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UNDERSTANDING ADDICTION AND CRIMINAL BEHAVIOR

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ABOUT THE INSTRUCTOR

Delbert Boone is one of the nation's foremost authorities on addiction and criminal behavior and other social ramifications associated with addicted individuals. His ability to consistently help drug offenders and addiction professionals understand the parallels between addiction and criminal behavior is well established.

Over the past 30 years Delbert Boone has worked with addicts from all walks of life. By relating his own struggles with addiction to alcohol and heroin and his incarceration, he has given hope where there previously was none. Boone has developed the tools to help individuals who are facing addiction to alcohol and other drugs, incarceration, depression, frustration, and loneliness.

Boone's primary work is through his own consulting and training firm, NND Productions, in which he consults with both local and federal correctional systems. He also works with school districts and law enforcement officials nationwide to deliver quality and effective substance abuse treatment programs, services and training.

Delbert Boone is an award winning film presenter for FMS, Productions, Inc. Since 1995, he has been honored with nine International Telly Awards and recognized for outstanding contributions at four American Corrections Association Film Festivals for his video/DVD programs. Boone is a Certified Substance Abuse Counselor, Certified Psychotherapist, American Institute of Clinical Psychotherapists and received his BS degree from the Central Michigan University.

Updated Evidence on Addiction and Criminal Behavior: Prevalence, Treatment, and Recovery

The framework this course provides for understanding the relationship between addiction and criminal behavior, covering the progression of substance use, the choices addiction drives, and the adjustments in thinking and behavior required for recovery, has been substantiated by recent large-scale research. That research quantifies the drug-crime relationship with new precision, documents what happens when courts mandate treatment instead of incarceration, identifies how co-occurring mental health conditions amplify both addiction and recidivism, and examines what prison-based and jail-based treatment actually does to return-to-custody and mortality.

The scope of drug use among incarcerated populations, which this course introduces through the personal narrative of someone who lived at the intersection of addiction and criminal behavior, was quantified in a 2026 global review published in Addiction. The review found that four in ten adults who enter prison meet diagnostic criteria for a drug use disorder, a rate approximately ten times that of the general population. Around a third of incarcerated individuals continue to use drugs during imprisonment, contributing to blood-borne virus transmission and other health risks. Drug use correlates strongly with both recidivism and markedly elevated mortality risk after release, and despite evidence supporting pharmacological and psychosocial interventions, significant treatment gaps persist globally (Favril et al., 2026). For the addiction-crime framework this course teaches, the message is that the treatment gap is not a local shortage. It is a global structural failure, and the counselor preparing to work with this population is stepping into that gap.

The court-mandated treatment dimension, relevant to how clients arrive in treatment through the criminal justice system, was examined in a 2025 qualitative evidence synthesis of 25 studies on legally-mandated non-custodial drug and alcohol treatment for justice-involved adults. Justice-involved adults perceived treatment orders as helping to reduce mortality and morbidity risk, improve their sense of self, and cope with emotions, though some experienced increased stress and an exacerbation of trauma. Most of the research focused on U.S. drug courts, none examined alcohol interventions exclusively, and no studies involved family members (France et al., 2025). This captures the ambivalence that court-mandated clients bring to treatment, the same ambivalence this course addresses through its emphasis on adjustment rather than forced change. Mandated clients may experience genuine therapeutic benefit while simultaneously resenting the coercion that brought them in, and effective counselors must hold both realities at once.

The role of co-occurring mental health conditions in amplifying both addiction and criminal behavior, a dimension this course addresses primarily through the lens of addiction alone, was examined in a 2024 statewide retrospective cohort study of 2,039 adults with opioid use disorder and criminal-legal involvement. Nearly half, 47 percent, had a concurrent mental health condition. Co-occurring disorders predicted higher rates of recidivism during the early stages of treatment, but group and individual therapy were associated with lower odds of recidivism, and individuals with co-occurring conditions required more intensive support upon discharge (Lawson et al., 2024). The clinical implication is direct: nearly half of the clients a counselor encounters at the addiction-crime intersection also carry a mental health condition that independently drives both substance use and criminal behavior. Treating the addiction without addressing the co-occurring condition is treating half the problem.

The course's framework for understanding how specific drugs produce specific criminal patterns received direct empirical support from a 2022 Swedish cohort study of 4,207 prison clients with substance use disorders. Over approximately 2.7 years of follow-up, 68 percent experienced criminal recidivism, but the risk factors for reoffending differed substantially across crime categories. Alcohol use was specifically associated with violent-crime recidivism, amphetamine and injection drug use predicted general recidivism, and heroin use and older age predicted property and drug-crime recidivism (Karlsson & Hakansson, 2022). This maps closely onto the offender typology this course teaches. Alcohol's pharmacological pathway tends to produce violent offending, while heroin's economically driven, compulsive pathway tends to produce acquisitive crime. Counselors cannot treat substance use and crime as a single clinical problem. The drug matters, the offense history matters, and the treatment plan must match the specific pathway the client traveled into the justice system.

The personality dimension of the addiction-crime relationship was quantified in a 2025 updated meta-analysis published in the British Journal of Psychiatry. Across 21 studies of violence outcomes, any personality disorder diagnosis was associated with roughly 4.5-fold elevated odds of violence (OR 4.5). Antisocial personality disorder produced the highest risk (OR 7.6), and borderline personality disorder was also substantially elevated (OR 2.6). Comorbid substance use disorder was a key source of heterogeneity across studies (Chow et al., 2025). This refines the framework in an important way. Antisocial personality disorder is not simply a comorbid feature of addiction in justice-involved populations. It is an independent and powerful driver of the same violent and antisocial behavior the addiction itself produces, and when both are present the treatment plan must address two interacting pathologies, not one pathology with a personality footnote.

The psychopharmacologic model of the drug-crime relationship was tested specifically for alcohol-related intimate partner violence in a 2025 meta-analysis of 20 studies. Greater alcohol-use frequency independently increased the odds of male-to-female IPV perpetration (OR 1.39), as did higher endorsement of traditional masculine norms (OR 1.12). The interaction between alcohol use and masculinity was non-significant, meaning the two operated as independent pathways to violence rather than amplifying each other (Willoughby et al., 2025). The clinical precision here is useful: alcohol is not violent on its own, and masculine identity is not violent on its own, but each contributes independently to partner-violence risk. A counselor delivering substance use treatment to a male client with a history of intimate partner violence must address both the drinking and the belief system the client carries about what it means to be a man.

The course's emphasis on substance-specific progression received further support from a 2023 meta-analysis of 66 studies examining young people aged 10 to 25 who use methamphetamine. Compared to non-using peers, methamphetamine-using youth were about 13 times more likely to meet diagnostic criteria for conduct disorder. Elevated rates of justice-system involvement and perpetration of violence appeared consistently, as did educational difficulties, and inhibitory-control deficits emerged as the most reliably affected cognitive domain (Guerin et al., 2023). This identifies methamphetamine as a pharmacologic driver of the precise cognitive and behavioral profile that predicts sustained criminal involvement: impaired inhibition, externalizing behavior, and disengagement from school. Counselors working with adolescent and young-adult clients on the methamphetamine trajectory are intervening at the developmental window where conduct disorder can crystallize into antisocial personality disorder.

The question of whether prison-based treatment programs reduce return-to-custody was examined in a 2024 retrospective cohort study of 5,549 individuals released from Australian prisons. The

Connections program, which facilitated opioid agonist treatment access and social services at release, did not lower return-to-custody rates (hazard ratio 1.01) but did increase treatment uptake (odds ratio 1.21 for accessing opioid agonist treatment). An early mortality benefit appeared within 28 days after release (0.25 percent versus 0.66 percent) but did not persist over longer follow-up (Sullivan et al., 2024). This illustrates the gap between treatment engagement and criminal desistance. Engaging people in treatment at release does not automatically reduce their return to prison. Breaking the addiction-crime cycle requires more than treatment access. It requires the sustained behavioral adjustments this course describes, alongside the housing, employment, and social support that make those adjustments possible.

The practical question of whether treating opioid use disorder during incarceration reduces the return trip through the justice system was addressed in a 2025 New England Journal of Medicine cohort study of 6,400 Massachusetts jail detainees with probable opioid use disorder. Those who received medications for opioid use disorder during incarceration, 42.4 percent of the cohort, had lower post-release risk of fatal overdose (adjusted hazard ratio 0.48), nonfatal overdose (0.76), all-cause mortality (0.44), and reincarceration (0.88) than those who did not. Post-release treatment engagement at 30 days was 60.2 percent among medication recipients versus 17.6 percent among non-recipients (Friedmann et al., 2025). This is the strongest available evidence that pharmacologically interrupting the opioid use disorder during incarceration measurably interrupts the return to criminal behavior after release.

A parallel 2024 study extended the finding to the state-prison setting. Using interrupted time-series analysis of 15,225 releases from Massachusetts prisons following statewide buprenorphine implementation in 2019, researchers found that post-release buprenorphine receipt roughly doubled over expected levels among men (21.2 percent versus an expected 10.6 percent) and all-cause mortality declined (1.9 percent versus an expected 2.8 percent). Opioid-overdose rates specifically, however, did not change significantly (Bovell-Ammon et al., 2024). The finding complicates the success story: scaling in-custody buprenorphine meaningfully increases post-release treatment engagement and reduces overall mortality, but it does not by itself eliminate overdose deaths. Structural factors, housing instability, employment barriers, fentanyl contamination, and lapses in treatment continuity, continue to generate overdose risk even when medication access is restored.

Reading the Offender: Which Drug, Which Crime, Which Pathway

One of the most useful things the recent evidence does is confirm that the course's refusal to treat "the addicted offender" as a single type is clinically correct. The crime-specific pattern documented in the Swedish cohort, alcohol tracking with violence, stimulants with general offending, opioids with property and drug crime, means that the intake question is never simply whether a client uses drugs and commits crimes. It is which substance, in what pattern, connected to which offenses, and by which pathway.

In practice this reshapes the assessment. A client whose violence appears when he drinks presents a psychopharmacologic pathway in which the substance itself disinhibits behavior that the person would otherwise contain, and the treatment plan centers on the drinking and on the situations and beliefs that surround it. A client whose crimes are burglaries and thefts that fund a heroin habit presents an economically driven pathway in which the offending is instrumental, a means of sustaining use, and the single most powerful intervention may be the medication and the stability that remove the daily financial

pressure to obtain the drug. A client immersed in a drug-selling network presents a systemic pathway in which the violence and offending arise from the illicit market itself rather than from intoxication or acquisition. These are not academic distinctions. Each pathway points to a different center of gravity for treatment, and a plan built for the wrong pathway will spend its effort in the wrong place.

The counselor's task, then, is to listen to the client's actual history closely enough to identify which pathway, or which combination of pathways, produced this person's particular entanglement of addiction and crime. The offender typology this course teaches is not a filing system. It is a working hypothesis about mechanism, and the mechanism determines the plan.

