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# Individuals Who Sell Drugs Placed in Treatment: The Perspective of Their Counselors

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Abstract

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## Abstract

Individuals who sell drugs are often mandated by legal forces to substance abuse treatment because of their criminal offenses and the belief they may have a drug problem. Previous researchers have noted this population may be disruptive in the treatment process, but it has not been explored in depth. The purpose of this phenomenological study was to learn the lived experiences of counselors who work with individuals who report a primary problem of selling drugs, not substance abuse, who are mandated to a substance abuse treatment program. Thirteen semi structured interviews were conducted with counselors who have worked with individuals who sell drugs that were mandated to participate in a correctional-based therapeutic community substance abuse treatment program. Interviews were transcribed and analyzed with the assistance of NVivo for meaning and themes. Data were examined through the theoretical lens of the social learning theory (SLT). The results of the study indicated counselors were prepared for their jobs through education and training to have longevity in working in a correctional environment and provided treatment services. The counselors found that individuals who sell drugs had a history substance use, which the individuals minimized. During treatment, counselors sought to challenge individuals who sell drugs to think and explore the effects of their behaviors. Counselors found individuals who sell drugs were able to engage in treatment to avoid negative consequences. The results of this research can encourage positive social change by initiating a discussion about assessments prior to drug treatment, characteristics of drug treatment program participants, and counselor training to improve quality of drug treatment services provided.

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# Dedication

I dedicate this to the people who have worked behind the walls. It is hard work and not always easy to be locked in too. Although the appreciation may not be expressed, there are lives that are being shaped by what you do.

Acknowledgments

I would like to thank my family and friends who have been with me in this process. It has been a long journey. I am grateful for the love and support I have received. I appreciate the understanding when I said no to things or came with my laptop.

Thank you to Dr. Haley who has been there since I started this dissertation and through its ups and downs. Thank you to Dr. Patton who came on as my methodologist. Your assistance and expertise are greatly appreciated. Thank you to Dr. Frazier for your feedback in review of my dissertation.

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# Chapter 1: Introduction to the Study

With this study, I explored the lived experiences of counselors working with individuals who sell drugs. These individuals are mandated to substance abuse treatment by the criminal justice system. Individuals who sell drugs may be mandated to substance abuse treatment but do not themselves report a significant substance abuse history. Limited literature addresses counselors' experiences with the population within the treatment setting. In conducting this research, I provided insight about counselors' experiences with individuals who sell drugs who are mandated to substance abuse treatment. This clinical perspective can provide insight on the current referral and treatment methods and initiate discussion about potential treatment alternatives.

In Chapter 1, I will provide background information about individuals who are arrested for selling drugs and how the criminal justice system handles those arrested for those charges. I will also identify the gap in the research, state the problem and purpose of this study, state the research question, identify the theoretical framework, state the nature of the study, define key concepts and state the assumptions, scope, delimitations, and limitations. I will then conclude the chapter with the significance of the study.

## Background

The *War on Drugs* during the 1980s was a time when there was an increase in the number of arrests for drug sales and manufacturing. In 1980, 22% of total drug offense violations and peaked at 36% in 1991 (Bureau of Justice Statistics [BJS], 2011). In 2014, almost 18% of drug related arrests were for drug sales and manufacturing (Federal

Bureau of Investigation [FBI], 2015). The serving of long prison sentences, or the threats of them, were not found to be deterrents in reducing drug sales (Johnson, 2003).

Criminal thinking is an individual's thought content and process that encourages the initiation and maintenance of continual lawbreaking behavior (Walters, 2006). Individuals with severe criminal thinking and low drug use problem severity or no drug use problems may be suited for services with a focus on criminal thinking errors (Knight, Garner, Simpson, Morey, & Flynn, 2006). Court systems have referred these offenders to substance abuse treatment with the belief that the behavior could be addressed therapeutically as it was connected to the disease of addiction (Murphy, 2011). Counselors in substance abuse treatment programs face many challenges as individuals who are incarcerated tend to be defensive and oppositional and are likely to relapse (Marshall & Serran, 2004; Perkins & Oser, 2014). Criminal history is examined by the criminal justice system to determine whether an individual is amenable to rehabilitative services (Marlowe et al., 2003). Individuals who sell drugs are often not appropriate for the treatment setting and may become disruptive to treatment activities (Peters, 1992).

After a thorough and exhaustive search, I found no current research that discussed counselors' experiences working with individuals who sell drugs who are mandated to treatment but who do not themselves use drugs. I wanted to learn about counselors' observations of, and interactions with, these individuals who primarily sell drugs who are mandated to substance abuse treatment. In learning counselors' experiences, a discussion could be initiated about current treatment referrals, treatment engagement, and recidivism of individuals who sell drugs who are mandated to substance abuse treatment. My study

could also create research opportunities to examine treatment placement from the perspectives of the individuals who sell drugs who are mandated to treatment.

## Problem Statement

In 2014, more than 1.5 million arrests occurred for drug related violations nationally (FBI, 2015). Of those arrests, almost 17% were for the sale or manufacturing of drugs (FBI, 2015). At the end of fiscal year 2012, all but 0.5% of individuals who had committed drug offenses within federal prisons were incarcerated for drug trafficking (Taxy, Samuel, & Adams, 2015). Most of these individuals received 10- to 20-year sentences (Taxy et al., 2015). At the state level, more than 12% of the prisoners were incarcerated for other drug offenses (Carson & Anderson, 2016).

Counselors, within the correctional environment, may face barriers with this population they serve (Marshall & Serran, 2004; Perkins & Oser, 2014). A gap in the literature exists regarding the lived experiences of counselors working with individuals who sell drugs who are mandated to substance abuse treatment but who do not themselves use drugs. Counselor educators and supervisors may be ill equipped to train counselors to work with, and meet the needs of, individuals who may not be appropriate for the treatment setting but who are mandated to participate. Treatment for incarcerated individuals is a method to reduce the likelihood of committing future criminal offenses (Knight et al., 2006; Olver, Stockdale, & Wormith, 2011). This takes place by addressing criminal thinking, which includes attitudes supportive of crime (Olver et al., 2011). Treatment based in cognitive behavioral techniques is an effective treatment approach for the reduction of recidivism among the offender population (Landenberger & Lipsey,

2005). Individuals who are convicted of selling drugs are often referred by the criminal justice system to substance abuse treatment due to their criminal offenses and the assumption they are addicted to drugs because they sell them (Miller, 2009; Tiger, 2011). They may not be best suited for intensive substance abuse treatment due to their lack of substance abuse history (Marlowe, Patapis, & DeMatteo, 2003).

Research was needed to advance the knowledge about counselors' experiences who work with individuals who sell drugs in treatment settings. After a thorough and exhaustive search, I found no current research about the lived experiences of counselors working with individuals who sell drugs who are mandated to substance abuse treatment, but who do not themselves use drugs. I did not find current literature that explored the effectiveness of substance abuse treatment with individuals who sell drugs or specific examples of how function in the treatment setting. Counselors have direct interactions with this population and can provide reports of behaviors observed, interventions used, and the effectiveness of treatment in bringing about change. Interviewing counselors helps to begin to understand what the individuals who sell drugs are experiencing and could be gaining from treatment from a clinical perspective. Alternatives to substance abuse treatment programs could be created by the criminal justice system to reduce inappropriate referrals to substance abuse treatment and address specific treatment needs to reduce recidivism of individuals who sell drugs as a result.

## Purpose of the Study

In this qualitative, hermeneutic phenomenological study, I examined the lived experiences of counselors working with individuals who sell drugs and who are mandated

to substance abuse treatment, but who do not report a significant substance use history. I interviewed counselors and learned about their experiences and insights in working with this population through the lens of the SLT. This provided a clinical perspective about the treatment engagement, treatment needs, and observations of peer interactions of individuals who sell drugs who are mandated to treatment.

## Research Question

What are the lived experiences of counselors who work with individuals who report a primary problem of selling drugs, who are mandated to a substance abuse treatment program, but who themselves do not use drugs?

## Theoretical Framework

The theoretical framework for this research is the SLT developed by Ronald Akers (Akers, 1985; 1998). Its foundation is from Sutherland's differential association theory (Sutherland, 1947 as cited in Akers, 1998). Differential association theory proposed that individuals learn criminal behavior through interacting with others who provide them with both criminal and anti-criminal patterns (Akers, 1998). In SLT, the individuals' probability to engage in criminal and deviant behavior will increase when they differentially associate with those who commit crime, have favorable definitions toward the acts, are exposed to criminal models either in-person or symbolically, and have received or anticipate greater rewards than punishment for engaging in the behavior (Akers, 1998). The four major components of this theory are differential association, differential reinforcement, definitions, and imitation, and I will further explain these points in Chapter 2 (Akers, 1998). I used SLT as a lens to understand the counselors'

behaviors and interactions with the individuals who sell drugs within the treatment program and the counselors' observations of convicted drug sellers interacting with their peers while in treatment. The SLT helped in the understanding of treatment engagement and treatment effectiveness in changing behaviors and thinking that counselors may report about the individuals who sell drugs who were mandated to treatment. I discuss the theory in more detail in Chapter 2.

## Nature of the Study

I used a qualitative hermeneutic phenomenological approach to learn about the lived experiences of counselors working with individuals who sell drugs and who are in substance abuse treatment, but who do not themselves use drugs. I selected this approach because it has potential to obtain specific information and detailed accounts about counselors' experiences with individuals who sell drugs. The qualitative approach is a process to explore and understand meaning that is given to a social or human problem (Creswell, 2009). Qualitative research communicates someone's experiences in his or her own words to tell a story (Patton, 2002). For this study, I used the hermeneutic phenomenological approach, which explores the nature or meaning of lived experiences. Van Manen (1990) describes *phenomenology* as the "systematic attempt to uncover and describe the structures, the internal meaning structures of lived experience" (p. 10). This specific type of phenomenology does not focus solely on obtaining information about lived experiences. Hermeneutic phenomenology is interpretive (Van Manen, 2014). Counselors provided their experiences, which were interpreted through SLT, to gain insight about individuals who sell drugs, who were mandated to treatment. This was an

opportunity to gain specific details about behaviors that are displayed and treatment engagement of individuals who sell drugs who are mandated to treatment.

I collected data through semistructured interviews with substance abuse counselors who worked in therapeutic community substance abuse treatment programs within a correctional facility. Through interviews, I had the opportunity to obtain detailed descriptions of experiences and insight from the counselors about their work with individuals who sell drugs who are in substance abuse treatment. I conducted the interviews using the web-based application Skype and audio recorded them. I transcribed them following the completion of each interview. I coded the interviews, which is the process of reviewing collected data and identifying significant terms for themes in accordance with procedures set forth by van Manen (2014). I interpreted the data that I collected through the lens of the SLT. I used NVivo to complete the process of coding and data analysis.

## Definitions

The following are definitions of key terms related to this research:

*Client*: A person in search of or referred to the professional of a counselor (American Counseling Association [ACA], 2014).

*Correctional facilities*: Correctional facilities include prisons or jails that are meant for the confinement or rehabilitation of individuals convicted of criminal offenses (Code of Federal Regulations, n. d.).

*Cognitive behavioral therapy* (*CBT*): CBT is an evidenced-based treatment practice that emphasizes identifying and changing maladaptive thinking to change behavior and enhance self-control (National Institute on Drug Abuse, 2012).

*Counselor*: A counselor is an individual within an addiction treatment program who provides support, education, and nonjudgmental confrontation when addressing clients psychological, social, and vocational issues (Lewis, Dana, & Blevins, 2014; Mercer & Woody, 1999).

*Criminal thinking*: Criminal thinking is an individual's thought matter and process that encourages the initiation and maintenance of continual lawbreaking behavior (Walters, 2006).

*Drug offense*: A drug offense is any violation of law that forbids the production, importation, distribution, possession, or use of certain specified controlled substances and synthetic narcotics (BJS, 2011).

*Incarcerated individuals*: Incarcerated individuals are individuals who are confined to a prison or jail or other environments in which they are locked up overnight (BJS, 2016).

*Individuals who sell drugs*: Individuals who sell drugs, also known as drug dealers, are individuals who are involved in the distribution of illicit drugs such as cannabis, heroin, or cocaine or narcotics that were provided by a distributor who expected money upon the drugs being sold or bought for sale (Atkyns & Hanneman, 1974; Murphy, Waldorf, & Reinarman, 1990; Shammas, Sandberg, & Pedersen, 2014).

*Offenders*: Individuals who are charged with, or convicted of, any type of criminal offense are called offenders within the criminal justice system (Code of Federal Regulations, n.d.).

*Recidivism*: Recidivism is the act of an individual who reengages in criminal activity following having been previously punished and released from incarceration. This includes individuals who are rearrested, reconvicted, or returned to custody with three years of release from incarceration or placement on probation (Pew Center on the States, 2011).

*Treatment engagement*: Treatment engagement is the commitment to the therapeutic process and participation in a collaborative relationship with the therapist to address and improve ones' condition (Lizardi & Stanley, 2010).

*Treatment retention*: Treatment retention is the length of time an individual remains in treatment (Krebs, Brady, & Laird, 2003).

*SLT*: SLT assumes that the same learning process can produce conforming and deviant behavior (Akers, 1998, p. 50). The behaviors' direction of conforming or deviant behavior is influenced by the context of social structure, interaction, or situation (Akers, 1998).

*Substance abuser*: A substance abuser is an individual who has a maladaptive pattern of substance use that causes adverse consequence because of repeated use (Center for Substance Abuse, 2005).

*Substance abuse treatment program*: A substance abuse treatment program provides services and interventions that are focused on treating substance use disorders

(Center for Substance Abuse, 2005). For the purpose of this research, substance abuse treatment programs will represent the therapeutic community within a correctional setting unless otherwise noted.

*Therapeutic community* (*TC*): A therapeutic community is a structured treatment modality that promotes a global lifestyle change which includes abstinence from substances and demonstration of prosocial attitudes and behaviors for successful reintegration back into society (DeLeon, 1989, Vanderplasschen et al., 2013).

## Assumptions

I identified multiple assumptions related to the execution of this study. First, I thought that I would be able to recruit enough study participants based on my recruitment strategy. All participants would be participating voluntarily. Second, I thought that the counselors could read and comprehend English to appropriately respond to my questions. Third, I assumed that I would be able to build rapport with each counselor. I also assumed the counselors will be open, honest, and share without bias. Fourth, I thought counselors were qualified for their counseling positions based on education and experience and that the counselors were educated and trained on the TC modality of treatment and know how to engage with individuals in the treatment settings. I assumed that counselors could define individuals who sell drugs, but who do not themselves use drugs. I assumed counselors would have been able to develop insight when working with individuals who sell drugs in a substance abuse treatment program during the course of their jobs. Fifth, I assumed that counselors adhered to their employers' policies and procedures as well as the ACA Code of Ethics in their counseling work.

Sixth, I assumed that the assessment protocol would be adequate to obtain detailed responses from the counselor participants. When asked, counselors should be able to explain reasoning behind responses given. I assumed the information gained during the interview would be adequate to apply the hermeneutic circle during data analysis. I was aware if my own personal thoughts and behaviors was influencing my conducting of this research.

In qualitative research, the researcher becomes engaged in the research to understand what is taking place and to learn the perspective of the participants in detail (Hathaway, 1995; Jacob 1998; Setia, 2017). Phenomenologists and hermeneuticists believe "a situation or occurrence cannot be comprehended without one's own knowledge about the situation (Hathaway, 1995, p. 546). The researcher's knowledge can act as a guide in interpreting the information obtained during the research (Hathaway, 1995). Specifically, with hermeneutic phenomenology, understanding individuals or situations is a result of understanding their culture, social context, skills and activities, and meanings (Benner, 1994; Wojnar & Swanson, 2007). There is a threefold forestructure of understanding which is applied when interpreting information. The components of the forestructure are fore-having (being familiar with a situation because of prior experience), fore-sight (prior experience provided a point of view used to make an interpretation), and fore-conception (prior experience creates expectations that might anticipate an interpretation) (Benner, 1994). The researcher must reflect on his or her own experiences to use the fore structure of understanding thought of by study participants (Benner, 1994; Wojnar & Swanson, 2007).

## Scope and Delimitations

I wanted to gain an understanding about the lived experiences of counselors working with individuals who sell drugs, but who do not report a primary problem of substance use, in the TC treatment setting while incarcerated in conducting this research. The Office for Human Research Protections (2004) defined *prisoners* as a vulnerable population. The lived experiences of counselors would be the focus of my research due to the lack of direct access to individuals who sell drugs. Counselors would provide details about their experiences with, and observations of, individuals who sell drugs who are mandated to treatment, but who do not themselves use drugs. This would provide a clinical perspective on the issue and add to existing literature on the population. There have been noted concerns in the literature about the appropriateness for individuals who sell drugs, but who do not themselves use drugs, engaging in substance abuse treatment due to the lack of substance use history and potentially posing a high risk to substance users who are in recovery (Marlowe et al., 2003; Peters, 1992). My research assists in understanding the treatment needs of individuals who sell drugs who are mandated to treatment, but who themselves do not use drugs, during or following their time in treatment from a clinical perspective.

I had the following delimitations in my study. I excluded counselors who have worked only in non correctional based treatment programs. Participants were counselors who have had at least 2 years' experience in the field, who had worked in a correctional-based therapeutic community setting, and who had identified working with individuals who sell drugs in this setting. Counselors did not have to be currently working in that

setting to be eligible to participate in the study. I excluded counselors who do not have a minimum of a master's degree. Individuals who sell drugs was the population that counselors were asked to share their experiences.

The delimitations of this study may influence the ability to transfer my findings to other counselors working with the drug offender population. Counselors' experiences working in a therapeutic community treatment program had to be minimum of 6 months. Counselors' education and experience could have influence how they interacted with the population and their observations related to treatment engagement.

## Limitations

I identified multiple limitations for my study. One limitation is that the counselors I interviewed had to have experiences, within the last 2 years, of working with individuals who sell drugs in a correctional setting. An additional limitation is that counselors' beliefs about individuals who have been convicted of crimes, substance users, and individuals who sell drugs could have influence their responses about their observations and engagement of these treatment program participants. A third limitation was that I interviewed counselors about their lived experiences in only the TC. Due to the structure of the TC in a correctional setting, TC participants and the counselors would be exposed to similar program materials, roles and responsibilities, and treatment environment. I did not explore the experiences of counselors who worked within other treatment modalities or settings as they may be less similarities across programs. I focused on the lived experiences of counselors within a specific treatment modality as TC is a notable modality within criminal justice settings. Another limitation is the

generalizability of the data. The participants interviewed were not representative of the all states that have TC programs in correctional settings and were not demographically diverse.

