CHAPTER 1: Core Strategies and Conceptual Framework for Criminal Conduct and Substance Abuse Treatment

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▶ Provide working definitions of the principles of psychoeducation, psychotherapy and counseling.

▶ Provide literature support for the importance of the psychoeducation method in *SSC*.

▶ Present the 10 core strategies of *SSC* and identify the five strategies that are foundational to the *SSC* program.

▶ Provide a graphic representation of the conceptual framework of *SSC*.

OVERVIEW

This chapter defines the conceptual framework and the core strategies for the treatment of judicial clients with substance abuse problems and the delivery of *SSC.* The first objective of this chapter is to define the meaning and goals of treatment and to help providers understand how *SSC,* as a specific treatment program, fits into the overall treatment framework. Since *SSC* relies on the principles of psychotherapy and counseling, the meaning and understanding of these terms will be addressed. In this discussion, we make it clear that correctional treatment needs to go beyond the traditional principles of psychotherapy. Second, we look at the core strategies that are used in the delivery of *SSC.* Finally, a conceptual framework will be presented which provides an integration of the process and structure of the treatment skills utilized in implementing the *SSC* curriculum.

UNDERSTANDING TREATMENT, PSYCHOTHERAPY AND COUNSELING

The *SSC* curriculum is a program for the treatment of persons with a combined history of substance abuse (SA) and criminal conduct (CC). However, there is often confusion among the terms treatment, psychotherapy and counseling. Following are some guidelines that help gain a better understanding of these terms as they apply to *SSC.*

Definition of Treatment

One way to understand the meaning of an approach or method is to define its goals. The traditional goal of treatment is to intervene in and change patterns of thinking and behavior that cause or are part of specific disorders and that lead to maladaptive and undesirable outcomes. Treatment is designed to address specific psychological and mental health symptoms that define these disorders. The two target disorders for *SSC* are: substance use problems and antisocial behavior that manifests criminal conduct (CC). We look at how these two disorders are defined and evaluated in *Chapter 6.*

This first goal of treatment is to eliminate or manage problems, or a harm avoidance approach. This is congruent with the medical model: to cure the ailment and eliminate the pain of the patient. However, in psychosocial treatment of substance abusing offenders, the goal is also the relief of pain and suffering of others and of society. Although this may be the goal of social medicine, it is not the primary objective - or even an objective in most cases - of the medical practitioner in the medicine.

The position can also be taken that this treatment goal can be defined as reducing harm or pain. This harm reduction model has been effectively applied to psychosocial and medical problems that impact on society, e.g., HIV/AIDS. This is often the goal of the treatment of an incurable disease. However, with respect to CC (criminal conduct), this is not an objective. Behaviors and disorders associated with CC may be approached from a harm reduction model such as reducing, if not eliminating, criminal thinking, harmful effects of substance use, time with criminal associates and antisocial behaviors associated with CC, but not defined as criminal behavior per se. But the goal of criminal conduct treatment is preventing recidivism (committing another crime).

The goal of *Phase I* of *SSC* is to help judicial clients establish a stable living pattern that is free of SA (substance abuse) problems and CC. It is directed at the first goal of treatment - elimination of the disruptive and maladaptive symptoms and behaviors of AOD (alcohol or other drug) abuse and preventing CC.

The second goal of treatment is to bring about growth and change that lead to positive outcomes and a more meaningful life. With respect to judicial clients, this also involves prosocial and responsible living. Although this may be the by-product of the first objective - elimination of symptoms - it is not a primary goal of that objective.

Within the framework of the medical model, the physician heals the broken bone, but once that is accomplished, the efforts of the practitioner have ended. In psychosocial treatment, the practitioner, in this case, the *SSC* provider (counselor, therapist), sees both goals as primary. The first objective of preventing recidivism must be accomplished in order to meet the second objective. However, when judicial

clients begin to experience positive outcomes and a meaningful life, and engage in prosocial actions and responsible living, the probability of achieving and sustaining the first goal of treatment is increased: maintaining a life free of SA problems and CC. *SSC Phases II* and *III* are directed at sustaining the accomplishment of the first goal of treatment and meeting the objectives of the second goal.

Dimensions of Treatment Services

Although there are different ways to conceptualize the taxonomy of treatment, we define treatment as organized across four dimensions as they occur within the judicial system: structures, modalities, specific treatment strategies or approaches, and specific programs. Each of these dimensions can be utilized to address specific types of problem behaviors or disorders, or in the case of this *Guide*, SA and CC.

Treatment structures

There is a broad continuum of treatment structures that operate within various judicial systems.

◗ Therapeutic community.

◗ Intensive residential treatment.

◗ Day treatment.

◗ Intensive outpatient.

◗ Regular outpatient.

◗ Aftercare or continuing care services.

With respect to the judicial system, all of these structures can be offered within an incarcerated setting, community corrections or parole and probation. For example, an outpatient program can operate within an incarcerated setting where inmates attend treatment once or twice a week.