A further refinement the recent evidence supports is that most real clients are not pure types. The person whose drinking drives violence may also sell drugs to fund the drinking, and the person whose burglaries fund a heroin habit may also become violent when using stimulants on the side. Polysubstance use is the norm rather than the exception in justice-involved populations, and it blurs the clean pathways the typology describes. This does not make the typology useless. It makes it a starting frame that the counselor then adjusts to the individual, asking which pathway dominates this person's history, which is secondary, and which substance is most likely to be the one that ends the person's life. The Swedish data is a reminder that even the protective-looking findings, such as sedatives functioning as a negative risk factor in that sample, are specific to context and should never be generalized into clinical reassurance. The counselor reads the individual, uses the typology to organize what he hears, and lets the dominant mechanism set the priorities of the plan while keeping the secondary pathways in view.

It is worth adding that the offense history itself is clinical data, not merely a legal record. The pattern of a person's charges over time, whether the crimes escalate in seriousness, whether they cluster around periods of active use, whether they change character when the drug of choice changes, tells the counselor a great deal about how tightly the addiction and the offending are bound together and about where an intervention is most likely to change the trajectory. Reading the record this way, as a longitudinal picture of a life rather than a list of infractions, is one of the skills that distinguishes effective work at this intersection.

The Two Pathologies: Addiction and Antisocial Personality

Among the more sobering findings in the recent literature is the magnitude of the violence risk associated with antisocial personality disorder, with pooled odds more than seven times those of people without a personality disorder. For counselors at the addiction-crime intersection this matters because antisocial personality disorder and substance use disorder co-occur far more often than chance, and when they do the counselor is working with two interacting conditions rather than one.

The practical difficulty is that the surface behaviors overlap. Deceit, manipulation, impulsivity, and disregard for others can all be products of active addiction, and they frequently resolve as the addiction is treated and the person stabilizes. The same behaviors can also be expressions of an enduring personality structure that will not resolve simply because the substance use stops. Distinguishing the two is not a matter of labeling a difficult client as antisocial and giving up. It is a matter of noticing whether the antisocial pattern predates the addiction and persists across periods of abstinence, because that pattern, if present, changes what treatment can realistically accomplish and over what timeframe.

Where an antisocial pattern is genuinely present, the evidence counsels neither despair nor naivety. Progress is possible, but it tends to come through structure, clear and consistently enforced expectations, and interventions that target antisocial thinking directly, rather than through insight-oriented approaches that assume a wish to change the counselor may be projecting onto the client. It also counsels honesty in the treatment relationship. A counselor who can see the pattern clearly, name its consequences without contempt, and still hold the door open is doing exactly the work this population requires, and is far more useful than one who is repeatedly surprised and wounded by behavior the diagnosis predicts.

This course's concept of the erosion of choice offers a useful bridge between the two conditions. Addiction narrows a person's options over time, converting what began as choices into compulsions, and antisocial personality narrows them from a different direction, through a habitual disregard for the constraints that ordinarily shape behavior. When both are present, the client's felt sense of having any real choice can be very thin, and part of the counselor's work is to help rebuild the experience of choice one small, concrete decision at a time rather than demanding a wholesale transformation the client cannot yet imagine. Progress with such clients is often measured in the accumulation of small kept commitments rather than in dramatic declarations, and a counselor attuned to that scale of change will see movement where a counselor waiting for a breakthrough sees only stagnation.

There is also a boundary lesson here that protects both the client and the counselor. Working with clients who have an antisocial pattern requires clear limits, consistent follow-through, and a refusal to be drawn into either the role of the mark who is manipulated or the role of the adversary who is fought. Holding a warm but firm structure, in which expectations are explicit and consequences are predictable, is not coldness. It is the environment in which a client whose life has been organized around evading structure can begin to experience structure as something other than a threat, and it models the kind of reliable relationship that many of these clients have rarely had.

Co-Occurring Mental Health Conditions in Everyday Practice

The finding that nearly half of justice-involved clients with opioid use disorder also carry a mental health condition turns co-occurring disorders from a specialty concern into the ordinary condition of the work. For the counselor, the applied lesson from the Lawson cohort is twofold: co-occurring conditions raise the risk of early reoffending, and yet therapy still reduces that risk, so the presence of a mental health condition is a reason to intensify treatment rather than to write off the case.

The common clinical error is sequencing, the belief that the client must first get clean and only then have the depression, anxiety, trauma, or psychosis addressed. Decades of evidence, reflected in the integrated-treatment consensus, indicate that treating the two conditions together works better than treating them one after the other, in part because each untreated condition tends to reactivate the other. A client whose panic or despair goes unaddressed has a powerful reason to keep using, and a client who keeps using has a powerful obstacle to psychiatric recovery. The counselor does not need to personally treat both conditions, but does need to make sure both are being treated, which means building and maintaining the connections to psychiatric care that integrated treatment requires.

The discharge point deserves particular attention. The same research found that clients with co-occurring conditions needed more intensive support at discharge, precisely the moment when support is most likely to thin out. Planning for that added intensity in advance, rather than discovering the need

after a client has destabilized, is one of the concrete ways the co-occurring evidence changes practice.

A practical diagnostic caution belongs alongside this. Active substance use and acute withdrawal can mimic almost every psychiatric presentation, producing depression, anxiety, paranoia, and mood instability that may recede with sustained abstinence, and this makes premature diagnosis a real hazard. The resolution is not to ignore mental health symptoms until some arbitrary period of sobriety has passed, which leaves the client suffering and at risk of returning to use, but to treat the presenting symptoms while holding the diagnosis loosely, reassessing as the person stabilizes. A counselor who documents what he observes carefully, communicates it to the prescriber, and revisits the picture over time serves the client far better than one who either dismisses every symptom as drug-related or locks in a diagnosis during the least reliable window for making one.

The engagement lesson from the co-occurring research also deserves emphasis. The clients at highest risk of early reoffending are precisely the ones a stretched program is most tempted to discharge for missed appointments or difficult behavior, yet they are the ones for whom continued therapy makes the largest difference. Building in the flexibility to keep working with a client who is struggling, rather than treating instability as grounds for termination, is both clinically indicated and, given the recidivism stakes, a matter of public safety. The co-occurring client who is hardest to keep is often the one who most needs to be kept.

Medications for Opioid Use Disorder: What Every Counselor Should Understand

The jail and prison studies reviewed above deliver a message that no counselor working with opioid-involved justice clients can afford to ignore: medication for opioid use disorder during incarceration and continued at release lowers the risk of overdose, death, and reincarceration. The Massachusetts jail data showed roughly half the risk of fatal overdose and meaningfully lower reincarceration among those who received medication, and more than three times the rate of treatment engagement a month after release. A broader 2024 systematic review and meta-analysis of 126 studies reinforced the point at the level of the whole field, finding that opioid agonist treatment sharply reduced the risk of death both in custody (hazard ratio 0.25) and in the community during the first weeks after release (risk ratio 0.24), and that therapeutic community programs reduced re-arrest (odds ratio 0.72) and reincarceration (odds ratio 0.66) as well (Macdonald et al., 2024).

For the counselor, the role is rarely to prescribe, which is the physician's decision, but is very often to inform, advocate, and hold the plan together. That work is easier when the counselor can answer the objections that still circulate. The claim that agonist medication merely trades one addiction for another confuses physical dependence, a manageable pharmacological state, with addiction, a behavioral disorder marked by compulsive use and harm. A client stabilized on a therapeutic dose of methadone or buprenorphine is not intoxicated, can work and parent and participate in counseling, and is far less likely to die. Being fluent in that distinction lets the counselor protect a client's access to treatment at the exact transitions, arrest, sentencing, transfer, and release, when it is most likely to be interrupted.

The Massachusetts prison data also delivers a caution that fits this course's larger theme. Scaling medication increased engagement and cut overall mortality but did not by itself erase overdose deaths, because the surrounding conditions of a person's life continue to generate risk. Medication is necessary

and powerful, and it is not sufficient on its own. It works best as the pharmacological floor beneath the behavioral and social work this course describes, not as a replacement for it.

It also helps the counselor to understand the three medications well enough to support an informed client choice, since the physician prescribes but the client lives with the decision and often turns to the counselor to talk it through. Methadone, a full agonist dispensed through structured programs, offers strong retention and is often the right fit for clients with long, severe histories, at the cost of daily dosing and program attendance. Buprenorphine, a partial agonist available through office-based prescribing, offers more flexibility and a strong safety profile, which suits many clients returning to work and family. Extended-release naltrexone, an antagonist that blocks opioid effects, appeals to clients committed to an opioid-free approach but requires a fully completed withdrawal before the first dose and does not carry the same population-level mortality evidence as the agonist medications. The counselor's contribution is not to steer the client toward a favored option but to make sure the choice is driven by the client's clinical situation and preferences rather than by institutional ideology, and to keep the conversation anchored in what the outcomes actually show.

A final applied point concerns the transitions where medication is most often lost. Arrest, transfer between facilities, and release are the moments when a stable medication regimen is most likely to be interrupted, and each interruption resets tolerance and raises overdose risk. The counselor who tracks these transitions for each client, who knows when a court date or a transfer is coming, and who works to keep the medication continuous across them is doing some of the most consequential work available at this intersection, even though it looks more like coordination than counseling.

The Reentry Window: The Most Dangerous Two Weeks

If there is a single window in which the addiction-crime relationship turns lethal, it is the first two weeks after release from incarceration, and every counselor who works with this population should know it cold. The foundational study, following more than 30,000 released inmates, found that the risk of death among former inmates was 3.5 times that of other residents overall, but during the first two weeks after release it climbed to 12.7 times that of other residents, with the relative risk of death specifically from drug overdose reaching 129 (Binswanger et al., 2007).

The mechanism is exactly the one this course teaches about tolerance. Incarceration enforces a period of abstinence that lowers the body's tolerance to opioids. The person released after months away from regular use frequently returns to the same neighborhood and the same cues, and attempts the dose their addiction remembers rather than the dose their body can now survive. A 2021 study using a self-controlled design quantified how sharply the danger spikes, finding that non-fatal overdose risk in the one-to-two weeks after release rose with an adjusted incidence rate ratio of 2.92, and, crucially, that being on medication for opioid use disorder cut overdose risk substantially, with adjusted rate ratios ranging from 0.33 to 0.41 during treatment (Keen et al., 2021). The intervention that closes the reentry window is the same medication continuity the jail and prison studies identified.

For the counselor, this converts an abstract fact about drugs and crime into a time-limited clinical task. Discharge and reentry planning is not paperwork to be completed whenever convenient. Naloxone in the client's hands at release, tolerance education delivered concretely rather than abstractly, an appointment scheduled within days rather than weeks, and wherever possible medication that is never

interrupted are the practical expression of everything the reentry evidence teaches. Where a client is leaving custody without medication arranged, same-week linkage to a prescriber belongs at the very top of the plan, because the window in which it matters most is measured in days.

Tolerance education deserves to be delivered concretely rather than left as a general warning, because clients routinely underestimate how much their bodies have changed. A client who used a particular quantity every day before incarceration often believes that returning to that quantity will simply feel normal, when in fact the months of enforced abstinence have reset his tolerance and made the remembered dose potentially lethal. Saying this plainly, that the first use after release is the single most dangerous dose he will take, and pairing it with take-home naloxone and instruction to a family member on how to use it, turns a frightening statistic into a concrete survival plan the client and his people can actually execute.