To address limitations, I had interview questions to identify when counselors' experiences with individuals who sold drugs took place. This helped counselors to understand past and current trends in treatment placement for individuals who sell drugs. Questions were also posed regarding what counselors' beliefs were with regard to the offender population and the subgroups of substance users and individuals who sell drugs. Even if counselors had experiences in other treatment settings and modalities, counselors were informed to share their experiences only with working in the correctional setting and the TC for their responses.

## Significance

The significance of this study was to learn from counselors about their experiences of working with individuals who sell drugs and who were mandated to substance abuse treatment but did not have a substance use history. In conducting this research, I contributed to the limited literature about counselors' knowledge of individuals who are incarcerated for selling drugs, who were mandated to treatment even though they themselves do not use drugs, and their associated behaviors and outcomes while in treatment. Counselors' experiences contributed to the insight in understanding this populations' level of treatment engagement and appropriateness for a highly structured substance abuse treatment program, such as a TC. If individuals who sell drugs do not believe the information in drug treatment is applicable to them, they may be

disruptive and resistant to treatment interventions as past research has supported (Peters, 1992). The counselors who work directly with individuals who sell drugs provided insight into whether substance treatment appears to be appropriate for this population.

Counselors, who work with individuals who sell drugs and who have been mandated into substance abuse treatment, shared their experiences on what they determine to be the strengths and weaknesses of referring these individuals to substance abuse treatment. The lived experiences of counselors who work with individuals who sell drugs could influence social change by initiating a discussion as to whether the separation of substance users from those individuals who primarily sell drugs is needed to influence positive treatment outcomes for both populations. My research results assist in further understanding the experiences of counselors working in correctional based treatment program settings and the challenges they face when working with the individuals who use or sell drugs. Counselor educators and supervisors will be better able to train counselors to address challenges and facilitate treatment services.

## Summary

In Chapter 1, I introduced my research study. I sought to learn about the lived experiences of counselors who work with individuals who sell drugs and who are mandated to substance abuse treatment programs, but who do not themselves use drugs. With this qualitative research study, I conducted semistructured interviews with counselors to learn of their experiences and their responses will be explored through the lens of the SLT. With this research, I contributed to the minimal literature about

individuals who sell drugs and their referral to substance abuse treatment from the perspective of the counselors who facilitate the treatment.

I will start Chapter 2 with an introduction and an explanation of the literature search strategy that I used. I will also provide an in-depth explanation about the theoretical framework for my study as well as provide information about individuals who sell drugs, the therapeutic community, and counselors who work with individuals who are incarcerated. I will discuss the past research related to my topic and after an exhaustive literature review, I will identify the gap I found in the research about the lived experiences of counselors working with individuals who sell drugs and who are mandated to substance abuse treatment, but who do not themselves use drugs.

# Chapter 2: Literature Review

If an individual has been arrested for drug possession or drug sales, the criminal justice system implies that the individual may also have a history of substance use (National Institute on Drug Abuse, 2014). Individuals who report primarily selling drugs may be referred or mandated to substance abuse programs for treatment due to their criminal offenses, punishment, and the belief they are addicted to drugs because they sell them (Miller, 2009; Tiger, 2011). The absence of significant substance abuse history may contribute to these individual's lack of amenability to treatment (Marlowe et al., 2003). Individuals who sell drugs may disrupt treatment activities and become triggers for individuals who are attempting to address their substance abuse issues and recovery (Peters, 1992). Although state prisons have seen a decrease in the number of admissions for drug offenses other than possession (i.e., drug trafficking, drug distribution, drug manufacturing), drug offenses still make up more than 17% of the corrections population. This is in both new court commitments and parole violations, whereas drug possession make up 7.8% and 8.7% respectively (Bureau of Justice Statistics, 2013). The former Attorney General, Jeff Sessions, released a memo in May 2017 directing prosecutors to pursue the most serious provable offense and to instate the use of mandatory minimum sentencing (Office of the Attorney General, 2017). These directions reverse previous directions that reduced the sentencing for some nonviolent drug violations (Ruiz, 2017). This could mean the continued referral of individuals who were incarcerated for selling drugs, to mandatory substance abuse treatment programs because of their criminal offenses and not their substance use history. Individuals who sell drugs have been noted

to undermine the commitment of a drug free-lifestyle that individuals who are drug users may be working toward in treatment (Peters, 1992).

With this study, I wanted to learn about the lived experiences of counselors working in corrections-based therapeutic community treatment model who work with individuals who report primarily selling drugs but who do not themselves use drugs. I was interested in exploring the perceptions and observations of counselors of how these individuals function in the treatment setting. After I conducted an exhaustive literature review, I could not find research regarding the specific experiences of counselors who work with individuals who sell drugs within a therapeutic community treatment setting.

Within this chapter, I will include the literature search strategy, theoretical orientation, and key concepts related to the topic. The concepts I will discuss include counselors working in therapeutic communities, the definition of *drug selling* and its history, the characteristics and motives of individuals who sell drugs, and the therapeutic community modality of treatment and its use within correctional settings.

## Literature Search Strategy

I conducted a literature search utilizing library databases and Internet search engines. The databases that I used were Academic Search Complete, Bureau of Justice Statistics, Dissertations and Theses at Walden University, ERIC, Expanded Academic ASAP, Google Books, Mental Measurements, Yearbook with Tests in Print, Open Library, Pro Quest Central, Pro Quest Criminal Justice, PsychARTICLES, PsychBOOKS, PsychINFO, Sage Premier, SocINDEX with Full Text, and Walden Library Books. I also used Internet search engines Google and Google Scholar.

The initial key search terms that I used were *drug dealers*, *criminal thinking*, *substance abuse treatment*, and *substance abuse counselors*. Additional key search terms that I used were *drug sellers*, *drug trafficking, selling drugs*, *narcotic sales*, *drug dealing*, *street dealers*, *offenders*, *inmate*, *drug offenders*, *cognitive distortions*, *incarceration*, *jail*, *therapeutic community*, *jail-based treatment drug treatment*, *residential substance abuse treatment*, *treatment engagement*, *Maryland, Baltimore*, *criminal lifestyle theory*, *criminal behavior*, *counseling professionals*, *perceptions*, and *lived experiences*. I used these terms alone or in combinations when searching databases and Internet search engines.

I conducted the initial search for peer-reviewed literature that was published within the last 5 years. I expanded the initial search time frame due to the limited material that I found. In conducting an exhaustive literature review, the literature I will be discussing may be beyond what would be considered current. I broadened the search to books, presentations, periodicals, dissertations, and statistical data to find current and historical data related to the topic. Due to the limited research regarding individuals who have been incarcerated for selling drugs, who are mandated to treatment, but who do not themselves use drugs. I also explored disciplines outside of counseling, such as business and education.

## Theoretical Foundation

The theoretical foundation that I used for this research to understand criminal behavior is the SLT developed by Ronald Akers, (Akers, 1985; 1998). SLT assumes that the same learning process can produce either conforming or deviant behavior (Akers,

1998, p. 50). Conforming behaviors, such as following the rules, or deviant behavior, such as participating in criminal activity, are influenced by the context of social structure, interaction, or situation (Akers, 1998). Akers developed this version of the SLT based on the differential association-reinforcement theory of criminal behavior, which had its foundation from Sutherland's differential association theory (Burgess & Akers, 1996; Sutherland, 1947 as cited by Akers, 1998). Sutherland proposed that individuals learned criminal behavior through interacting with others who provide them with both criminal and anti-criminal patterns (Akers, 1998). The balance of these patterns will determine whether individuals conform with abiding by the law or participate in deviant behavior. The differential association-reinforcement theory incorporated the concept that behavior can be differentially reinforced by its consequences (Akers, 1998).

Akers's (1998) SLT central definition is an individual's probability to engage in criminal and deviant behavior will increase when they differentially associate with those who commit crime, have favorable definitions toward the acts, are exposed to criminal models either in-person or symbolically, and have received or anticipate greater rewards than punishment for engaging in the behavior. Variables mutually motivate and control delinquent and criminal behavior and promote and undermine conformity (Akers, 1998). Yarbrough, Jones, Sullivan, Sellers, and Cochran (2012) described SLT as being the general theory of crime to explain a range of crimes from violence to substance use. This theory will be used to understand counselors' engagement, communication, and behaviors with individuals who sell drugs who are placed in substance abuse treatment,

but who do not themselves use drugs. The main components of this theory are differential association, differential reinforcement, definitions, and imitation (Akers, 1998).

*Differential association* is the process of communication and interactions with others that can be direct and indirect and verbal and nonverbal (Akers, 1998, p. 52). Associations can influence the amount, frequency, and probability of reinforcing conforming or deviant behavior based on exposure and priority given to them (Akers, 1998). Sellers et al. (2005) noted that experiencing the definitions and behaviors of others can have a powerful influence on an individual's own definitions and behaviors. Akers (1998) acknowledged that family and its dynamics can affect future delinquent and criminal behavior as well as peer associations. Counselors verbal and nonverbal interactions with the individuals who sell drugs in a substance abuse treatment setting can shape counselors' beliefs and influence counselors' interactions with that population.

*Differential reinforcement* is a learning mechanism in which behavior is a result of the frequency, amount, and probability of the rewards and punishments experienced following the engagement of the behavior (Akers, 1998). Counselors' use of techniques will be influenced by responses received from the individuals who sell drugs. If the benefits of engaging in the act outweighs the costs, the act will be carried out (Sellers et al., 2005). Behavior is "strengthened through reward (positive reinforcement) and avoidance of punishment (negative reinforcement) or weakened by aversive stimuli (positive punishment) and loss of reward (negative punishment)" (Akers, Krohn, Lanza-Kaduce, & Radosevich, 1979, p. 638). Counselors who experience or observe positive interactions and engagement among peers in treatment with individuals who sell drugs,

because of an intervention, may continue to incorporate the intervention along with praise to positively reinforce the behaviors.

*Definitions* are the beliefs, attitudes, justifications, orientations, and values individuals hold that influence the engagement or non-engagement of behavior (Akers, 1998; Sellers et al., 2005). These are verbalizations, cognitions, and behaviors that can directly reinforce and act as cue stimuli for other behavior (Akers et al., 1979). These definitions can be shaped by peer associations or experiences. Counselors' definitions could influence their engagement and use of techniques with the individuals who are incarcerated for selling drugs who are in mandated treatment, but who do not themselves use drugs. Individuals are likely to engage in a behavior when the behavior is positively defined or defined as justified (neutralizing definition) (Boeringer, Shehan, & Akers, 1991).

*Imitation* is the observation and modeling of others' behaviors (Akers, 1998). These role models can include the significant others the person admires, those with whom the individual has a perceived personal relationship with, and those with whom the individual has directly observed (Sellers et al., 2005). Models of behavior can also be found in pictorial, verbal, and visual depictions in the media (Akers, 1998). After the first experience with the behavior, imitation is not as important as the definitions, which are shaped by the experience (Akers et al., 1979). Modeling can have a facilitative effect in maintaining or changing behavior (Akers, 1998). Counselors should be consistent in how they address individuals who sell drugs who are in treatment in order encourage treatment engagement and as a training method for other staff.

SLT is a theory that has been tested, strongly supported, commonly endorsed as a theory of crime and deviance (Cochran, Masklay, Jones, & Sellers, 2017). A significant portion of the research is on predicting and explaining substance use (Akers & Lee, 1999; Akins, Smith, & Mosher, 2010; Kim, Akers, & Yun, 2013; Mui, Sales, & Murphy, 2014). SLT has also been applied in the understanding of intimate partner violence (Cochran et al., 2017; Cochran, Jones, Jones, & Sellers, 2016), and behavioral self-control (Boman, Ward, Gibson, & Leite, 2012; Yarbrough et al., 2012). After an exhaustive literature search, I found no literature on the application of this theory regarding the lived experiences of counselors working with the offender population.

Yarbrough et al. (2012) sought to determine whether differential association, differential reinforcement, and procriminal definitions were moderated by an individual's level of self- control when examining varying criminal propensity. Middle school and high school students volunteered to participate in a cross-sectional study to examine crime and delinquency. Of the 1,674-student sample, 621 high school students and 1,043 middle school students composed the population. The sample was evenly split by gender. The sample was predominantly White at 74%. The research question was to what extent did differential association, differential reinforcement, and procriminal definitions interact with self-control for SLT to be viewed as a general theory of crime. The researchers hypothesized that peers would significantly interact with self-control and differential association, differential reinforcement, and procriminal definitions would operate equally across levels of self-control (Yarbrough et al., 2012).

The students completed a 17-item scale to assess antisocial behavior and an 11-item scale for self-control. The SLT components, definitions, peer associations, and reinforcements were assessed based on the four types of delinquency: skipping school, stealing something worth $50 or less, hitting someone with the idea of hurting them, and using marijuana. Definitions were operationalized through the evaluation of four types delinquency with responses ranging from 1 (strongly disagree) to 4 (strongly agree). The higher valued responses would indicate procriminal definitions (Yarbrough et al., 2012). The researchers measured peer associations by asking participants to report what portion of their friends committed any of the four types of delinquency. The researchers measured reinforcements by asking participants if friends respected the study participant for getting away with any of the four types of delinquency (Yarbrough et al., 2012).

The researchers' results further supported the use of SLT as a general theory of crime (Yarbrough et al., 2012). Each social learning component and self-control was independently related to antisocial behavior (Yarbrough et al., 2012). Peers and definitions components were found to be strongly correlated to antisocial behavior ($r$ = .39) (Yarbrough et al., 2012). Differential associations and differential reinforcements were not found to moderate self-control ($r$ = .41), which may be attributed to the type of data that was collected and the study being cross-sectional. Reinforcements were not found to have interacted with self-control nor was it found that the effect of peers was moderated by self-control (Yarbrough et al., 2012).

Yarbrough et al. (2012) noted limitations of the research. One limitation was the study was a cross-sectional design. The results were from data collected at one moment

in time and throughout the participants' developmental process as they age. The results of this study may not be generalizable to all adolescents as the participants were only from Largo, Florida. Another limitation was that all criminological constructs were not reviewed. The authors noted an exhaustive list of SLT constructs were tested within the study, but additional ones, such as opportunity, could have been assessed to reveal other person-environment interactions. Researchers suggested this study be replicated to further explore theory in conjunction with antisocial behavior (Yarbrough et al., 2012).

Person-environment interactions can affect antisocial behavior in multiple ways (Yarbrough et al., 2012). This study is relevant to the current study as it provides a non-substance abuse application of SLT and its use as a general theory of crime. In learning about the lived experiences of counselors with individuals who sell drugs, one area of focus will be understanding individuals who sell drugs in the environment of a substance abuse treatment program and their peer interactions. Self-control and the environment may affect the thinking and behaviors related to selling drugs and other delinquent behaviors from the counselor perspective.

I selected SLT for the current study to facilitate in the understanding of the lived experiences of counselors working with individuals who sell drugs who were mandated to substance abuse treatment, but who do not themselves use drugs. This will be the lens to facilitate my understanding of counselors reported observed interactions of individuals who sell drugs with substance users in treatment. This theory will be the framework for understanding what counselors are working with and observing with these individuals in

treatment. The elements will provide a lens for understanding the beliefs and behaviors counselors may experience when working with individuals who sell drugs.

After I conducted an exhaustive literature search, there was no research found that studied the application of Akers' SLT to individuals who sell drugs or to the lived experiences of counselors working in a substance abuse treatment program. This theory has been characterized as a general theory for crime and can be applied to a range of criminal behavior (Yarbrough et al., 2012). This research can provide insight into the application of this theory with specific populations and settings. As a result of learning the counselors' lived experiences, the identified rehabilitative needs can enable individuals who sell drugs to learn to control criminal behavior and promote conformity. Counselors, who work with these individuals, can help to identify problematic behavior and might be able to provide insight as to what steps need to be taken to address and change the behavior of those incarcerated for selling drugs, but who are not substance users. This understanding can either encourage or discourage the continued referral to substance abuse treatment of individuals who sell drugs, but who do not report the use of drugs.

### Counseling Professionals Working in Therapeutic Communities

Information in this section pertains to the understanding the role and experiences of counselors who work with individuals in substance abuse treatment. I did not find literature on the lived experiences of counselors who have worked with individuals who were convicted of selling drugs and then were mandated to a substance abuse treatment program, but who do not themselves use drugs. The literature that was

reviewed was on substance abuse counselors and their experiences working with individuals. Subtopics in this section include (a) counselor training, (b) counselors' experiences working with individuals who are incarcerated, and (c) counselors' experiences working within correctional facilities.

**Counselor Training**

Within the field of substance abuse counseling, there a can be a range of educational backgrounds. Culberth (2000) noted that counselors who were nonrecovery, who had no history of substance abuse or addiction, were likely to have a graduate degree and a professional license; whereas recovery counselors usually had a high school diploma and a substance abuse certificate. Counselors in recovery demonstrate a commitment to the profession by seeking education and certification to maintain themselves professionally in the field (Curtis & Eby, 2010). Sias, Lambie, and Foster (2006) found substance abuse counselors with higher levels of education had increased conceptual complexity, cognitive functioning, and moral reasoning. Licensed counselors described themselves as being confident in their ability to provide substance abuse counseling (Chandler, Balkin, & Perepiczka, 2011). This was based on their training in ethics, experiences treating substance abuse or related issues, or taking an elective course about substance abuse counseling during their time in school (Chandler et al., 2011).

Counselors are expected to practice within their scope of competency and based on their credentials engage in supervision or continuing education credits for further training (ACA, 2014). Schmidt, Ybañez-Llorente, and Lamb (2013) noted supervisors within the addiction field are found to be overworked, not prepared to supervise, and

overburdened. This may limit their ability to provide quality supervision, which may contribute to the significant number of ethical violations reported among substance abuse counselors (Schmidt et al., 2013). In their research, West and Hamm (2012) found that only 16 out 57 clinical supervisors in their study had taken formal course work in clinical supervision. Counselor training, workshops, and self-study approaches increase counselor knowledge, but have minimal influence on counselor behavior and implementation of evidence-based practices (Olmstead et al., 2011). Olmstead et al. (2011) found that private treatment programs did not provide their counselors initially, or annually, with training for programs they were responsible for disseminating. There were no set guidelines for training hours established (Olmstead et al., 2011). The need to improve education curriculum, courses, training, and supervision of counselors has been identified in order to ensure effective services are being provided to clients within treatment programs (Lee, 2014; Olmstead, Abraham, Martino, & Roman, 2011; Rakovshik & McManus, 2010). For this study, only counselors with a master's degree, who have worked in a TC within a correctional facility for at least two years, are eligible to participate.

