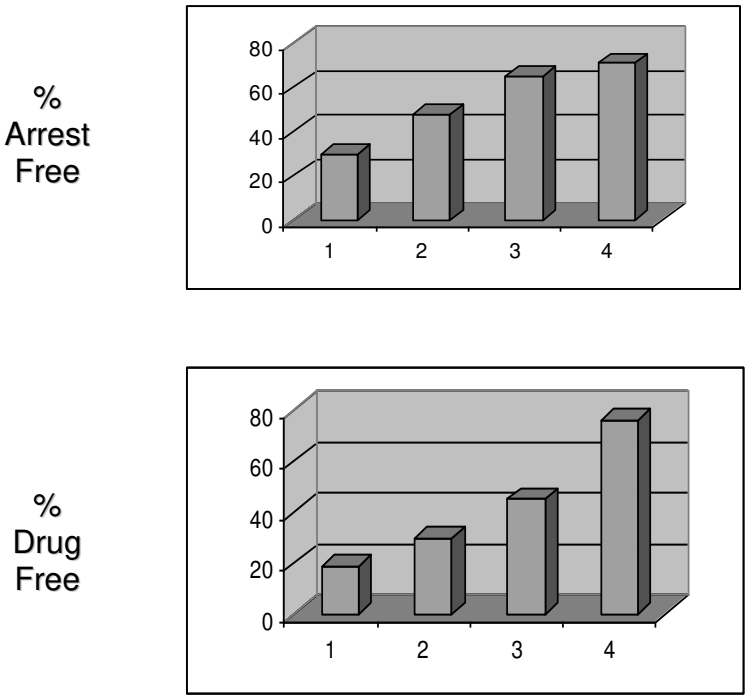
Research and Assessments

Recidivism can be defined in terms of readmission, rehospitalization, regression, reoffending, reconviction, resentencing and other so-called, "R" words. Most states measure rates of reincarceration for a specific period of time after release. The author prefers the variables of relapse and rearrest. And, no treatment is not the only cause of recidivism in corrections and criminal justice. Clients may also receive substandard or "inadequate" treatment, inappropriate or "wrong" treatment, incompetent or "bad" treatment, excessive placements/referrals or "too much" treatment.

Rate of Recidivism for Criminal Offenders With No Treatment



18 Months After Release From Prison



1=no treatment
2=in prison TC only
3=work release TC only
4=both in prison and work release TCs

A national research project has been conducted in which Resocial Group™ has proven to be a successful substance abuse and cognitive behavioral intervention for adult felony offenders. As of August 2000 the following agencies/locations have been assessed: a private day reporting center in Indiana; a public probation office in West Virginia; and a private medium security prison, and a private community corrections halfway house in Colorado. Of approximately 88 clients studied, 94% were male, 77% White, 11% Black and 11% Hispanic. 14 was the average group size. 90% of the clients attended a self help group, individual counseling and/or one or more other groups in addition to Resocial Group™.

83% of the clients were relapse free for the duration of group. 90% were arrest free for the duration of group. 76% were both relapse and arrest free for six months after completing the group. The outcome studies are ongoing. A goal is to track clients and measure success rates for at least 18 months after completing the group.

Research Update

"A fifth Resocial Group (TM) was studied in 2001 (the first graduating clients completed their six months on 12/26/01). The setting was a Substance Abuse Mental Illness (SAMI) Intensive Treatment Program (ITP) for adult males in Youngstown, Ohio. 80% of the clients were White and 20% were Black/African American. Based on standardized assessments used by the program, all had more than one Substance Use Disorder (SUD) (i.e., they had polysubstance abuse and dependence diagnoses) in addition to Antisocial Personality Disorder (APD). The minimum group size was 4. The maximum was 8. There was a single Resocial Group (TM) Certificated Facilitator who is employed as a counselor at a county chemical dependency program. None of the clients were terminated for non-compliance or dropped out of the group. All attended a self help group, individual counseling and/or another group while attending Resocial Group (TM) and all have been transferred to another group following the completion of Resocial Group (TM). 100% of the successful graduates were both relapse free and arrest free for the duration of group. The program uses random and periodic drug testing. The facilitator said that she enjoyed using all of the techniques but that goal setting was her favorite because "The men seemed to think the hardest on this one." Her only suggestion for modifications or changes was that there wasn't always enough room for the clients to write the topics on the 'Choosing Partners and Companions' worksheet. One of her clients made the following comment: "What this (does) is get us back to using our brains!" The facilitator has been asked to track the same clients at six months, nine months, twelve months and eighteen months after completing the group."

"A sixth Resocial Group (TM) at a mental health center in Wadesboro, North Carolina was assessed from August 2001 to January 2002, however, the statistics involving these 15 clients, favorable or not, cannot be used. The facilitator at this agency admitted numerous clients who did not meet the required coexisting diagnostic criteria of APD and SUD. (All of the clients had a past or present alcohol and/or other drug abuse and/or dependence, but many were enrolled with Adult Antisocial Behavior instead of the other required diagnosis of APD.) Enforcement of admission criteria is important so that the treatment is both appropriate and necessary and clients are not harmed clinically or financially by being placed in the wrong intervention. The copyright and trademark release form clearly discusses this issue. The Certificated Facilitator of Resocial Group

(TM) was reminded that the group was designed for a specific population of adult offenders with APD and SUD and the research and treatment involving other diagnostic categories has not been conducted. (Adult Antisocial Behavior is antisocial behavior but it is not due to a mental disorder such as APD, Conduct Disorder or an Impulse-Control Disorder.) The facilitator was still paid the $10 stipend for completing the 30-item questionnaire."