The reentry window also reframes what counts as success in the days around release. It is tempting to treat the goal as continued abstinence and to read any use as failure, but for a client at the highest-risk moment the more immediate goal is survival, and harm-reduction steps that keep the person alive through the danger window are not a betrayal of recovery but a precondition for it. A client who survives a lapse in the first two weeks can continue the work. A client who does not, cannot. Holding that priority clearly, without abandoning the longer aim of recovery, is part of what it means to apply the reentry evidence responsibly.

Criminal Thinking and the Work of Adjustment

This course frames recovery as a matter of adjustment, a reworking of the thinking and behavior that addiction and criminal life together produced. The evidence on cognitive programs designed to do exactly that rewards a careful, two-sided reading. The most widely used such program, Moral Reconation Therapy, has been studied in a meta-analysis of 33 studies and more than 30,000 offenders, which found a small but genuine effect on recidivism, an overall correlation of about .16, that was larger for adults than juveniles and larger in institutional than community settings. The same analysis noted, with useful honesty, that effects were smaller in studies conducted by the program's owners than by independent researchers (Ferguson & Wormith, 2013).

More recent and more rigorous evidence tempers easy optimism. The first true randomized controlled trial of the program, studying 341 justice-involved adults in mental health residential treatment, found no significant difference in one-year rearrest between usual care at 20.2 percent and the added program at 24.9 percent. A central reason emerged in the engagement data: only 37 percent of those assigned to the program received even a minimum dose. Among the subgroup that did engage, per-protocol analysis showed greater improvement on criminal associates, days incarcerated, legal problem severity, and alcohol use (Blonigen et al., 2022).

The lesson aligns precisely with this course's framing. Cognitive adjustment is not something a program does to a client. It is work the client has to do, and a curriculum delivered on paper, or completed by a minority of those referred, will not reproduce the average effects reported in the literature. There is also a deeper point about compliance versus change. A client can move through a workbook and give the expected answers without any genuine shift in how he construes his choices, his victims, or his options. The distortions this course names, minimization, entitlement, the victim stance,

the hostile reading of others, yield only when the client examines his own thinking rather than performs agreement. That is why the counseling relationship matters as much as the curriculum. A counselor who builds enough trust that the client will risk honesty, who works from the client's own life rather than generic scenarios, and who treats resistance as information rather than insubordination is far more likely to produce the internal adjustment that a completion certificate only approximates.

The specific distortions this course teaches are worth working with by name, because each has a characteristic function that the counselor can learn to recognize and address. Minimization shrinks the harm the person has caused so that it no longer demands a response. The victim stance reframes the person as the one wronged, which neutralizes accountability by relocating it onto others. Entitlement asserts a right to take what is wanted, and a power orientation reads every interaction as a contest of dominance to be won. These are not merely bad attitudes to be corrected by argument. They are load-bearing beliefs that have protected the client from shame and organized his behavior for years, and they do not fall to confrontation. They loosen when the client, in a relationship safe enough to allow it, begins to notice the cost of the distortion in his own life and to test what happens when he sets it down.

This is also where the concept of adjustment does more honest work than the language of transformation. A client is unlikely to become a different person, and framing the goal that way invites both grandiose promises and inevitable disappointment. What the client can do is adjust, one distortion at a time, one situation at a time, gradually building a way of thinking and acting that does not lead back to use and offending. Measuring progress at that scale, in the small shifts rather than the grand conversion, keeps both counselor and client oriented to changes that are real and achievable, and it matches the incremental, engagement-dependent picture the outcome research describes.

What Actually Works in Correctional Treatment

Behind the specific programs sits a larger question this course implicitly raises: what, across the whole field, actually reduces the reoffending that addiction drives? The dominant answer for three decades has been the Risk-Need-Responsivity framework, which holds that the intensity of treatment should match the client's risk level, that treatment should target the changeable factors statistically linked to reoffending rather than needs that do not drive crime, and that services should be delivered in a style matched to the client's abilities and motivation.

The recent evidence is more nuanced than the framework's popularity suggests, and the nuance is worth passing to practitioners honestly. A 2023 meta-analysis of randomized trials of community-correction programs, examining 25 studies, reached two findings that belong together. Full participation in a program significantly reduced recidivism, confirming that completed, engaged treatment works, and yet programs that strictly followed the Risk-Need-Responsivity template performed similarly to those that did not, suggesting that engagement and dose may matter at least as much as fidelity to any single model (Duan et al., 2023). That reading is reinforced by a 2019 Cochrane review of interventions for drug-using offenders with co-occurring mental health problems, which pooled 13 randomized trials and found that therapeutic community programs, compared with usual care, were associated with substantially less subsequent criminal activity (risk ratio 0.67) and a much lower likelihood of return to prison (risk ratio 0.40) (Perry et al., 2019).

Two applied principles follow. First, match intensity to risk. The natural pull in any program is

toward its easiest, lowest-risk clients, yet intensive intervention aimed at low-risk clients yields little and can even do harm by disrupting the stability that was already protecting them. Reserving the most intensive services for higher-risk clients is a clinical safeguard, not merely an efficiency. Second, target the factors that actually drive this client's offending, antisocial thinking, antisocial associates, substance use, and the like, rather than defaulting to a standard curriculum, and then attend relentlessly to whether the client is actually engaging and completing, because that, more than the label on the program, is where the measurable reductions in crime come from.

The risk principle deserves particular emphasis because it is the one most often violated in ordinary practice, and violating it can actively backfire. The natural pull in any program is toward its most cooperative, lowest-risk clients, the people who show up and engage easily and make the work feel successful. Yet intensive intervention delivered to low-risk clients yields little benefit and can worsen outcomes, partly by disrupting the employment, family, and prosocial ties that were already protecting them, and partly by grouping them with higher-risk peers whose influence runs the wrong way. Reserving the most intensive services for higher-risk clients is therefore a clinical safeguard, not merely a matter of allocating scarce slots efficiently, and it argues for using a validated risk assessment rather than a gut impression to decide who receives what.

The need principle carries an equally practical caution that fits this course's emphasis on targeting the drivers of behavior. Clients present with many genuine problems, low self-worth, vague distress, physical complaints, that deserve compassion but are not the factors statistically driving their offending. Spending a limited course of treatment on needs that do not reduce recidivism, however sympathetic, tends to leave the criminogenic drivers untouched. This does not mean ignoring a client's suffering. It means keeping the plan honest about which targets, antisocial thinking, antisocial associates, and substance use chief among them, are the ones the evidence links to future crime, and making sure those are actually addressed rather than crowded out by problems that are real but not criminogenic.

The responsivity principle, the third leg of the framework, is the one that most directly concerns how the counselor works rather than what the plan targets, and it is easy to underestimate. It holds that services should be delivered in a manner matched to the individual client's abilities, learning style, culture, and readiness, because even a well-targeted intervention fails if the client cannot absorb it as delivered. A client with limited literacy handed a dense workbook, a client in the grip of untreated depression asked to do demanding cognitive homework, or a client whose culture the program does not understand will disengage from treatment that might have worked if it had met him where he was. In practice, responsivity is much of what a skilled counselor does intuitively: adjusting pace and language, building motivation before demanding change, and shaping the work to the person in front of him. The evidence that engagement drives outcomes is, in large part, evidence for responsivity, because a client only engages with treatment he can actually take in, and the counselor's attunement to that fit is not a soft supplement to the real work but one of its central mechanisms.

Trauma Beneath the Behavior

Behind a large share of the clients this course describes sits a history of childhood trauma that predates both the substance use and the offending. Recognizing this is not a way of excusing criminal behavior. It is a way of understanding the developmental pathway that produced the adult in the room, because that pathway points toward what treatment must reach. A 2021 scoping review of 12 studies found a higher prevalence of adverse childhood experiences among people with substance use disorder than in the general population, along with a positive association between such experiences and both the development and the severity of the disorder (Leza et al., 2021).

The pathway extends into criminal involvement. A 2021 study of 417 detained youth found that cumulative childhood adversity significantly predicted reoffending among both boys and girls, and that a significant part of that effect ran through substance use severity, so that trauma helped drive substance use and substance use in turn helped drive reoffending (Weber & Lynch, 2021). That chain maps directly onto the progression this course teaches, and it locates an origin point upstream of the behaviors that bring clients into the justice system.

For practice, the trauma evidence reframes what a correctional setting often reads as defiance, hostility, or manipulation. Behaviors that look antisocial are frequently trauma adaptations that once served a protective function. Trauma-informed care does not mean lowering expectations or abandoning accountability. It means recognizing that punishment layered onto an untreated trauma history tends to reinforce the very cycle it intends to interrupt, and that a setting which is predictable, that explains what will happen and why, that offers choices where it can, and that avoids unnecessary confrontation gives the underlying material a chance to be worked with rather than continually defended against. Screening for trauma should be routine, and it should be paired with a plan for what the program will do with what it learns, because inviting disclosure and then offering nothing can do more harm than not asking.

The correctional environment itself can retraumatize in ways the counselor should anticipate. Searches, restraint, isolation, and the pervasive loss of control that define incarceration can echo earlier experiences of powerlessness and abuse, so a client may arrive at a session already activated by the day's events, presenting as hostile or shut down for reasons that have nothing to do with the counselor. Reading that presentation as a trauma response rather than as defiance changes what the counselor does next, replacing escalation with the predictability and sense of safety that allow a dysregulated client to settle. None of this lowers the expectation that the client take responsibility for his behavior. It simply recognizes that a nervous system braced against threat cannot do the reflective work that adjustment requires, and that establishing enough safety for that work to happen is a prerequisite rather than a luxury.

There is also a link between trauma and the very distortions this course addresses. A worldview organized around threat, mistrust, and the expectation of harm is often a reasonable adaptation to a childhood in which those things were real, and the hostile attributions and self-protective aggression that look like criminal thinking frequently grew from that soil. Treating the trauma and treating the thinking are therefore not competing priorities but two angles on the same underlying structure, and progress on one often opens room for progress on the other. A counselor who can hold both in view, addressing the thinking while respecting its origins, reaches a depth that neither a purely cognitive nor a purely trauma-focused approach achieves alone.

The Mandated Client: Coercion and Genuine Change

A large share of the clients this course prepares counselors to serve arrive not because they chose treatment but because a court ordered it, and the recent qualitative evidence gives texture to what those clients actually experience. They frequently perceive real benefit, a reduced risk to health and life, an improved sense of self, better emotional coping, while at the same time some experience the coercion as a source of stress and, for those with trauma histories, as something that can reopen old wounds (France et al., 2025). Both things are true at once, and the counselor's stance has to accommodate both.

The practical mistake is to treat mandated status as a verdict on the client's potential. Coerced entry into treatment does not preclude genuine change, and a substantial body of practice wisdom holds that clients who begin under external pressure can, over time, internalize goals that were initially imposed. The counselor's task is to work with the ambivalence rather than against it, acknowledging openly that the client did not choose to be there while still inviting the client into a version of the work that serves the client's own stated interests, staying out of trouble, keeping custody of children, holding a job, staying alive.