**Counselors Working with Individuals who are Incarcerated**

Working with individuals who are incarcerated can be challenging due to their tendency to be defensive and oppositional (Marshall & Serran, 2004). Counselors may experience challenges with individuals who are incarcerated due to a substance abuse disorder, mental health disorder, or both (Sung, Mellow, & Mahoney, 2010). To reduce challenges, individuals who are incarcerated should receive feedback that reduces blame

and has a positive therapeutic stance. Individuals who are incarcerated lack of trust and belief that their criminal history will be viewed as unacceptable makes them anticipate rejection from professionals (Marshall & Serran, 2004). When a supportive and encouraging environment is created, individuals who are incarcerated have been found to be motivated to effectively participate in the treatment (Marshall & Serran, 2004). Counselors can assist in generating change by modeling prosocial behavior in being flexible, warm, and empathetic. Opportunities for appropriate behaviors of individuals who are incarcerated to be reinforced should be created while in treatment (Marshall & Serran, 2004).

Taxman and Bouffard (2003) examined how counselor characteristics, especially counselors' treatment orientation, influenced the development and delivery of effective treatment services to clients involved in drug court. The researchers conducted their study with four drug court sites within California, Louisiana, Oklahoma, and Missouri based on their length of operation. The researchers collected data about program implementation using structured, direct observation methodology. Each program experienced a 4-day on-site visit to observe meetings provided by the sites. The observers were trained graduate students. The observers were attended an intensive training that covered therapeutic models, practice coding session, and pre-test of the methodology (Taxman & Bouffard, 2003). The observers were trained graduate students who observed group sessions facilitated by the counselors with the clients and recorded time spent in activities, treatment topics, recorded narrative information, and summary scales (Taxman & Bouffard, 2003). The summary scales provided additional detail about the services that

were being offered at the program (Taxman & Bouffard, 2003). The scale categories were cognitive-behavioral, education and aftercare, safety and self-exploration, 12-step (Alcoholics Anonymous/Narcotics Anonymous) and TC (Taxman & Bouffard, 2003). Program counselors completed surveys about their educational background, credentials, previous counseling experiences, and typical counseling and related duties. Two additional questionnaires included questions about counselors' personal beliefs regarding the cause of individuals' drug abuse through the application of theory as well as counselors' thoughts about the components needed for effective treatment. Only 38 surveys (54 %) were completed and returned (Taxman & Bouffard, 2003).

The counselors, who were surveyed, had an average age of 41 (Taxman & Bouffard, 2003). An age range was not stated for the surveyed participants. The participants were ethnically diverse with Caucasian (28.6%), African-American (28.6%), and Hispanic (23%) counselors. There was a significant number with a high school diploma (40 %) and several with a bachelor's degree (no percentage provided), and 40 % were in recovery.

Counselors appeared to be knowledgeable of the various types of therapeutic interventions which coincided with their belief of the philosophies of the causes of addition. The counselors believed the causes of addiction were related to the personalities or experiences of individuals. Counselors did not have a strong tendency to use one therapeutic model over another when working with clients. The survey results indicated that counselors would benefit from additional training to understand the different therapeutic models to select one model to use (Taxman & Bouffard, 2003). Taxman and

Bouffard (2003) noted counselors increased their ability to work and treat diverse offender populations when they were educated and understand other models. Although not current, this article provides insight into the training needs of counselors working with individuals who use drugs and criminal justice involved.

In reviewing the literature about counselors working with individuals who are incarcerated, one area of focus is how the work is affecting the counselors regarding burnout, turnover, and compassion fatigue (Carrola, Olivarez, & Karcher, 2016; Oser, Biebel, Pullen, Harp, 2013; Perkins & Sprang, 2013; Young, 2015). Prevention and intervention services are proactive measures that can be taken by program management to address the emotional well-being of staff working in the programs (Perkins & Sprang, 2013). Perkins and Sprang (2013) interviewed 20 substance abuse counselors, who work with individuals in prison and community facilities, and had them complete the Professional Quality of Life Scale (ProQOL R-IV) and the General Empathy Scale (GES). The researchers assessed the compassion fatigue, burnout, and compassions satisfaction of the counselors to examine if the substance abuse service delivery features that may be connected to professional quality of life. Study participants who scored high on the Compassion Fatigue Subscale on the ProQOL-IV found that working with women was more challenging (Perkins & Sprang, 2013). Women do not seek treatment at the same rate as men, which may mean they are deeper into their addiction by the time they receive help (Perkins & Sprang, 2013). Participants with personal connection, whether it was the participants' themselves or family member, with recovery, may be more susceptible to compassion fatigue (Perkins & Sprang, 2013).

Perkins and Oser (2014) sought to explore the differences between substance abuse counselors used in prison versus community settings regarding level of organizational support and job frustration. The research also examined if organizational support was associated with job frustration. The researchers hypothesized that counselors working in community settings would have higher levels of organizational support and lower levels of job frustration and that counselors who believe there is higher levels of organizational support would describe lower levels of frustration (Perkins & Oser, 2014).

In this study, the researchers characterized organizational support as the sharing of information, brainstorming, advising, feedback, emotional support, and assistance with tasks. They further defined job frustration as circumstances that interfered with the counselor's job performance (Spector, 1997). Researchers used data from the National Criminal Justice Treatment Practices Survey which was conducted by the Criminal Justice Drug Abuse Treatment Studies (CJ-DATS) in 2005. The paper and pencil survey examined organization factors and addiction treatment services for the criminal justice population with data being collected from prisons, jails, probation and parole, and community treatment providers (Perkins & Oser, 2014).

The researchers measured the independent variables were counselor characteristics, workplace setting, and organizational support and the dependent variable of job frustration. Due to missing survey data, the researchers were only able to use 267 out of 281 participant surveys. The survey used a 5-item Likert scale for item responses. The researchers used descriptive statistics and an ordinal logistic regression analysis. Counselors working in a prison setting only represented 29% ($n$ = 77) of the overall

sample. The characteristics of these counselors were male (*n* =37), White (*n* = 53*),* in recovery (*n* = 16), with a master's degree or higher (*n* = 22), and an average of 6.2 years in current job experience (*n* = 6) (Perkins & Oser, 2014).

Perkins and Oser (2014) hypotheses were supported regarding organizational support and job frustration. In comparing substance abuse counselors who work in prison and community-based treatment environments, the researchers found that community-based counselors experienced less job frustrations and reported higher level of organizational support (Perkins & Oser, 2014). Counselors in prisons tended to have a reduced amount of resources and available wraparound services. Correctional facilities are bureaucratic institutions, which may have workers feel alienated. The environment has an emphasis on safety and security and not on rehabilitation (Perkins & Oser, 2014). The multivariate analyses found that White substance abuse counselors experienced higher rates of job frustration than non-White counselors (*OR* = 2.07; 95% CI = 1.26-3.38) (Perkins & Oser, 2014).

Perkins and Oser (2014) noted limitations related to the study. One limitation was their use of secondary data, which may not have appropriately measured the key concepts. An additional limitation was the low rate of response. Counselors who were frustrated with their work situation may have chosen not to complete the survey which could have influenced the findings. The surveys were self-report which can also lead to questions of participant honesty and the effect of negative affectivity (Perkins & Oser, 2014). The survey sample was not nationally representative, which influences the generalizability of the results. Perkins and Oser (2014) noted as another study limitation

that job frustration was a comprehensive construct that was measured by a single question item.

This study is relevant to the current research study because it provides insight into the characteristics of those working with individuals who are incarcerated. With an increasing demand to provide substance abuse treatment services for individuals in various settings, it is believed to be important to be aware of the characteristics of those who treat them (Perkins & Oser, 2014). The study findings indicated that the environment may affect the counselors' ability to do their job if they experience job frustration and lack of organizational support. A supportive work environment can reduce counselor burnout and job turnover, which can affect treatment services (Perkins & Oser, 2014). When supported, counselors feel protected from negative consequences that are a result of job frustration (Perkin & Oser, 2014).

**Counselors' Experiences Working within Correctional Facilities**

Prisons are viewed as places that can be unpredictable due to the common occurrence of institutional changes and unusual or unusual events (Ramluggun, Lindsay, & Pfeil, 2010). At times, there can be emphasis on safety for staff and those incarcerated more so than on rehabilitation (Resig & Lovrich, 1998). As a result of criminal or addictive thinking, the population can be can be difficult and dangerous (Masters, 2004). This can contribute to the barriers of trying to treat the individuals while incarcerated. Due to the environment, counselors who work within prisons face multiple roles, such individual counselor and environmental consultant, as well as multiple responsibilities, such as solving ethical dilemmas and maintaining confidentiality (Scott, 1985).

Counselors also may encounter treatment participants who may not be receptive to being mandated to treatment (Shearer & Ogan, 2002). Treatment participants' resistance may also be a result of counselors' lack of skill in addressing participants' needs, providing inadequate goal setting, or using bad or inflexible treatment programs (Masters, 2004). Counselors, who work with mandated individuals in treatment services, should inform them of the consequences of not participating appropriately in treatment program (ACA, 2014).

With the researchers interviewing substance abuse program participants in a correctional substance abuse treatment setting, the participants' responses identified that primary motivation for treatment participation was the potential for an early parole opportunity (Goodrum, Staton, Leukefeld, Webster, & Purvis, 2003). Parole opportunity, which is an early release from incarceration, may overshadow the desire to participate in the program. Goodrum et al. (2003) also highlighted that the prison environment can place strain on the program staff and participants. Staff of the substance abuse program noted that race, lack of institutional support, and lack of staff as challenges to facilitating treatment. The participants of the program expressed that the difficulties related to the program were the lack of counselors' understanding and minimal opportunities for individual counseling (Goodrum et al., 2003)

After conducting an exhaustive literature review, I did not find literature on the lived experiences of counselors who have worked with individuals who primarily sell drugs in a substance abuse treatment program, but who themselves did not use drugs. Existing literature is limited about how this population engages in a substance abuse

treatment program from the counselors who provide them with clinical services. Research is needed to advance the knowledge about counselors who work with individuals who sell drugs, but who do not themselves use drugs, within treatment settings. The SLT is a framework through which to understand the counselors' observations and interactions with the individuals who sell drugs, but who do not themselves use drugs, within the treatment program. In obtaining the lived experiences of the counselors working with these individuals, additional research can be initiated to further explore counselors' experiences and current treatment options.

## Individuals Who Sell Drugs

The topic of this section is individuals who sell drugs and their placement in substance abuse treatment when they themselves do not use drugs. Subtopics among this section will include (a) a drug control history description of individuals who sell drugs, (b) description of individuals who sell drugs, and (c) treatment options for individuals who sell drugs.

### Drug Control History

Substance use became an increased problem with the 19th-century inventions of the hypodermic needle or syringe, the isolation of morphine from opiates, and the commercial sale of heroin initiated in 1898, and the isolation of cocaine hydrochloride from the coca plant (Johnson, 2003). The use of the hypodermic syringe and the use of opium and morphine to treat the wounded from the American Civil War are the blame for significant amount of drug addiction here in the United States (Levy, 2014). Physicians were using the needles to administer the drugs to the soldiers. The drugs were used to

treat pain, diarrhea, headaches, hemorrhoids, typhus, syphilis, and neuralgia (Levy, 2014). In the decades following the war, there was an increase in the number of people who were using opiates and their methods of administration were by smoking or orally (Levy, 2014). The commercial sale of heroin and cocaine ultimately led to international agreements in the 1920s to limit sales for medical purposes (Johnson, 2003). The Bureau of Narcotics ultimately became involved to ensure that doctors were not prescribing these substances to individuals with a substance abuse problem (Johnson, 2003).

Drug control in the United States initiated in the early 20th century, with the creation of the Federal Bureau of Narcotics (FBN) (Drug Enforcement Agency [DEA], n. d.). Although the agency was viewed as being responsible for stopping drug addiction, it focused on the international drug trade, especially heroin (Pembleton, 2015). Along with the FBN, there was the Bureau of Drug Abuse Control (BDAC) to assist with drug law enforcement. This agency's focus was the control of drugs such as depressants, stimulants, and hallucinogens (DEA, n. d.). With multiple agencies working toward the same cause, the FBN and BDAC merged together and was replaced with the Bureau of Narcotics and Dangerous Drugs (BNDD) from 1968-1973 (DEA, n. d. a). The purpose of this new agency was to work with state and local governments to reduce their drug trade, work internationally to suppress the trade of drugs, and to facilitate ad nationwide campaign of research and education on drug abuse and its effects (DEA, n. d.).

The National War on Drugs was initiated and became law under President Nixon in the 1970s (Amundson, Zajicek, & Hunt, 2014). A majority of the money was allocated for prevention and treatment with the other one third was for interdiction and

enforcement (Amundson et al., 2014). This brought about the creation of the Drug Enforcement Administration (DEA) in July 1973. This agency still exists and remains focused on the national and international drug trade and drug education (Amundson et al., 2014).

The BJS was created in December 1979 under the Justice Systems Improvement Act of 1979 to gather, analyze, publish, and dispense information regarding crime and the criminal justice system as the local, state, and federal levels (BJS, n. d.). The BJS' collection of data enables the agency to track trends in criminal activity and assess the demographics of those who are involved with the criminal justice system. Data are collected and analyzed annually and periodically on the local, state, and national levels. The BJS is a component of the Office of Justice Programs within the Department of Justice (BJS, n. d).

Data reflected a significant spike in the number of individuals incarcerated related to drug offenses in the 1980s and the numbers have continued to fluctuate over time (BJS, 2013). The FBI Uniform Crime Reporting Reprogram (UCR) defines drug abuse violations as any violations of law that, "prohibit the production, importation, distribution, possession, or use of certain controlled substances" (marijuana, opium, and cocaine and their derivatives, and synthetic narcotics) (BJS, 2011, p. 12). These violations are further separated by possession or use and sale or manufacture. Twenty-two percent of arrests in1980 were for drug sale or manufacture violations and these arrests peaked at 36% in 1991 and dropped to 19% by 2009 (BJS, 2011). Additionally, in the 1980s, the Anti-Drug Abuse Act of 1986 was integral part of the war on drugs as it

reinstated mandatory minimum sentencing for drug possession and provided money to engage in drug enforcement (Eisen & Chettiar, 2015).

During the 1990s, the DEA's focus became to address both supply and demand of drug enforcement (DEA, n. d. b). Federal agencies worked to reduce the drug supply both overseas and within the United States, when advertising programs by Partnership for a Drug-Free America emphasized, which the reduction of demand through prevention, education, and treatment (DEA, n. d. b). In order to address both sides of drug enforcement, the DEA budget continued to increase reaching over a billion dollars in 1997 (DEA, n. d. c). Cocaine and crack were still the top problematic drugs, but authorities, during the early 1990s, experienced an increase in the use of heroin and marijuana (DEA, n. d. b). Smugglers were beginning to bring in more heroin into the United States via South America as opposed Asia, where it had been primarily from previously, which contributed to the increased supply (DEA, n. d. b). During the late 1990s there was an increase in methamphetamine use as it became the "poor man's cocaine" (DEA, n. d. c, p. 104).

During the 21st century there was an uprising in use of ecstasy and prescription opiates, such as OxyContin (Oxycodone) (DEA, n. d. d). There were increased initiatives to decrease the presence of drug cartels and other internationally organized drug trafficking (DEA, n. d. d). The DEA sanctioned operations, such as Operation Funk, Operation Double Candy Box, and Operation Wildfire, and investigated and brought awareness to drug use, prevention, and trafficking. In recent years, efforts have been focused on addressing heroin use and overdoses that have been on the rise for the last

decade (DEA, 2015a). Heroin with its increased amount of trafficking into and within, the United States, and sheer number of users, has been identified by law enforcement agencies as the primary drug threat (DEA, 2015a). Project Synergy III was to address the synthetic designer drug industry, which has also seen an increase in usage (DEA, 2015b). A report from the Charles Colson Task Force on Federal Corrections in 2015 noted that 99.4% of the individuals who were convicted of drug offenses in the federal prison system were convicted of drug trafficking with a majority of the individuals who were convicted of drug offenses not being the organizational lead or responsible for direct violence (Taxy & Kotonias, 2015) These individuals who were convicted of drug offenses served an average of over nine years due to mandatory minimums and federal sentencing guidelines.

**Individuals Who Sell Drugs**

Individuals who sell drugs, also known as drug dealers, are individuals who are involved in the distribution of illicit drugs such as cannabis, heroin, or cocaine or narcotics that were provided by a distributor who expected money upon the drugs being sold or bought for sale (Atkyns & Hanneman, 1974; Murphy et al., 1990; Shammas et al., 2014). The public and law enforcement have historically referred to individuals who sell drugs by various terms such as drug offenders, the pusher, and dope pusher (Atkyns & Hammond, 1974; Langer, 1977). Individuals who sell drugs exist because "a sufficient number of people desire to use drugs" (McMillian, 2012, p. 854).

Drug markets have had a significant effect on poor and minority neighborhoods (Rivers, Norris, & McGarrell, 2012). Visible drug markets were typically found in

predominantly Black neighborhoods that were characterized as being poor and with higher unemployment and dropout rates (Ford & Beveridge, 2004). In examining the current demographics of individuals with drug selling related offenses within federal correctional facilities, the population was predominantly Black (38.8%) and Hispanic/Latino (37.2%) and between the ages of 30-29 (Taxy et al., 2015). With the overall individuals who were convicted of drug offenses in the Federal system, there is also variation in race by drug of choice used and sold (BJS, 2015). Individuals who are convicted of crack cocaine were mainly Black (88%), powder cocaine users were predominantly Hispanic or Latino (54 percent), and methamphetamine were largely White (48%) (BJS, 2015).

**Reasons for selling drugs.** The decision to sell drugs may be influenced by a variety of reasons. In the literature, individuals engaged in selling drugs had reasons that included: (a) the belief that there are limited job opportunities due to a lack of skills and education; (b) the appeal of a lifestyle that comes with money, luxury items, power, and sex; and (c) personal substance use (Adler & Adler, 1983; Duck, 2016; Floyd & Brown, 2012; Murphy et al., 1990; Sevigny & Caulkins, 2004; Tunnell, 1993; VanNostrand & Tewksbury, 1999).

Among young adults, individuals who sold drugs are viewed as individuals who earn the most money and have the most sex partners (Floyd & Brown, 2012). Drug selling became a popular career choice for individuals who wanted fast and easy money and to obtain their own drugs (Ünlü & Ömer Demir, 2012). Selling drugs has been described as the “American Dream” to gain financial security, obtain a disposable

income, and to have a lavish lifestyle that could not be obtained through employment (Little & Steinberg, 2006; Murphy et al., 1990; VanNostrand & Tewksbury, 1999).

Floyd et al. (2010) explored the youth involvement in selling drugs as it related to their own substance use. Floyd et al. (2010) posed two research questions: does the type of drug used cause a variation in the relationship between substance use and drug dealing and is the receiving of public assistance connected to drug dealing? Two hypotheses were generated for this study. The first hypothesis is a reduction in the drug trade could occur with the use of substance use or abuse prevention and treatment due to the extent substance use if connected to drug dealing. The second hypothesis tailored interventions may be needed if the relationship between substance use and drug dealing various across race and socioeconomic status (Floyd et al., 2010).