"A seventh Resocial Group (TM) was studied from April 2001 to October 2001. The location is Advantage Treatment Center in Denver, Colorado. Advantage functions as a day reporting center and outpatient program, and is owned and operated by Independence House, a community corrections agency that is designated as an alcohol and drug abuse treatment facility by the Alcohol and Drug Abuse Division of the Colorado Department of Human Services. The facilitator is the author working as an independent contract therapist with Social Solutions Corporation. This is the first known group with a variety of clients mixed together (diversion halfway house residents from Independence House, diversion nonresidents from Independence House, transition halfway house residents from Independence House and other Denver area residential facilities, Treatment Accountability for Safer Communities clients, Colorado Department of Corrections parolees, and Colorado Department of Corrections ISP inmates). (Municipal Court and District Attorney Diversion Program clients are now being accepted as well.) Most of the clients have had numerous treatment failures in traditional therapy programs. The group is coed. It meets weekly from 6:00 - 7:30 p.m. on Mondays. Because of numerous referrals in the past with a waiting list to start attending, a second group was started at the same location by another Certificated Facilitator of Resocial Group (TM). 24 clients attended during this six-month period specified above. 21 (88%) were relapse free (i.e., only 3 clients had positive urine drug screen or breath test results) during their attendance; and 19 (79%) were arrest free (i.e., only 5 clients absconded, escaped, had probation revoked or were reincarcerated). 8 (33%) graduated from the group (i.e., completed 24 or more sessions successfully); 5 (21%) were terminated from the group for non-attendance (i.e., they missed more than three sessions) [Only three absences are allowed during the six months of Resocial Group (TM). Clients are automatically terminated on the fourth absence. There is no differentiation between excused and unexcused absences. The group also has a zero tolerance policy regarding tardiness (i.e., clients must be exactly on time). If a client is even a minute late, he or she is not allowed to stay and it counts as an absence.]; 5 (21%) were terminated from the group because they were no longer in community corrections due to probation/parole violations or resident/nonresident violations; 3 (13%) are currently in compliance and still in the group; and 3 (13%) were transferred because it was determined that they were clinically or financially inappropriate after they started attending. All graduates completed written, thirty-item satisfaction surveys. Word for word answers to three of the questions are seen below. Responses have been edited for spelling and punctuation only for the reason of readability."

"What is your favorite aspect of Resocial Group (TM) and why?"

"The favorite aspects I've had are teaching me goal setting and responsibility."

"The role play is my favorite."

"Goal setting because I like to see what I'm going to accomplish on paper."

"Sociodrama- it increases my understanding of myself and others."

"The general discussions and role playing. Role playing usually lightens things up. It is entertaining and very insightful. People express a lot of very clear and deep-seated feelings. Thoughts are projected truthfully."

"Well, I really like role training because you get to act out your situation. I like acting."

"Goal setting. Allows me to shoot for something, accomplishment."

"Role rehearsal, because it gives me the opportunity to be open and make people laugh."

"How does this group compare with other counseling or therapy?"

"Honestly, it doesn't. You have to be a major factor in this course. It is all about me (you)."

"This group compares with other counseling and therapy in that it helps deal with behavioral and substance abuse problems."

"Most groups are basically the same but this group offers role playing and role reversals and showing one's feelings in certain situations."

"It is a lot harder. You have to pay attention better and you can't just coast through it."

"Just about even."

"I think this group allows us to open up much more FREELY. I have learned to enjoy our discussions. We have all learned to express ourselves in a positive perspective."

"Well, they're pretty much the same but Rand doesn't go for the bull stuff at all."

"This group was better for me than others because I wasn't too much a participant in other groups. Other groups had too many people or just didn't care."

"What else would you like to say about Resocial Group (TM)?"

"It is a real help if you let it be. You can learn some good things to help yourself, family and friends with real life situations."

"The group has stirred some real emotions in myself. I've learned to admire how people can face up to some really hard situations and remain positive. Compared to some of the other difficult domestic problems, mine have been light. I think that people in this class have given me some very VALUABLE solutions to my problems. I appreciate their patience in listening to my unending 'soap opera' problems. I think that Rand is a very good leader and truly does care about our problems. I'm not saying this to suck up or anything, I really mean it. I think this has been a good class and he has helped me in thinking about and facing my problems."

"Resocial Group (TM) is a group that can be taken... much is to be learned in this group and it is a good group."

"This group is a real eye opener. It grabs you at first and it's kinda cool. This group really does make you think a lot before you act. Rand is a good teacher, kinda weird sense of humor, but he's a good guy."

"This survey has covered about everything."

"I feel I can get a lot out of Resocial Group (TM) if each person gives his/her opinions and sits and listens to see what's going on with others."

"It's been a long six months and I think I have successfully completed a course beyond most, and am glad it is now behind me."

"I would like to thank all those who were so patient, understanding and lenient with me when things weren't going too good for me. I would also like to thank Rand for all the knowledge and wisdom. It was, is, and always will be greatly appreciated."

Five (5) other clients successfully completed this group this year and two (2) more are scheduled to graduate this month. A recent (January 2002) graduate of Resocial Group (TM) (a DOC ISP client from the Northeast Parole Office and TASC program in Westminster, Colorado) had the following to say about the program offered through Social Solutions Corporation at Advantage Treatment Center in Denver. His favorite aspect of the group is "goal setting and charts. The charts give me insight to my behaviors and hope for positive change. Goal setting gives me incentive to make positive change." "It compares favorably (to other groups) in that it helps clients gain some type of understanding as to the 'hows' and 'whys' of their behavior and the opportunity to change for the better." His least favorite aspect is "(attendance, because) it takes too long and we are unable to associate while it is being taken." "I understand the time limitations but I would like to see a little more time reserved for open discussion." One of his peers who graduated a couple of weeks later (also a DOC ISP inmate, but from the Englewood Parole Office in Colorado) said, "It is a group for people whom have antisocial behaviors and substance abuse problems and learn how to replace these behaviors with effective alternatives (by) unlearning and relearning." "It has helped me to get insight of a lot of my past events and to understand myself better, to discover active alternatives (and) learn and practice new skills." "The other groups I have been in don't or haven't dealt in diagramming of relationships, role exploration or goal setting." He also stated, "I think our instructor should have a one on one once a month with us." "It has helped in giving me a better understanding about my behavior patterns and how to deal with them in a different perspective."

A one (1) year outcome study involved an eighth group at Social Solutions Corporation/CSC in Adams County, Colorado (from 3/31/03-3/29/04): Clients who attended at least 1 session: 40. Male: 39 (98%); Female: 1 (2%). Referred by TASC: 17 (43%); DOC: 6 (15%); private halfway house: 11 (28%); other: 6 (15%). Clients currently attending group successfully: 12 (30%); Clients who completed group successfully: 7 (18%). Clients discharged from group unsuccessfully because of relapse: 0 (0%); Clients discharged from group unsuccessfully because of rearrest: 5 (13%); Clients discharged from group unsuccessfully because of noncompliance with group attendance policy: 10 (25%)*; Clients discharged from group for other reasons: 6 (15%). *This high rate of terminations for nonattendance, is due, at least in part, to the group moving more than 10 miles to a different location for administrative contract reasons, and some clients and/or their referring agents not supporting the change because of an understandable inconvenience due to distance of travel.