This is where the course's language of adjustment rather than forced change earns its keep. A client who feels that treatment is one more thing being done to him will comply at the surface and change little underneath. A client who comes to see some part of the work as his own, however it began, is the client in whom real adjustment takes hold. Meeting mandated clients with respect for their autonomy, even inside a coercive structure, is not softness. It is the condition under which the mandate has a chance of producing anything durable.

A concrete way to work with the ambivalence is to separate the parts of the situation the client cannot control from the parts he can. He did not choose to be ordered into treatment, and pretending otherwise insults his intelligence and invites resistance. What he can choose is what he does with the time, and framing the work around his own goals, whatever they are, rather than around the court's requirements, gives him a reason to participate that is his rather than the system's. Many mandated clients have been told what to do for most of their lives, by families, schools, and the justice system, and a counselor who instead asks what the client wants and then aligns the work with it is offering something genuinely different that can, over time, convert compliance into investment.

The dual role that court-mandated work often creates deserves honest handling as well. The counselor who must report on a client's progress to a court occupies a position that mixes help and monitoring, and clients know it. Naming that reality openly, being clear about what will and will not be reported, and refusing to pretend the surveillance is not there tends to build more trust than an unconvincing posture of pure alliance. Clients at this intersection are highly attuned to being handled, and a counselor who is straight with them about the constraints of the role, while still advocating for them within it, earns a credibility that makes the rest of the work possible.

Beyond Access: Why Engagement Is Not Enough

It would be a comfortable conclusion that connecting justice-involved clients to treatment is, by itself, the solution. The evidence does not permit that comfort. The Australian Connections study engaged more people in opioid agonist treatment and produced a short-lived mortality benefit, yet it did not reduce return-to-custody at all over two years. Treatment access moved one outcome and left another untouched.

For the counselor, this is a crucial corrective against measuring success by enrollment. Getting a client into treatment is a beginning, not an accomplishment, and the addiction-crime relationship this course describes is not severed by a referral. What the broader evidence suggests separates programs that reduce reoffending from those that do not is the presence of the surrounding scaffolding, stable housing, employment or education, prosocial relationships, and continuity of care that survives the transition out of custody. These are the conditions under which the behavioral adjustments this course teaches can actually be sustained, and without them even well-delivered treatment tends to erode.

The applied implication is that the counselor's work reaches past the treatment hour into coordination that is often unglamorous, the housing referral, the employment linkage, the warm handoff to a community provider, the appointment confirmed rather than merely suggested. For a justice-involved client, the seams between systems are where outcomes are won or lost, and treating those seams as part of the clinical work, rather than as someone else's problem, is what turns access into desistance.

The Connections finding also guards against a demoralizing misreading of the counselor's own effectiveness. When a client who engaged well in treatment returns to custody, it is easy to conclude that the treatment failed or that the client was never serious. The more accurate reading is that treatment moved the outcomes it can move, health, engagement, survival through the highest-risk window, while the outcomes it cannot move on its own, the ones that depend on housing, employment, and the social world the client returns to, stayed where the surrounding conditions left them. This is not an excuse for low expectations. It is a realistic account of what any single program can and cannot accomplish, and it points the counselor's advocacy outward, toward the housing and employment and continuity supports that the evidence says are decisive, rather than inward toward self-blame or the conclusion that the client was beyond help.

Building the Plan Around the Person

Everything in this supplement converges on a single practical demand at the point of first contact: the treatment plan has to be built around the specific person, drawing on the whole cluster of factors the evidence identifies rather than defaulting to a standard protocol. A plan assembled from the findings gathered here begins by mapping which substances the client has used and the role each has played, because the drug shapes both the risk and the intervention. It identifies which criminogenic needs actually drive this person's offending, distinguishing the changeable factors linked to reoffending from the many real problems that do not drive crime. It screens for the co-occurring mental health conditions that nearly half of these clients carry and for the trauma history that sits beneath so many of them. It captures the social and material context, housing, employment, family, and peer network, that

determines whether any behavioral gains can be sustained. And it locates the client in the justice cycle, because a person two weeks out of custody presents a different and more urgent risk profile than one who has been in the community for a year.

The point of that breadth is not a longer file. It is a plan that matches the person. An assessment that surfaces an untreated trauma history, a stimulant problem the charge never mentioned, a co-occurring depression, and a release date two weeks away yields a very different and far more accurate plan than one that records only a primary drug and a criminal charge. Each element then points to a concrete priority: medication where opioids are involved, continuity across the reentry window, cognitive work on the specific distortions this client carries, integrated treatment where a mental health condition is present, and the housing and employment linkages without which the rest tends to erode.

This is also where the personal-narrative pedagogy at the heart of this course earns its clinical value. The course teaches through the story of someone who lived at the intersection of addiction and crime precisely because a single life makes visible how the factors the evidence measures separately actually interact in one person. The counselor's assessment is, in effect, an effort to understand each client's own version of that narrative, how the substance use began, how it eroded choices, how the offending grew alongside it, and what would have to change, inside the person and around him, for the story to turn. Holding the plan and the person's story together, so that the interventions answer the actual history rather than a generic template, is what turns the evidence assembled here into help that fits the individual in the room.

A brief composite illustrates how the pieces fit. Consider a man in his thirties entering treatment on a court order after a burglary conviction, with a heroin history that began after an injury, a period of stimulant use layered on in recent years, an untreated depression that predates the drug use, a childhood marked by violence at home, and a release from jail two weeks behind him. Read through the evidence in this supplement, none of these facts is incidental. The opioid history and the recent release make medication continuity and overdose prevention the most urgent priorities, because the reentry window is where he is most likely to die. The added stimulant use warns that no medication will cover that part of the picture and that a behavioral approach will be needed there. The depression that predates the use signals a co-occurring condition that must be treated alongside the addiction rather than after it. The childhood violence points to a trauma history beneath the criminal thinking, and the burglary itself fits the economically driven pathway in which the offending is instrumental to sustaining use. A plan that addresses only the drug of the current charge would miss most of what determines whether this man lives and whether he returns to prison. A plan built from his actual story, sequencing medication and reentry safety first, then integrated treatment for the depression and trauma, cognitive work on the specific distortions that sustain the offending, and the housing, employment, and prosocial connections that make any of it durable, is what the evidence gathered here actually recommends. The individual case is where the separate findings become a single course of action.

The Social Network: Antisocial Peers and Prosocial Ties

Among the criminogenic needs the correctional evidence identifies as genuine drivers of reoffending, the client's social network ranks with substance use and antisocial thinking as one of the most powerful, and it is one this course's attention to the whole life of the offender brings naturally into view. A person who leaves treatment or custody and returns to the same network of people who use and offend faces a daily environment engineered, in effect, to pull him back. The relationships that surround the client are not a backdrop to the addiction-crime problem. They are part of its machinery, supplying access to substances, models of criminal behavior, a shared worldview that normalizes both, and a sense of belonging that recovery initially threatens rather than replaces.

This creates one of the hardest practical dilemmas in the work, because asking a client to change his social world is asking him to give up, at least for a time, the only community he may have. The people who use and offend alongside him are often also his oldest friends, his family, and the only ones who have accepted him, and a counselor who treats them merely as contaminants to be removed misunderstands what he is asking. The more workable path acknowledges the real loss involved and helps the client build alternative connections before dismantling the old ones, through recovery communities, employment, faith or cultural settings, and relationships with people who are living the kind of life the client is trying to move toward. Desistance research consistently finds that durable change is bound up with new prosocial bonds and new roles, worker, partner, parent, member, that give the person both a reason and a support for staying out of trouble.

For the counselor, this means treating the client's relationships as an explicit target of the work rather than a private matter outside the clinical frame. It means mapping who is in the client's life and what each relationship pulls toward, helping the client anticipate the moments when the old network will reassert itself, and treating the slow construction of a new social world as central clinical work rather than an afterthought. A treatment plan that changes a person's thinking but returns him unchanged to the same surrounding relationships has left one of the strongest drivers of his behavior fully intact.

From Recovery to Desistance: The Counselor's Long Game

This course teaches that recovery from the intersection of addiction and criminal behavior is a matter of sustained adjustment rather than a single decision, and the research assembled here explains why the adjustment has to be sustained. Desistance from crime, like recovery from addiction, is a process rather than an event. It unfolds over years, it is punctuated by setbacks that are part of the pattern rather than proof of failure, and it depends on changes not only inside the person but in the conditions of the person's life.

Several threads in the evidence converge on this long view. Medication interrupts the pharmacology but does not by itself rebuild a life. Cognitive programs shift thinking, but only when the client genuinely engages and only alongside the other conditions of change. Trauma and co-occurring conditions sit beneath the surface and reassert themselves if left untreated. Treatment access without housing, work, and prosocial connection tends to fade. Taken together, these findings describe recovery and desistance as the slow accumulation of small, reinforcing changes, in the person's thinking, in the person's health, and in the person's circumstances, rather than as a switch that flips.

For the counselor, the practical meaning is a particular kind of patience, one that holds high expectations and a long horizon at the same time. It means reading a relapse or a new charge as information about which part of the cluster still needs attention rather than as a reason to give up on the client. It means recognizing that the counselor is rarely the only force acting on the outcome, and that the housing worker, the prescriber, the employer, and the client's own relationships are all part of the work. And it means holding, through all of it, the stance this course models: that the client's history explains a great deal and excuses nothing, that change is both expected and possible, and that the work of getting there is shared. That combination of accountability and compassion, informed by exactly the evidence gathered here, is the ground on which effective work with justice-involved clients is built.

It is worth naming, finally, what this long view asks of the counselor personally. Work at the intersection of addiction and crime exposes the practitioner to repeated relapse, to clients who return to custody, and to the slow pace of change in people whose lives have been organized against it, and that exposure can harden into cynicism or wear down into burnout. The evidence assembled here is, among other things, a defense against both. It shows that the interventions work, that medication saves lives, that engaged treatment reduces crime, that the reentry window can be survived, and it shows equally that a single relapse or a new charge is a predictable feature of a long process rather than a verdict on the client or the counselor. Holding that realistic hope, neither the naive expectation that treatment transforms people quickly nor the despair that concludes nothing helps, is itself a clinical skill, and it is sustained by knowing what the research actually shows. A counselor who understands both why addiction and crime travel together and what genuinely interrupts that partnership is equipped to stay in the work for the long horizon it requires, and to keep offering, case after case, the patient and evidence-informed help on which recovery and desistance depend.

Understanding Addiction and Criminal Behavior

Introduction

Treating addiction can be a confusing, sometimes frustrating matter for anyone in the field, and often we are not quite sure where to start. This course is designed to help you understand addiction and some of the behavior associated with criminal justice clients. The goal is to help clients take an honest look at the choices they have made as a result of their addiction to alcohol or other drugs. Upon completion of this course you will gain an understanding of how to move clients toward the goals of treatment, healthy thinking and sobriety.

It is important to realize that people usually enter treatment because they have to, not because they want to. Whether they are court mandated, referred by another treatment facility, brought in by a family member, or even check themselves in, they usually enter into treatment because their behavior in combination with their life circumstances has created an unmanageable condition. In fact, before family members, law enforcement, and treatment specialists know somebody has a problem, that person has more than likely already figured out they have a problem with alcohol, drugs, and/or criminal activities.