Treatment modalities

There are different treatment modalities offered within these treatment structures. They include: group, individual, family and marital treatment. Also included as treatment modalities are: vocational services; medical services; and psychotropic medica-

tions management. Psychosocial treatment modalities are usually platformed on the basic principles of psychotherapy and counseling. We consider these to be generic principles that are basic to the delivery of treatment and define specific modalities, e.g., individual therapy, group therapy, etc.

Treatment strategies

Various treatment strategies or approaches can be used within the broad domain of treatment. These are based on theory (usually personality) and research that support the efficacy of the approach. Some of these approaches are: behavioral; cognitive-behavioral; psychodynamic; relapse prevention; motivational enhancement; client-centered, etc. Most often, several of these strategies are used in working towards the achievement of treatment goals. For example, cognitive-behavioral therapy will utilize a client-centered approach to establish a working and therapeutic relationship with a client or group. As with treatment methods, the fundamental and common principles of psychotherapy and counseling provide the foundation for all psychosocial therapies. For example, cognitive-behavioral, client-centered, psychodynamic strategies or approaches are built on the common principles of psychotherapy and counseling, to be discussed below.

Specific treatment programs

In the past 40 years, there have emerged specific programs that are directed at addressing specific disorders or problems, e.g., sex-offender, violent offender, anger and aggression management, depression, personality disorders, etc. *SSC* is a specific program directed at addressing individuals with the co-occurring problems of SA and CC. In the *Resource Guide* (Wanberg & Milkman, 2008), we outline a number of programs that are designed to treat judicial clients with or without a SA focus.

Specific treatment programs can be nested within broad judicial structures, such as prison settings, or nested within the various treatment structures outlined above, e.g., a therapeutic community. Or, specific programs can be stand-alone, and represent the treatment structure and modality. For example, *SSC* can be offered within a prison setting, within

a therapeutic community, or as a stand-alone out-patient treatment program in and of itself. As with treatment methods and strategies, the common principles of psychotherapy and counseling provide the foundation for specific treatment programs.

Defining Psychotherapy and Counseling

We noted above that the generic principles of psychotherapy and counseling represent the foundation of most treatment methods and approaches. Because of this, and because *SSC* utilizes these principles, it is important that providers have an understanding of these principles. Although much of this discussion is couched in the one-one therapy relationship, it also applies to group treatment.

Psychotherapy has been defined as "a situation where two people interact and try to come to an understanding of one another, with the specific goal of accomplishing something beneficial for the complaining person" (Bruch, 1981, p. 86), achieving personal change and growth (Rogers, 1951, 1980) and changing "...the patient's image of himself from a person who is overwhelmed by his symptoms and problems to one who can master them" (Frank, 1971, p. 357). It can also be defined in terms of its goal: either symptom relief or cure - the prevention of recurrence (Seligman et al., 2001, p. 11).

Patterson, in his seminal work, *Theories of Counseling and Psychotherapy* (1966), defines counseling and psychotherapy as "processes involving a special kind of relationship between a person who asks for help with a psychological problem and a person who is trained to provide that help" (p. 1). Over 30 years later, he (Patterson & Hidore, 1997) gave a similar definition as a psychological relationship between a person (client), whose progress in self-actualization has been blocked or impeded by the absence of good interpersonal relationships, and a person (therapist) who provides that relationship (p. xiii).

Strupp's (1978) definition is commonly accepted by most in the field. He defines psychotherapy as "an interpersonal process designed to bring about modifications of feelings, cognitions, attitudes and behaviors which have proved troublesome to the person seeking help from a trained professional" (p. 3).

Lang (1990) also sees psychotherapy as "a relationship and interaction between an individual with an emotionally founded problem who is seeking help... and an expert who is capable of assisting him or her in effecting its resolution..." (p. 3). He defines the core dimension of psychotherapy as the object relationship between the patient and therapist and the interpersonal interaction that unfolds on the basis of this relatedness (p. 219). Bateman, Brown and Pedder (2000) see psychotherapy as "a conversation that involves listening to and talking with those in trouble with the aim of helping them understand and resolve their predicament" (p. xiii).

Jerome Frank defines psychotherapy as a process through which a socially sanctioned healer works to help individuals to overcome psychological stress and disability based on a theory of the sufferer's difficulties and a theory of the methods to alleviate them. He identifies five features common to all forms of psychotherapy (Frank, 1963, 1974): 1) a trusting and emotional relationship between client and therapist; 2) a therapist genuinely concerned about the sufferer's welfare and is committed to bring about some kind of desirable change; 3) a conceptual framework that explains what has happened and what will happen; 4) methods to bring about change and/or restore health; and 5) the theory, approaches and outcome are linked to the dominant worldview of the client's culture.

This *Guide* treats psychotherapy and counseling as having similar meanings and the terms are used synonymously. However, there has been some debate about whether they are synonymous. The term psychotherapy was first used in the late 1880s (Efran & Clarfield, 1992) when psychological problems came to the forefront in medicine ("psyche" meaning mind, and "therapeia" meaning treatment). Carl Rogers used the term counseling in the 1930s and 1940s to "side-step" the legal restriction that only medical doctors were allowed legally to practice psychotherapy (Dryden & Mytton, 1999).