The author's APD/SUD Screening™ (Antisocial Personality Disorder/Substance Use Disorder Screening™) is being used across the country. Providers in Michigan, Nevada, New Hampshire and New Jersey have recently introduced this assessment in their programs. The APD/SUD Screening™ is being translated to Spanish for introduction in and outside the U.S. The APD/SUD Screening™ was translated to French for private use by forensic psychologists in Switzerland in August 2000. Sociology educators from Puerto Rico and South Africa have also been trained by the author to use this instrument (and facilitate Resocial Group™).

Cognitive Behavioral Treatment

Teaching options and alternatives

Communication
Decision-making
Problem solving

Practicing the newly learned skills

Graduating only once able to demonstrate change

Success is equal to change

Adult Antisocial Behavior

(American Psychiatric Association: *Diagnostic and Statistical Manual of Mental Disorders*, Fourth Edition, Text Revision. Washington, D.C., American Psychiatric Association, 2000.)

"This category can be used when the focus of clinical attention is adult antisocial behavior that is not due to a mental disorder (e.g., Conduct Disorder, Antisocial Personality Disorder, or an Impulse-Control Disorder).

Examples include the behavior of some professional thieves, racketeers, or dealers in illegal substances."

Conduct Disorder "Checklist"

(American Psychiatric Association: *Diagnostic and Statistical Manual of Mental Disorders*, Fourth Edition, Text Revision. Washington, D.C., American Psychiatric Association, 2000.)

_____Onset prior to age 10 years
_____Onset after age 10 years

_____Aggression to people and animals
_____Destruction of property
_____Deceitfulness or theft
_____Serious violations of rules

_____Few problems/minor harm to others
_____Number/effect between mild and severe
_____Many problems/considerable harm to others

Antisocial Personality Disorder

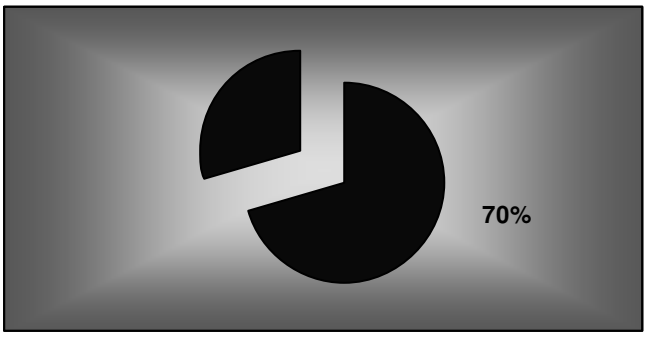
(American Psychiatric Association: *Diagnostic and Statistical Manual of Mental Disorders*, Fourth Edition, Text Revision. Washington, D.C., American Psychiatric Association, 2000.)

"A. There is a pervasive pattern of disregard for and violation of the rights of others occurring since age 15 years, as indicated by three (or more) of the following:

(1) failure to conform to social norms with respect to lawful behaviors as indicated by repeatedly performing acts that are grounds for arrest
(2) deceitfulness, as indicated by repeated lying, use of aliases, or conning others for personal profit or pleasure
(3) impulsivity or failure to plan ahead
(4) irritability and aggressiveness, as indicated by repeated physical fights or assaults
(5) reckless disregard for safety of self or others
(6) consistent irresponsibility, as indicated by repeated failure to sustain consistent work behavior or honor financial obligations
(7) lack of remorse, as indicated by being indifferent to or rationalizing having hurt, mistreated, or stolen from another

B. The individual is at least age 18 years.
C. There is evidence of Conduct Disorder with onset before age 15 years.
D. The occurrence of antisocial behavior is not exclusively during the course of Schizophrenia or a Manic Episode."

Criminal Offenders with Persistent Antisocial Behaviors and Experiences



Substance Dependence

(American Psychiatric Association: *Diagnostic and Statistical Manual of Mental Disorders*, Fourth Edition, Text Revision.
Washington, D.C., American Psychiatric Association, 2000.)

(Requires 3 or more of the following):

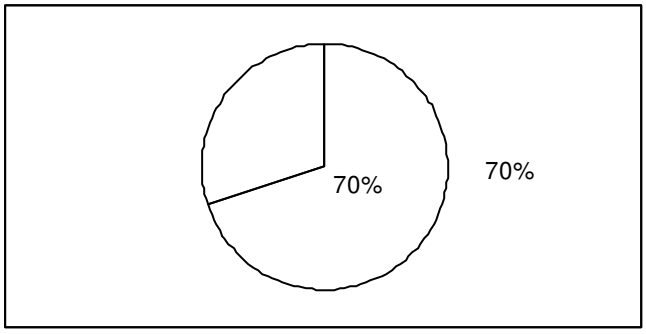
Increased Tolerance;
Withdrawal;
Increased Quantity or Duration;
Persistent Desire or Inability to Decrease or Discontinue Use;
Increased Time to Obtain or Recover;
Social/Occupational/Recreational Impairment;
Continued Use Despite Awareness of Related Physical or Psychological
Problems.

Substance Abuse

(Requires 1 or more of the following):

Recurrent Use Resulting in Social/Occupational/Educational Problems;
Recurrent Use in Physically Hazardous Situations;
Recurrent Substance-Related Legal Problems;
Continued Use Despite Awareness of Related Social or Interpersonal Problems.

Criminal Offenders with Chronic Substance Abuse Problems



APD/SUD Screening™ (Antisocial Personality Disorder/ Substance Use Disorder Screening™)
Referrals to APD, SUD or Resocial Group™/ Other Co-occurring Cognitive Behavioral Treatment

rtkannenberg@juno.com (303) 232-0767

Part 1: Antisocial Personality Disorder[1] (APD) Screening
(All 4 blanks must be checked to meet APD screening criteria)

_____ Before the age of 15 years, at least 3 of the following are indicated (Circle the 3 or more that apply):
⇒ aggression to people or animals
⇒ destruction of property
⇒ deceitfulness or theft
⇒ serious violations of rules or laws

_____Is at least 18 years-old currently.

_____ Since the age of 15 years, at least 3 of the following are indicated (Circle the 3 or more that apply):
⇒ repeatedly performs acts that are grounds for arrest
⇒ repeatedly lies, uses aliases or cons others for personal profit or pleasure
⇒ repeatedly fails to plan ahead
⇒ repeatedly involved in physical fights or assaults
⇒ repeatedly unsafe or dangerous with self or others
⇒ repeatedly fails to sustain consistent work behavior or honor financial obligations (and/or to maintain an enduring attachment to a spouse or romantic partner and/or to be a responsible parent)
⇒ repeatedly indifferent to or rationalizing having hurt, mistreated, or stolen from another

_____ The 3 or more indicators seen above do not occur exclusively during the course of Schizophrenia or a Manic Episode.