It is important to understand that entering into treatment or any other therapeutic setting regardless of the method is usually accompanied by a great deal of anger, depression, loneliness, confusion, and especially client resistance. Often the addict may have even tried sobriety and recovery on their own and failed at it once, twice, or even several times, reinforcing feelings of societal bias, failure and incompetence.

Criminal justice offenders often think thoughts of hate and anger. They blame others for putting them where they are. They often think thoughts of self-pity, "Poor me. If only I was not in the wrong place at the wrong time." They can think about how life has given them a bad deal and how life is unfair. There might be some truth in those thoughts. Someone may have informed on them. Maybe they were in the wrong place at the wrong time and life can be unfair. Although possibly true, this type of thinking will not change the real fact: You are where you are, and now the question is, what are you going to do about it?

This course contains information to help the person who lives inside the addict or offender, his private person, who wakes up at three in the morning and wonders where his life is going. As an addiction professional, it is your job to manage and challenge the client in hopes of motivating them towards change.

Change

Most people resist change, therefore I like to explain that they need to make "adjustments" in their thinking and behavior. I know the importance of making adjustments in the way you deal with the world, adjustments that make change possible. I have been in prison; I have been addicted to alcohol and heroin. My life became too painful to endure, so I had to make major adjustments in my thinking and my behavior. Your client is the same as me; they can make the necessary adjustments that will bring about change if they want to badly enough. I know that being where they are is a thing that hurts, but they do not have to keep doing the same thing over and over. As an addiction therapist, it is your job to help them see where they have been, and help them understand that they have work to do, because ultimately they are in charge of their life.

Drug Use Abuse and Consequences

The consequences the addict and people around them suffer are very real, but addiction causes the addict to hide from these painful truths.

Most addicts entering into recovery or already in recovery often feel that there is nothing wrong with them. Instead they feel as though something is wrong with you for thinking that something is wrong with them. In fact, clinicians of all backgrounds and educational levels often assess clients as "resistant" when they are merely exhibiting one of the classical manifestations of the illness we call addiction. It is these same clinicians who use terms such as denial to quickly label and classify their client. Clients in turn latch on to this term and internalize it and it too becomes yet another barrier to be dealt with by the clinician.

I believe that the way most in recovery handle and address their "drug problem" gives them the *illusion of self-control and of will power*. This is the very nature of addiction, it affects the way the addict thinks and reacts to certain situations and is one of the main sources of true client resistance.

Often when a person enters a therapeutic group in a correctional setting, treatment setting, or in the community, there are those who advise them, either directly or informally not to listen to what the addiction staff and other experts have to say. This further fosters the conspiracy stranglehold on people entering treatment and increases the difficulty level for the addiction professional. Again, this serves as yet another barrier you must deal with and only compounds any resistance already demonstrated by the client.

I will explain how drugs act on the body and how alcohol and other drugs affect the brain. To abuse a drug is to be changed by it. There is no such thing as a hard drug or a soft drug, all drugs have a profound effect on the user, both physically and mentally. Often people ask me, "Delbert, why did you use heroin?" My answer, "because it made me feel good." Some drugs make you feel good and some make you feel relaxed or powerful. They all change you by making your brain act differently.

As time passes and you keep using, you become addicted and you will find that you are no longer in control of the drug. Your drug addiction is in control of you, it is calling all the shots in all areas of your life.

Drugs are classified into different types, according to the effect they have on the user's body and brain. The most basic form of classification is to call them "uppers" and "downers", stimulants or depressants.

Below is a list of how people feel when using drugs:

Stimulants (Uppers)	Depressants (Downers)
Excited	Relaxed
Powerful	Calm
Smart	Tuned out

If a person has a high tolerance for a drug they can use a lot of it, a low tolerance is the opposite. A person with a low tolerance only needs to use a small amount of the drug to get the same effect from it.

Most addicts start with a low tolerance, but as they continue to use the drug they find that they need more and more to get the same effect.

It is at this point, that I usually ask my client to write down the name of their drug of choice and how much they took the first time they used. Then I ask them to write down how much of the same drug did they use during their heavy use. By doing this exercise the addict has just outlined how their tolerance to their drug of choice developed over the years.

It is important for the addict to understand how tolerance grows by changing the way his or her brain works. The higher their tolerance for drugs, the more money they must spend on the drug and the more time they spend chasing after or using their drug. With many drugs, large amounts of money are needed every day, this happens when tolerance develops and a person becomes addicted. In other words, increased tolerance equals addiction. How many heroin addicts need at least four to six bags each and every day? This costs money, and unless the addict is rich, they had to do things, many times unlawful, to get the money to buy their drugs. Many addicts have

done things for drugs that they would never have done prior to their addiction. Some addicts deal drugs, some rob family members, and some addicts sold themselves or robbed and hurt other people. These are things that most addicts did not want to do, but their tolerance or addiction to drugs was calling all the shots.

Let's look at the onset and progression of alcohol and other drug addiction:

Early Stage

1. Surreptitious drinking
2. Avid drinking
3. Preoccupation with drinking
4. Guilt about drinking (culture bound)
5. Indefinable fears
6. Increased tolerance

Middle Stage

1. Loss of control over drinking/inability to abstain
2. Alibi system (rationalization/denial/projection)
3. Personality distortion
4. Blackouts
5. Avoid reference to alcohol problems
6. Attempts to control-abstain/change pattern/geographical change
7. Life becomes more alcohol centered-jobs, friends, family, are obstacles to drinking
8. Increasing emotional augmentation
9. Neglect of nutrition
10. Physical deterioration
11. Mental anguish

Late Stage

1. Prolonged intoxication's
2. Blackouts progress
3. Impaired central nervous system functioning
    a. judgment
    b. motor
    c. sensation
    d. emotional
4. Decrease in alcohol tolerance
5. Vague fears, although alcoholic psychosis is rare
6. Progressed physical impairments
7. Usually marked withdrawal

Source: Alcohol Use, Misuse, and Addiction, State of OR, Division of Mental Health Programs for Alcohol & Drug Problems, 1978, pp 112 and 114

As an addiction professional it is your responsibility to challenge the client by taking them through the chronological progression of the illness. Encourage them to work through the progression of their addiction, by writing a time line of events and behaviors, starting with Early Stage thru Middle and or Late Stage.

Withdrawal from alcohol and other drugs happens as soon as the last hit or drink wears off. We know that every drug affects the brain, that change allows the user to feel "good". It does not matter if it is crack, cocaine, heroin, alcohol, marijuana or any other drug. The user gets that high or good feeling because the chemistry of their brain changed when they added the drug.

A drug of choice is the addict's favorite drug. It is the one they like above all others. In many cases, it is the drug that got them addicted. Sometimes drugs are used together to create a different type of high. In this case both drugs could be called drugs of choice. Many times, the addict will change their drug of choice throughout their life.

It is important to have your client think about the first drug of choice in their life and have them write down what it was, and what they liked about it.

Parallels between Addiction and Criminal Behavior

As mentioned earlier, it is a known fact that addiction can and in many cases does lead to criminal behavior. The use of illegal drugs is often associated with buying drugs, using drugs, selling drugs, and driving under the influence of alcohol or other drugs. These crimes often translate into vehicular homicide, so called crimes of passion, assault, murder, robbery, burglary, domestic violence and child abuse. It must be noted that not every theft, assault, murder or other felony crime is drug related, but a huge number are.

It's obvious that our criminal justice system is overburdened with drug abusing offenders who cycle through the system while continuing to use drugs. Ninety-eight percent of the people in penitentiaries go home, and unless we break the cycle of drugs, violence and crime, they will end up back on the street, committing more crimes and then right back in the criminal justice system still hooked on drugs.

The parade of addicts doing time is endless and I guess you could say that addiction never misses its mark. Addiction is a democratic process, and it doesn't care if you're white or black, rich or poor, short or tall…it makes no difference at all.

The parallels between addiction and criminal behavior are evident. In 2012, according to the U.S. Department of Justice (DOJ) nearly 7 million adults were involved with the criminal justice system, including nearly 5 million who were under probation or parole supervision. 1 in 100 U.S. citizens are currently confined in jail or prison, DOJ estimates that about 70 percent of State and 64 percent of Federal prisoners regularly used drugs prior to incarceration. DOJ's study also showed that 1 in 4 violent offenders in State prisons committed their offenses under the influence of drugs.

Why? Because addiction changes the way you think and the way you make decisions. Think about it, if you were unable to eat for three days, most likely, all of your thoughts would revolve around food or getting something to eat. The longer you go hungry… the more you would think about food. The psychological aspect of addiction works in much the same fashion.

Most of the addicts thoughts focus on "getting high" or obtaining his or her drug of choice.

Below are four questions I often ask a client:

1. Did you ever try to stop using?
2. If so, explain why and describe what happened.
3. Who would you say you hurt the most with your drug use?
4. Explain how and why.

Then I ask them to look at their answers. Do they represent the psychological aspects of addiction?

As an addiction professional working with addicts within the criminal justice system it is important to understand some thoughts about how your clients might view themselves.

Everybody has a view of himself, that view might vary or be different from person to person. Some people see themselves as "good" while others see themselves as "bad".

Most people have ideas about who they are. Perhaps one person may think he is "good looking" while another may think he is "ugly", or we could add "smart" or "not smart" to these self thoughts. There are many areas where we all have an opinion about who we are.

Criminal addicts are no exception, they too see themselves in certain ways. Let's take a brief look at some possible self-thoughts that some offenders might use.

Robin Hood - This person sees himself as a romantic figure. He is taking from those who have and giving to those who have not. Of course, nobody else gets much of anything, because Robin usually keeps all of it.

The Rebel - Often views himself as being at war with the system. Because he is at war, everything and everybody are fair game. It is fair to take other people's property because they are not one of "us," so they must be one of them. It may even seem okay to them to steal from family members.

The Victim - This person breaks the law because of something that has happened to him. It can be a lot of different things, it might include growing up in an abusive home or in the foster care system or it might be skin color or social abuse. This list goes on and on.

The Innocent - This offender is the one who is "not." He never did the crime he's doing the time for. If you confront him, he will admit some parts of a crime, such as being in the wrong place at the wrong time, but he will never take responsibility for his actions.

The Godfather – This person thinks he is going to be the next head of a crime empire. He is full of plans and wants the power and fear that he believes goes with being a big player.

There are many different ways the criminal addict views himself and his addiction to alcohol and other drugs only magnifies his self thoughts. They seem to live on the edge, while healthy people avoid them.

Most criminal addicts are in the habit of doing what they want to do, when they want to do it. Everyone wants to do things that make them feel good, and that's okay. What is not okay is when what we want becomes more important than what we need. In other words, "doing first and thinking later."

Addiction has a way of impairing your ability to reason. Getting high is most important. Nothing else matters. It has been said that, "*For every action, there is a reaction*" somewhere on this planet and addiction is no different in that regard. Addicts lead with their emotions when it comes to thinking things out. In their words, "they do first and think later". Addiction has a way of impairing your ability to reason. "Getting high" is all important and nothing else matters. "It doesn't matter that it's ten degrees outside and all I have on is a t-shirt, or that my friend needs his car back, because I'll explain." Addicts live their lives based on emotion over intellect, and it leads them to trouble time

and time again.