These researchers used a data set from the National Survey on Drug Use and Health and had data from 13,706 Black and White adolescents from the United States. The measure used for the study focused on socioeconomic status (SES), substance use in the last 12 months, availability of drugs, and drug distribution. The researchers collected the data between 2005 and 2009 from civilian, non-institutionalized adolescents who were 12 years and old throughout the United States and the District of Columbia. To encourage willingness to report honestly about behaviors and confidentiality during the in-person interviews, the researchers did not collect the names and a computer-assisted method were used (Floyd et al., 2010).

The researchers analyzed the data via descriptive statistics and a backwards stepwise logistic regression (Floyd et al., 2010). Floyd et al. (2010) found similarities in

drug selling behaviors across race with varying patterns of substance use. Black adolescents who used marijuana were found to be 13 times more likely to engage in selling drugs than those who were not using marijuana. Other substances used for personal use, cocaine (AOR = 1.8; 95%, CI = 1.06, 2.97), hallucinogens (AOR = 1.9; 95%, CI = 1.26, 2.86), and misuse of prescription drugs (AOR = 2.6; 95%, CI = 1.78, 3.79) did not influence the adolescents significantly in the engagement of selling drugs (Floyd et al., 2010). The availability of crack and marijuana among Black adolescents also influenced their drug selling (AOR = 1.5; 95% CI = 1.06, 2.27). White adolescents who used marijuana, hallucinogens, cocaine, and prescription pills were more positively associated with selling drugs. White adolescents who misused prescription drugs were three times more likely to be selling drugs. The results indicated that White adolescents were less likely to sell drugs out of economic deprivation and those who received public assistance were less likely to be sellers (6.4%). No relationship was found between drug dealing and socioeconomic status among Black adolescents (Floyd et al., 2010).

VanNostrand and Tewksbury (1999) conducted 20 semistructured interviews to examine the motives of individuals who sell drugs and how to operate a drug business without being discovered. The findings were then used to offer suggestions related to future drug war policy. Most of the study participants were African American ($n$ = 16), whereas the remainder were White. Eighty percent of the participants were male. The mean age was 31 years, with an age range of 19 to 48 years. Of the participants, 30% were married, whereas 70% were divorced or never married, and 80% had children. Ninety-five percent of the participants identified themselves as crack dealers and

recreational drug users, with the drugs of choice typically being marijuana and cocaine. All participants had at least one drug conviction of either drug trafficking or drug possession. Each person was also participating in a drug court program in a Midwestern city and were identified by group counselors as having a history of selling drugs or to have been likely involved with selling drugs (VanNostrand & Tewksbury, 1999).

VanNostrand and Tewksbury (1999) found the three motives that encouraged participants to sell drugs were financial gain, greed, and the lifestyle. With the financial gain, selling drugs was the primary source or additional source of income to support themselves and their families. Selling drugs was an opportunity to earn fast money and stability as there was perceived obstacles to obtaining substantial gainful employment. Those whose motive was greed sold drugs to obtain luxuries and enhance their lifestyles as their basic needs were being met, because they had conventional employment, or they operated legitimate businesses (VanNostrand & Tewksbury, 1999).

The participants in this study reported averaging $2000 to $5000 a day in earnings from selling drugs (VanNostrand & Tewksbury, 1999). They maintained employment or their businesses as a visible means for the selling of drugs (VanNostrand & Tewksbury, 1999). The third reason for selling drugs was infatuation for the lifestyle. Selling drugs is a fast-paced lifestyle that afforded the participants money, recognition, power, and respect. The participants in this study reported being able to live in nice neighborhoods and obtain possessions, which caused them to continue to sell once reaching the point of financial stability (VanNostrand & Tewksbury, 1999). The dealers would avoid detection by engaging with known customers, selecting safe locations to conduct transactions,

properly managing the drugs and money, and maintaining employment (VanNostrand & Tewksbury, 1999).

VanNostrand and Tewksbury (1999) noted that there needs to a shift in demand reduction versus supply reduction. This would be a proactive approach to the issue of drugs as the current approach is reactive. VanNostrand and Tewksbury (1999) noted the need for funding and increased accessibility for prevention, education, and treatment to address the drug problem. VanNostrand and Tewksbury (1999) stated a need for the criminal justice system to aid in reforming drug dealers rather than focusing on detecting, arresting, and incarcerating them.

Tunnell (1993) explored the relationships between selling and using drugs, connections with buyers and sellers, and the buying and selling networks from the perspective of those who were incarcerated for drug trafficking. The participants were men incarcerated at a medium security prison for drug trafficking. There were eight Caucasian and two African American participants who ranged in age from 29 to 46 years. Only two participants had their General Education Development (GED) and the others had not completed high school. Their work histories were noted as being erratic and in menial jobs, which included construction, the restaurant industry, the Army, and church pastor. Data was collected via official records, which was used for demographic and arrest and incarceration histories, loosely-structured individual interviews, and field notes (Tunnell, 1993).

Participants reported they initially became involved in selling drugs to support their own substance use as teenagers (Tunnell, 1993). Of the 10 participants, eight

reported being always addicted to drugs, which is why they continued to sell drugs. The majority sold the drug they were addicted to which was primarily Dilaudid (Hydromorphone) and cocaine. Selling drugs allowed participants to have continued access to their drug of choice and potentially make a profit. It also afforded them the ability to make informal connections with future buyers. They could make some money and gained status and excitement from selling. Only two of the participants made selling drugs into a career choice and the others did not want to advance beyond their operations which was low- to mid-level. Their beliefs were that "real dealers" did not get caught by law enforcement or were incarcerated at federal prisons (Tunnell, 1993).

Moyle and Coomber (2015) examined the motivation, behaviors, and roles of those who have a drug addiction and engage in selling drugs. In a span of five months, thirty semistructured interviews were conducted with 'user-dealers.' Participants were obtained through the snowball sampling method. There were 20 male participants and the remaining female and their ages ranged from 19 to 52. Eighty-seven percent identified heroin as their drug of choice, but many were poly-substance users as they used stimulants and downers with varying frequency in addition to the heroin (Moyle & Coomber, 2015).

From the participants' interviews, it was indicated that the primary motive for selling drugs for the user dealers was to support their own substance use (Moyle & Coomber, 2015). The participants reported they struggled to support themselves and their basic needs as a majority of their money went to personal substance use. Participants (64%) reported selling drugs to people they referred to as acquaintances. They were not

motivated by making a profit, but by obtaining their substance of choice. Selling drugs afforded them the ability to avoid crimes such as robbery, theft, and sex work and it was viewed as less harmful and risky. Participants described selling drugs as a convenient option and a way to control their addiction (Moyle & Coomber, 2015).

These studies are examples as to why individuals initiate and continue selling drugs. In conducting semistructured or loosely structured interviews, researchers were able obtain direct responses from participants about their experiences. Based on the provided direct quotes and interview analysis, it appeared the participants were forthcoming in the interview process about their activity related to selling drugs. A limitation of the studies is the transferability of results. Participants, in each study, were limited to individuals located in one area's criminal justice system. An additional limitation is that samples for each study were not equally diverse in race or gender. Each study had a race that was dominant in the sample. This current study can be a reference as counselors share their lived experiences working with individuals who sell drugs. Counselors may have insight regarding these individuals and their reasons for becoming involved in selling drugs as result of the program participants disclosing their history during groups or initial assessments.

**Treatment for Individuals Who Sell Drugs**

In an exhaustive search of the literature, there was no peer-reviewed research found regarding clinical treatment specifically for drug dealers. Highland and Dabney (2009) obtained participants for their study from a Drug Dealer Intervention, but there was no specific information provided about the program. The search did yield a

newspaper article regarding treatment for individuals who sell drugs. Kane (1995) reported about an experimental program being conducted at an Alcohol and Drug Recovery program in Maryland. The identified "drug dealers" who were on probation were referred to this agency for weekly 90-minute group sessions. The sessions focused on behavior change and vocational training. This program was to help separate the drug dealers from the drugs users as program directors found that, "the drug dealers didn't want to be in therapy and the addicts were reluctant to open up in the presence of dealers" (Kane, 1995, para. 4). Michael Bergeson, head of the narcotics unit for Maryland's state's attorney's office, believed that not everyone involved with drugs needed treatment. He stated that those dealers, who were not addicted to drugs, were not in need of treatment. Director Barry Wilen, of Alcohol and Drug Recovery, stated that drug dealers have their own addiction that should addressed (Kane, 1995). A further search did not yield additional information or outcome data about this experimental program.

Gaudenzia, Inc. (2010) has developed a curriculum specifically for individuals who sell drugs titled: Drug Dealer's Program. This eight-week program focuses on the three motivations for selling drugs: (a) As a way for the substance abuser to make money to support his or her addiction, (b) As a way for a person to earn easy money or escape poverty, and (c) there is compulsion behavior- addiction the high or risk of selling (Gaudenzia, Inc., 2010). Participants in the program are expected to be honest about their selling and identify changes that they need to make in his or her lifestyle, behavior, and attitudes in order to prevent a return to selling. Participants are further expected to complete given assignments, use a relapse workbook, and develop a personal recovery

plan from selling drugs. I conducted a further search about the curriculum which did not yield additional information about the current use of this program in the Gaudenzia treatment programs nor was literature found regarding program outcomes.

**Individuals who sell drugs and who are referred or mandated to substance abuse treatment.** Individuals with drug-related offenses are often referred to substance abuse treatment due to their criminal offenses and noted history of substance use (Tiger, 2011). Individuals have learned that reporting a history of substance abuse could result in reduction of sentencing, increased chance for leniency, or placement in a program versus prison by the criminal justice system (SAMHSA, 2005). Therefore, individuals who sell drugs may decide to falsify a history of a substance abuse problems to avoid serious consequences (Marlowe et al., 2003). Once threatened to be returned to a judge or incarceration, they might decide to report they have an addiction (Marlowe et al., 2003). Subsequently, these individuals who sell drugs maybe become eligible for diversion programs and avoid incarceration (Marlowe et al., 2003).

In New York, individuals who sold drugs were utilizing revamped Rockefeller drug laws to get released from jail by advocating that they needed treatment due to marijuana abuse (O'Shaughnessy, 2010). Clinical staff that assessed individuals for treatment appropriateness needed to be aware that someone may want to participate in treatment to look favorable to the court or views it as a strategy, even though they do not have a substance use problem (SAMHSA, 2005). Assessment tools are not designed to determine if someone is being dishonest with their self-reported substance use (Marlowe et al., 2003).

In Kansas, the Kansas Sentencing Commission developed an alternative drug policy (S.B. 123) to implement community-based treatment to nonviolent substance using individuals (*Kansas Law Review,* 2014). The emphasis was placed on the substance users and not those who sell them the drugs. This law implements probationary supervision and mandatory drug treatment for individuals who qualify. The qualification criteria included being convicted of unlawfully possessing a controlled substance and whether it was the individual's first or second offense. individuals, who have been convicted of offenses related to the selling of drugs, such as manufacturing and distribution, are not eligible to participate in the treatment program (*Kansas Law Review,* 2014). This criterion would prevent individuals who have been convicted of selling drugs from being placed in the program in which they are not appropriate for due to their charges.

In California, it is estimated that annually 50,000 nonviolent individuals enter the criminal justice system (Urada, Gardiner, & Anglin, 2011). The California Substance Abuse and Crime Prevention Act (SACPA) (Proposition 36) enabled these individuals to participate in community drug treatment versus incarceration. Probation agents, in survey responses about the SACPA, indicated that the SACPA was not intended for individuals who sell drugs or for those who have committed violent acts (Urada et al., 2011). Probation agents believed, "they often require more supervision and time of the probation officer, diverting from those probationers who seek to change and require assistance" (Urada et al., 2011, p. 55). A separation of users and sellers was done by agents and the implied belief that those who sell drugs may not be seeking change or need of assistance.

Drug courts and other problem-solving courts (mental health) were developed in the 1980s as a method to address drug-involved individuals with increased criminal justice supervision and treatment (DeMatteo, 2010). In addressing the underlying problems of substance use and mental illness through court supervision, there would be a reduction of recidivism. In reviewing the literature, DeMatteo (2010) noted drug courts may be capturing individuals who misuse drugs and not those who are have diagnosable or clinically significant substance use disorder. Since drug court was meant for drug dependent participants, it may hinder those higher functioning individuals that need to attend to work, school, or child care responsibilities. Individuals who do not have a significant substance abuse problem, may be subject to group sessions with high risk individuals, self-help groups, and motivational interviewing that is focused on substance use (DeMatteo, 2010). In identifying an alternative treatment for nondrug dependent drug court individuals, the focus was on secondary prevention intervention. The emphasis being on preventing the development of a substance use disorder. The intervention included steps to enhancing motivation, functional analysis, activity scheduling, and self-monitoring amongst individuals, as well as, judicial status hearings (DeMatteo, 2010). Although this article highlighted the need for treatment alternatives for nondrug-dependent individuals, it did not specify if the nondrug dependent individuals were individuals who sold drugs.

Due to the rate of drug involved individuals, correctional facilities have become viable settings to screen, assess, and treat this population (Krebs et al., 2003). Individuals who sell drugs, as previously noted, may be mandated to a treatment program due to their

offenses. Peters (1992) highlighted that individuals who sell drugs may not be appropriate for in-jail substance abuse treatment. It was noted that,

> Inmates who have a history of drug dealing, but who deny regular drug use, are often inappropriate for in-jail treatment and may significantly disrupt treatment activities. Drug dealers' present reminders of high-risk situations for relapse to other program participants and may attempt to solicit new drug sales while enrolled in treatment. Dealers frequently lead other inmates to question newly developed beliefs and attitudes about treatment and may undermine commitment to a drug-free lifestyle and encourage a return to maladaptive beliefs and behaviors of the peer drug culture (para. 28).

They may become problematic in the treatment setting and may cause those who need the treatment to become unfocused on learning tools to prevent relapse (Peters, 1992).

Individuals who sell drugs may be find themselves referred or mandated to a TC program, which has become the prominent modality of treatment within correctional facilities (Barnett, 2009). The first correctional TC program was implemented in 1969 at the federal penitentiary, United States Penitentiary, Marion (Lipton, 1998). It was designed by Dr. Martin Groder based on transactional analysis training and group therapy experiences while in California (Lipton, 1998). The peer group or community was intended to be the vehicle of change using group counseling in conjunction with concepts and language of the transactional analysis (Lipton, 1998). Over the years, TC programs have continued to be implemented and evolve within federal, state, and local facilities to

respond to the increased number of drug involved individuals and to aid in the reduction recidivism (Jensen & Kane, 2013; Knight, Hiller, & Simpson, 1999; Mitchell, Wilson, & MacKenzie, 2007; Olson & Lurigio, 2014).

## Substance Abuse Treatment: The Therapeutic Community Defined

The topic of this section is substance abuse treatment, provided within the TC, which is used to treat individuals within the criminal justice system who have a history of substance use or drug-related offenses. Subtopics within this section will include (a) demographic information about those currently incarcerated within the United States (U. S.) for drug abuse violations (b) the purpose of treatment for this population, and (c) the effectiveness of treatment in general and the effectiveness of mandated treatment specifically.

**Demographics.** There is a desire and a need to treat this ever-growing population of drug abuse violators to reduce substance use and criminal activity (Chandler, Fletcher, Volkow, 2009). As of September 2014, 50% of the male federal prison population consisted of individuals with drug abuse violations (BJS, 2015). Within state facilities, drug offending males made up 15% (186,000 inmates) of the population (BJS, 2015). The lack of life skills, the experience of incarceration, and reentry obstacles contribute more to recidivism than criminality (Krisberg & Marchionna, 2006).

**Treatment purpose.** The objective of drug treatment is to encourage a significant reduction in drug use that may not have happened without treatment (Gerstein, 1990; Pelissier et al., 2000; Olson & Lurigio, 2014). Additionally, treatment may assist in, "reducing street crime, developing educational or vocational capabilities, restoring

employment, averting fetal exposure to drugs, or improving general healthy, psychological functioning, and family life" (Gerstein, 1990, p. 845). When substance users (heroin and cocaine) participate in substance abuse treatment, there is a reduction criminal behavior, including the selling of drugs (Wexler, Lipton, & Johnson, 1988). Substance abuse treatment programs can address more than just individuals' substance use. Treatment provides an opportunity for individuals to adequately prepare for societal reentry and obtain applicable skills to cope with life stressors in order to avoid returning to drugs, alcohol, or criminal activity upon release (Hkansson & Berguland, 2012; Severson, Burns, Veeh, & Lee, 2011)

**Treatment effectiveness.** Johnson (2003) noted that over time criminal justice practitioners have found that the cycle of arrest, incarceration, and probation has had little influence on drug use and minor criminality. Mandating substance abuse treatment may be the most effective in reducing selling (Johnson, 2003). Long prison sentences may continue to exacerbate the problem as individuals who are incarcerated for long periods of time can have increased criminal thinking and attitudes (Mandracchia & Morgan, 2010).

Individuals who are incarcerated may find themselves coerced into substance abuse treatment. Individuals who are place in treatment by referral from the criminal justice system are typically assumed to be admitted not by choice (Prendergrast et al., 2009). Legally mandated or court-ordered treatment and coercive treatment are used due to the research findings that correctional treatment programs reduce recidivism (Parhar, Wormith, Derkzen, & Beauregard, 2008). Gowan and Whetstone (2012) described the

mandatory, state-subsidized treatments, which are affiliated with drug court and other diversion programs, as “strong-arm rehab” (p. 70). These programs were intended to control the poor and re-socialize these individuals, which in most cases were poor African Americans (Gowan & Whetstone, 2012). Mandated or coerced treatment sanctions were not found to be effective in custodial (correctional) settings, yet they are still employed (Parhar et al., 2008). Individuals may experience a perceived lack of personal choice to participate in these settings in which they are mandated to than individuals mandated in community settings. Day, Tucker, and Howell (2004) discussed the favored term “pressured” versus coerced regarding individuals participating in treatment. The decision to engage in treatment is influenced by the potential negative consequences that can be imposed. Although the terms are similar, individuals may feel as those in being pressured there is a level choice in determining whether to be compliant (Day et al., 2004).

**The Therapeutic Community**

The topic of this section is the TC and its use within the criminal justice system. Subtopics within this section will include (a) definition, components, and structure of the TC, (b) why the use of the TC as a modality of treatment, (c) TCs in correctional facilities, (d) CBT within a TC, and (e) treatment retention and recidivism.