Most experts in the field see the two as having the same or similar processes and methods. Dryden and Mytton (1999) view the two as having the same meaning, both referring to helping individuals with personal or relationship problems directed at bring-

ing about self-improvement and emotional changes so as to improve personal functioning.

Patterson (1966) concluded that there is no essential difference between the two in terms of the process, methods or techniques, the goals or expected outcomes, the relationship between the client and therapist or the clients involved. The one distinction he notes is that counseling sometimes refers to work with less disturbed clients with special change needs, and psychotherapy may refer to work with the more seriously disturbed persons. Ivey and Simek-Downing (1980) also saw this as a noteworthy distinction: counseling directed at assisting "normal people" to achieve their goals or to function more effectively; and psychotherapy as a longer term process concerned with the implementation of personality change.

George and Cristiani (1981) concluded from their literature review that the distinction is on a continuum, with counseling directed more at aiding growth, focusing on the present, aimed at helping individuals function adequately in appropriate roles, more supportive, situational, problem-solving and short term; whereas psychotherapy is more reconstructive, analytical, focused on past and present, directed at more severe emotional problems and at change in basic character and personality (p. 8).

Another differentiation between counseling and psychotherapy lies in the former lacking in a connection with a theoretical orientation. Most psychotherapies rest on some specific orientation such as psychodynamic, cognitive, behavioral, interpersonal, etc. (Roth & Fonagy, 2005). Counseling does not necessarily represent a unitary theoretical orientation, tends to be defined by the setting in which it takes place, tends to treat the relationship between the client and counselor as one of equals, usually focuses on current problems in a pragmatic manner, and is premised on the client-centered principles of empathy, warmth, and genuineness (Roth & Fonagy, 2005, p. 13).

In summary, the above definitions indicate that both psychotherapy and counseling have several factors in common: 1) there is a trusting and working relationship; 2) an interpersonal context; 3) a trained and professional provider who has concern and empathy for the client's pain and welfare; 4) a theory of psychological and behavioral problems; 5) a method of how to approach those problems; 6) a client who presents with a unique set of problems; and, 7) an expectation of change found within the context of a set of cultural and societal values.

Shifting the Paradigm for Correctional Treatment

All of the above definitions are essentially egocentric. As discussed in the *Preface* to this *Guide*, if treatment is to be effective with correctional clients, traditional therapy, as defined above, needs to shift the paradigm from egocentric approaches to including sociocentric approaches. Thus, correctional therapy is not just concerned about the symptoms, disorder, welfare and healing of the individual client; it also focuses on the client's responsibility to others and the community. This shift in therapy represents one of the core strategies of *SSC* and is discussed below.

THE CORE STRATEGIES OF THE TREATMENT PLATFORM

SSC is built around 10 core strategies. These operationally define the foundation of *SSC*. In this chapter, we provide a summary of all 10 strategies. Five represent foundational strategies for *SSC* and will be briefly summarized in this chapter and then addressed in separate chapters. These are: Developing an effective client-provider relationship; multidimensional and convergent validation assessment; facilitating learning and growth and the stages of change; the cognitive-behavioral model for change; and relapse and recidivism prevention. The other five strategies will also be addressed in this chapter.

1. **Developing a Therapeutic Relationship Through Motivational Enhancement and a Therapeutic Alliance**

The **first core strategy** is building a therapeutic relationship of trust and rapport with clients through developing a therapeutic alliance and motivational enhancement. The therapeutic relationship and motivational enhancement represent a foundational

strategy of CC and SA abuse treatment, and are discussed in more detail in *Chapter 2* and in the *Resource Guide* (Wanberg & Milkman, 2008).

Many judicial clients initially present with a considerable degree of defensiveness and resistance to involvement in therapy. They also have considerable distrust of treatment providers and counselors in the judicial system. They often see judicial counselors as "on the side of the system," and see counselors as "in it for the money." Clients with greater character problems and antisocial histories have higher probabilities of dropping out of treatment.

The therapeutic alliance provides the basis for the motivation to change and is a predictor of treatment retention and outcome. Once a therapeutic alliance is forged, self-regulating skills may then be learned through motivational counseling, therapeutic confrontation and reinforcement of responsible and positive behaviors.

There is a great deal of research evidence supporting the efficacy of motivational enhancement as an important component in building the therapist-client relationship and implementing treatment readiness and change in AOD abuse clients. The counselor-client relationship, therapeutic stance and alliance, motivational enhancement and use of reflective acceptance in managing resistance and ambivalence, and counselor cultural competency, as these are related to the treatment of judicial clients, will be discussed in more detail in *Chapter 2.*

2. Multidimensional Assessment Based on Convergent Validation

The **second core strategy** for *SSC* is that screening and evaluation are based on a convergent validation model that involves a multidimensional assessment of the client's condition at admission to *SSC* and the client's progress and change during treatment.

Effective screening and in-depth assessment of the SA judicial client will use self-report and other report in order to converge on the best estimate of the client's past and current life-adjustment problems and motivation and strengths for responsible living and change. Assessment is most effective when it is based on the idea that the origins, expressions and continuation of AOD use and abuse and CC are multidimensional in nature (Wanberg & Horn, 1987). Individuals will vary according to how they fit the different causes and patterns of AOD abuse and CC and different patterns of life-adjustment problems. Effective intervention is based on a comprehensive and accurate assessment of the problems and resiliency factors for each judicial client.