A man once said, "Emotions are what we have the most of but know the least about." You cannot get away from your emotions because they are part of you. Addiction turned your intellectual process upside down and now you need to turn that process right side up.

Intellect over Emotion

By using your intellect first, you can be proactive instead of reactive in the situations you face. Being proactive gives you time to use all the knowledge and skills you've acquired. You can formulate better. Avenues of resolve are a lot clearer. Reactive decisions are usually based on emotion and are not given much thought. You act on the moment without regard for the end result. "I'll take this money now and deal with the consequences later."

It is important that the addict learn to function in a healthy manner, their intellect will carry them a lot further than their emotions, and their life will be a lot more manageable.

Exercises I often ask clients to work through are:

1. List three examples of situations you were involved in when your emotions did the talking. What was the outcome?

2. List three examples of situations you were involved in when you let your intellect do the talking. What was the outcome?

3. Compare your answers in #1 and #2. Which explains the better outcome? Explain.

Addiction attacks four vital life areas:

1. Physically
2. Psychologically
3. Socially
4. Spiritually

Let's take a brief look at how addiction attacks the client's four vital life areas. It is important that each client understand the long-range detrimental effects of each substance classification on his physiological state. Openly discuss some of the medical consequences of prolonged abuse. Contrasting the normal, physiological state of being,

as opposed to that of a drug dependent person, will offer the client an opportunity to thoroughly evaluate his past and present physiological state. The four vital life areas that need to be addressed are:

1. **Physically:** The physical symptoms as a result of alcohol and other drug use can range from increased heart rate, bloodshot eyes, dry mouth and throat, impaired or reduced short-term memory, impaired or reduced comprehension, altered sense of time, reduced ability to perform tasks requiring concentration and coordination, impairments in learning and memory, perception, judgment, and more.

2. **Socially:** *A*ddiction affects every single person it comes into contact with. As addiction progresses, the need to escape from the emotional and psychological pain also increases. This behavior repeats itself, and as long as the addict continues to use alcohol or other drugs the cycle never ends. It is also important to explain how the illness affects everyone around the addicted person, especially family members. As the family becomes sick from the disease, they will develop exaggerated defenses to protect them from the pain. Each family member will adapt a set of behaviors that cause them the least amount of stress and pain. Survival skills and behavior patterns are learned while growing up, usually from parents and other key adults in their lives. However, many adults from alcoholic families were unable to rely on their parents as positive role models. They often grew up in families characterized by uncertainty and fear, as well as physical and psychological abuse. Rules, attitudes and behaviors fluctuated between periods of drinking and sobriety. To survive the constant change and confusion, many children developed unique coping skills and behaviors that helped them adapt and survive and further drive them to a sub-culture. While these behaviors can be helpful in some situations, they can cause unhealthy problems in day-to-day life.

3. **Physiologically:** Rational thought involves using intellect over emotion and irrational thought uses emotion over intellect. Because most addicts will tend to think that the psychological effects of drug addiction vary from one individual to another, enough time should be taken to thoroughly explain that several of the psychological aspects associated with addiction remain rather constant from a clinical point of view, (criminal thinking and anti-social behavior). It is important to remove the fallacies surrounding the "personalized" myths that each addict may entertain about his addiction and his "unique" experience. Since the basic psychological concepts of cognitive thinking, cognitive dissonance and behavior modification relate to many of the factors governing addiction, you should make a credible effort to explain the concepts, always drawing a correlation between the interplay of addiction and how it influences the decision making process. This will present an opportunity for you to aid the addict in developing a sense of self-awareness and help him distinguish between needs, desires, thoughts, feelings and emotions. As an addiction professional, you should begin the process of explaining how a person's personality alters itself to substantiate his drug use, and how that process is common, regardless of age, gender, creed, color, sex,

social status, etc.

4. **Spirituality:** The way in which we see ourselves in the world is greatly affected by the mind altering chemicals we ingest. The addict very easily develops a sense of grandiosity and omnipotence.

We must always remind the addict that addiction changes the way you think and what you do. It also determines where you are going to go and who you are going to be with. One sentence can actually define what addiction is all about: "I used when I didn't want to or I used when I hadn't planned to". Addiction even determines what a person says…"I'm not using", "I lost the money", "It's only my business", "I'm not bothering anyone", and "Nobody knows I'm using". One of the most frightening aspects of addiction is that the person caught up in it seldom realizes what is going on. Addiction makes you think that you are always right and everyone else is wrong. Once a person uses long enough and his thinking becomes impaired, he starts to think like that on a regular basis whether he's under the influence or not.

Most recovering addicts that finally get help use at least one of five recommended ways. If you could look into a recovering addict's life, you would probably see that at least one of five things has happened.

Working with Resistance

Addiction creates a natural **resistance towards recovery**. The illness blocks out the pain of using and creates a "resistant network" fueled by the addict's intellect. One of the underlying themes I always emphasize is that "**the longer you use, the more sophisticated your alibi system becomes and the more resistant you become to treatment."**

As an addiction professional, it is important to recognize when resistance occurs and to understand the role you play in helping the client break through the insidious nature of his illness. The addict's alibi system is a part of the pathology of addiction. Two basic types of client resistance are **passive** and **aggressive**. Cognitive therapeutic thinking enforces many of these as classic types of resistance:

Passive

Guarded

Weak

Procrastination

Silence

Grandiosity

Irresponsible behavior

Poor attention span

Blames others

Rationalization

In need of constant attention

Isolation

Projection on to others

Minimization, points out inequities and faults in "the system"

Building up self at the expense of others

Lying, omission and alteration of truth

Aggressive

Explosive temper

Over sensitivity

Hostile overt behavior and physical acts

Responses which are vague in nature

Diversionary answers

Extreme feelings of happiness or sadness

The following is an assignment I normally use with clients, asking them to answer in detail the following:

1. List the ways addiction has impacted you physically.

2. How do you feel when you meet a counselor or therapist for the first time?

3. Explain how you feel addiction has affected you socially.

4. Explain how your addiction and criminal activity has impacted your family.

5. List at least five examples of alibis or excuses you have used in the past to continue using drugs and staying involved in criminal activity.

6. Looking back, who have you disappointed and how with your alcohol/drug use and criminal activity?

7. List ways you have disappointed yourself.

8. List some of the alibi's you have used. Give at least five examples.

9. When listing your alibi's, tell why you think they are passive or aggressive.

10. What do you expect to get from this program?

Alcoholics and addicts develop elaborate "defense" systems as a result of the pathology of their illness. A defense system for the addict is a way of avoiding or not seeing the truth. Such defenses protect people from emotional pain and should not be considered as necessarily good or bad. It can however, become unhealthy when it results in confusion and the inability to recognize a problem.

Therapy should begin by explaining the therapeutic process and defining what therapy is in a meaningful way to the client. If the therapeutic environment is mandated by the criminal justice system, it only adds to the dynamics and resistance you will face as an addiction professional.

The "mandated client" typically does not seek therapy voluntarily and may often feel the criminal justice system is filled with inequities and inconsistent rules. Understanding this will be valuable to you when evaluating readiness for treatment. Since offender clients often solve problems in a manner consistent with criminal activity and drug use, in their mind, you, the addiction professional, are a part of their problem since your goal is to stop alcohol/drug use and criminal activity from occurring in their life. I will discuss some common ground rules for therapy which include:

Trust (based on behavior)	**Rapport**
Acceptance of Rules	**Empathy**

As an addiction professional, your style and personality often determines what occurs in therapy. Elements which can lead to failure during the therapeutic process include a lack of empathy on your part, a failure to decisively respond to clients, and premature and incorrect interpretations of the clients' words or actions.

Working with resistant clients is often an overwhelming experience and knowing how to engage them is more of an "art" than a science. Because of the nature of the disease, talking with an addicted client is usually an emotionally charged situation. Knowing what to say and when to say it is generally the dilemma most clinicians face. Treating addiction effectively hinges on a better understanding of its pathology and the psychological dynamics involved.

How to Deal with Denial

Denial is a psychological mechanism or process human beings use to protect themselves from something threatening to them by blocking knowledge/awareness of that thing from their awareness. It is an unconscious process which can be seen, for example, when a person is suffering from a terminal illness, but seems to be genuinely unaware of that fact. It is a buffer against unacceptable reality. The denial of alcoholics and addicts consists of their lack of awareness of their excessive and/or inappropriate use of chemicals and the resulting harmful consequences.

It refers to the fact that chemically dependent people have no "insight", i.e., they do not have the basic understanding that they have an illness. The reason for this blindness is that, along with the gradual development of the illness, a denial system insidiously develops which protects them from knowledge that this is happening.

Healthcare professionals often say that addicted clients are in denial. If that were actually true, then the client would have no idea that their life was falling apart due to

their use of mind-altering chemicals. The client would not know that they had lost a job, or their lights were turned off, or that their family had put them out.

Clients know they're in trouble and they fight desperately to give you reasons why. If you listen closely to what they say, you'll find out that what we label as "denial" is actually an alibi. Alibis are different from denial and should be handled in a different manner.

Defenses an addict uses to substantiate drug use:

Rationalization **-** We tell ourselves stories, through mind pictures and self talk, to help control situations in our daily life. The addict uses unhealthy rationalizations extremely well and usually relates their circumstances to a run of "bad luck".

Minimization **-** We minimize things in order to do what it is we need to do every single day. As addiction progresses the addict will begin to minimize the impact it is having on his life and value system.

Projection **-** Addicts have a unique way of projecting, or blaming others and the system for the unpleasant things that have happened in their life.

Alibi System vs. Denial

An addict knows his life is falling apart around him, but he has an alibi for why it is happening. The more intellect he has, the more sophisticated his alibi system.

Examples:

- The addict does not believe he really has a problem with alcohol or drugs.
- The addict knows that a problem exists, but says, "It's not that bad."
- The addict thinks using alcohol or other drugs help him to cope with pressures and feel better, and he thinks everybody does it.
- The addict rationalizes that he is under a lot of stress, so those around him should be able to understand why he uses.
- The addict believes he is not addicted because he does not use every day.
- The addict blames others by saying, "If you had a wife like mine, you'd get high too."

Addiction is calling all the shots in his life, it determines the time, the place and the state of his being on a consistent everyday basis.

Self-imposed Limitations and Behaviors

Making Excuses**:** For example: "I used because I was depressed" or "I used because no one understands me."

Blaming: Allows the build-up of resentments and takes the focus off you, and puts it on others. For example: "You always expect so much of me. Who wouldn't drink?"

Lying: Confuses, distorts, and takes the focus off your behavior. Example: Making up stories that are simply not true, or omitting and leaving out major sections.

Redefining: Shifting the focus of an issue to avoid solving the problem. For example:

Question - "Why have you stopped going to AA or NA meetings?" *Answer* - " I feel that the language of the Big Book is old fashioned, and too religious."

Super-optimism: For example: "I can stop using if I put my mind to it. I don't need any support."

Making Fools of Others**:** By putting other people down, you take the focus off yourself and your behaviors.

Assuming: For example: "Nobody cares about me anyway." Statements like this give you an excuse to blow up, get angry or to use.