**Definition, components, and structure of the TC.** The TC is a treatment modality that is used in various treatment settings. De Leon (1989) whose seminal work on the TC stated the primary goal of the TC is a change in lifestyle which includes abstinence from illicit substances, the cessation of anti-social activity, obtainment of

employment, and the demonstration of prosocial attitudes and values. The successful integration of social and psychological goals can result in stable recovery (DeLeon, 1989). The TC uses social and psychological therapy that was meant to address attitudes, beliefs, personal responsibility, and behaviors in a group setting with peer interaction being as significant component of the treatment process (Olson & Lurigio, 2014; Stohr et al., 2002). Veale, Gilbert, Wheatley, and Naismith (2015) noted that psychodynamic therapist characterize the TC as an environment and program in which the social and group process relate to therapeutic intent. The community, which is staff and peers, is the structural foundation and primary method of treatment through the demonstration of pro-social behaviors (Gale & Sanchez, 2011; De Leon, 1989). Therapeutic communities are known for the process of habilitation as participants may need to learn life skills and disciplined behavior versus relearning (Gowan & Whetsone, 2012).

With the TC model, adopted from his previous works, De Leon (1989) described the TC perspective as having four components. The *View of the Disorder* characterizes the substance abuse as a disorder of the whole person as the areas of cognition, beliefs, behavior, and mood may be affected. Addiction is seen as a symptom. The *View of the Person* highlights the demographics and backgrounds of individuals who may enter treatment. Despite their differences, all those in treatment present with impeded social function and personality that caused or was a consequence of the substance use. The component of *View of Recovery* is the idea that rehabilitation is global as it looks at the psychological (transformation of behavior, thinking, and feelings associated with substance use) and social (create a responsible, substance free lifestyle) goals which

when integrated can lead to stable recovery. It also incorporates motivation, self-help, social learning, and treatment as an episode. The final component is *View of Right Living*. This component stressed the need for appropriate social living. Values that are noted as being essential to social learning and personal growth are truth and honesty, work ethic, personal accountability, self-reliance, responsible concern, and community involvement (De Leon, 1989).

The TC is a highly structured, phase format treatment modality. The treatment day may start at early as 7 a.m. and conclude at 11 p. m. (De Leon, 1989). The operation of the community is primarily peer driven under the guidance of staff (De Leon, 1989). Each community member is given a job function that is assigned within the community based on treatment seniority and progress. Clients are encouraged to become self-reliant as well as part of the community to improve its overall functioning. The staff act as the rational authorities and oversee client activities and groups as well as facilitate therapeutic groups. Those staff, who are in recovery, are to role model personal change and demonstrate how their rehabilitation enables them to be in the role of staff in the community (DeLeon, 1989).

Participants of the TC engage in a phase format that guides their course of treatment (DeLeon, 1989). The length of these stages depends on the client progress and the designated length of treatment. The first stage is orientation. Treatment participants receive education about the TC and begin to integrate into the community. Phase two is the primary phase of treatment in which participants focus on socialization, personal growth, and psychological awareness through the engagement of treatment activities.

Phase three is the reentry phase which is further divided into early and late reentry. In this phase, participants are expected to demonstrate self-management with little reliance on the structure and oversight of staff. With early reentry, participants remain at the facility and begin to work with their counselor on plans for community separation. They may have begun working or attending school outside of the treatment facility. In late reentry, participants no longer reside at the treatment facility. They are expected to continue to engage in their early reentry activities and have weekly contact with their counselor for support. The culmination of this phase includes a graduation for participants who have remained clean for the year (DeLeon, 1989).

In some treatment settings, there have been modifications made to the TC structure. Dye, Ducharme, Johnson, Knudsen, and Roman (2009) examined modified TCs and how they can maintain the core elements of the TC. These elements are TC perspective, hierarchy, clients as therapists, work as therapy, aspects of program, and disciplinary actions. The TC modifications include applying the model to special populations (women, adolescents, and individuals with co-occurring disorders), less confrontation, flexibility with treatment phases, and increasing the individualization of treatment. To assess the therapeutic elements, the Therapeutic Community Survey of Essential Elements Questionnaire (SEEQ) was used by the researchers. This tool's dimensions are: TC Perspective, Education and Work Activities, The Agency: Treatment Approach and Structure, Community as a Therapeutic Agent, Formal Therapeutic Elements, and Process. This research was a national study examining 380 community-based therapeutic community programs that took place between 2002 and 2004.

Researchers selected programs utilizing a two-stage sampling design in which programs were randomly selected and then further screened for eligibility. In total, 380 programs took part in the study. The researchers analyzed the data using the structural equation modeling techniques (Ducharme et al., 2009).

The researchers found that the therapeutic community elements were not significantly affected in most modified TCs (Ducharme et al., 2009). Modification to structure and intensity were the most significant factors effected in adhering to traditional TC elements. This included Hierarchy, Work as Therapy, Aspects of the Program, Disciplinary Actions, and Clients as Therapists. The modified TCs maintained adherence to the TC perspective of right living. Outpatient and short-term residential program did not fully maintain core elements due to the length of time clients are enrolled. Time does not allow group development and a stable hierarchy. It was suggested that future research address this issue with the outpatient programs (Ducharme et al., 2009).

**Why the therapeutic community.** Therapeutic community treatment is intended for individuals who have major behavior and social deficits as well as a history of serious criminal activity. Therapeutic communities have been implemented with various populations and settings to address substance abuse and mental health issues with adolescents and adults (Darke, Campbell, Popple, 2012a; Dickey & Ware, 2008; Dye, Roman Knudsen, & Johnson, 2012; Ramaprasad & Kalyanasundaram, 2015). Those who participated in therapeutic communities reported less drug use, criminal activity, and the ability to maintain employment following treatment (Galassi, Mpofu, & Ahtansou, 2015; Gerstein, 1990; Mitchel et al., 2007). A primary goal of this modality of treatment is to

change behavior, thinking, and feelings associated with substance use (Barnett, 2009). There is also an emphasis on teaching positive family leadership, healthy problem-solving skills, the ability to control anger, depression, and dangerous emotions, identify and overcome addiction, and gain personal insight (Barnett, 2009).

Debaere, Vanhele, and Insleger (2014) explored the TC through participant observation to understand how and why the TC works to produce successful outcomes. A researcher herself went into a TC in Belgium for a period of three weeks and then returned to the facility presenting as a staff person. The researcher's observations found that participants of the program experienced a three-step process during their time in treatment, which started with understanding that, 'Addicted people don't feel,' the experience of an emotional awakening from being in the TC environment, and cognitive ability develops once exposed to tools (Debaere et al., 2014, p. 4). The TC was described by the participants as a frustrating and a holding environment. Participants were expected to follow a daily schedule and to use tools to vent their frustrations with activities or behaviors in the community. The community was described as a holding environment, meaning it was physically and psychological safe due to the absence of drugs, cut off from the outside world, and there were clear-cut rule of conduct. This was a reason why participants choose to stay in treatment. The longer participants are in treatment they could develop their cognitive ability which enables them to better regulate their affect (Debaere et al., 2014).

**Therapeutic community in correctional facilities.** The number of individuals has increased over the years because of mandatory sentencing for offenses and the

number of individuals who are abusing drugs (Knight, Hiller, & Simpson, 1999). Due to the rate of substance using individuals, correctional facilities have become viable settings to screen, assess, and treat this population (Krebs et al., 2003). Some implementation of prison-based treatment programs was met with skepticism, but the reduction drug use, drug selling, infractions, and violence, which enhanced facility security, were welcomed benefits (Lipton, 1998). Therapeutic communities have been implemented within correctional facilities and have been consistently found to be effective in reducing recidivism and drug use (Ojmarrh, Mackenzie, & Wilson, 2012).

The therapeutic community model of treatment has been modified and become a prominent modality of treatment within correctional facilities (Barnett, 2009). Therapeutic community programs are implemented within a correctional facility in areas separated from the general population (Hiller et al., 1999). Programs, within correctional facilities, often have the benefits of, "better living conditions, a safer environment, parole release considerations, and opportunity to possibly change one's lifestyle" (Wexler, Lipton, & Johnson, 1988, p. 6). The services are typically provided where inmates reside which can limit privacy and influence trust amongst participants (Bouffard & Taxman, 2000). A form of funding for therapeutic communities within a correctional environment is through Residential Substance Abuse Treatment for State Prisoners (RSAT).

The creation of the Residential Substance Abuse Treatment for State Prisoners (RSAT) assisted state and local governments with the ability to develop, implement and improve residential programs in state and local correctional and detention facilities and to enable the creation and maintenance of community-based aftercare (United States Bureau

of Justice Assistance [USBJA], 2005). The RSAT funding was initiated by Department of Justice through the Violent Crime Control and Law Enforcement Act of 1994 (Miller & Miller, 2011). All states had the ability to obtain funding if they met the requirements: (a) program participation is 6 to 12 months, (b) the treatment facility is physically distinct and separated from general population, (c) the program emphasis is on substance abuse, (d) the program contains components the develop behavioral, cognitive, social, and vocational skills, and (e) the program will have appropriate drug testing for participants (Miller & Miller, 2011). Residential Substance Abuse Treatment for State Prisoners programs allows for correctional staff and the treatment community to develop a program that address substance abuse and prepare for community reentry. A national evaluation of RSAT programs found that programs used on or a combination of the therapeutic communities, cognitive behavioral approaches, or 12-step program modalities (USBJA, 2005).

Wormer and Persson (2010) examined the treatment needs of individuals within the Federal Bureau of Prisons (BOP). Within federal prisons, there is the Residential Drug Abuse Program (RDAP) which is a modified therapeutic community that uses phases and CBT (Wormer & Persson, 2010; Federal Bureau of Prisons, n. d.). All substance abuse treatment programs offered by the BOP seek to address anti-social attitudes and belief to decrease the possibility of future misconduct and recidivism (Wormer & Persson, 2010). An informal survey of RDAP participants found that 88 percent only enrolled in the program to receive a year off their sentence. This along with individuals who were advised by their lawyer to report a substance abuse history

influence the environment of the TC. Individuals who do need the program may not eligible based on admission criteria, or do not want to participate, because they do not receive time off their sentence. Seventy percent did report learning about themselves and their issues from being in the program. To reduce the institutional population, there is an impetus to use drugs courts. This would be for non-violent individuals and they would be subject to intense supervision along with drug and cognitive behavioral treatment. With this study, there is no distinction regarding the types of charges and history of offenses (Wormer & Persson, 2010).

The Western Missouri Correctional Center, implemented a TC program in 2000 (Barnett, 2009). The TC was to provide individuals an opportunity "to confront and change criminal behavior, attitudes, and thinking" (Barnett, 2009, p. 249). From the perspective of the Department of Corrections, the purpose of the program was to reduce recidivism and to have improvement in behavior among individuals housed at the institution (Barnett, 2009).

The program materials and equipment needed to participate were paid for by the individuals (Barnett, 2009). Individuals wishing to participate in the program must have minimal institutional infractions within the last six months. Individuals were expected to complete an application and essay expressing their desire to participate in the program. They were then subject to an interview with peers and Staff Review Board in which they share why they want to participate in treatment, their current steps toward change, and admit to their current offense or criminal lifestyle. Individuals must receive majority vote from the Offender and Staff Review Board to participate. Once in the program,

individuals were expected to attend, at minimum, 10 groups per month in addition the mandatory groups of Orientation, Facilitating 101, Thinking Reports, and a choice of a corrective thinking class. Individuals were expected to confront peers and hold each other accountable as needed while in the program (Barnett, 2009).

The South Idaho Correction Institution (SICI) implemented a Residential Substance Abuse Treatment (RSAT) program for parole violators with substance abuse problems that found themselves reincarcerated (Stohr et al., 2002). The length of the program was nine months and was designed to address participants' addiction and criminality. The RSAT program combines cognitive self-change and 12 step programming (Minnesota Model of Chemical Dependency), within a three-month phase process. The program emphasis was on identifying thinking and behaviors which contribute to the risk of relapse for substance abuse and criminal behavior. Their strategies include the use of the group process, thinking reports, and journals. Participants moved through each and gained additional responsibility along with their seniority. Program participants were expected to be highly engaged in the therapeutic community with selecting their roles and their roles of their peers to maintain the functioning of the community. The aftercare component of the program enabled a continuum of care for program participants, which was also designed to help reduce recidivism (Stohr et al., 2002).

**CBT within the therapeutic community.** The TC incorporates a cognitive behavioral component to address and change problematic thinking that lead to substance use and criminality (Talpade & Marshall-Story, 2014; Wormer & Persson, 2010; Federal

Bureau of Prisons, n. d.; Miller & Miller, 2011; Melnick, Hawke, & Wexler, 2004). CBT focuses on the idea that beliefs and thought patterns influence behavior and feelings (Sharf, 2008). In identifying and changing maladaptive thinking, one should experience behavior change (Sharf, 2008). CBT is a noted evidence-based treatment practice for substance abuse (Sharf, 2008). Cognitive behavior therapy also emphasizes the development of skills to encourage abstinence from substance use, but to also address potential co-occurring problems (Carroll & Onken, 2005). Carroll and Onken (2005) noted that, "cognitive behavior approaches, such as relapse prevention, are grounded in social learning theories and principles of operant conditioning" (p. 1454).

Landeberger and Lipsey (2005) conducted a meta-analysis to examine the effects of CBT on the recidivism adult and juveniles who were incarcerated. Their purpose was to identify factors that associated with the variation in treatment effects. The researchers selected articles based on the intervention, participants, outcomes measures, research methods, and source. Their search strategy included various databases, cross referencing bibliographies, internet searches, journals, and informal sources. Of the 2947 citations for adults and 1487 for juveniles, the researchers selected fifty-eight studies. For each study, the researchers coded descriptive and outcome data. Categories included publication type, research design, type of recidivism, treatment length, CBT treatment type, age, and recidivism risk.

Overall, CBT was found to be effective in reducing recidivism. Individuals who participated in treatment were 1.53 ($p < 0.001$) times more likely to not recidivate within 12 months of completing treatment than those who did participate in treatment

(Landeberger & Lipsey, 2005). The mean recidivism rate was 0.40 for the control group. The mean for the treatment group was 0.30 which meant there was a 25% decrease in the recidivism rate. The researchers used a multiple regression analysis to find the moderator factors that influenced treatment outcomes. These factors included the offender's level of risk, the implementation of the treatment, and the presence or absence of treatment elements, such as anger control and interpersonal problem-solving components. The results also indicated that the general CBT approach, and not a specific program or version, were responsible for the overall positive effects on recidivism (Landeberger & Lipsey, 2005). The CBT effects were found to be greater for individuals who were at a higher risk for recidivating. Programs that provide intense treatment with the emphasis on criminogenic needs use CBT and social learning approaches (Landeberger & Lipsey, 2005).

This research had limitation and strengths in its execution and findings. The study included a limited number of random assignment designs ($n$ =19). Most the studies included programs that were for research and demonstration purposes and not conducted in the real world. With the limited data on CBT in correctional settings at the time, it is uncertain if these results would be routinely obtained. Further research will need to be conducted to determine the optimal CBT program and conditions that the most effective (Landeberger & Lipsey, 2005).

The findings of this research indicated that CBT can reduce recidivism in high risk individuals when the conditions are favorable (Landeberger & Lipsey, 2005). This study highlighted that quality program implementation is represented by low treatment

dropout rates, close monitoring of quality and fidelity of the treatment implementation, and appropriate CBT training for providers (Landeberger & Lipsey, 2005). This study also challenged the assumption of high risk individuals are not amenable to treatment as CBT effects were greater with individuals who were at high risk for recidivism. Those who are at high risk for recidivism have been found to have high levels of criminal thinking (Mandracchia & Morgan, 2010; Yang et al., 2013).

**Criminal thinking.** Although the emphasis is on reducing or eliminating substance use, another objective of substance abuse treatment is addressing criminal thinking and criminality. Criminal thinking can be characterized as, "thought content and process conducive to the initiation and maintenance of habitual lawbreaking behavior" (Walters, 2006, p. 88). Criminal thinking has been consistently reported to be predictive of poor treatment engagement and deficient client functioning (Best, Day, Campbell, Flynn, & Simpson, 2009; Garner, Knight, Flynn, Morey, & Simpson, 2007). Criminal history is a factor that is examined to determine if an offender is amenable to rehabilitative services (Marlowe et al., 2003). The high rate in which drug-addicted individuals report engaging in criminal activity indicates the rational and incorporation of a criminal thinking curriculum in drug treatment (Javier, Jose, Alfonso, & Raúl, 2013).

Mandracchia and Morgan (2010) examined the relationships between individual characteristics and criminal thinking styles to further understand criminal thinking and its role in recidivism. It was believed that their need to be efficient determined which individuals are at high risk for recidivism to provide them with treatment. Treatment that is effective in reducing criminal recidivism will have the three principles incorporated:

risk principle (intensive treatment provided to high risk individuals), need principle (emphasis should on dynamic risk factors that promote criminal behavior), and responsivity principle (the benefits of cognitive, behavioral, and social learning-based treatment and individualized treatment) (Andrews et al., 1990).

Study participants were 435 males within the Texas Department of Criminal Justice. The Black and Hispanic participants each made up 32.1% of the sample ($n$ = 139) and White participants were 27.5% ($n$ = 119). Their average sentence length was 20.2 years with crimes typically being property, drug, violent, or sexual. Participants were asked to complete a demographic form which included the status variables of age, educational attainment, incarceration information, and reception of mental health services and the Measure of Offender Thinking Styles ([MOTS] (Mandracchia, Morgan, Garos, & Garland, 2007). The MOTS is an exploratory factor analysis of 77 thinking errors which resulted in a three-factor model (control, cognitive immaturity, and egocentrism) for dysfunctional thinking (Mandracchia & Morgan, 2010).

The researchers analyzed the relationship between offender and criminal characteristics through canonical correlation (Mandracchia & Morgan, 2010). The canonical correlation statistical significance was set at .300. The status variables except age were significantly loaded. The three criminal thinking factors, control, cognitive immaturity, and egocentrism were all found to be significantly loaded at .555, .992, .640 respectively. Participants with high levels of criminal thinking were not obtaining mental health services (.799), had completed more years of education (.452), had longer sentences (.342), and had served more time on their current sentence (.465). They could

be considered “lifestyle criminals” (Mandracchia & Morgan, 2010, p. 31). These factors could be used to assist identifying which individuals maybe are more susceptible to recidivating. Treatment clinicians should be cognizant and provide appropriate services for individuals who have been incarcerated for significant periods of time as that contributes to increased criminal thinking and attitudes (Mandracchia & Morgan, 2010).

This study adds to the literature on factors that increase the likelihood of recidivating, but it does not provide information as to why those with these factors have higher levels of criminal thinking (Mandracchia & Morgan, 2010). This population may need cognitive behavioral interventions that focus on altering antisocial cognitions (Mandracchia & Morgan, 2010). Their referral to a TC program may occur because of the cognitive behavior component and the effectiveness of TC to reduce to crime (Galassi, Mpofu, & Ahtansou, 2015; Gerstein, 1990). It was noted that some of the participant crimes were drug related but did not indicate a history of substance abuse. This may also encourage their referral to a treatment program due to their offense (Miller, 2009; Tiger, 2011). This relates to the current research as it identifies how counselors working in substance abuse treatment programs may find themselves working with those who may not meet the criteria for that type of treatment.