This is another foundational strategy for *SSC*. The *Resource Guide* provides a chapter on exploring these issues. *Chapter 6* in this *Guide* provides specific methods and operational approaches to the differential screening and assessment of the presenting problems of *SSC* clients and their change and outcome in treatment.

3. Integrating Education and Therapeutic Approaches

The **third core strategy** of *SSC* is psychoeducation. This involves building and integrating a knowledge base around key concepts and change skills that are essential in the change process. It lays the groundwork for treatment with education being learner-centered and therapy focusing on the process of cognitive, affective and behavioral change.

We look at the general issues related to this *SSC* strategy. In *Chapter 2,* we look at the provider's role in integrating psychoeducation and therapy, and then how these areas are integrated in the *SSC* curriculum.

Support for psychoeducation in treatment

There is strong support in contemporary treatment literature, particularly that which is CB oriented, for the use of knowledge building, and psychoeducation in the treatment process.

Wright (2004) sees psychoeducation as a shared feature of CBT. "CBT is well known for using psycho-educational procedures to assist patients with learning new patterns of thinking and behaving" (p. 357). Psychoeducation is seen as an important component in the CB treatment of most psychosocial problems including panic disorders and agoraphobia (McCabe

& Antony, 2005), social and general anxiety disorders (Ledley & Heimberg, 2005; Waters & Craske, 2005), obsessive-compulsive disorders (Clark, 2004), the borderline personality disorder (Klosko & Young, 2004), and in treating AOD problems (Washton & Zweben, 2006). In applying the principles of acceptance, mindfulness and cognitive-behavioral therapy to the treatment of anxiety, Orsillo et al. (2004) state that "consistent with traditional cognitive-behavioral approaches, our introduction to treatment includes psychoeducation" (p. 87).

Ross et al. see cognitive approaches that are directed at helping judicial clients modify their antisocial attitudes, correct thinking errors and inappropriate social perceptions as involving more training and education than therapy (Hollin, 1990; Ross et al., 1988). From a cognitive perspective, judicial clients have failed to acquire the necessary reasoning and problem-solving skills to deal with the various cognitive, social, economic, behavioral and situational factors that lead to CC (Foglia, 2000). Education and training are important steps in helping judicial clients acquire these reasoning and problem-solving skills.

Clients learn key concepts and skills through psychoeducation. Washton and Zweben (2006) illustrate the importance of this method in relapse prevention strategies when they state: "...one of the most important strategies is to teach patients how to prevent a slip from developing a full-blown relapse" (p. 216). They see client education as one of the components of an integrated approach to treatment (p. 73). They stress that educational approaches are of particular value in the precontemplative and early stages of change. "Taking an educative, non-confrontational stance avoids the problems of stimulating defensiveness and getting into power struggles - the primary pitfalls of working with patients in the precontemplative stage" (p. 175).

Judy Beck sees educating patients around core beliefs and coping strategies as an essential component of treatment (2005, p. 270). She stresses that some clients "need additional psychoeducation before they are willing to engage in problem solving" (2005, p. 179).

Most literature sources, then, see psychoeducation as a valuable method to teach clients key concepts around their problem condition as well as key CB concepts and skills to bring about change. It can give clients some reassurance around their particular problems and conditions and can increase motivation for treatment. It can help them understand the process and risks related to relapse and recidivism.

What makes psychoeducation effective

Psychoeducation is more effective when based on cognitive processing and when clients can relate the knowledge and skills to their personal lives and problems (Dees et al., 1991; Farabee & Leukefeld, 2002; Farabee et al., 1995). All sources stress that relevancy is essential, that growth and change result from learned skills and knowledge, and that material should be presented in brief segments (Washton & Zweben, 2006). All warn of the dangers of being too didactic and engaging in lengthy lectures.

As noted, CB therapies rely heavily on psychoeducation. Since there is a robust set of literature to support the efficacy of CB treatment (see *SSC Resource Guide,* Wanberg & Milkman, 2008), we can assume that psychoeducation must provide a measurable contribution to the positive outcomes of CB. To what extent is unknown, and no substantive research was found in this area.

Two modes of including psychoeducation

Psychoeducational approaches are utilized in two ways. First, they can be stand-alone programs where judicial clients are required to complete educational classes or groups as part of treatment (Springer et al., 2003). These are usually didactic sessions that provide information about AOD use and abuse followed by interactive discussion. Although supportive of the use of psychoeducational approaches, Springer et al. (2003) acknowledge that as stand-alone approaches, there is little research as to their efficacy. They do point to a couple of studies that lend support to the stand-alone approach (Pomeroy et al., 2000; Anderson & Reiss, 1994).

A second approach is to integrate psychoeducation into the therapeutic process. This involves combin-

ing the presentation of knowledge and information with therapeutic and treatment methods which facilitate change (McNeece & DiNitto, 1994). Facilitator interaction is important, but also includes the interactive methods discussed above with the objectives of: 1) increasing motivation and commitment to treatment; 2) enhancing life-management, communication and relapse prevention skills (Springer et al., 2003).

