



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'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 Central Michigan University.

Addiction and Criminal Behavior: Updated Evidence on 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 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 a prison-based treatment program's effects on 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 approximately four in ten adults entering prison meet diagnostic criteria for a drug use disorder, a rate approximately ten times the general population. Roughly one-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 post-release. Despite evidence supporting pharmacological and psychosocial interventions, significant treatment gaps persist globally (Favril et al., 2026). For the addiction-crime framework this course teaches — which emphasizes that addiction drives criminal behavior through tolerance, compulsion, and the erosion of choices — the Favril et al. data confirms the scale of the problem at a global level. Four in ten people entering prison have a diagnosable drug use disorder, and one in three continues to use during incarceration. The treatment gap this course implicitly addresses when preparing counselors to work with this population is not a local shortage — it is a global structural failure.

The court-mandated treatment dimension — relevant to this course's discussion of 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. The research found that justice-involved adults perceived treatment orders to "reduce mortality/morbidity risk, improve sense of self and coping with emotions," though some experienced increased stress and trauma exacerbation. The review revealed that most research focused on U.S. drug courts, none examined alcohol interventions exclusively, and no studies involved family members (France et al., 2025). For the treatment engagement framework this course describes, the France et al. finding captures the ambivalence that court-mandated clients bring to treatment — the same ambivalence this course addresses through its emphasis on adjustment rather than change. Mandated clients may experience genuine therapeutic benefit while simultaneously resenting the coercion that brought them to treatment, and effective counselors must hold both realities simultaneously.

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%) had concurrent mental health conditions. Co-occurring OUD and mental health disorders predicted higher rates of recidivism during the early stages of treatment. However, therapeutic interventions including group and individual therapy reduced recidivism risk, and individuals with co-occurring conditions required more intensive support upon

discharge (Lawson et al., 2024). For the addiction-criminal behavior framework this course provides, the Lawson et al. finding adds a clinical complexity this course should acknowledge: nearly half of the clients counselors encounter at the addiction-crime intersection also have 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% 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. Heroin use and older age predicted property and drug-crime recidivism (Karlsson & Håkansson, 2022). For the typology of offenders with SUD that this course teaches, the Karlsson and Håkansson data is a near one-to-one mapping onto Goldstein's tripartite framework: alcohol's psychopharmacologic pathway produces violent offending, while heroin's economic-compulsive pathway produces 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 criminal legal system.

The personality dimension of the addiction-crime relationship was quantified in a 2025 updated meta-analysis of 21 studies published in the *British Journal of Psychiatry*. Across pooled samples, any personality disorder diagnosis was associated with a 4.5-fold elevated odds of violence. 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 identified as a key source of heterogeneity in the recidivism outcomes (Chow et al., 2025). For counselors working at the addiction-crime intersection, the finding refines the framework: 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. When both conditions 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 factors operated as independent pathways to violence rather than amplifying each other synergistically (Willoughby et al., 2025). For the framework this course provides, the Willoughby et al. finding specifies the psychopharmacologic pathway with clinical precision: alcohol is not violent on its own, and masculine identity is not violent on its own, but each contributes independently to the risk of partner violence when present. Counselors delivering substance use treatment to male clients with a history of IPV 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 approximately 13 times more likely to meet diagnostic criteria for conduct disorder. Elevated rates of justice-system involvement and

perpetration of violence appeared consistently across studies, as did educational difficulties, and inhibitory-control deficits emerged as the most reliably affected cognitive domain (Guerin et al., 2023). For the addiction-crime framework, the Guerin et al. finding 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 not simply treating a substance use problem; they are intervening at the developmental window where conduct disorder crystallizes into antisocial personality disorder.

The question of whether prison-based treatment programs reduce return-to-custody — the practical outcome that validates the treatment approach this course prepares counselors to deliver — was examined in a 2024 retrospective cohort study of 5,549 individuals released from Australian prisons between 2008 and 2015. The Connections program facilitated opioid agonist treatment access and social services for people exiting prison. Program participation did not lower return-to-custody rates but did increase treatment uptake. Early mortality benefits were noted within 28 days post-release but were not sustained over longer follow-up periods (Sullivan et al., 2024). For the treatment framework this course describes, the Sullivan et al. finding illustrates the gap between treatment engagement and criminal desistance — engaging individuals in treatment upon release does not automatically reduce their return to prison. The addiction-crime relationship this course teaches is real, but breaking it requires more than treatment access alone; it requires the sustained behavioral adjustments this course describes alongside the housing, employment, and social support that make those adjustments sustainable.

The practical question of whether treating opioid use disorder during incarceration reduces the return trip through the criminal legal system was addressed in a 2025 New England Journal of Medicine cohort study of 6,400 Massachusetts jail detainees with probable opioid use disorder. Individuals who received medications for opioid use disorder during incarceration (42.4%) 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) compared with those who did not. Post-release treatment engagement at 30 days was 60.2% among MOUD recipients versus 17.6% among non-recipients (Friedmann et al., 2025). For the addiction-crime framework this course provides, the Friedmann et al. data 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 jail-based findings to the state-prison setting. Using interrupted time-series analysis of 15,225 releases from Massachusetts prisons following statewide buprenorphine implementation in April 2019, the researchers found that post-release buprenorphine receipt approximately doubled over expected levels (males: 21.2% vs. expected 10.6%) and all-cause mortality declined (1.9% vs. expected 2.8%). Opioid-overdose-specific rates, however, did not change significantly after implementation (Bovell-Ammon et al., 2024). For the treatment framework, the finding complicates the Friedmann success story: scaling in-custody buprenorphine meaningfully increases post-release treatment engagement and reduces overall mortality, but it does not by itself eliminate opioid overdose deaths. Structural determinants — housing instability, employment barriers, fentanyl contamination, lapses in treatment continuity — continue to generate overdose risk even when medication access is restored.

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)

Excited
Powerful
Smart

Depressants (Downers)

Relaxed
Calm
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:** Addiction 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

Diversiory 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)
Acceptance of Rules**

**Rapport
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 addiction 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 keeps 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 to 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 disdain 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 unhealthy 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 called 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 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 DIFFERENT 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