I'm Unique: "No one can tell me what to do."

Conning: Figuring out what you can get or take from other people, and using them or controlling a situation to satisfy your needs or desires.

Vagueness: Being unclear to avoid being pinned down. "I guess", "Probably", "Maybe", "I'm not sure", "I smoked pot occasionally", and "I've used it".

Aggression: Scaring or intimidating others verbally or physically so that they will agree with you or leave you alone.

Power Plays: Walking away during a disagreement, or organizing others to support your anger.

Victim Playing: Acting like the king, or whining and acting helpless to get others to do something for you.

Drama/Excitement: A distraction that keeps the focus off your own behavior.

Secretive and Closed Minded**:** Opposite of going to any length for whatever works, resistant.

Image and Self-definition: For example: "That's me. That's just the way I am."

Grandiosity: For example: "I can drink a six pack without wobbling."

Staying in the Safety Zone: Withholding information because of the fear of confrontation.

Learned Behaviors

The things we believe about ourselves and the way we interact with people in our lives make up our beliefs and behaviors. We develop core beliefs as a response to childhood experiences. Growing up in a dysfunctional or chemical-addicted family contributes to negative beliefs. To explain childhood experiences we might develop beliefs such as:

- I can't trust anybody.
- I am the only person I can depend on.
- Things never work out the way I want them to.
- Life is hard work.
- People don't tell the truth.
- There is something wrong with me.
- I'm a failure – I never do anything right.
- Life is hard work.

Negative Beliefs

Most addicts are not aware of their beliefs, but view them instead as a fact of life.

- Seeing things as either black or white
- Seeing yourself as a failure
- Putting other people down
- Using words "always" or "never" to describe events
- Dwelling on the negative, ignoring the positive
- Refusing to see the positive
- Expecting disaster at every turn
- Holding other people responsible for your problems
- Feeling mistreated
- Making assumptions about what is going to happen in the future, and convincing yourself that you are right
- Thinking that everything anyone does or says is a direct reaction to you
- Believing that you have no control over the events in your life
- Rather than recognizing something as a mistake or problem, you label yourself as a mistake or problem

Effective Decision Making and Communication

If you don't want to come back to the penitentiary or treatment program, you first have to take a good look at how you got there.

Addicts have trouble taking a "good look" look at their life because there is too much garbage in the way. Addiction teaches you to use self-pity like a weapon, an effective way to ignore the hurt. Self-pity gives the addict the perfect alibi and a way to feel normal with his failure. He often thinks, "Of course I failed. They were out to get me" or "You'd steal too if you were in my shoes."

The unhealthy pathology of addiction continues to consume the client and even the addict has trouble distinguishing the truth. It's like a game called three-card Monte.

The addict thinks he is dealing, but he finds out that addition is calling all the shots. With his mind clouded and his vision blurred, he's left to undo what addiction has done.

Learning the art of effective honest communication is not an overwhelming task. Honesty is the centerpiece. The only quality the client needs is courage. Courage enough to look inside and honestly say what they see. Being a product of addiction is one thing, but staying that way is a choice.

Two key areas that need to be addressed:

1. Honesty
2. Courage

Honesty – First you have to be honest with people around you, if you are not, sooner or later all trust will be broken and communication stops. The other important part to honesty is that you have to be honest to yourself. If you are not honest with yourself, trust in yourself becomes broken, one of the worst things that can happen to a person.

Courage – Without courage the addict will not honestly look at their life. They will skip the painful parts of their life, and will lie to themselves about why they cannot honestly look at their past. For the addict, most of the time honest communication about his or her life will be painful. They may think, "I can't believe I did that," they might feel like saying "screw it". This is where they will need the courage to push on towards sobriety and a healthy lifestyle without the use of alcohol or other drugs.

Scientists say, "For every action, there is a reaction somewhere on the planet." Addiction is no different in that regard. Addicts lead with their emotions when it comes to thinking things out. In other words, they do first and think later.

Addiction has a way of impairing your ability to reason. Getting high is most important. Nothing else matters.

You have often heard it said that people, places and things influence decisions; nothing is more true for most addicts. Many times people they were with swayed their decisions and the places they went swayed their decisions. When you make decisions, you make choices. If they chose to go with people who used drugs or chose to go where drugs were used, their choices swayed their decision to use drugs.

An exercise to help the client understand decisions and choices in their life, I ask them to explain the following:

1. Think about the people you chose to be with.
2. Think about the places you chose to go to.

3. Explain how these people and places swayed your decision to use alcohol or other drugs.
4. Think about how your decisions have affected your life.

Types of denial

Denial is one of the major symptoms of addiction. It impairs the judgment of affected individuals and results in self-delusion which keeping addicts locked in an increasingly destructive pattern.

1. Outright denial: A natural defense of addiction that helps the addict develop an alibi to justify why all the "bad things" are happening in his life.

2. Rationalization: We tell ourselves stories, through mind pictures and self talk, to help control situations in our daily life. Addicts use unhealthy rationalizations extremely well and usually relate their circumstances to a run of "bad luck".

3. Minimization: We minimize things in order to do what it is we need to do every single day. As addiction progresses addicts begin to minimize the impact it is having on their life and their value system.

4. Hostility: As addiction progresses addicts defend themselves against those who label them as an addict or alcoholic by becoming angry or making threats.

5. Diversion: Addicts have a unique way of changing the subject whenever they are confronted about their addiction.

6. Projection: Addicts have a unique way of accusing or blaming other people, situations or the system for the unpleasant things that have happened in their life. Refusing to accept responsibility for their actions.

7. Intellectualizing: Some addicts analyze the problem, looking for causes, while ignoring their own personal responsibility, they refuse to really accept on a "gut level" basis what chemical addictions mean to them personally.

Reasons for Denial or Alibis

1. To avoid pain or embarrassment: sometimes a person will deny how much they drink or use because they are afraid they will be lectured to.

2. Ignorance: a person may not know how much they drink or drug, they may not count or keep track.

3. Blackouts: a person may have no memory.

4. Other organic damage: can affect memory.

5. Lack of feedback from others: society avoids confronting individuals with addictive behavior; nobody says anything so that the chemically dependent person may not know that his/her drinking is any different than anyone else's.

6. Family/friends/employees cover up and clean up the mess. The addict or alcoholic is protected from the reality.

7. Euphoric reality: we tend to remember the good times associated with drinking or drugging, not the hangover; we think we are more relaxed, more sociable, more competent when drinking or using other drugs.

8. Alcohol and other drugs decrease anxiety: but we all need a little anxiety in order to learn. If we wipe out all of our anxiety, we wipe out our ability to remember and to learn other coping mechanisms.

Client resistance, is it normal or abnormal? Client resistance when you are talking about addiction is normal and a part of the pathology of addiction. Because the longer an addict uses, the more resistant he becomes to treatment because he is trying to hide more of himself.

Morals/Values: Home, job, respect, family, children**.** When an addict or alcoholic becomes involved with their drug of choice, traditional morals and values become secondary and the alcohol/drugs slowly become the priority in the addict's life.

Lying, disappointment, and double-crossing slowly erode the values as getting high becomes the priority.

Addicts often look back and wonder what happened to those traditional morals and values they were raised with. As they do this, they become disillusioned, frustrated, and disappointed. This can last for years. Addicts can't understand how and why they are out of compliance with the traditional morals and values which they were raised with.

Therapy says, "You should want to help yourself" But, doing so makes the addict look at the disappointment in his other life. One of the first things you will need do as an addiction professional is work on trust.

Understanding Therapy/Clinical Skills

How do you establish trust? Through talking? No. It is a two way street through the establishment of rapport between you the addiction professional and the client.

If you are going to impact your client, you need to understand the client's frame of references.

It is important to realize that most addicts and offenders are not really quite sure how all the drama came about in their life.

Communication should be the primary tool of the therapist. Resistance should be looked at as a normal part of the pathology of addiction.

It is very important to listen. . . . Do not turn the relationship into a power struggle. Be empathetic; allow your client to tell their story un-interrupted.

Respect must be a part of the relationship between you and your clients. This takes patience. Many times, addicts are not conscious of the resistance they are putting up.

The basic relationship between the addiction professional and the client is to guide the client back toward societal norms.

As the addict becomes aware of why things evolved in their life, they will start to become more aware of the positive possible outcomes for their future.

Addicts need to get anger and unreasonable resentment out of their life. They also need to get rid of negativity, guilt, shame, and blaming, and start managing their egos and try to avoid grandiosity, and learn to recognize their sophisticated alibi system.

Therapist's tools to address and embrace client resistance:

1. Trust
2. Rapport
3. Lines of Communication

4. Rules and Expectations-most clients due to their illness have an all out distain for rules and regulations.
5. Peer Modeling

All prior rules were broken. The client doesn't know why they broke them.

Common Alibi's: Rules are for chumps, I have never been good at it, and I have trouble with authority.

Expectations cause the client to resort back to being un-predictable, irresponsible and displaying unreliable behavior. Some clients have high anxiety, "I am worried that I won't be able to meet those expectations," "I have never been able to meet expectations."

Addiction and the alibi system tells the client that he or she is not that good at talking and so they don't want to come to group or therapy.

The client is capable of handling rules and expectations because they did it in an un-healthy manner before. But, now in therapy, addiction tells the client they cannot meet the rules and expectations.

One of the ways to establish trust and rapport is to listen to the whole story from the client in a meaningful way, which lets them know you care. Then, you can help the client recognize what really happened in their life.

It is important to remember that most of what actually happened in the addict's life he has tried to forget.

You must learn to be patient enough to let the client tell his or her story and listen to exactly what happened.

The Disease Concept of Alcoholism

In 1956, the American Medical Association declared alcoholism as a disease. Since that time there has been a lot of scientific study trying to understand how the disease works. One of the most famous of these involved the study of twins. These twins had been separated at birth. They were adopted by different families. The scientists focused on how the twins were the same, even though they grew in different homes.

What the scientist found showed that twins who were born to an alcoholic parent or parents were more likely to develop alcoholism. This shows a clear link to the genetic

part of growing up. In other words, what your parents passed on to you genetically can affect whether you are an alcoholic or not. The word genetics only means the traits you have inherited or gotten from Mom and Dad. You do not have to know them to get these traits or qualities. This is one piece of evidence that substantiates alcoholism/addiction as a medical problem.

The body also gives you signs, like coughing and sneezing, when you are sick. These signs are also called symptoms. When several signs or symptoms appear together, it is call a syndrome. A syndrome is another way to tell if something is a disease or if a disease is present. For example, red spots, itchiness and fever are all symptoms. Together these symptoms become the syndrome for measles.

It is important to have the alcoholic or addict look at the various signs or symptoms listed below and identify the symptoms they have.

1. You need more alcohol/drugs to get the same feeling; a high tolerance has developed. Do you remember how much gave you a high the first time? How did much did it take the next time?

2. You suffer from withdrawal. This can be as mild as a hangover or as nasty as needing detox.

3. You drink/use drugs for longer or more than you meant too. You have a loss of control.

4. You have wanted to cut down or control your use.

5. You spend a lot of time doing the drinking/using drugs or getting over the drinking and drugs.

6. You have given up people, places or things because of your drinking/drug use.

7. You keep drinking/drugging despite knowing you have a physical or psychological problem that is probably caused or made worse by drinking/using drugs.