Part 2: Substance Use Disorder[1] (SUD) Screening
(At least 1 blank must be checked to meet SUD screening criteria)

_____ Past or present, at least 3 of the following are indicated
(Circle the 3 or more that apply):

⇒ increased tolerance
⇒ withdrawal
⇒ increased quantity or duration
⇒ persistent desire or inability to decrease or discontinue use
⇒ increased time to obtain or recover
⇒ social/occupational/recreational impairment
⇒ continued use despite awareness of related physical or psychological problems

_____ Past or present, at least 1 of the following are indicated
(Circle the 1 or more that apply):

⇒ recurrent use resulting in social/occupational/educational problems
⇒ recurrent use in physically hazardous situations
⇒ recurrent substance-related legal problems
⇒ continued use despite awareness of related social or interpersonal problems

Part 3: Referral
(Circle 1 appropriate disposition)

A. Refer to cognitive behavioral treatment that deals with pervasive pattern of disregarding and violating the rights of others if only APD screening criteria are met.

OR

B. Refer to cognitive behavioral treatment that deals with substance abuse or substance dependence if only SUD screening criteria are met.

OR

C. Refer to RESOCIAL GROUP™ or other cognitive behavioral treatment that deals with co-occurrence of pervasive pattern of disregarding and violating the rights of others and substance abuse or substance dependence if both APD and SUD screening criteria are met.

[1] (American Psychiatric Association: *Diagnostic and Statistical Manual of Mental Disorders*, Fourth Edition, Text Revision. Washington, D.C., American Psychiatric Association, 2000.)

Three Recommendations for Treating Cross Cultural Offenders

1. Ask the client to explain ethnic differences that *he* thinks are relevant
2. Avoid using jargon when talking about *your* theories or techniques
3. Never make blanket statements about *any* culture

Three Recommendations for Treating Religious Offenders in a Secular Setting

1. Discuss the reality that in our society people are supposed to be responsible for their own actions
2. Introduce the idea that most belief systems define personal growth and development as positive concepts for an individual and his community
3. Talk about how the goal of respecting the rights of others is accepted as basic by most religions in the world

Three Recommendations for Treating Gay and Lesbian Offenders In or Out of Prison

1. Encourage clients to talk about the perceived or real differences between physical pleasure and emotional attraction when talking about homosexual behavior
2. Discuss the facts that any consensual sexual behavior may be against the rules and that even same sex rape is definitely against the law, violent and about power and control
3. Talk about the normal and positive aspects of same gender relationships in terms of social support and self esteem

Three Recommendations for Treating the Offender with English as a Second Language (ESL)

1. Ask the client to repeat your directions to demonstrate clear understanding
2. Use an interpreter (peer or professional) when available (professional preferred)
3. Assess the client for boredom and frustration regularly

Three Recommendations for Treating the Learning Disabled (LD) Offender

1. Carefully explain instructions for participation
2. Demonstrate how to do all activities and assignments
3. Observe behavior and give immediate feedback

Repeat steps as necessary

Three Recommendations for Treating Chronically Mentally Ill (CMI) Offenders

1. Assess for any changes in affect, appearance or overall involvement
2. Openly discuss any concerns that you have about safety
3. Document, report and refer as needed

Three Recommendations for Treating Female Offenders in Coeducational Programs

1. Never place just one woman in a coed group (3 or more would be best)

2. In a perfect world, groups would have a fairly even mix of men and women
   and male and female co-facilitators (who liked to work with each other!)

3. Pay attention to important issues (including, but not limited to, parenting, physical and sexual abuse, self image, self destructiveness, anger management, codependency, adult child dynamics, depression, divorce recovery, the different reasons women use drugs, etc.)

Three Recommendations for Treating the Gang Affiliated Offender

1. Clarify the program and group rules

2. Set mutually agreed upon treatment goals

3. Provide consistent leadership

Models of Socialization

Persistence-Beyond-Childhood Model of Socialization

(*Political Socialization and Resocialization of American Youth and Young Adults: The Process of Learning, Unlearning, and Relearning Political Norms, Values, Attitudes, and Behaviors*, Rand L. Kannenberg, Denver, Colorado, 1984)

- stresses the importance of early learning and the implication is that the patterns of behavior and attitudes are lifelong
- goal is to transmit culture and written and unwritten rules of conduct (laws and customs) to the younger members of our society and that the culture and conduct are maintained beyond childhood
- objectives include respecting and obeying authority, conforming to rules, being a dedicated worker and responsible citizen
- family and peer groups are informal/primary socializing agents (and person is unaware of process)
- schools and churches are formal/secondary socializing agents (and process is obvious to person)

Constant Change Model of Socialization

(*Political Socialization and Resocialization of American Youth and Young Adults: The Process of Learning, Unlearning, and Relearning Political Norms, Values, Attitudes, and Behaviors*, Rand L. Kannenberg, Denver, Colorado, 1984)

- suggests that adulthood provides different experiences and events later on in life that make socialization an ongoing process
- changes (conflict or improvements) in living situation, work, health, responsibilities, etc. can reinforce, reverse or revise patterns learned from childhood
- new peer groups can also alter earlier learning

Interaction Model of Socialization

(*Political Socialization and Resocialization of American Youth and Young Adults: The Process of Learning, Unlearning, and Relearning Political Norms, Values, Attitudes, and Behaviors*, Rand L. Kannenberg, Denver, Colorado, 1984)

- recognizes that people are not automatically influenced by experiences
- focus is on the interaction between internal composition (character/personality structure) and external circumstances (environmental/social opportunities)
- a close minded individual will have fewer changes as compared to the person who is willing and/or able to experiment with new ideas and activities and increase independence and responsibilities
- someone who is too rigid about previously learned norms and values may be unable to reach full potential of development as an individual

RESOCIALIZATION

- the unlearning and relearning of norms, values, attitudes and behaviors
- a process of being liberated from what was previously taught and learned in the family, peer groups, school and church
- changing roles, relationships and living situations and replacing them with effective alternatives that benefit self and others

Voluntary Resocialization in Involuntary Settings

Teaching self motivated *reconstruction* or *transformation* of experiences and behaviors in formal organizations or total institutions such as correctional or substance abuse programs

Resocialization Steps

- Gain some insight into impact of past events and experiences and resulting emotional reactions
- Briefly explore present feelings, pressures and conflicts
- Assess current living and work situations, peer and partner influences and other aspects of social environment
- Discover active alternatives to ineffective roles and relationships and ways to make better choices that benefit self and others
- *Learn and practice new skills including how to make daily decisions, problem solve and set goals/plan for the future*