Yang et al. (2013) examined how individuals’ pretreatment static risk of criminal history and dynamic risk of criminal thinking and treatment engagement influence recidivism. The researchers designed the study to (a) to evaluate if criminal history directly influences treatment engagement or does it influence treatment engagement through criminal thinking, (b) to more conclusively determine the effects of risks and

treatment engagement on recidivism, and (c) to examine if treatment engagement mediates the effects of risks on recidivism. Their hypotheses were that criminal history would be positively associated with criminal thinking, criminal history and criminal thinking will have a positive relationship with recidivism, and treatment engagement would mediate the influence of the risks on recidivism (Yang et al., 2013).

Study participants were 653 individuals who participated in one of four prison-based therapeutic community substance abuse treatment programs for a period of 6 to 12 months. Much of the sample were male ($n$ = 382) and the overall mean age was 34.8 with the range being from 18-67 with both genders. Participants were predominantly Caucasian ($n$ = 281) with the remainder of the participants being Hispanic ($n$ = 188) and African American ($n$ = 180). Criminal history and criminal thinking were measured at the onset of treatment. The Lifetime Criminal Involvement subscale was used from the TCU Criminal History Scale to assess criminal history. Criminal thinking was assessed via six items related to the areas of entitlement, rationalization, and personal irresponsibility. Treatment engagement was assessed with items related to treatment participation, treatment satisfaction, counselor rapport, and peer support forms. Recidivism, for the purposes of this research, was being rearrested for a felony offense within 12 months of release. This information was obtained reviewing the Department of Public Safety records (Yang et al., 2013).

The researchers used descriptive analyses and structural equation modeling analyses (Yang et al., 2013). Statistically significant correlations were found among criminal thinking components and treatment engagement components. The components

of rationalization ($r = .45$, $p < .001$) and personal responsibility ($r = .45$, $p < .001$) were statistically significant. All the treatment engagement components were found to be statistically significant, such as treatment participation ($r = .29$, $p < .001$), treatment satisfaction ($r = .58$, $p < .001$), counselor rapport ($r = .69$, $p < .001$), and personal support ($r = .53$, $p < .001$).

Sixteen percent of the sample was arrested within a year of being released. A lengthy criminal history, more criminal thinking, and low treatment engagement was connected to a recidivism risk (Yang et al., 2013). In examining the first hypothesis, the researchers found that criminal thinking predicted treatment engagement, but not criminal history. The second hypothesis was also supported as the researchers found that criminal history was positively associate with rearrests. An indicator of criminal thinking, personal irresponsibility, was also positively correlated with re-arrest. For the third hypothesis, the researchers found that criminal history had direct and indirect effects, through criminal thinking and treatment engagement, on recidivism (Yang et al., 2013).

Researchers noted multiple limitations in the execution of this study. One limitation was the use of the re-arrest data (Yang et al., 2013). Due to the time needed to process, the public records may not be an accurate depiction of the number of rearrests. Another limitation is the use of only self-reported measures of predictors. A third was the measurement of treatment engagement was measured as early engagement and did not capture the whole treatment experience. A fourth limitation is the study did not account for programmatic or contextual factors that have been known to influence treatment engagement and recidivism (Yang et al., 2013).

Yang et al. (2013) further added to the literature that individuals with higher levels of criminal thinking are at a higher risk to recidivated once released. Treatment interventions should focus on enhancing treatment engagement as well decreasing post-release risk behaviors. This study indicated how substance abuse treatment programs are expected to address not only substance abuse issues with its participants, but also criminal thinking (Yang et al., 2013). This research further supports the referral to substance abuse treatment programs to treat not only substance use, which may lead inappropriate treatment referrals if the primary problem is not substance use. Counselors working in treatment programs should assess criminal thinking in addition to substance use when attempting to develop a treatment plan for participants.

**Treatment retention and recidivism.** Although the modified TC program was found to be more effective in retaining individuals in treatment (Krebs et al., 2003), issues with retention may still present. Individuals who left a TC early had significantly lower expectations of success for their treatment experience (Darke, Campbell, & Popple, 2012b). Therapeutic Community programs have moderate to high retention rates with one set of findings being 57% rate of retention at the three to six-month mark in treatment (Mulder, Frampton, Peka, Hampton, & Marsters, 2009). In examining various types of corrections-based treatment programs, Krebs et al. (2003) found that older individuals were likely to stay in treatment longer than their younger counter parts.

A noted factor in the research that contributed to retention is the treatment environment. Emphasis should be kept on maintaining a good environmental atmosphere (Debaere et al., 2014). A sense of community and therapeutic activities contributed most

to the "ward atmosphere" (treatment environment) (Carr & Ball, 2014). The perception of the atmosphere was the most important predictor of resident dropout from the program. The system of peer-to-peer monitoring and feedback motivated program participants to engage in prosocial, helping behavior (Warren et al., 2013). This helps to maintain a quality social climate in the treatment community, which can influence individuals to remain in treatment over time (Warren et al., 2013).

Individuals, with a significant history of noncompliance, (e.g., not adhering to program rules), and who demonstrated low behavioral control, did not finish the TC treatment program (Talpade & Marshall-Story, 2014). It was suggested that individuals should be screened for these behaviors and should either be placed in alternative treatment settings or be subject to intensive behavior modification techniques while in the TC (Talpade & Marshall-Story, 2014). Krebs et al. (2003) noted that knowing which programs best retains participants helps identify which programs to implement and how to improve existing programs to obtain the desired outcome.

Treatment success is usually measured by individuals' ability to remain employed, refrain from drug use and criminal activity, and avoid needing public aid (Krebs et al., 2003). Therapeutic Community treatment programs have been found to be effective in reducing rates of re-incarceration, drug misuse, and re-arrest with individuals who use drugs, when compared to other programs (Galassi, Mpofu, & Ahtansou, 2015). Positive treatment outcomes have been associated with age, motivation for treatment, length of time in prison treatment, and time in aftercare (Galassi et al., 2015; Hiller et al., 1999; Messina, Burdon, Hagopian, & Prendergast, 2006; Lurigio, 2000; Staton-Tindall et

al., 2009; Wexler, Falkins, & Lipton, 1990; Welxer, DeLeon, Thomas, Kressel, & Peters, 1999)

Hiller, Knight, and Simpson (1999) examined the outcomes of individuals who participated in In-Prison Therapeutic Community (ITC), followed by residential aftercare and their rate of recidivism. Their research had a sample of 396 parolees with 293 completing the Kyle New Vision ITC in Texas and the remaining in a matched non-treated general population comparison group. The treatment group was further broken down to those who completed ITC only ($n$ = 123) and those who completed ITC and the 3-month residential community-based aftercare at the transitional therapeutic community (TTC). The participants were predominantly African American (45%) and between the ages of 26 and 35. They had extensive drug-related criminal backgrounds and 36% of the participants were incarcerated at the time for a drug charge. The researchers gathered information on the clients from client self-report on various questionnaires, which included information about drug use, psychological functioning, and treatment motivation and the Texas Department of Public Safety Criminal History Record Information database for recidivism data (Hiller et al., 1999).

The researchers used a quasi-experimental design with the use of survival regression and logistic regression analysis (Hiller et al., 1999). The results found that those who completed the ITC and the TTC had lower risk of being rearrested following their release and increased elapse time before being rearrested. The TTC provided an opportunity for participants to gain additional stability upon release as relapse potential is high within 90 days of completion (Hiller et al., 1999). The two treatment groups had

reduced risk of rearrests when compared to the general population group. There multiple reports of dissatisfaction with the TTC due to a lack of continuity from the ITC. The lack of "community" effected completion rates and feelings toward the program. Hiller et al. (1999) suggested it is necessary for providers to strengthen the aftercare programs to match what is experienced during the ITC (Hiller et al., 1999).

Talpade and Marshall (2014) examined the retention and progress of the Second Chance Demonstration Project, which was a therapeutic community treatment that was offered in a Fulton County, Georgia jail. This TC was implemented with the purpose of reducing the recidivism of the individuals through the treatment of substance abuse and mental health issues. The program included components such as cognitive restructuring through CBT, coping strategies, anger management, education, and parenting skills. Following the completion of the program, program participants were eligible to obtain housing, education, treatment, and therapy services. The researchers evaluated the progress over a period of nine months (Talpade & Marshall, 2014). The researchers' questions were: (a) What are the cognitive behavioral responses of the client in the therapeutic community and (b) How was thinking changed over time in the therapeutic community? (Talpade & Marshall, 2014). These questions were reflected in the hypotheses that (a) There will be differences in the risks, needs, and the daily behavioral records between current program requirements, (b) Those who are dismissed and there will be differences in the cognitive behavior responses as a function of the levels of clients, and (c) There will be differences in the criminal thinking, social functioning, psychological function, motivation for treatment which will be expected to change over

points in treatment: baseline, after six months, and at pre-release (at approximately nine months) (Talpade & Marshall, 2014).

Talpade and Marshall (2014) evaluated the program with a mixed method approach to learn the cognitive behavioral responses of participants and their changes in thinking during treatment. The study was a mixed factor design, which included two between-group factors and one within-group factor. The participants were 30 male high risk, repeat individuals. Participants' average age was 28.5 with a range from 20 to 38. The sample was predominantly Black ($n$ = 26). Sixteen of the participants had a history of a co-occurring disorder. Participants completed the Correctional Offender Management Profiling for Alternative Sanction system (COMPAS) and the Client Evaluation of Self and Treatment (CEST). The COMPAS assessed the criminogenic needs, risk, drug use, and mental health. The researchers administered the CEST at onset of treatment, then again at six months into treatment, and finally again prior to release. Most participants were in treatment for approximately nine months. The CEST evaluates motivation, psychological functioning, social functioning, and criminal thinking, and engagement. The researchers also posed open-ended questions to obtain cognitive behavior responses regarding criminal thinking (Talpade & Marshall, 2014).

Over a nine-month period, there were improvements in the cognitions and psychological functioning of most program participants making the overall outcomes good (Talpade & Marshall, 2014). Those participants whose screenings indicated a history of noncompliance, and displayed low behavioral control, did not finish the program. The researchers' first hypothesis was supported as a Mann-Whitney U test

found significant differences between current participants ($n$ = 23) and dismissed participants ($n$ = 7) on the measures of risk of noncompliance (Mann-Whitney U = 4.5, $p$ = .012), risks related to social environment (Mann-Whitney U = 39.0, $p$ = .042), and disciplinary actions and setback (Mann-Whitney U = 25.0, $p$ = .012.

The chi-square analysis of cognitive behavior response addressed hypothesis number two and found there were significant shifts in cognitions items, "Use of force and violence is sometimes appropriate," "What do you want in life," and "What do you need in life?" (Talpade & Marshall, 2014, para. 28). In testing the third hypothesis, there were decreases in depression and hostility among some participants related to time $F(2,26)$ = 4.10, $p$ = .029). Although program participants made changes as result of the program, there was no reduction in the criminal thinking measures of risk taking and cold-heartedness and areas such as problem recognition, self-esteem, and decision-making (Talpade & Marshall, 2014).

Positive participant outcomes existed for those who were not dismissed from the program (Talpade & Marshall, 2014). The results highlighted the need to conduct appropriate screening to identify those who may need intensive behavior modification techniques to shape low impulse control and noncompliance (Talpade & Marshall, 2014). The results support the effectiveness of the CBT as part of TC programs (Landberger & Lipsey, 2005).

A study limitation is that client progress may have been affected by a lack of stakeholder support of the program and staff changes. This informs the current research study as this is an additional example of the use of TC and the CBT component within

the programs that is expected to address factors outside of substance use. Counselors may have to attempt to address multiple issues with participants during their time in treatment which may contribute to recidivating.

Mitchell et al. (2007) conducted a meta-analysis of 66 treatment program evaluations to examine if incarceration-based substance abuse programs help to reduce recidivism. The goal of the study was to determine the effectiveness of these programs regarding post release criminal activity and substance use (Mitchell et al., 2007). The researchers examined studies that were experimental and quasi-experimental evaluations of juvenile and adult programs. Their criteria for study inclusion were studies that had interventions specifically targeted for substance users, and which used an experimental or two-group quasi-experimental design that also had a form of comparison group and measured post-release offending or drug use. The researchers also determined that the studies to be included needed to be conducted between 1980 and 2004, which would allow the researchers to calculate an effect size. Bibliographic databases, websites, and hand searches through journals were the methods in which articles were found for the analysis (Mitchell et al., 2007).

Mitchell et al. (2007) examined the five different program types which included therapeutic communities (TCs), residential substance abuse treatment (RSAT), group counseling, drug offender specific boot camps, and drug maintenance programs. The TC is the considered to be the most intensive modality as it attempts to negate the correctional environment and has program participants primarily running the treatment (Mitchell et al., 2007). Participants are expected to challenge one another regarding their

behavior and attitudes, but also praise and support pro-social changes. Individuals are in treatment for 6 to 12 months at a time and are house separately from the general population. The RSAT-funded programs are typically based on the TC model and last the same duration of time (Mitchell et al., 2007).

Group counseling programs exist that focus on drug education, self-help, life skills, and cognitive and behavioral skills training (Mitchell et al., 2007). There could be a component of individual counseling within this modality. The boot camp programs are highly structured and mimic military basic training. Significant confrontation exists between instructor and individuals, but it has been found that the self-discipline learned may lead to a reduction of recidivism (Mitchell et al., 2007). The final treatment approach was the narcotic maintenance program which would include methadone (Mitchell et al., 2007).

Of the 66 evaluations, 30 were TC, 10 of which were RSAT programs, 25 were counseling program, 5 narcotic maintenance programs, and 2 were boot camps (Mitchell et al., 2007). From each study, an effect size was selected and coded along with moderator variables. The researchers found that TC, RSAT, and group counseling programs were found to be effective in reducing the occurrence of re-offending and substance use upon release (Mitchell et al., 2007). The mean odds ratio for TC was statistically significant at 1.38 (95% CI 1.17 – 1.62, $p = < 0.05$). The mean odds ratio for RSAT was statistically significant at 1.39 (95% CI 1.10 – 1.76, $p = < 0.05$). The mean odds ratio for group counseling was statistically significant at 1.50 (95% CI 1.25 – 1.79, $p = < 0.05$). Boot camp programs were found not effective in reducing recidivism based

on the minimal data that could be analyzed. The odds ratios in the two evaluations on these types of programs was less than 0.14 (Mitchell et al., 2007).

With the narcotic maintenance programs, researchers found that those programs were effective in reducing post release drug use, but not reducing recidivism. The random effects mean odds ratio was large (1.94) and evaluations found lower rates of post release drug use among participants versus non-participants. The researchers found the Therapeutic Communities to be effective with various study samples, which indicates the ability to apply this modality to a wide range of individuals. Although the results were mixed, the researchers found an overall a reduction in post-treatment drug use (Mitchell et al., 2007). The only statistically significant mean odds ratio for drug use was TC 1.42 (95% CI 0.95 – 2.09, $p = < 0.10$) (Mitchell et al., 2007).

With this study, researchers added to the literature regarding the effectiveness of different treatment modalities to address the substance abuse among individuals while they are incarcerated. It is suggested these findings should influence the decisions of policy makers as they seek effective programming interventions (Mitchel et al., 2007). There is a lack of understanding which components of treatment programs are the most significant and combination of components are most effective (Mitchel et al., 2007). Due to general methodological weakness, researchers' findings could be vulnerable to alternative explanations (Mitchel et al., 2007). This study highlights how substance abuse treatment programs address more than just the substance use of it participants. With TCs having a larger effect on re-offending, this may encourage the referral of individuals to treatment who do not meet the criteria for that type of treatment. The referral of

individuals may be encouraged for those who sell drugs, so the program can potentially change criminogenic attitudes, attachment of antisocial peers, maladaptive cognitive process, or others psychosocial characteristics that maintain or develop their criminality (Mitchell et al., 2007).

The TC has been found to be effective method to treat individuals in the area of substance abuse, mental health, criminal thinking, and recidivism. The treatment environment promotes individuals coming together to support one another as well being educated by treatment staff using CBT. The TC incorporates the four components of SLT as it encourages individuals to work together (differential associations) to adhere to TC structure as well as the fostered norms and values of the community (definitions and imitation). Treatment compliance and application of information will influence individuals' treatment experiences and outcomes (differential reinforcement). Counselors working in TCs may be working with individuals who do not identify substance use a primary problem as the TC is viewed as program that can treatment multiple issues. This current research seeks to learn the lived experiences of counselors working with individuals who identify as drug dealers who are mandated to treatment.

## Summary

In Chapter 2, I described how I conducted my literature search, defined my theoretical foundation, and identified literature related to key variables related to the study. My literature search consisted of using multiple databases and search engines and terms related to my research. The theoretical foundation for this study was the SLT (Akers, 1985; Akers, 1998). I will use this theory to analyze the counselors reported

experiences with individuals who have been incarcerated for selling drugs, who are mandated to be in treatment, but who do not themselves use drugs. The literature I reviewed contained information about the history of drug control, characteristics of individuals who sell drugs, therapeutic community within a correctional setting, and counselors working in therapeutic communities and individuals who are incarcerated. There were articles that were not published in the last five years that were included as they provided relevant data on the topic and current data was limited. I completed an exhaustive literature review. In my literature search, I did not find information about the lived experiences of counselors who have worked with individuals who sell drugs in a substance abuse treatment program. I identified a gap in the research upon the conclusion of my literature review. A gap in the literature exists regarding about the lived experiences of counselors working with individuals who sell drugs within substance abuse treatment programs, but who do not themselves use drugs. In Chapter 3, I will describe the research methodology that I used to learn about the lived experiences of counselors to address the gap in the research.

# Chapter 3: Research Method

Individuals who sell drugs are often referred or mandated to substance abuse treatment programs based on their criminal offenses and authorities' belief that these individuals may be substance users because of their involvement with selling drugs (Miller, 2009; Tiger, 2011). However, minimal data suggest that this population engages in treatment. I used a qualitative, hermeneutic phenomenological approach for this study to learn about the lived experiences of counselors who work with individuals who sold drugs, and who are now in substance abuse treatment but who do not themselves use drugs. The counselors' lived experiences can help to fill the gap in the literature about the individuals who sell drugs and how they respond to treatment when they do not have a history of substance use.

In Chapter 3, I will discuss my research design and rationale, my role as the researcher, as well as my methodology, sampling method, instrumentation, procedures, and my data analysis plan. Furthermore, I will discuss issues of trustworthiness and ethical procedures. In these sections, I will provide detailed information as to how I will conduct this study.