Now I suggest that you have them go back and look closely at this list. If they have any of these symptoms, they need to look at them. If they have three or more in their life, we can be pretty sure they have the disease of alcoholism or drug addiction.

Additional treatment exercises I frequently think about and write at this point are:

1. Have you ever thought you would have one or two drinks and ended up getting loaded? How many times did this happen?

2. Have you ever tried to control your use?

3. How many days of work or school did you miss because you were hung-over? How much of your life was spent drinking or drugging?

4. Have you lost people in your life because of your drinking or drugging? Make a list.

5. Have you lost jobs? How many?

6. Have you given up hobbies or sports? Describe.

Encourage the alcoholic/addict to be honest in answering these questions, because the answers are for them. They should be encouraged to answer these questions for each drug they used.

Treatment Works – If You Work It

After years of research, they listed the five best ways an addict can help himself: *detox, rehab, outpatient, individual counseling, A.A. or N.A*. The medical professional also knows that if an addict does at least three of the five recommended things, he will increase his chances of living sober by approximately 50%. In other words, if you complete rehab, outpatient, A.A. and N.A., or detox, outpatient, N.A. and A.A., you will increase your chances of remaining drug-free. Obviously, if you use all five of the recommended ways your chances improve tremendously. The harder you work and the longer you stay with the recommended program, the longer the program stays with you. It's kind of simple if you think about it.

Defending the idea of alcoholism and addiction as a treatable disease is sort of a funny thing to do. It is a treatable illness. There are millions of alcoholics and addicts that are living a healthy drug free life. These people took steps in their life to get better. As they worked at their recovery, they started to have a life free of drugs. I regularly tell clients, if you really want to see people getting better from this disease, go to meetings of AA/NA.

I do not think people really question whether treatment works; I do think they get mixed up as to how it works. There are many ads on TV or on billboards that say,

"Treatment Works." In a very important way this statement is only part of the truth. An alcoholic or addict can have the best doctors, psychiatrists and addiction counselors in the world and still not get better. They can spend thousands of dollars on treatment and still keep using drugs. Many addicts do. They go in and out of detoxes and rehabs. They spend months in places that are supposed to help them. Then they come back home and get high or drunk within a week or a month. Other using addicts and alcoholics look at that person and say, "You see, treatment does not work." Thoughts like "once a junkie, always a junkie" or "I'll die with a bottle in my hand or a needle in my arm" are bouncing around in the addicts' heads. Hope is lost and they keep on using.

Let me cut to the chase. Drug and alcohol treatment does not work. The addicted person does the work. The addict cannot hold their breath waiting for treatment to fix them. It doesn't work that way. The addict will be using in no time. It is the same for most diseases. If the person with high blood pressure goes to the hospital, the doctor will give him pills, but they cannot make them take the pills. If the medicine is not taken their high blood pressure does not go away.

It is the job of the addiction professional to give the addict the "medicine" they need; like go to AA/NA, to change the people they hang out with, to change the places they go to, to work the program. The addict will be given a lot to do. These things are their medicine, if they do not take it and follow instructions nothing in their life will change.

Questions I often ask the client:

1. Do you think alcoholism and addiction are treatable? Explain why you believe this.

2. Think of people you know who are in recovery and write down the changes you have seen them make.

3. Does their life appear to be any better since they stayed with the recommended program? If so, how?

4. Write some thoughts you have about the changes you plan to make to get well.

5. What sort of work are you ready to do for your recovery? Be honest.

6. What do you think of AA/NA? Are you willing to go? Write your answers and discuss with your counselor or group.

Progression Theory of Addiction

One of the characteristics of addiction is that it is progressive. In other words, if a person keeps using alcohol or other drugs, it will always get worse. Even if a person stops using for a period of time, when he starts using again, it will always be worse. In fact, it will be like he never stopped using at all.

Even if the addict changes his drug of choice, his or her addiction will still get worse. Their addiction will take them places they never wanted to go.

"First the man takes a drink. . .then the drink takes a drink. . .
then the drink takes the man."

Addiction is incurable. Let me reinforce this statement . . . **addiction is incurable**, there is **no cure**. The alcoholic/addict can only arrest their illness by not using any type of alcohol or mind-altering drugs. It may sound easy, but remind the addict that the ones who have achieved sobriety and a healthy lifestyle have used the five recommended ways of kicking addiction.

Powerlessness, Hopelessness and Unmanageability

An addict sometimes has trouble understanding what powerlessness, hopelessness and unmanageability mean. They sometimes have trouble connecting these words to their own life. They know that there were times when they felt hope, times when they felt they were in control and times when they felt like they could manage their life. But addiction creates grand illusions and has a unique way of hiding the choices in the addict's life. Addiction is a very tricky illness. It plays games with the addict's mind.

An addict might think, "I didn't use today, so I must not be an addict," or "I can quit any time I want to." He might also say one thing, but really be feeling something else.

Some Examples are:

What an addict says	What an addict feels

"I used when I didn't want to" "I used more than I wanted to"	Powerlessness
"I stopped for awhile, but then I started using again" "People tried to help me, but I just kept using"	Hopelessness
"It hide money from myself, but I would always find it" "I said I would never get locked up, but here I am"	Unmanageability

In the 12 Steps of A.A. and N.A. the addict will see words like powerlessness, hopelessness and manageability. All three words are part of addiction. They are all a part of the steps to sobriety.

I routinely use these exercises as examples of powerlessness, hopelessness and unmanageability in the addict's life.

1. List three examples of things you were powerless about when you were using.

2. List three examples of things you felt hopeless about when you were using.

3. List three examples of things you were unable to manage when you were using.

4. If you never used alcohol or other drugs again, would any of the examples you gave still be a problem in your life? Explain.

5. Write a short paper that outlines the 12 Steps of AA.

In conclusion:

People ask me all the time, Delbert, what do we need to do about alcohol and other drug addiction and the answer's been in front of us all the time. If we truly want to do anything about alcohol and drug addiction and misuse in this country, there are basic components that we have to begin to understand. The first component is the awareness component. We have to do all we can in this country to raise the level of awareness regarding the alcohol and drug misuse and abuse, because there are so many people who don't recognize addiction when they see it. This is something we have to work on twenty-four hours a day, seven days a week. Look at all the mental health labels that we have for kids now in the United States of America, because when people are using chemicals, they show you a thousand different sides of themselves in a day's time.

We have to have an education component. We should do as much as we possibly can to educate our society, particularly our young people, regarding the true consequences of alcohol and drug abuse. I think the way the media and music industry glorifies what is going on surrounding drug and alcohol use is extremely misleading and confusing to kids. I believe we need to send a strong message to kids that it's against the law for them to drink or use drugs. We also need to help them understand that there are certain hazards and consequences that go with drinking and using drugs. We need to help them understand that alcohol and drug abuse has a way of robbing them of the freedom to choose which direction they want their life to go in. At the same time, we need to be supportive as a family and a community about their social well being.

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Appendix A: Understanding Addiction and Criminal Behavior

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 to us 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 using the answer sheet 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. Then click on 'View Lesson Quiz' and you will be presented with the electronic 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.

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

Answer the following questions by selecting the most appropriate response.

1. Delbert Boone has developed the tools to help individuals facing _____.
   a. loneliness
   b. frustration
   c. depression
   d. incarceration
   e. addiction
   f. all of the above

2. Most people enter treatment because they want to, not because they have to.
   a. true
   b. false

3. To abuse a drug is to be _____.
   a. fulfilled
   b. happy
   c. changed by it
   d. popular
   e. wealthy

4. According to Delbert, drugs can be divided into two categories, "hard" or "soft"
   a. true
   b. false

5. When using depressants, users tend to feel _____.
   a. happy
   b. powerful
   c. smart
   d. relaxed
   e. angry

6. The early stage in the progression of addiction can involve _____.
   a. blackouts
   b. indefinable fears
   c. nutrition neglect
   d. personality distortion
   e. alibi system

7. The late stage in the progression of addiction can involve _____.
   a. CNS impairment
   b. physical deterioration
   c. guilt
   d. alibi system
   e. emotional stress

8. Withdrawal from alcohol and drugs happens as soon as the last hit or drink wears off
   a. true
   b. false

9. According to the US DOJ, 1 in ____ violent offenders acted under the influence
   a. 3
   b. 4
   c. 5
   d. 6
   e. 8

10. The Rebel believes that he is at war with _____
   a. his inner self
   b. the military
   c. the system
   d. clergy
   e. nobody

11. Addicts lead with _____ when it comes to thinking things out.
   a. reason
   b. intellect
   c. fear
   d. their emotions
   e. anger

12. All but this comprise the four vital life areas that addiction attacks.
   a. socially
   b. physically
   c. spiritually
   d, psychologically
   e. monetarily

13. Rational thought involves using intellect over emotion
   a. true
   b. false

14. Addiction solidifies the way you think and what you do
   a. true
   b. false

15. Addiction creates a natural _____ towards recovery
   a. resistance
   b. ambivalence
   c. yearning
   d. flow
   e. path

16. An example of passive resistance would be _____
    a. rationalization
    b. silence
    c. weakness
    d. procrastination
    e. isolation
    f. all of the above

17. Aggressive resistance is exemplified by _____
    a. lying
    b. building up
    c. over-sensitivity
    d. guarded behavior
    e. grandiosity
    f. all of the above

18. Denial is a conscious process humans use to block awareness of a threat
    a. true
    b. false

19. Redefining is defined as _____ the focus of an issue to avoid solving the problem
    a. concentrating on
    b. shifting
    c. exaggerating
    d. understanding
    e. ignoring

20. Most addicts are not aware of their beliefs, but view them instead as a fact of life
    a. true
    b. false

21. _____ gives the addict the perfect alibi and a way to feel normal with failure
    a. Honesty
    b. Celebration
    c. Conversation
    d. Self-pity
    e. Treatment

22. Society should avoid confronting addicted individuals so as not to alienate them
    a. true
    b. false

23. In an addict, traditional morals and values become _____ and the drug becomes _____.
    a. priority, secondary
    b. valued, boring
    c. secondary, priority
    d. innate, weaker
    e. strong, weak

24. According to Delbert, _____ should be the primary tool of the therapist
    a. communication
    b. group therapy
    c. role playing
    d. videos
    e. humor

25. This is a therapist's tool to address and embrace client resistance
    a. rapport
    b. trust
    c. peer modeling
    d. communication
    e. rules
    f. all of the above

26. Most of what has actually happened in the client's life he has tried to remember
    a. true
    b. false

27. The American Medical Association declared alcoholism a disease in _____
    a. 1936
    b. 1956
    c. 1947
    d. 1984
    e. 1990

28. If an addict has the best doctors, psychiatrists and counselors treatment will work
    a. true
    b. false

29. One of the worse characteristics of addiction is that it is _____
    a. regressive
    b. temporary
    c. static
    d. progressive
    e. minor

30. Delbert believes the first component in treating addiction is _____
    a. education
    b. denial
    c. grief
    d. compassion
    e. awareness