How education differs from psychotherapy/counseling

As discussed above, psychotherapy and counseling involve basic principles that are used across various treatment dimensions, structures, modalities, approaches and specific programs. However, do counseling and psychotherapy (therapy) differ from psychoeducation?

Patterson (1966) states that most in the field would agree that counseling and psychotherapy "deal with the conative or affective realm - attitudes, feelings, and emotions, and not simply ideas" (p.3). He sees teaching or education as being concerned only with the rational, non-ego-involved solution of problems. "Where there are no affective elements involved, then the process is not counseling, but is probably teaching, information giving, or an intellectual discussion" (p. 3). Patterson clearly indentifies counseling and psychotherapy as not just the giving of information, advice, suggestions or recommendations. He sees them as influencing and facilitating behavior change.

4. Facilitating Learning and Growth and the Stages of Change

The **fourth core strategy** and another foundational approach of *SSC* is facilitating the client's process of learning and growth and structuring treatment around the stages of change. We briefly summarize this strategy here and then address it in greater detail in *Chapter 3.*

This strategy is based on two assumptions: 1) that learning and growth occur in phases; and 2) when people make changes, they go through specific stages of change.

First, with respect to learning and growth, the work of Kurt Lewin (Ham, 1957; Lewin, 1935, 1936, 1951) and Werner's Orthogenetic Principle (1957) identify three phases of responding that formulate the basis of learning and growth: a global, undifferentiated response; a differentiative or sorting out response; and an integration or "putting together" response. Although these phases of growth are seen as natural processes, they are facilitated in treatment by applying three methods of therapeutic communication: 1) getting clients to openly share their problems and concerns or "tell their story"; 2) provide feedback to the clients so that they "hear their story"; and 3) strengthen and reinforce clients' effort to "act on their story."

Second, research has indicated that people go through various stages when making changes in addictive lifestyles. From this research, the transtheoretical model of change was formulated (Connors, Donovan & DiClemente, 2001; Prochaska & DiClemente, 1992; Prochaska, DiClemente & Norcross, 1992).

Building on the three phases of learning and growth, and a three-stage model of change using the findings of the transtheoretical model, the *SSC* treatment protocol is structured into three treatment phases (Wanberg & Milkman, 1998): **Challenge to Change; Commitment to Change;** and **Ownership of Change.**

Challenge to Change represents the pre-contemplative, contemplative and preparation for change stages. The **Commitment to Change** represents both the determination and action states in the transtheoretical model. The **Ownership** stage, representing action and maintenance, occurs when judicial clients live up to their relapse and recidivism prevention goals because they want to do it for themselves and their community.

Judicial client treatment strategies for achieving increased self-regulation for preventing AOD relapse and CC recidivism must fit the client's level of awareness, cognitive development and determination to change patterns of thoughts and behaviors.

Effective treatment will use the right strategies at particular stages of each client's process of change. For example, a person in the comtemplative stage (challenge) may not respond well if initially placed in action-orientated treatment.

5. Cognitive-Behavioral Approach

The **fifth core strategy** and another foundational approach of *SSC* is that the concepts and methods of cognitive-behavioral change provide the basis for the treatment of the substance abusing judicial client. One of the most significant advances in treating individuals with AOD use problems and/or criminal conduct has been in the field of cognitive-behavioral psychology. From a review of the CB literature, summarized in the *Resource Guide* (Wanber & Milkman, 2008), a CB treatment approach specifically designed for *SSC* was developed.

The term cognitive-behavioral therapy (CBT) is used quite broadly to refer to approaches that focus on the interplay between thought, emotion and action in human functioning and in psychopathology (Freeman, Pretzer, Fleming & Simon, 1990). Although there are varying forms of CBT, most would agree with Hollen and Beck (1986) who define cognitive-behavioral therapies as "those approaches that attempt to modify existing or anticipated disorders by virtue of altering cognitive processes" (p. 443).

SSC is built around the two traditional cognitive-behavioral (CB) approaches: cognitive or thought restructuring or helping clients learn the skills of changing thoughts so as to modify or change behavior; and social and interpersonal skill building. However, a third approach has been added to this work that utilizes the basic methods and concept of CBT: moral and community responsibility skill building, or *Social Responsibilty Therapy* (SRT) discussed below. The CB model specifically adapted for *SSC* is addressed in detail in *Chapter 4.*

6. Relapse and Recidivism Prevention

Relapse and recidivism (R&R) prevention is the **sixth core strategy** and another foundational approach of *SSC.* The literature clearly indicates that relapse prevention is an integral component of the treatment of substance abuse. However, clear and concise models for recidivism prevention, with a distinct conceptual framework, are not well identified in the literature.

The principles of relapse prevention as defined by Marlatt (1985a) and adapted by Wanberg and Milkman (1998) are applied to both relapse and recidivism prevention in the *SSC* protocol. Effective judicial client treatment will have separate though linked models for addressing R&R and R&R prevention. R&R prevention is another foundational strategy for *SSC.* It is addressed in *Chapter 5.*

7. Focusing on Moral Responsibility to Others and the Community - SRT

An essential strategy in the treatment of CC is a focus on the moral responsibility to others and the community, the **seventh core strategy.** CC is based on antisocial attitudes and behaviors that have a common outcome: they destroy the basic fabric of a positive and harmonious society; they go against society. Thus, strategies for building moral responsibility towards others and the community are essential elements of CC treatment.

