Treating the Antisocial Addict: Treatment Planning

Practical Treatment Planning For Addicted Offenders

If you're working with offenders, particularly those who've been incarcerated, you should expect to see a significant amount of antisocial behavior mixed in with substance abuse.

We use the term *antisocial behavior* (AB) to refer to a cluster of attitudes, beliefs, and character traits that correlate strongly with criminal recidivism. For instance:

- An oppositional attitude towards authority
- History of impulsive behavior
- Low tolerance for frustration
- Difficulty controlling anger
- A preference for intimidation or threats to get one's way
- Attraction to danger or risky situations
- A pattern of irresponsibility in the face of obligations or expectations, and
- Pronounced defensiveness or the absence of remorse when confronted

Offender populations are rife with such traits. It usually begins with conduct disorder in childhood. Once ingrained, a pattern of antisocial behavior becomes a principal obstacle to recovery. The life chaos produced by AB undermines any effort to establish sobriety. Likewise, relapse to drugs or alcohol encourages a return to criminal activity, despite its very real consequences.

Identifying the Problem

Criminal activity is often directly or indirectly the product of a longstanding disorder of behavior and personality. When that is the case, it requires special attention through an integrated treatment plan that addresses antisocial attitudes along with addiction.

Try the Antisocial Behavior Profile from the RSI Tools for Treatment Professionals library to make an initial assessment of your client's involvement in antisocial behavior.

If the AB Profile shows significant evidence of antisocial behavior, it is wise to formulate a treatment plan that addresses both addiction and antisocial behavior in a co-equal manner.

Developing a Treatment Plan

Begin with a general statement of the problem, such as "Antisocial attitudes and behavior increase risk for recidivism". It's deliberately broad to permit you to address a range of interrelated problem behaviors.

> This client has *two* primary disorders, and they're linked to the point where you can't address one without addressing the other.

The goals of treatment for antisocial behavior should be:

1. To increase knowledge of the causes and dynamics of addiction and antisocial behavior;
2. To promote self-diagnosis for both problems;
3. To introduce effective methods of treatment for persons with AB and substance abuse;
4. To develop a viable plan of ongoing monitoring and supervision to support recovery and counter the tendency towards recidivism; and
5. To instill in the individual a sense of personal accountability for what happens in the future.

When a client has a clear pattern of antisocial behavior, we list it along with his addiction problem as follows:

Problem: Chronic substance dependence and antisocial behavior increases risk for relapse and recidivism.

This client has *two* primary disorders, and they're linked to the point where you can't address one without addressing the other.

Now let's take a moment to re-examine the client's history to identify other problems that might impact treatment. Where possible, avoid jargon. Use simple sentences to make clear statements.

Putting Problems in Order

Once we've identified the problems we plan to address, we prioritize them in order of importance.

First, we want to address those problems that might directly interfere with our client's chances of successfully completing treatment.

Imagine it's the first day of treatment. Look back at the problems you identified. Which must be addressed in the next few weeks? Which can be put off for a while? After each, write N for now or L for later.

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Next, order the "Nows" in terms of urgency. Which has to be addressed today? Tomorrow? Five days from now? When finished, we should have the initial problems for our problem list.

Repeat the process with the "Laters". There may be some you can refer out or postpone.

> ...everything on this initial problem list should relate clearly to the diagnostic summary

When finished, you have a problem list. You should discuss it with the client, make sure he understands and agrees with it, and incorporate some of his own ideas and aspirations. Remember, to the client, his biggest problem may be last night's argument with the girlfriend. It's up to you to explain why drug and alcohol addiction is more important.

If you aren't sure about the priority of a particular problem, try applying the "So What?" test:

Say your client complains of feeling depressed. Ask yourself, so what? Is that unexpected at this point? Is there any evidence of a comorbid depressive disorder? What would be the consequences if we relied on simple reassurance, or even did nothing at all?

The truth is, many newly sober people have a variety of physical and psychological complaints which go away by themselves. They also have legitimate medical and psychiatric needs. Your job—with the help of a physician and other members of the treatment team --- is to figure out which are which. At this point in recovery, the client can't do that.