RESOCIAL GROUP™

Co-occurring Cognitive-Behavioral Treatment for
Antisocial Personality Disorder
and Substance Use Disorder(s)

90 minutes/once weekly
24 sessions (minimum), flexible, open-ended
14 clients maximum group size

Topics:

Substance Abuse and/or Dependence
Dishonesty
Breaking Rules and Laws
Carelessness
Aggressiveness
Irritability
Irresponsibility
Indifference
Impulsivity

Curriculum:

Choosing Partners and Companions

- Written & Verbal Exercises about Relationships
- Role Rehearsal and Training
- Decision Making, Communication and Problem Solving Skills

Planning for the Future

- Goal Oriented Homework

Referral Criteria:

Chronic Substance Abuse and/or Dependence
Persistent Antisocial Behaviors and Experiences
(a pattern of negative thinking and acting that disregards and violates the rights of others)

Resocial Group™ Topics

- **Substance Abuse**
  (using alcohol or other drugs resulting in legal problems; use causing problems at home, work or school; using in dangerous situations; use contributing to physical or psychological problems)

- **Dishonesty**
  (to deceive, defraud, cheat, lie, use aliases or con)

- **Breaking Rules and Laws**
  (violating rules or laws at school, work, in the community)

- **Carelessness**
  (being reckless, negligent, unhealthy, dangerous or unsafe)

- **Aggressiveness**
  (being hostile, violent, assaultive, fighting or attacking)

- **Irritability**
  (easily or chronically annoyed, angry, testy, grouchy or sensitive)

- **Irresponsibility**
  (not accountable, undependable, unreliable, not trustworthy)

- **Indifference**
  (unconcerned, apathetic, detached, disinterested, lack of remorse, rationalizing)

- **Impulsivity**
  (reactionary, inability or unwillingness to plan, prepare or think things out)

Daily Schedule for Resocial Group™

				1 **Dishonesty & Substance Abuse** *Diagramming of Relationships*	**2** **Dishonesty & Substance Abuse** *Role Exploration*	**3** **Dishonesty & Substance Abuse** *Goal Setting*
4 **Breaking Rules & Laws & Substance Abuse** *Diagramming of Relationships*	**5** **Breaking Rules & Laws & Substance Abuse** *Role Exploration*	**6** **Breaking Rules & Laws & Substance Abuse** *Goal Setting*	**7** **Carelessness & Substance Abuse** *Diagramming of Relationships*	**8** **Carelessness & Substance Abuse** *Role Exploration*	**9** **Carelessness & Substance Abuse** *Goal Setting*	**Aggressiveness & Substance Abuse** *Diagramming of Relationships*
11 **Aggressiveness & Substance Abuse** *Role Exploration*	**12** **Aggressiveness & Substance Abuse** *Goal Setting*	**13** **Irritability & Substance Abuse** *Diagramming of Relationships*	**14** **Irritability & Substance Abuse** *Role Exploration*	**15** **Irritability & Substance Abuse** *Goal Setting*	**16** **Irresponsibility & Substance Abuse** *Diagramming of Relationships*	**Irresponsibility & Substance Abuse** *Role Exploration*
18 **Irresponsibility & Substance Abuse** *Goal Setting*	**19** **Indifference & Substance Abuse** *Diagramming of Relationships*	**20** **Indifference & Substance Abuse** *Role Exploration*	**21** **Indifference & Substance Abuse** *Goal Setting*	**22** **Impulsivity & Substance Abuse** *Diagramming of Relationships*	**23** **Impulsivity & Substance Abuse** *Role Exploration*	**Impulsivity & Substance Abuse** *Goal Setting*

SOCIOMETRY
Diagramming of Relationships

(*Who Shall Survive? A New Approach to the Problem of Human Interrelations*, J.L. Moreno, M.D., Washington, D.C., 1934. Supported by the National Committee on Prisons and Prison Labor.)

Definitions

Socionomy	the psychological activities of groups
Sociometry	measuring relationships within groups
Sociometric Test	requiring an individual to choose his associates
Sociometric Goal	to become an active agent in matters concerning your own life situations

CHOOSING PARTNERS AND COMPANIONS AT HOME, WORK AND SCHOOL

Measuring relationships and activities in groups.

Behavior/Experience_____

Draw three charts diagramming groups at home (the family), work or school using the spaces and the key seen on the next page. Illustrate the current topic (dishonesty, breaking rules and laws, carelessness, aggressiveness, irritability, irresponsibility, indifference or impulsivity and substance abuse) _____ in past and present relationships and then draw a chart showing future relationships and how they would be different without _____.

Assumptions: Our social environments have a significant impact on our experiences and attitudes, including how some of us learned about _____ as a consistent pattern of behavior. Accordingly, changing groups or changing the relationships within groups may allow us to make positive social changes including eliminating _____ as one of our behaviors.

Goals: Clarify our perception of events that have occurred in the past. Increase our understanding of how our negative thinking and acting was learned (but do not blame others for our own actions). Increase our insight and awareness of pressures and conflict caused by or related to _____ that we witnessed, were directly affected by or were responsible for creating ourselves. Make positive choices about positive partners and companions which can only improve the way we see the world, make daily decisions and feel about each other and ourselves. The experiences of pressure and conflict will be decreased. The emotions of sympathy, rejection, fear and anger will also be decreased when _____ is eliminated.

_____ in Past Relationships

_____ in Present Relationships

Future Relationships without _____

KEY

∇ = boy ∇= man ***D/A*** = person in group with substance abuse problems

0 = girl 0 = woman **C/J** = person in group involved in criminal justice system

Lines drawn from one individual to another
represent the emotional reaction or behavior of the one individual to the other.
An **arrowed line** indicates **one-sided** behaviors or reactions.

A **crossed line** represents **two-sided** behaviors or reactions.

A **blue line** represents ***sympathy***
A **yellow line** represents ***rejection***
A **green line** represents ***fear***
A **red line** represents ***anger***
A **black line** represents _____

Adapted from:
Who Shall Survive? A New Approach to the Problem of Human Interrelations by J.L. Moreno, M.D.
Nervous and Mental Disease Publishing Co., Washington, D.C., 1934.

What are we looking for in the three boxes?