We define moral responsibility as a complex set of attitudes and behaviors directed at respecting the rights of others, being accountable to the laws of society, having positive regard for and caring about the welfare and safety of others, and contributing to the good of the community. In essence, it means engaging in responsible thinking and actions towards others and society.

Traditional psychotherapy, including cognitive-behavioral treatment, is egocentric. It puts the person at the center of its focus, with the goal of relieving the pain and suffering of individuals, e.g., depression, anxiety, stress, disturbed thinking, substance abuse.

Within the framework of egocentric approaches, sociopathy, antisocial disorders, criminal conduct and character pathology were often viewed as not treatable. When traditional egocentric treatment was applied to these groups, the outcomes were poor. This

merely reinforced the belief that antisocial patterns and criminal conduct would not respond to treatment.

In order to effectively address and treat antisocial and criminal patterns, we must shift the paradigm and go beyond an egocentric psychology to a sociocentric and holistic framework. This involves moving towards a connected consciousness and relational empathy (O'Hara, 1997). We build on the gains and strengths of egocentric psychology and include a sociocentric approach. We see social responsibility therapy (SRT) as a necessary component of correctional treatment.

Some began advocating the importance of moral and social responsibility in the treatment of antisocial persons in the 1990s. Ross et al. (1986) made this a focus in their *Reasoning and Rehabilitation* treatment program for offenders. Snortum and Berger (1989) early on indicated that the variables of personal morality and social morality are important in impaired driving and other offender deterrence. Wanberg and Milkman (1998) made this a central focus in the first edition of this work and in the education and treatment of impaired driving offenders (Wanberg, Milkman & Timken, 2005).

Mauck and Zagummy (2000) state that the areas of moral and social obligation have been conspicuously absent in the research and treatment of correctional clients. With respect to impaired driving, they found that the level and sense of moral and social obligation on the part of a peer to intervene in drunk driving behavior significantly predicted the success of impaired driving intervention.

It wasn't until the early 2000s that traditional CB psychotherapy saw its importance in treating the antisocial personality disorder. As noted in the *Preface,* Beck et al. (2004) stress the importance of moving antisocial clients towards interpersonal consideration and moral functioning (p. 169) and towards responsibility towards others and a commitment to the guiding principles for the good of society (p. 179).

8. Integrating the Therapeutic and Correctional

Effective treatment of the SA judicial client inte-

grates the principles of therapy with correctional deterrence. Outcome research indicates that effective treatment integrates sanctions with treatment approaches (Andrews & Bonta, 2003). In essence, treatment providers become partners with the judicial system in helping to administer the judicial sentence.

Our review of the literature for this and our previous work (Wanberg & Milkman, 1998) clearly indicates that sanctioning and punishment alone are not effective methods to prevent recidivism (see Andrews & Bonta, 2003). It also indicated that treatment intervention alone is not as effective as when intervention is integrated with the sanctioning process. The **eighth core strategy** of *SSC* is that of integrating the efforts of the sanctioning and judicial system with the efforts of the treatment system.

There are some traditional differences between the treatment of AOD abuse and intervention and treatment of CC. First, alcohol abuse by adults in and of itself does not have legal implications and the treatment of AOD abuse does not necessarily involve sanctions; only certain behaviors associated with AOD use such as impaired driving or the possession of illegal drugs.

Treatment outcomes for AOD abuse can tolerate relapse. Such treatment or education is usually psychotherapeutic and it is client-centered in that treatment starts with the client's goals, needs and expectations. The healing expectations come from the client.

The treatment of judicial clients always involves sanctions: treatment and sanctioning are almost always integrated. The client's referral to treatment is often part of the judicial sentence. Recidivism prevention and goals must take a "zero tolerance" position for criminal conduct. Recidivism is not tolerated and when occurring, the provider and judicial client must engage the correctional and judicial processes. Correctional treatment is both client-centered and society-centered. It is correctional and parenting with a focus on behavior that violates society. The change expectations, at least initially, come from society - from outside the offender.

Thus, when addressing CC recidivism, the focus must be on cognitive, affective and pre-recidivism behavior with these elements being considered as leading to recidivism such as thinking about committing a crime, spending time with criminal associates, and becoming involved in other high-risk situations or high-risk thinking that lead to CC.

The confrontational process is also different. The provider in the correctional role states, "I confront you with me, I represent the external world you have violated and I confront you with the values and laws of society and I expect you to change." The provider or therapist represents society in the intervention process and is the client's "victim" as is any other member of society who is potentially impacted by criminal behavior. The provider has the clear role of helping to administer the judicial sentence along with providing services and treatment to the judicial client. The intervention referral and the sentence are clearly linked.