Now use the chart to record your master problem list. (A Problem List Template is available in the RSI library under Tools for Treatment Professionals.) As you create the list, note which items you'll address now, which can postponed until later in the rehab process, which problems will be revisited much later, during continuing care, and which need to be referred out.

Later on, as problems are resolved, you'll note the date of resolution. If you make a referral, don't forget to add it to your discharge summary.

You may add problems as treatment progresses, but if you have to change it too much, it's a sign your initial assessment was incomplete. And by the way, everything on this initial problem list should relate clearly to the diagnostic summary. If it doesn't, your summary didn't contain all the necessary information..

Formulating Goals

Each goal addresses a particular problem. The larger problem of antisocial behavior can be addressed either as follows:

Problem:
Chronic antisocial behavior, leading to criminal recidivism

Goal:
Make measurable improvements in target areas of behavior

Or through smaller goals addressing its component behaviors:

Problem	Goal
Tendency to angry outbursts leads to violence.	Help client learn to manage anger and avoid violence
Lack of remorse interferes with motivation for change in behavior.	Address denial, rationalizing, minimizing, and externalizing to increase awareness of negative consequences to others
Pattern of irresponsibility interferes with compliance with court requirements.	Develop sense of accountability to and compliance with Court orders
Reliance on conning and intimidation interferes with appropriate relationships	Help client develop alternative ways of meeting needs in relations with others
Pattern of quitting employment due to per-sonality conflicts with supervisor undermines stable lifestyle and economic success .	Develop alternative ways of resolving conflicts in workplace while maintaining employment.

Treating the Antisocial Addict: Treatment Planning

If the client qualifies for a diagnosis of Antisocial Personality Disorder (ASP) we'll treat that as a unitary disorder.

Goals are just general statements of direction. They remind us of our destination, without showing us how to get there.

Examples:

- Develop understanding of the effects of your behavior on others
- Maintain regular attendance at 12 Step meetings.
- Re-establish relationship with siblings.

It's not uncommon for an addicted offender to get "stuck" during the course of treatment --- in other words, to reach a point where he's no longer making progress. When that happens, ask yourself, "what one step could he take which directly increases his chances of improvement?" By returning to the larger goal, you can sometimes think of another way to get there.

Developing objectives

Objectives are the steps involved in achieving a goal. Well-designed objectives are *specific, behavioral,* and *measurable*.

It's important to be precise. If the objectives are vague, the treatment plan "map" is difficult to follow—as if you'd instructed someone to meet you tomorrow morning somewhere in Texas.

When the goal involves a change in attitude or belief, then what you're doing is called **psychoeducation**, or therapeutic learning.

Suppose your client acknowledges the need to give up heroin and cocaine but expresses a continuing attraction to the glamour (*translation*: excitement and high living) of the dealer's lifestyle. This is the old "I want to have my cake and eat it too" dilemma. The client wants help to avoid drug use, but not so he can life a healthy lifestyle. His barely hidden goal is to be a more successful (*translation*: profitable) drug dealer.

Put it this way: just as alcoholics fantasize about being social drinkers, antisocial offenders cling to the dream of being a successful criminal—despite the rapidly accumulating body of evidence indicating this goal is no longer possible.

You might state the problem, goal, and objectives as follows:

Problem

Client remains attracted to drug dealing lifestyle.

Goal

Increase understanding of inevitability of drug relapse risk from dealing lifestyle.

Objectives

1. *Have client learn more about relapse due to "slippery places and people";*
2. *Undermine get-rich-quick fantasies of criminal lifestyle;*
3. *Get them to "compare in" with other addicts who have had to renounce lifestyle (at NA meetings).*

Plan

Review with client at next session.

Three principles for treating antisocial addicts

Principle One: Get past defenses to address attitudes and beliefs.
Antisocial behavior is, at root, irrational, unrealistic, and self-defeating. But because of his defenses, the addict can't easily see this. In order to treat AB, you must first get past the denial, rationalization, externalizing, and minimizing to make essential changes in attitude.