_____ in Past Relationships

how we learned (experienced witnessed)
negative thinking and acting
and the emotional reactions

_____ in Present Relationships

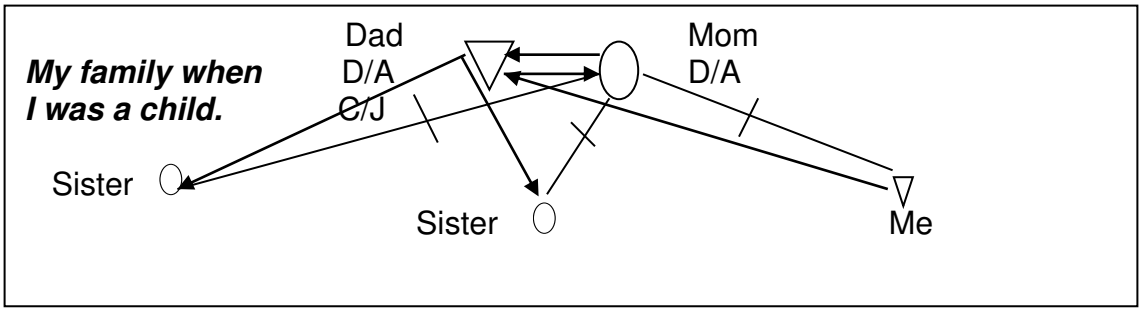
current relationships and patterns
in our behaviors, attitudes, pressure, conflict
and the partners and companions we have chosen

Future Relationships without _____

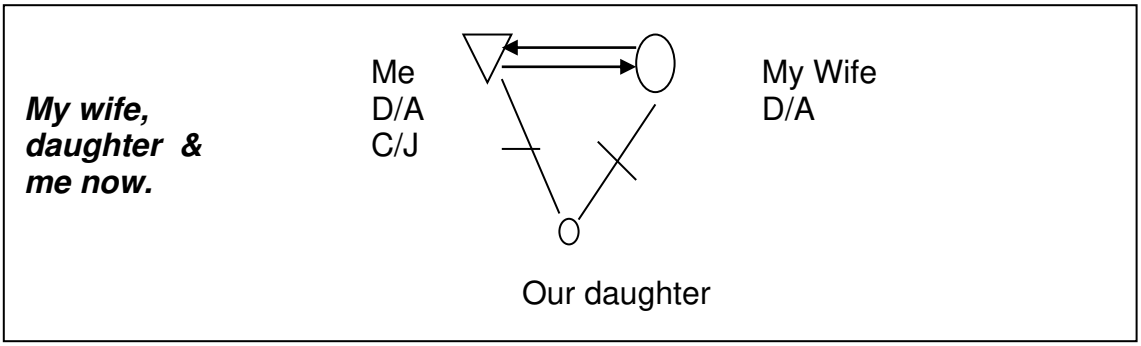
the "test" (choosing our "associates")
and making positive changes
(changing behaviors and relationships)

Examples

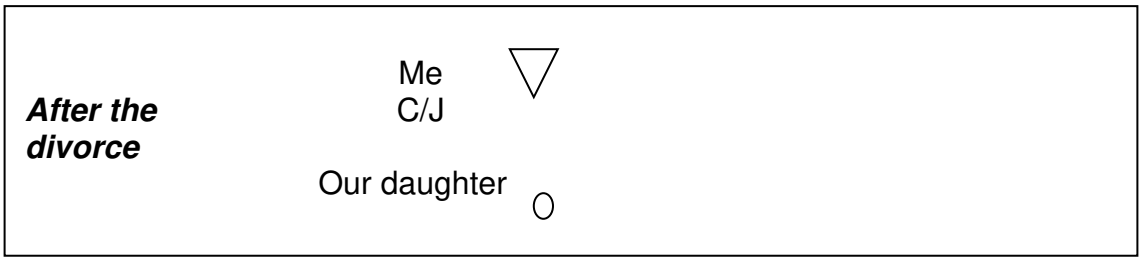
DISHONESTY AND SUBSTANCE ABUSE in Past Relationships



DISHONESTY AND SUBSTANCE ABUSE in Present Relationships



Future Relationships without *DISHONESTY AND SUBSTANCE ABUSE*



SOCIODRAMA

(*Sociodrama: Who's In Your Shoes*, Patricia Sternberg and Antonia Garcia, NY, 1990.)

What it is...

- focused on "*here and now*" (present day) only
- learning about *human relations* (to increase understanding of *self, others and the world*) from small group interaction
- an opportunity to practice *problem solving, decision making and other new skills or behaviors*
- about transmitting *information, communication and inspiration*
- *a way for clients to actively participate in the process of* growth and development
- *role training* (*role exploration, rehearsal and expansion*) to find a better way to play an old role or try new roles by spontaneously acting out agreed upon *hypothetical social situations*
- a *safe environment* with *support and feedback* about how effective and satisfying the skills, behaviors or roles are
- *a forum for clarifying* values, feelings *and new and different ways to* experience relationships

What it is not…

- Never a specific client's problem or real life situation
- No private or personal issues
- Not about the past

No attacks or verbal abuse allowed

Sociodrama Stages

WARM-UP:
Ready the "*Enactors*" *by* identifying the *shared central issue* (always substance abuse combined with one of the 8 behavior patterns for Resocial Group-see Lesson Plan), ask participants to generate examples of the identified behavior (they may be similar to personal experiences or events but not real life examples).

ENACTMENT:
The participants take turns playing the different roles, practicing how to behave, learning from mistakes and successes, reassessing their thinking and values, and directly expressing feelings about the experience.

SHARING/COOLDOWN:
The conclusion, a time to reflect and talk about insights (how they connected with what they just saw or experienced and how it does relate to their own lives).

Sociodrama Terms/Techniques

(*Sociodrama: Who's In Your Shoes*, Patricia Sternberg and Antonia Garcia, NY, 1990.)