The provider in the therapeutic role states: "I confront you with you, I confront you with what you say you want and need and the contradictions in your thinking, emotions and behavior that violate your own needs and goals." The provider, in the therapeutic role, always works towards helping clients achieve their agenda and assume responsibility for their own behavior.

What is most important in this integration process is that the provider responds at least initially to the correctional process within the framework of the therapeutic role. For example, when clients violate the terms of their judicial order, such as using illegal drugs, violating the requirements of probation or parole, or admit to breaking the law, the provider first manages this situation from a therapeutic stance. The provider works with the client's thoughts, underlying beliefs and emotions that led to that behavior and helps the client to identify the triggers that led to that behavior. However, the provider has the judicial obligation of engaging and informing the correctional system in sanctioning or correcting the behavior that violates the judicial status of the client. This is done from a therapeutic perspective, and if there is a therapeutic alliance, then many clients will take responsibility to engage and inform the judicial

system around their infractions.

This core strategy is also addressed in *Chapter 7, Section II,* with respect to operational guidelines of working with the judicial system and enhance the partnership between the judicial and therapeutic systems.

9. A Cohesive Group That Elicits a Prosocial Identity

The **ninth core strategy** of *SSC* is to build a treatment group that becomes a primary source of therapeutic change and the development of prosocial attitudes and behavior. In order to do this, the provider works at building positive "in group" identity, continually strengthens the prosocial behavior of the group and group members, applies motivational enhancement and therapeutic counseling skills to the group itself, and continues to foster group cohesiveness.

The judicial client's treatment group becomes the laboratory for learning self-control, responsible actions towards others, and learning and practicing prosocial attitudes and behaviors. The cohesive prosocial group becomes a major force in bringing about change in the client. Group membership becomes an important aspect of the client's emerging identity as a responsible, caring, and productive member of society. Methods for developing and enhancing a cohesive group that can become a vehicle for change are discussed in *Chapter 7.*

10. Reentry and Reintegration Into the Community

The **tenth core strategy** of *SSC* is to use all of the possible resources and skills to enhance successful reentry and reintegration of clients into the community. Reentry and reintegration are seen as important focuses in the judicial system and have become a major objective in criminal justice treatment (Knight, Simpson & Hiller, 1999; Wexler, 2004; Wexler, Melnick & Chaple, 2007).

Between 2001 and 2004, the federal government allocated over $100 million to support the development of new reentry programs in all 50 states (Petersilia, 2004). The National Institute of Corrections,

the American Probation and Parole Association, the National Governor Association, and State Departments of Corrections have each created special task forces to work on the reentry issue.

There is a robust set of literature that provides cogent evidence that aftercare programs reduce the rates of rearrest and reincarceration (e.g., Knight et al., 1997; Inciardi et al., 1997; Inciardi et al., 2002; Pelissier et al., 1998; Wexler, 1995; Wexler et al., 1999). Aftercare from prison is most effective if it involves a structured program such as a residential treatment program or transitional structured care such as a halfway house. Studies indicate that offenders who participate in these programs were better able to negotiate employment, find a more stable residential arrangement and had lower rates of rearrest following release from prison (Hiller et al., 1999; Knight, Simpson & Hiller, 1999). A summary of the efficacy of continuing care and aftercare programs is provided in the *Resource Guide* (Wanberg & Milkman, 2008).

Seiter and Kadela (2003) defined reentry programs as those that specifically focus on the transition from prison to community; or initiate treatment in a prison setting and link with a community program to provide continuity of care. Parole is the judicial structure that is utilized to manage the reentry and reintegration process. However, the parole system does not meet the treatment needs of judicial clients.

Reentry and reintegration are just as important for those who are not incarcerated, but sentenced to probation. Although these offenders remain in the community, there is a quality of being "removed" from normal community living by virtue of being in the judicial system. Release from community judicial supervision results in identifiable reentry and reintegration needs that must be met in order to capitalize on the efforts of supervision. Unfortunately, few programmatic efforts are made to address reintegration from probation.

Reentry and reintegration must involve more than judicial supervision and include services to address the treatment needs of the judicial client. Ideally, it should start once the offender enters the judicial system. Thus, reintegration begs the necessity of continuing care beginning with the first entry point into the system and ending with an effective aftercare program.

Field (2004) points out that effective continuing care involves services for offenders that are designed to prevent recidivism, and which are found across the continuum from arrest, diversion, conviction, probation, revocation, jail, prison, and parole or post-prison supervision; or, for the probation client, from arrest through the term of probation. He offers the critique that although continuing care may exist in exceptional programs, it is not a common and integral part of the judicial system. In fact, he notes that, with respect to linking together these specific points, "the offender is confronted with and by a system that largely isn't a system in the usual sense" (p. 33-34).

Field (2004) identifies a number of barriers and obstacles to continuing care in offender treatment: segmentation of the judicial system; lack of or poor coordination between corrections and treatment programs; failure to provide offenders post-release structure outside of parole; attenuation of incentives and sanctions at post-release; lack of aftercare services in the community; lack of experience by treatment providers in working with offenders; and the usual crunch - lack of funding.