Principle Two: antisocial behaviors are interrelated, so address them as a whole.
Antisocial behavior perpetuates itself. For instance, your low tolerance for frustration leads to angry outbursts which get you fired, resulting in cash shortages that motivate crime, resulting in arrests that land you back in jail, leaving you broke and without resources upon release, resulting in taking bad jobs to make a quick buck, engendering feelings of resentment and frustration that lead to conflicts with your boss, resulting in getting fired, and so forth….it's a vicious circle. Treatment must address the *syndrome* of antisocial thinking and behavior that affects many areas of life.

Principle Three: link addiction and antisocial behavior.
This integrates the treatment experience. The antisocial addict doesn't experience addiction and antisocial behavior separately. To him, it's all part of "my problem". Treatment works best when it's based on the precept that an addict can't stay clean sober without addressing antisocial behaviors, and can't address your antisocial behaviors without staying clean and sober.

(*To help the addict get in touch with some of the attitudes and beliefs that engender antisocial behavior, you can use the "Brief ASB Inventory" tool from RSI's Tools for Treatment Professionals.*)

Treating the Antisocial Addict: Treatment Planning

Treatment Plan Review (TPR) Groups

Try an "each one, teach one" approach, pairing addicts up to support one another's efforts. In regularly scheduled Treatment Plan Review groups, members assist one another in completing treatment plan assignments. Participants bring their treatment plans to the session and make formal contracts with others to fulfill the requirements. For instance, if Bill's treatment plan requires him to stop focusing on his ex-wife instead of himself, while Mike's is to address his tendency to externalize, they might make this agreement:

Bill: for the next week, will point out to Mike whenever he hears him blaming other people or circumstances for being in the program;

Mike: for one week, will remind Bill every morning that he needs to focus on his own problems & not his ex-wife.

Common Problems that arise in learning to formulate treatment plans

1. Focusing on childhood

Try not to get caught up in the assumption that antisocial behavior is really the result of your client's attempt to 'self-medicate" some emotional or psychological distress rooted in childhood. We don't really know what causes antisocial behavior—or why some people become antisocial while others don't, despite very similar early environments. Stick to the here and now —that's where change occurs.

2. Letting people ventilate

Ventilating negative emotions may make the client feel better temporarily, but doesn't correlate with positive outcome. What counts is action. Just as the addict learns to stick to sobriety in the face of craving, the antisocial individual learns that certain behaviors must be avoided, no matter how you feel at the moment.

Cognitive approaches (such as RET) can be helpful in teaching the newly sober to deal with difficult or uncomfortable feelings.

Next: *Treating the Antisocial Addict: Working the Treatment Plan*

See Also: *Treating the Antisocial Addict: Sample Case Study*

Common Problems and Goals

Problem	Goal
Denies adverse consequences of antisocial behavior, despite evidence	Increase awareness of adverse effects of his behavior on others
Minimizes (externalizes, rationalizes) criminal involvement (or consequences)	Increase awareness of extent and severity of behavior (or consequences)
Resistant to 12 Step involvement because of (list reasons)	Reduce objections to 12 Step involvement to facilitate support for recovery
Not self-motivated for continued recovery, as shown by (evidence)	Increase personal responsibility for recovery through (how measured?)
Living environment not conducive to recovery (tell how)	Alter living environment to lessen risk of recidivism
Work environment not supportive of recovery (tell how)	Alter work environment to increase support for recovery
Not committed to proper treatment for coexisting disorder (name)	Achieve commitment to treatment of (name of disorder)
High risk for relapse (give reasons)	Reduce risk of relapse through relapse prevention activities
Unstable living environment	Stabilize living environment through alternate arrangements (describe what)
Enabling (or provoking) relationship with (who?) undermines treatment	Address enabling (or provoking) behaviors to support treatment

This chart is meant to serve only as a guide to effective phrasing of problems and goals. Remember, all your goals shouldn't sound exactly alike.