Role Reversal
changing positions to increase understanding of the other side or perspective, to get unstuck

The Double (Mind/Feeling Reader)
stands/sits behind the person he's doubling for, the facilitator and participant observers say what they think the person in the role is feeling (verbalizing body language), the double agrees or disagrees with you (enactors cannot respond directly to the double)

Time Out/Freeze
stopping and holding positions while the facilitator points out observations or gives feedback

Mirror
an observer steps in to play the role the same way to see what it feels like

Future Projection
trying out actions and planning for future roles and relationships

"Aha!"
the statement made when the "light bulb" experience takes place

Goal Setting/Planning for the Future

Must be 2 objectives about substance abuse (including continued treatment and aftercare)

Must be 2 objectives about criminal behavior (current legal problems)

Must be 2 objectives about antisocial behavior (i.e., dishonesty, breaking rules and laws, carelessness, aggressiveness, irritability, irresponsibility, indifference, and/or impulsivity)

At midpoint of treatment (halfway through program), client does review and update of 3 goals

When completing program, client does discharge planning to see if 3 short term goals accomplished and 3 long term goals still apply

Resocial Group™

Planning for the Future /Goal Sheet

Reminders:

- Goals must be *achievable* and *measurable*.
- There must also be a "who," "what," "where," 'why," "when/when/when" (start date, frequency, and duration), and "how" for each goal.
- Talk about what you WILL DO, not what you won't do.
- Short-term goals are those that can be accomplished while you are still a member of Resocial Group™.
- Long term goals are those that can only be accomplished after successfully graduating from Resocial Group™ (because the skill hasn't been learned yet or the opportunity to get involved in the behavior or activity won't be available until after graduation).
- One of substance abuse goals must include continued treatment and/or aftercare plans (in addition to regular attendance and participation in this group, which is assumed).
- Your criminal behavior goals must include legal alternatives to the unlawful behavior that brought you into the system this time.
- The antisocial behavior goals must include legal alternatives to two (2) primary problem areas/patterns of negative thinking and acting (and you cannot work ahead).
- Sign/date goal sheet the first time used and initial/date each additional goal. Never write more than one (1) goal per group. Review (update/delete/add) after three (3) goals, and do discharge planning after six (6) goals (instead of writing new goals).

Example:
Substance Abuse Short Term Goal:

*"I (WHO) **will** go to AA meetings (WHAT) here in jail (WHERE) to get support from other alcoholics and addicts (WHY) every Friday night (WHEN) for six months (WHEN) starting this week (WHEN) by making arrangements with my counselor and case manager to get passes off the living unit (HOW)."*

(Because AA meetings are offered on Friday nights and the client is eligible to go, this goal is achievable. Making arrangements to get the passes, attendance and participation can all be measured.)

Client Name_____

Substance Abuse Goals:

Short Term

_____
_____
_____
_____
_____
_____

Long Term

_____
_____
_____
_____
_____
_____

Criminal Behavior Goals:

Short Term

_____
_____
_____
_____
_____
_____

Long Term

_____
_____
_____
_____
_____
_____

Antisocial Behavior Goals:

Short Term

_____
_____
_____
_____
_____
_____

Long Term

_____
_____
_____
_____
_____
_____

Client signature _____

Date _____

Counselor signature _____

Date _____

Case Manager signature _____

Date _____

Probation/Parole Officer Signature _____

Date _____

Resocial Group™

Planning for the Future/Goal Sheet

SAMPLES

Substance Abuse Goals:

Short Term
Effective immediately I will have clean urine samples every week in prison for 3 months by using no drugs/alcohol and by taking Antabuse regularly as directed so I can stay in the therapeutic community.

Long Term
I will refer myself to the 90-day halfway house recovery program in L.A. for aftercare in the community within 2 weeks after graduation from Resocial Group™ in 6 months.

Criminal Behavior Goals:

Short Term
Starting now I will be write-up free in housing and education every day for 3 months so I can get a single room by applying to the living unit Inmate Council by July 1.

Long Term
I will make restitution payments of $100 per month by mailing money orders to DOC after I'm released in 6 months starting that month and until paid off in 3 years to comply with the order.

Antisocial Behavior Goals:

Short Term
I will take at least a 15-minute time out and do thought stopping and journaling as necessary when feeling angry, having violent thoughts, or as suggested by staff here in the program beginning today and for the next ninety days.

Long Term
I will make and record at least 3 job contacts a day in the downtown area starting immediately and until I get a job due in 2 weeks, and keep it for at least 9 months so I can stay in the house.

Resocial Group™ - Appropriate Settings

- Prison
- Jail
- Boot Camp
- Halfway House
- Inpatient/Residential Program
- Work Release
- Partial Hospitalization
- Intensive Outpatient
- Day Reporting
- Outpatient

Resocial Group™ - Treatment Categories

(U.S. Department of Health and Human Services)

- Group Therapy
- Group Education
- Specialized
    - *Skills*
    - *Diagnosis*

Resocial Group™- <u>Guidelines/Rules</u>

- abstinence/sobriety
- honesty
- compliance
- safety
- order
- moderation
- dependability
- participation
- readiness
- confidentiality

Resocial Group™ - Facilitator Skills

1. Use board to write down assignment.
2. Verbally introduce behavior pattern problem area (topic).
3. Highlight relationship with alcohol/other drugs.
4. Explain technique or skill relevance to subject.
5. *Review rule or guideline of concern in this section (any 1 of 10).*

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Appendix A: Post Test and Evaluation for ***The Offender and Addiction – Cognitive Behavioral Therapy***

Directions: To receive credits for this course, you are required to take a post test and receive a passing score. We have set a minimum standard of 80% as the passing score to assure the highest standard of knowledge retention and understanding. The test is comprised of multiple choice and/or true/false questions that will investigate your knowledge and understanding of the materials found in this CEU Matrix – The Institute for Addiction and Criminal Justice distance learning course.

After you complete your reading and review of this material, you will need to answer each of the test questions. Then, submit your test online for processing. This can be done in the following manner:

Submit your test via the Internet. All of our tests are posted electronically, allowing immediate test results and quicker processing. First, you may want to answer your post test questions found at the end of this appendix. Then, return to your browser and go to the Student Center located at:

http://www.ceumatrix.com/studentcenter

Once there, log in as a Returning Customer using your Email Address and Password. Go to 'My Courses" then to the subject course. Then click on 'View Lesson Quiz' and you will be presented with the electronic exam.

NOTE: THE EXAM QUESTIONS AND /OR ANSWERS MAY BE IN A DIFERENT ORDER IN THE ONLINE EXAM

To take the exam, simply select from the choices of "a" through "e" for each multiple choice question. For true/false questions, select either "a" for true, or "b" for false. Once you are done, simply click on the submit button at the bottom of the page. Your exam will be graded and you will receive your results immediately. If your score is 80% or greater, you will receive a link to the course evaluation. You will also receive a link to the Certificate of Completion. This is the final step in the process, and you may save and / or print your Certificate of Completion.

If, however, you do not achieve a passing score of at least 80%, you will need to review the course material and return to the Student Center to resubmit your answers.

Answer the following questions by selecting the most appropriate response.