## Research Design and Rationale

This research was a qualitative, hermeneutic phenomenological design. The population was substance abuse counselors who work, or have worked, in TC within correctional facilities. Potential participants were counselors that provided servers to individuals who sold drugs, who did not have significant substance use histories, and who were mandated to substance abuse treatment.

The primary research question was: What are the lived experiences of counselors who work with individuals who report a primary problem of selling drugs but who do not themselves use drugs, who are then mandated to substance abuse treatment program? The phenomenon I examined was the lived experiences of the counselors who treat these individuals who sell drugs and who are mandated to substance abuse treatment. I asked counselors to share their experiences working in a correctional based treatment setting with individuals who sell drugs.

Qualitative research is the practice of locating things or people in their natural environment, gathering data, and finding meaning in what was found (Denzin & Lincoln, 2011). Issues can be studied in-depth and in detail with this method (Patton, 2002). Data can be collected from multiple sources which include observations, field notes, photographs, interviews, and documents (Denzin & Lincoln, 2011). The data gathered are then analyzed and organized into themes, patterns, concepts, insights, and understandings (Patton 2002). Researchers seek to understand the meanings participants place on problem or issues, which may be done through a theoretical lens (Creswell, 2017). Interviews was my method of data collection for this study. Interviews typically have probing, open ended questions to obtain in-depth responses about a participant's experiences, perceptions, opinions, feelings, and knowledge (Patton, 2002). The qualitative approach was an effective method to gather specific details from counselors about how individuals who sell drugs engage in treatment.

Phenomenology is one of the five qualitative approaches to research (Creswell, 2017). Phenomenology is a human science and is the explanation of experiential

meanings we live as we live them (van Manen, 1990; 2014). Phenomenology examines the world as we become aware of it (van Manen, 2014). Husserl described phenomenology as a rigorous science, which would enable "a firm basis for natural science to root itself" (van Manen, 2014, p. 90). An emphasis is placed on the experience of the *what*—the intentional object, thing, entity or event as it appears in consciousness (van Manen, 2014). Phenomenology seeks how knowledge comes into being and challenges grounded assumptions (van Manen, 2014).

I selected the phenomenological approach to learn about the phenomena of the lived experiences of the counselors who treat individuals who sell drugs, but who do not themselves use drugs, but who are mandated to substance abuse treatment. I examined the phenomena through the lived experiences of counselors working with these individuals in treatment. In conducting interviews, I captured the descriptions of the counselors' experiences and how they experience these mandated clients (Patton, 2002). In engaging in phenomenological reflection as described by van Manen (2014), I bracketed the everyday attitude toward about the subject (epoche) and then return to the experience as lived (reduction). There is an emphasis on the correlation of the *what* of experience (the noema), and "how it is experienced (the noesis)" (Sloan & Bowe, 2014, p. 9). I needed to identify and analyze these to get to the essences of the experience (Sloan & Bowe, 2014).

The specific type of phenomenology I used for this study will be hermeneutic phenomenology, which is "interpretive-descriptive" phenomenology (van Manen, 2014, p. 26). The six research activities of hermeneutic phenomenological research are (a)

identifying a phenomenon that is of interest; (b) investigate the lived experience rather than as one conceptualizes it; (c) ponder themes that describe the phenomenon; (d) describe the phenomenon by way of writing; (e) keep a strong and oriented pedagogical connection to the phenomenon; and (f) demonstrate the balance of research context by reflecting on the part and the whole (van Manen, 1990). With these research activities, the researcher needs to engage in hermeneutic epoche-reduction, which is an awareness of his or her own subjective feelings, assumptions, and preunderstanding and practice openness (van Manen, 2014).

The phenomenological approach originated with Edmund Husserl and Martin Heidegger in the early twentieth century (van Manen, 2014). Husserl developed transcendental phenomenology which is also known as descriptive phenomenology (Sloan & Bowe, 2014). Emphasis is on the "experience" of the what—the intentional object, thing, entity or event as it appears in consciousness (van Manen, 2014, p. 91). No interpreting, explaining, or theorizing should take place by the researcher (van Manen, 2014). With hermeneutic phenomenology, the emphasis is on understanding the meaning of the experience through identifying themes in the data and interpreting the data (Sloan & Bowe, 2014). Researchers who use hermeneutic phenomenology seeks to obtain the subjective experiences others (Kafle, 2011). Heidegger described this type phenomenology as a method to understand an individual's nature and the world one lives in to gain a general nature of being (Schacht, 1972). Heidegger believed the goal was to allow the things of the world to have their own voice (van Manen, 1990). In just

obtaining pure descriptions, there would be a lack in understanding choices as they relate to a person's history (Flood, 2010).

**Role of the Researcher**

In qualitative research, the researcher acts as the primary instrument for data collection (Creswell, 2009). Interviews are one most used methods when conducting qualitative research (Creswell, 2017). I conducted interviews to learn about the lived experiences of counselors who have worked with individuals who sold drugs, but who did not themselves use drugs, but who were mandated to substance abuse treatment. The phenomenological reflection is retrospective in that it is the reflection of experiences that have already passed and are not currently being lived through (van Manen, 1990). In this inquiry, I explored the treatment experiences and engagement of individuals who sell drugs from the counselors' perspective. In hermeneutic phenomenological research, the focus is on the lived experience and "how" the things of the lived experience appear to a person's consciousness (van Manen, 2014, p. 91).

As a qualitative researcher, I needed to be aware of presuppositions about the phenomenon prior to the start of the study (Connelly, 2010). I worked for over six years, in a therapeutic community treatment program in a correctional facility. I often encountered individuals who were mandated to treatment who reported that selling drugs was their primary problem not substance use. At times, significant challenges with treatment engagement existed which resulted in groups disrupted with inappropriate comments related to substance use or the treatment environment. Other counselors and I worked to engage these individuals and to provide relevant examples regarding their

identified problem. I initiated the use of the Gaudenzia Drug Dealers curriculum and created a group specifically for individuals who primarily sell drugs, but who did not themselves use drugs. I personally facilitated for several months and trained additional staff who eventually started facilitating the group. I need to acknowledge my own personal experiences as a counselor working with individuals who sell drugs and how that may influence how I conduct the interviews and my application and interpretation of the SLT with the data collected.

I engaged in epoche, which will be discussed further in data analysis. Epoche means to refrain from judgment, to look at things a new way (Moustakas, 1994). Since I have experience with this phenomenon, I needed to be aware if I am negatively influencing the interview or analysis process. I used an interview protocol, but I monitored follow up questions that I may ask to ensure they are not guiding the responses in a particular direction (Creswell, 2017).

## Methodology

In the methodology section, I will include information that describes the actions needed to facilitate the study. Specifically, I will discuss the participation selection, instrumentation, the development of the instrument, procedures for recruitment, participation, and data collection, and the data analysis plan. In providing this information, other researchers will have the ability to duplicate this study in the future.

### Participant Selection Logic

The type of sampling I used for this study is purposeful, also known as purposive sampling, and specifically criterion sampling. With purposive sampling, I selected study

participants who I believed had the experiences I wanted to learn about in order to answer my proposed research question (Frankfort-Nachmias & Nachmias, 2008). I did this using criterion sampling, which is described as selecting participants who have experienced the phenomenon based on a predetermined criterion (Creswell, 2017; Patton, 2002). In having a predetermined criterion for participants, I was able to recruit the appropriate participants to participate in the study. I further screened for appropriateness participants who identify themselves as meeting the criterion. Counselors, with whom I have a working relationship, were not be eligible to participate in this study.

The participant population for this research was individuals who were counselors or identified themselves as counselors despite their job title. The counselors had to have a minimum of a master's degree human services related discipline and needed to have at least two years of experience working in the field of counseling. The counselors needed to have experience working in a therapeutic community treatment program within a correctional facility. Their experience working in a therapeutic community treatment program was a minimum of six months. I assumed that the counselors met the minimum qualifications for the counseling position they hold. The counselors needed to have had experiences working with individuals who were referred to the treatment program and reported primarily selling drugs, but not using drugs. The counselors' experiences with individuals who sell drugs was via direct contact either through individual counseling or group sessions. I relied on counselors' self-report to establish that potential participants have met the criteria to participate in the study.

I estimated conducting 10 interviews with for this study. I continued to screen, identify, and interview until I reached saturation. Saturation can be defined as when no new information obtained from the interviews adds any new information to the understanding of the phenomenon, (Creswell, 2017). I believed that ten counselors would provide a range of experiences to gain an understanding of the experiences and level of engagement of individuals who have been incarcerated for selling drugs who are mandated to substance abuse treatment, but who do not themselves use drugs. No set sample size requirement exists with qualitative research as the sample size can be contingent on what the researcher wants to know, the purpose of the research, credibility, and time (Patton, 2002).

I planned to use the e-mail assigned to me by my university to assist with study recruitment. I included the criteria for participation in these recruitment announcements. I planned to send an email (Appendix A) with the flyer (Appendix B) to companies that I am aware of and researched that have or have had contracts with federal, state, or local entities to provide substance abuse treatment in correctional settings. I planned to conduct phone interviews for these participants. The study information would be sent to multiple entities in an effort to obtain a range of experiences and a diverse counselor demographic. My contact information, which was my email address, was to be included so interested participants can contact me directly about study details. I posted the flyer in my university's participant pool and the ACA Connect community website to recruit participants. The ACA Connect site is forum for ACA members to post resources and

engage in discussions (ACA, 2016). There is an area named Call for Study Participants in which individuals can post requests for study participants (ACA, 2016).

I planned to contact potential study participants via email. I planned to use this initial contact to set up a telephone call for screening and to send them the informed consent (Appendix C). I planned to use the phone screening checklist to determine eligibility for the study (see Appendix D). I planned to inform all those contacted that they will be receiving a follow up phone call. For those who are selected for interviews, I planned to inform them they were selected and attempt to set up an interview time and location. For those who are not selected for interviews, I planned inform those that were to be selected that I would l keep their information and if they agreed, I would contact them if additional interviews needed to be conducted.

**Instrumentation**

In this section, I described the instrumentation that was used for this research study. I asked study participants to complete an informed consent document (Appendix C) prior to engaging in the phone screening (Appendix D). I collected data from study participants via a personally developed initial phone screening and an interview protocol (Appendix E). The questions included on the protocols, as suggested by Creswell (2017) and van Manen (2014), are open ended and should focus on experiences as they have been lived through and gain the views and opinions of the participants that are being interviewed. I also developed these questions based on the theoretical framework of the SLT to gain detailed information about the counselors' lived experiences. I also included on the interview protocol demographic questions such as race, ethnicity, date of birth, and

age. I will further discuss in Chapter 4 the revisions that occurred with the interview protocols and informed consent.

Interviews were to be conduct face-to-face, when possible. They were completed using Skype, which is an online meeting site. I created a personal, secure account. The interviews were audio recorded to enable transcription of all interviews upon their completion. I used a digital audio recording device.

I personally developed the interview protocols that were used for the phone screening and interviews. The protocol includes open- and closed-ended questions. I developed the interview protocol questions to answer the research question of what are the lived experiences of counselors who work with individuals who have been convicted of selling drugs, but who do not themselves use drugs, but who are then mandated to substance abuse treatment who report not having a substance abuse problem. The open-ended questions were developed to gain information about the counselors' experiences with individuals who sell drugs regarding treatment engagement, behaviors observed, personal interactions, and statements about the beliefs of individuals who sell drugs have about their treatment experiences. I used follow up questions, when necessary, to obtain additional information for the initial questions response.

**Procedures for Recruitment, Participation, and Data Collection**

I posted the flyer in my university's participant pool and the American ACA Connect community website. I had to adjust my recruitment procedures with the IRB when my initial efforts were unsuccessful. I conducted an online search of companies and states within the United States Department of Correction (DOC) website to research if

their facilities provided TC programs. I contacted those companies and the applicable state DOC facilities to recruit participants.

I contacted interested individuals via telephone and email to set up a telephone screening time. The developed phone interview protocol was used during this screening. All responses will be recorded.

I conducted all interviews. The time allotted from the interviews was no more than 90 minutes. Each participant was subject to one interview. I audio recorded the interviews. Interview protocol responses were to be noted during the interview. The audio recording enabled transcription of the interviews. I compared the notes and transcription to ensure answers are noted appropriately. I transcribed all the interviews.

Upon the completion of the transcription and data analysis, I planned to share summaries with participants about the overall themes found and how this research can affect social change. I planned to schedule 15-minute time slots for each participant to review this information. Following the debriefing, I did not intend to conduct any further follow up interviews with study participants about the study. Participants were not required to engage in follow-up interviews nor did participants request to do so.

**Data Analysis Plan**

In phenomenological research, the process of identifying meaning within the lived experiences is thematic analysis (van Manen, 2014). I analyzed the interview responses based on answering the posed research question of what were the lived experiences of counselors with individuals were who sell drugs who are mandated substance abuse treatment and do not report a substance abuse problem. I organized and type up all the

notes from the phone screening and interviews. I transcribed all interviews. Initially, I kept all documents for participants in name-labeled manila folders and then upload into NVivo.

For data storage and analysis, I used NVivo. It is a software program developed by QSR International that can be used to analyze, manage, and shape data collected (Creswell, 2007). Creswell (2017) noted the following benefits for utilizing a computer program: (a) aids with the location of material for sorting; (b) aids with taking a closer look at the data; (c) aids with visual production of codes and themes and; (d) aids with the linking of codes, themes, or documents to aid the review of data. I planned set up the program prior to collecting data and created a file for each participant interviewed. I planned to upload and store data collected (i. e. recordings, notes, and transcriptions). I would use NVivo to categorize and code information and to identify themes that may emerge, and I will use the node feature, which compiles data that is related to a text search query, theme, or topic I specify (QRS International, n. d.). For example, I created a node for each interview question, so I could examine all responses in one area. I used the search queries to identify themes or frequently used words or phrases within the data. I selected NVivo because I had previous experience working with the program. I believe the software assisted my ability to organize and analyze the data I collected.

Phenomenological analysis should be directed by a phenomenological question related to the lived meaning of a human phenomenon that experientially recognizable and accessible (van Manen, 2014). I conducted the analysis for this study done through the theoretical framework of the SLT. I used the four major components (differential

association, differential reinforcement, definitions, and imitation) when I engaged in the steps of the phenomenological analysis. In phenomenological analysis, the first step is the epoche (van Manen, 2014). Epoche, or bracketing, means to refrain from judgment or stay away from, to look at things a new way (Moustakas, 1994; van Manen, 2014). The researcher must be aware of, and eliminate, personal bias and personal involvement in the subject matter (Patton, 2002). These may influence the researcher's ability to understand the living meaning of the phenomenon (van Manen, 2014). I needed to bracket my assumptions, common beliefs, and the scientific explanations of which I am aware. With reduction, I referred to my previous experiences for additional insight.

To assist in interpreting the data, I used the hermeneutic circle. I used this type of analysis to enhance understanding of the parts to the wholes, and the wholes to the parts (Patton, 2002; Schwandt, 2007; Smith, Flowers, & Larkin, 2009). The cycle can take multiple place times until the whole and the parts can be connected harmoniously (Schwandt, 2007). An examination of the whole is first and then examining how the parts play a role and give the whole meaning. Every interpretation depends of other interpretations to be understood and always happen within background, which includes traditions, beliefs, and practices (Schwandt, 2007). The researcher seeks to find the true meaning of the data through understanding all presented components and background at that moment (Patterson & Williams, 2002; Schwandt, 2007). I would acknowledge my beliefs about the phenomenon being studied and how it relates to the participants perspectives (Peck, 2008).

The imaginative variation is the process in which the researcher seeks to grasp the structure essences of experience (Moustakas, 1994). The researcher groups the identified significant statements into "meaning units" or themes (Creswell, 2007, p. 159). With the use of the meaning units, the researcher will create a textural description, based on the participants, that does contain what was experienced (Patton, 2002). The structural description focuses on how they experienced what they experienced (Moustakas, 1994). It contains how the experience took place with examining the setting and context that phenomenon took place (Creswell, 2007; Patton, 2002, p. 486).

The final step in phenomenological analysis is a composite description (Creswell, 2017). This description combines the textual and structural descriptions into one universal description of the experiences of the study participants (Moustakas, 1994). This step of the analysis offers a synthesis of the meanings and essences of the participants' experience (Moustakas, 1994). In this section, I would note experiences that are shared by counselor participants that do not fit with the overall themes. I would note specific statements that were made that do not align.

## Issues of Trustworthiness

In qualitative research, validity is characterized as the acceptability and convincibility of the study (van Manen, 2014). Gibbs (2007) noted that qualitative reliability demonstrates the researcher's method is consistent among different researchers and projects. To establish the trustworthiness of a qualitative study, researchers use terms such as *credibility, transferability, dependability,* and *confirmability* (Lincoln & Guba, 1985, p. 300).

To establish credibility, I would review for saturation and use participant review. Saturation is defined as continuing to obtain data until the data obtained does not provide additional insight in the phenomenon or category that is being explored (Creswell, 2017). I planned to conduct interviews with study participants and monitor when I had reached the point of saturation in order to remain focused on the posed research question. I would assess that there were no gaps or unexplained phenomena in the content of the interviews (Givens, 2008). If I continue to seek new information, I could diminish the information obtained (Givens, 2008). This may involve adjusting the number individuals interviewed. Upon the completion of the interview, I would ask the participants if they would like to receive a copy of their transcription for review. Participants can examine the data for accuracy.

Transferability is as another component to explore when addressing trustworthiness in qualitative research. It is also noted as external validity and it defined as the degree to which findings can be applied to other contexts or settings (Trochim, 2006). A thick description, which is described as rich, detailed, and concrete, of findings, along with a varied study sample can increase the transferability of a study (Patton, 2002). Detailed descriptions enable readers to feel as though they have or could experience what was described by study participants (Creswell & Miller, 2001).

The qualitative reliability counterpart is dependability. Gibbs (2007) suggested transcription check and code cross-checking as methods to enhance dependability. I planned to review all transcriptions for errors once the transcription process is complete (Creswell, 2017). For code cross-checking, I planned to review that definitions of

meaning units are consistent throughout the analysis process (Creswell, 2009). I planned to create a master list as reference for myself and those who review my collected data.

A fourth term and set of techniques used to address issues of trustworthiness in qualitative research is confirmability. This is the qualitative counterpart to objectivity (Trochim, 2006). This is term is defined as, "the degree to which results could be confirmed or corroborated by others" (Trochim, 2006, para. 7). It is suggested that the researcher engage in ongoing checking and rechecking of data, review and describe negative instances that contradict previous findings, and facilitate a data audit at the study's conclusion (Trochim, 2006). There is also concern in qualitative research with reflexivity. Reflexivity is the acknowledgment that the result of the research will reflect the background, milieu, and predictions of the researcher (Gibbs, 2007). I do have a personal connection with the phenomenon that could influence outcomes. I needed to emphasize neutrality and identify any biases that arise during the study (Connelly, 2010). My dissertation committee was to engage in the ongoing review of the interview transcripts and data analysis to ensure that issues of trustworthiness have been appropriately addressed and to make suggestions when needed.