The reentry and reintegration task is also made difficult because of the cautious and negative attitudes in the community towards persons with a history of criminal conduct, particularly those with violent and sexual offense histories. Many types of employment and many employers screen out persons with a felony history. This only points to the importance of addressing reentry and reintegration.

Continuing care and aftercare involve more than providing offenders with a structured setting in making the transition back to the community, e.g., halfway houses, community corrections facilities. They must also involve a treatment program component. One of the values of programs such as *SSC* is that they go beyond judicial supervision and link the treatment dimension to the reintegration process. In essence, one could conclude that these programs are reentry and reintegration efforts in and of themselves. One

of their goals is to enhance the offender's adjustment to normative community living.

Even though we can construe these programs as having the goal of reintegration, at the same time, such programs need to have built-in components and sessions that address specific issues relevant to reentry and reintegration. This would involve connecting clients with community reinforcement programs that continue beyond formal treatment. Support and self-help groups are major components of these programs.

Effective reintegration involves helping clients re-establish supportive and positive relationships with their significant others and their primary social units. These connections are powerful elements in implementing responsible living and change. *Phase III* of the *SSC* curriculum includes sessions that address these issues. *Chapter 7* provides some specific guidelines for implementing the reentry and reintegrating processes.

PROGRAM CONCEPTUAL FRAMEWORK

Utilizing the learning and growth model, the stages of change and approaches to assessment, a conceptual framework for the delivery of *SSC* to judicial clients was developed. This structure involves three phases of intervention which have been described above.

This conceptual framework is provided in *Figure 1.1*. For each phase of treatment, the following are identified and defined:

◗ types of assessment completed;

◗ counseling and therapy goals;

◗ process goals;

◗ the provider skills that facilitate learning, self-improvement, responsible living and change;

◗ facilitation methods and techniques;

◗ treatment and correctional goals and expected experiences;

◗ treatment strategies;

◗ transtheoretical stages of change.

CHAPTER REVIEW

Criminal Conduct and Substance Abuse Treatment: Strategies for Self-Improvement and Change (SSC) - Pathways to Responsible Living was developed out of evidence-based treatment approaches directed at changing the cognitive structures that determine antisocial attitudes and behavior upon which criminal conduct is based. In addition to these targets of change, substance abuse patterns that interact with CC are also primary targets.

The principles of psychoeducation, psychotherapy and counseling, which represent the integrating threads of the *SSC* fabric, are defined. Also discussed are the two ways that the *SSC* program can fit into the judicial system: either as a nested program within more comprehensive judicial structures; or as a stand-alone program in a community outpatient setting.

The 10 core strategies of *SSC* which operationally define the underlying assumptions of the program were summarized. The five foundational strategies are addressed in more depth in subsequent chapters: 1) the therapeutic relationship, *Chapter 2*; 2) multidimensional and convergent validation model for assessment, *Chapter 6*; 3) phases of learning and growth and the stages of change, *Chapter 3*; 4) the CB approach as the primary treatment platform, *Chapter 4*; and 5) the strategies of relapse and recidivism prevention, *Chapter 5*.

The other five core strategies, discussed in some detail, are addressed in subsequent chapters as they relate to the five foundational models of *SSC*. The 10 core strategies are integrated into a graphic presentation and conceptual framework of the *SSC* program as presented in *Figure 1.1*.

F I G U R E   1 . 1 Conceptual Framework for the Treatment of the Substance Abusing Judicial Clients

TREATMENT PHASES	CHALLENGE TO CHANGE	COMMITMENT TO CHANGE	TAKING OWNERSHIP FOR CHANGE
CHANGE PROCESS	**UNDIFFERENTIATED**	**DIFFERENTIATED**	**INTEGRATIVE**
ASSESSMENT	Screening/in-depth	Progress and Change	Progress and Change
COUNSELING AND THERAPY GOALS	Clients tell story Unpack thoughts, feelings and problems	Help clients hear their story Sort out, identify thoughts/feelings	Help clients act on their story Putting together Reinforce change
COUNSELING AND THERAPY SKILLS	Responding attentiveness Encouragers to share Reflective acceptance	Reflection skills Therapeutic confrontation Correctional confrontation Change clarification	Change Reinforcements
FACILITATION METHODS AND TECHNIQUES	Interactive teaching Interactive work sheets/ journaling Multi-media presentations Role playing Skills rehearsal Group processing		
TREATMENT AND CORRECTIONAL GOALS	Build trust Caring environment Self-evaluation Self-disclosure Build AOD, CC and CB knowledge base Resolve ambivalence Thinking change MAP R&R prevention R&R prevention plan	Maintain trust Caring environment Self-awareness Apply knowledge Self-control Prosocial attitudes/ behavior Revise/extend	Maintain trust Caring environment Self-change
TREATMENT STRATEGIES	Psychoeducation Therapy alliance Stages of change Basic CB skills R&R prevention Partnership with judicial system Cognitive behavioral map Phase I Closure	Cognitive restructuring IPR skills *Social Responsibility Therapy* (SRT) CB Map-STEP method Phase II closure	Balanced lifestyle Healthy lifestyle SSC graduation
TRANSTHEORETICAL STAGES OF CHANGE	Precontemplative Contemplative	Preparation Action	Continued action Maintenance