1. Antisocial Personality Disorder is exclusively an adult diagnosis.

    a. True
    b. False

2. Indicators of Antisocial Personality Disorder include:

    a. breaking rules and laws
    b. impulsivity
    c. aggressiveness
    d. irresponsibility
    e. all of the above

3. Antisocial Personality Disorder may only be diagnosed if there is evidence of aggression, destruction and/or deceitfulness before the age of 15.

    a. True
    b. False

4. A diagnosis of Antisocial Personality Disorder requires that:

    a. there not be a thought disorder as well
    b. there not be a depressive disorder as well
    c. the problems begin no later than 18 years of age
    d. all of the above
    e. none of the above

5. Conduct Disorder is a child/adolescent only diagnosis.

    a. True
    b. False

6. Which of the following statements are correct:

    a. Adult Antisocial Behavior is due to a mental disorder.
    b. Impulse-Control Disorder, Antisocial Personality Disorder and Conduct Disorder are mental disorders.
    c. Adult Antisocial Behavior is a diagnostic category for all age groups.
    d. Adult Antisocial Behavior is always chronic.
    e. Adult Antisocial Behavior is always acute.

7. Conduct Disorder may be rated as mild, moderate or severe.

   a. True
   b. False

8. Substance Dependence requires increased tolerance and withdrawal.

   a. True
   b. False

9. Substance Abuse may only be diagnosed in the following case:

   a. substance related problem at home
   b. substance related legal problem
   c. substance related problem at work
   d. substance related problems at school
   e. use in physically hazardous situation

10. Counselors should not use clinical terminology with clients.

    a. True
    b. False

11. Counseling with gay and lesbian offenders should include discussions about the possibility of differences between pleasure and attraction.

    a. True
    b. False

12. When treating a learning disabled offender:

    a. give feedback
    b. explain
    c. observe
    d. demonstrate the task(s)
    e. all of the above

13. Coeducational therapy groups are encouraged as long as:

    a. it is recognized that women may use drugs for different reasons
    b. there are coed facilitators whom are attracted to each other
    c. there are coed facilitators whom tolerate working together
    d. there is a female facilitator to support the one female client
    e. none of the above

14. Most people are not aware that they are being socialized by family members and peers.

a. True
b. False

15. Theories of socialization include explanations that:

a. early learning persists beyond childhood
b. changes in adulthood can alter earlier learning
c. most people are not aware that they are being socialized by teachers and preachers
d. both a. and b.
e. both b. and c.

16. If someone is rigid, close minded or dogmatic in their thinking and feeling, they may be unable to reach full development as an individual.

a. True
b. False

17. Resocialization is defined as the unlearning and relearning of:

a. norms
b. values
c. attitudes
d. behaviors
e. all of the above

18. Socialization agents in American society include the family, peers, schools and churches.

a. True
b. False

19. Helping clients change the way that they think, feel, have relationships and control impulsive behaviors benefits:

a. self
b. others
c. no one
d. self and others
e. none of the above

20. An involuntary client cannot be voluntarily resocialized.

    a. True
    b. False

21. Resocialization does not include gaining insight into past events and exploring present feelings.

    a. True
    b. False

22. Cognitive behavioral therapy includes which of the following:

    a. teaching alternatives to problem behaviors and experiences
    b. being discharged or released only when successful
    c. doing homework which includes practicing the new skills
    d. all of the above
    e. none of the above

23. Resocial Group™ addresses the co-occurring problems of persistent patterns of disregarding and violating the rights of others and substance abuse or dependence.

    a. True
    b. False

24. Which of the following statements is not correct about Resocial Group™:

    a. sessions are generally held for 90 minutes
    b. frequency of visits is usually once weekly
    c. there is no maximum group size
    d. this clinical treatment program is for adults only
    e. all of the above

25. The curriculum for Resocial Group™ includes substance abuse and eight other topics (specific experiences and behaviors related to criminal thinking and acting).

    a. True
    b. False

26. Sociometry:

a. is also known as diagramming of relationships
b. requires clients to make decisions about the people they spend time with
c. is the same as doing a simple family tree
d. both a. and b.
e. none of the above

27. The clinical relevance or importance of asking clients to do sociometry in group therapy is so that they can determine:

a. where they first learned the negative thinking and acting related to substance abuse and how it affected them and others around them
b. how they have repeated the pattern of negative thinking and acting related to substance abuse and how they have hurt others in the process
c. what their future relationships might look like without the negative thinking and acting and without the substance abuse
d. All of the above
e. None of the above

28. Clients must write the topic (one of the eight examples of criminal behaviors or experiences) and substance abuse in 11 places (including the final blank in the answer key) on the two pages of the sociometry exercise.

a. True
b. False

29. In the diagramming, if a behavior or emotional reaction is two-sided, the line is arrowed in both directions.

a. True
b. False

30. Sociodrama is not:

a. about a specific client's real life situation or problem
b. an opportunity to receive support and feedback
c. focused on present day issues
d. all of the above
e. none of the above

31. Sociodrama can also be understood as exploring, rehearsing, expanding or training in the areas of playing old roles or trying new roles.

    a. True
    b. False

32. Sociodrama stages should be in this order:

    a. enactment, cooldown, warm-up
    b. warm-up, cooldown, enactment
    c. warm-up, enactment, cooldown
    d. all of the above
    e. none of the above

33. In a sociodrama enactment, the double shows the group what he or she observed and thinks the enactor was feeling, and the mirror tells the group what he or she observed and thinks the enactor was feeling.

    a. True
    b. False

34. What is the one exception to always doing “here and now” enactments?

    a. role reversal
    b. double
    c. mirror
    d. future projection
    e. none of the above

35. Sociodrama allows clients the opportunity to practice problem solving, decision making and communication.

    a. True
    b. False

36. In social goal setting, the client does a review and update halfway through treatment, and makes certain that the short term goals are accomplished and long term goals still relevant when completing the program.

    a. True
    b. False

37. The Planning for the Future exercise requires the following:

a. clients may talk about what they're not going to do
b. clients must write where, why and how they're going to do their goal
c. clients must state when they're going to start, how often and for how long they're going to do it
d. Both a and b are correct responses
e. Both b and c are correct responses

38. Goal setting addresses:

a. substance abuse goals
b. criminal behavior goals
c. antisocial goals
d. all of the above
e. none of the above

39. Criminal behavior goals may include legal alternatives to any crime that the client was convicted of (whether or not he or she assumes responsibility for it).

a. True
b. False

40. Which of the following is correct regarding the Goal Sheet for Resocial Group™:

a. short term goals must always be written before long term goals
b. a client may only write a goal about a particular antisocial topic if it has already been addressed in group
c. substance abuse goals are required before criminal behavior goals
d. all of above
e. none of the above