**Ethical Procedures**

In conducting this study, I needed to ensure ethical procedures are taking place to protect the welfare of the participants and the integrity of the data collected. I needed to follow the steps I identified in this chapter and stated in the approved Institutional Review Board study, 02-09-18-0236072. I also needed to adhere to the guidelines set forth for by the ACA regarding research and publication (ACA, 2014). I also needed to

follow the guidelines for treatment for human participants as set for by the National Institutes of Health that I reviewed (Appendix F).

For advertising, I planned to send an email with the flyer attached to identified companies for study participants. Potential participants were to communicate with me via email about their desire to participate in the study. I was also to use the same flyer to upload in my university's participant pool and the ACA Connect community website. I was to await responses. Upon receiving responses, I was to initiate phone screening.

Upon setting up initial phone screenings, potential study participants were to review and complete the informed consent. I planned not screen potential participants until I have received the document. This is to protect them as potential participants and myself as the researcher. I wanted them to be aware of the nature of the study, the interview processes, time requirement, and analysis for them to make an informed decision about participating. All participants were informed that the data would be kept confidential and no identifying information would be included in my results. I assigned all participants a pseudonym to protect their identities. A pseudonym is alternate participant identifier that protects the anonymity and confidentiality of study participants (Allen & Wiles, 2016).

I explained data collection and storage when reviewing the informed consent to participants. All data was collected by myself and stored in a secured locked box in my home. My dissertation committee were the only individuals that may have access to my collected research data. This included all documents such as consent forms and notes and electronic recordings. Data was also stored electronically within NVivo on my personal

computer which is password protected. I backed up all data up using a dedicated flash drive, which will also be stored in the lock box. All data will be kept for a period of five years and then destroyed.

I also made participants aware they can remove themselves from the study at any given time and for reasons that do not have to be disclosed to me. If participation in the study results in an adverse event, a participant would be provided with SAMHSA National Helpline number, which is 1-800-662-HELP (4357). This 24-hour hotline connects individuals with mental health or substance abuse services (SAMHSA, 2017). In the event of an adverse occurrence, I planned to contact my dissertation chair and the Institutional Review Board (IRB) to report the incident.

## Summary

In this chapter, I described the qualitative methodology and phenomenological approach I took to learn about the lived experiences of counselors working with individuals who sell drugs who are in a substance abuse treatment program, but who do not themselves use drugs. I conducted semistructured interviews with recruited counselors. I used a personally developed interview protocol to complete initial phone screenings and interviews. All interviews were to be recorded and transcribed for analysis. I planned to use NVivo to store and organize the data collected. To address issues of trustworthiness, data collected was to be reviewed multiple times by myself and reviewed by study participants for accuracy. I ensured that ethical procedures are adhered to in order to protect the welfare of participants and the integrity of the research. In Chapter 4, I will describe the employment of the study. I will describe the setting, the

demographics of the participants, the data collection process, the data analysis, evidence of trustworthiness, and the results of the study.

# Chapter 4: Results

My purpose in this qualitative, hermeneutic phenomenological study was to learn about the lived experiences of counselors working with individuals who sell drugs, who are mandated to substance abuse treatment, but who do not themselves use drugs. I collected information from study participants through interviews to learn and gain understanding about these lived experiences. The areas that I focused on were the treatment engagement, treatment needs, and observations of peer interaction of individuals who sell drugs who are mandated to treatment, but who do not themselves use drugs.

I will present information about the data collection process and results of the 13 interviews conducted with study participants within this chapter. This will include the study setting, study participant demographics, describe data collection and analysis, review evidence of trustworthiness in relation to strategies stated in Chapter 3, and report the results in relation to the research question.

## Setting

I conducted the interviews via Skype. In-person interviews were not conducted due to the location of study participants. Study participants identified themselves as being at work or at home at the time they were being interviewed. They were in an area that they deemed private. Participants appeared to be alert and engaged in the interview with no distractions. My location was either at home or a private office at work based on the date and time of the interview.

## Demographics

The 13 study participants represented multiple therapeutic community programs in correctional settings from five states within in the United States. All participants met the criteria for study participation based on the phone screening I used during the time of their screening, which I will discuss further in data collection. I assigned all participants a pseudonym to protect their identities and to maintain confidentiality about their program and I will use the pseudonym throughout about the reporting of the data. Eight females and five male participants completed interviews. Their ages ranged from 27 to 76 years ($M$ = 52). There were 11 White/Caucasian and two African American study participants. Three of the 13 participants identified their highest level of education as a doctoral degree. Only one participant had 6 months of working in a correctional-based therapeutic community. The others ranged from 2 to 9 years of working in a TC. Several of the participants had titles as supervisors at their programs but still identified themselves as counselors as they were still providing direct services to clients.

## Data Collection

I received IRB approval (02-09-18-0236072) and attempted to recruit participants through posting on the ACA Connect website and Walden Participant Pool on February 10, 2018. I found no participants via these methods. I submitted a Change of Procedure request to the IRB on February 27, 2018 to be able to contact state Department of Corrections (DOC) substance abuse programs within the United States directly via telephone or email. I also requested to include snowball sampling, as eligible participants

may recommend other people to contact for potential study participation. The additional methods of recruitment were approved on March 13, 2018.

I went to state DOC websites and searched programs that were provided at correctional facilities. I identified correctional facilities that were noted to have a substance abuse treatment program or specifically a TC program. I created a list. I started to contact facilities and speak with program counselors and program directors or supervisors about my study and potential participation. I would send the approved email correspondence, study flyer, and informed consent for review on request. I conducted the first interview on March 23, 2018, after conducting the phone screening and coordinating a time for the interview. I was able to set up multiple interviews as result of snowball sampling. The individuals whom I initially contacted connected me with potential study participants.

I conducted eight interviews from March 23, 2018, to April 9, 2018. I was interviewing Janice and she stated that her program clients were voluntary and not mandated to treatment. I identified that the phone screen protocol did not include the language "mandated to treatment" in the participant criteria confirmation Item D. that is reflected in the interview protocol question, "What are your experiences working with individuals who sell drugs who are mandated to treatment in the therapeutic community, but do not report a primary problem of substance abuse?" I consulted with my dissertation committee and it was determined that I needed to submit a Change of Procedure request to the IRB to update the phone screen protocol (Appendix G) and the study participation criteria in Item D to read, "D. Had direct interaction with individuals

who reported a primary problem of selling drugs and not using drugs who were mandated to treatment." I updated the informed consent as well (Appendix H). I submitted the request of April 20, 2018 and it was approved on May 3, 2018.

I continued to identify and call facilities for potential study participants. I found that at some facilities the TC program was no longer available or had transitioned to another program. I also found that programs did not have staff that met the criteria for study participation. Programs did not have staff with master's degrees. There were staff who were not able to engage in research without the study proposal being formally reviewed by the state's DOC research committee. I continued to call and conduct follow-up calls. I was able to interview five additional participants. I completed my final interview on June 25, 2018. I conducted a total of 13 interviews during data collection.

**Interviews**

The data collection method I used for this study was interviews. Participants completed the phone screening interview. Via e-mail, I provided participants with the informed consent, in which they agreed to the terms of study participation. All participants completed the full interview. I used Skype for interviews. I conducted no interviews in person. I recorded all interviews with a digital voice recorder. I uploaded the voice recording to the computer and reviewed for quality upon the completion of the interview. I have kept any notes taken during the interviews in a locked file cabinet. Interviews lasted between 25 and 60 minutes.

I personally completed the transcription of all interviews. I transcribed interviews shortly after completing the interviews. The time to transcribe an interview varied based

on length of the interview. I determined that member checking was not needed as there was no need for additional clarity upon the completion of transcribing each interview. I completed all transcriptions and stored them in NVivo.

## Data Analysis

I used the plan that I described in Chapter 3 for data analysis. The first step of phenomenological analysis is for a researcher to engage in epoche. Epoche is when a researcher refrains from judgement to look at a phenomenon in a new way (Moustakas, 1994; van Manen, 2014). Throughout the analysis process, I remained aware of my own beliefs and experiences working in corrections and with individuals who sell drugs. I knew I needed to remember that my study participants' experiences are unique to them and may vary from mine.

I applied the hermeneutic circle in reviewing data. I started with the research question and started reviewing the interview responses and their connection to the question. I engaged in this cycle multiple times to gain understanding of the between the whole (research question) and the parts (interview responses) and built on my understanding with each cycle.

I identified themes from Chapter 2 headings and the interview protocol questions during the imaginative variation step of analysis. In NVivo, I created nodes for each identified theme. I highlighted statements that fit the appropriate node. I began to identify subthemes and listed them in a Word document when coding. The essence of the lived experiences of counselors working with individuals who sell drugs were in the themes and subthemes, which include working within a correctional setting, their work team, job

training, and their interactions with, and observations of, individuals who sell drugs who were mandated to their therapeutic community treatment program. The themes include job preparedness: beyond the degree, team spirit, behind the walls: working within a correctional facility, the therapeutic community: the treatment program, counselor experiences with individuals who sell drugs, and what does it mean to work with individuals who sell drugs. I will discuss these themes and subthemes in detail in the results section below.

I developed textural and structural descriptions of the identified theme or subtheme from interview question responses of the participants. These descriptions enabled me to synthesize the meanings and essences of the experiences shared by participants to develop an overall experience of study participants. One discrepant case was identified among the participants. Participant Janice stated that all individuals who participated in the therapeutic community program she worked in were voluntary and not mandated to treatment. I will discuss this case and the implications for this study in depth in the results section below.

## Evidence of Trustworthiness

I followed the plans established in Chapter 3 to address trustworthiness. I spoke with my dissertation chair and methodologist throughout data collection and analysis to ensure my study was conducted appropriately and ethically sound.

### Credibility

Credibility is defined as the accurate interpretation of the participants' meaning in the results (Creswell, 2017). Patton (2002) noted that overall research credibility was

affected by the credibility of the researcher for example, training, experience, and presentation of self. As the researcher, I shared with participants that I was a doctoral student and the research was for my dissertation. When asked, I shared my professional credentials and my current occupation. I followed the procedures that I submitted to the IRB for data collection. I provided all participants with the informed consent and reiterated that participation was voluntary. I presented all questions on the interview protocol to each participant. I kept all data collected confidential and stored it appropriately.

I continued to obtain study participants until my dissertation chair, my methodologist and I believed I had reached saturation. The sample size is contingent upon what the researcher wants to know, the purpose of the research, credibility, and time in qualitative research (Patton, 2002). It appeared to me that there was a possibility that new information could be obtained in completing additional interviews after completing and transcribing the initial eight interviews. I completed five additional interviews. I believed that I had reached saturation as no new significant information was presented in question responses after completing the transcription of those interviews.

I did remove the step of member checking that I noted in Chapter 3 when I submitted my IRB application. I informed participants that they may be contacted for follow-up questions upon the completion of transcription if there were questions regarding any statements made. No follow up contact was made as there were no questions regarding statements made during the interview upon the completion of

transcribing. My methodologist reviewed my themes and supporting participant quotations for accuracy of interpretation.

**Transferability**

Transferability is defined as the degree to which findings can be applied to other contexts and settings (Trochim, 2006). I sought to provide rich, detailed description of my procedures and the findings of the study. I believe the findings can be applied to other counselors working in corrections based therapeutic community. Study participants were open and transparent about their experiences. Education and training did not prevent them from identifying challenges in their work environment and working with the identified client population. The participants' experiences appeared to be consistent in regard to working within corrections and with the population of individuals who sell drugs, although their longevity in corrections based therapeutic community and locations varied. The data I collected aligns with literature presented in Chapter 2 about counselors working with corrections, which I will be discuss further in Chapter 5.

**Dependability**

Dependability is reviewing transcriptions and code cross-checking for reliability (Gibbs, 2007). I attempted to complete all transcriptions within 10 days of completing the interview, to increase my remembering the context of responses, in case there was an issue when transcribing. I personally completed all transcriptions. I reviewed audio recordings as needed when reviewing transcriptions if there appeared to be an error. I presented identified themes and supporting quotes to my methodologist to obtain feedback about themes, subthemes, and their alignment with the research question. I

defined meaning units during data analysis and ensured they were consistent as I reviewed the data.

**Confirmability**

Confirmability is the extent that results can be confirmed or corroborated by others (Trochim, 2006). I thoroughly checked the data I collected. In analyzing data, I followed the steps I described in Chapter 3. I used epoche to be aware of my personal bias and involvement with the topic of the research. I informed interview participants that I previously worked within correctional based therapeutic community when appropriate. This appeared to provide participants with reassurance that I may have experienced some of the feelings or interactions they may have experienced in their work within corrections and the population of individuals who sell drugs. This allowed me to review the data in multiple ways including through the lens of the selected theory SLT. My methodologist reviewed the data collected and provided feedback.

## Results

I will report the results of the study in this section. I will present themes and subthemes that identified based on the data collected. The themes include job preparedness: beyond the degree, team spirit, behind the walls: working within a correctional facility, the therapeutic community: the treatment program, counselor experiences with individuals who sell drugs, and what does it mean to work with individuals who sell drugs**.**

**Theme 1: Job Preparedness: Beyond the Degree**

Study participants had to have a minimum of a master's degree as their level of education. Three participants that stated they had doctoral degrees. I assumed all participants met the qualifications to be in their current position. Nancy shared about the training she experienced at the onset of her employment which she needed in addition to her education background. Nancy stated:

> When we first started working in the program, we were provided with training with in house by the program administrator and the current clinicians that [*sic*] in the program to be able to do the job because there is definitely this interesting thing you work in. You need to learn how to work in corrections and then you also work in a substance abuse program in corrections.

Daniel noted the importance of ongoing learning outside of his graduate school education. He shared:

> I think the secret you know is not to point to an individual training that I've never had so much as to have retraining and to have things that I think I know challenged . . . . So, we always have to be listening, open, and willing.

Cathy, too, shared that even with education and state credentials as a certified substance abuse counselor and supervisor, she is "You know, I am constantly being trained."

I identified several subthemes within this theme: (a) Department of Corrections (DOC) Training; (b) Continuing Education Training, (c) Training Needs, and (d) Supervision.

**Department of corrections training.** Some participants identified that they had to participate in training required by DOC. The training was to enable participants to learn about the DOC rules and procedures. Outside of Ronald, all participants had multiple years working within DOC. This training was meant educate them about working in correctional facility and maintaining security within such a facility. Ronald shared that his training experience through DOC was minimal. Ronald stated:

> They teach you the bare bones of what we need to do to comply with security and uh, that is, I think, unfortunate because the fact that we counselors do not have a lot of training with security means that the inmates, uh, figure us as easy marks for getting away with things.

Several participants participated in training at the DOC academy which was 1 to 3 weeks long. For Nancy, the training was required by her facility to work. She stated:

> So, anyone who works um for the Department of Corrections is required to go through training. So, our first job is security so that was the initial requirements and education. Anything from us setting [*sic*] good boundaries, being aware of all this around you in [*sic*] and up to restraints and how to shackle somebody.

Caroline expressed that the academy training was beneficial, and she was able to gain what she needed to know about working in a correctional facility. Caroline shared how the training prepared her for the environment: “We had to go through the three-week beginning orientation training at the academy. We had to learn fire arms. We had to learn self-defense and I really think that was a pivotal time for me.” Cathy described DOC

training as, ". . . they go over all the scenarios: the bad ones and the good ones about what could happen to you."

Daniel and Steven had previous experience working as correctional officers prior to becoming counselors. Both shared similar experiences of obtaining their education and ultimately seeking their current positions. Daniel shared, "In my career, I actually started out as a correctional officer 35 years ago. Um, and then I got my education and and [sic] got promotions through different counseling levels." Steven started as a Corrections Officer I and returned to school. He stated, "I got my bachelor's degree and my master's degree and went to a as a Caseworker II. And now I'm an Addictions Counselor II."

**Continuing education training.** Multiple participants were required to attend continuing education training. Deborah shared that there is some redundancy in attending training. She expressed, "A lot of times it's that same training over and over again. So, it's kind of hard to pick something where you are actually going to learn something." Three participants, Cathy, Natalie, and Steven, identified that they were required to attend at least 40 hours of training a year. Natalie stated, "We are required to have 40 CEUs (Continuing Education Units) a year, but you know I do more than that." Other study participants noted they had to attend annual training but did not specify the number of hours that needed to be obtained.

Participants had attended several trainings and conferences offered by their company or other entities. These trainings included motivational interviewing, trauma, Post-Traumatic Stress Disorder (PTSD), staff liabilities management, information about opiate addiction, deception detection, Cardiopulmonary Resuscitation (CPR)/First Aid,

risk assessments, and family systems. Linda and Caroline were able to attend the European Federation of Therapeutic Communities Conference in Ireland aboard previously. Janice shared about her experience in her organization's TC training. Janice had this training at the onset of her employment. Janice shared aspects of the training:

> Basically, you go to a TC for a whole week during the day and you act as if you are a client…. You create your philosophy, follow the rules, you have to pull each other up. So, you get to experience some of what clients feel.

She felt challenged and out of her comfort zone as it was her second week at the job and had little knowledge of the TC.

Matthew reported being able to participate in trainings in order for him become a trainer. Matthew and other staff attended 2 or 3-day trainings on curriculums. Upon the completion of the training, and facilitating the curriculum ten times, a person can be considered a Master Trainer. At the time of the interview, Matthew obtained a certificate as a Master Trainer. Matthew shared:

> I just completed my 10th of class of teaching Thinking for a Change. So, I've actually uh I got my certificate as a master trainer. So now I can go and train staff uh the curriculum to be able to teach that now.

Matthew shared there were other curriculums he would like to pursue a certificate as a Master Trainer. Deborah was also seeking to become a trainer in a specialized curriculum. Deborah wanted to pursue becoming a Love and Logic facilitator for her training hours.

**Training needs.** It appeared that based on the education and ongoing training, participants felt as though they were prepared in their roles as counselors. Some participants identified specific topics in which they were interested in gaining more knowledge. The trainings included: co-occurring (substance abuse and mental health) disorders, trauma, CBT, and documentation. Cathy stated, "I would like to have more additional training on, more material even for what you're talking about- drug dealers." Ronald expressed:

> There is trainings [*sic*] that I would like to see done on a monthly basis. I would like to spend a half hour every month getting a report on what the new nicknames are for the various substances.

Participants appeared open to attending training and learning new information. Linda stated what trainings would be beneficial to her job, "I think that having trauma information and how to use interventions like mindfulness and CBT and DBT and all that stuff are really, really important." Her organization would have in house training on these areas or pay for staff to attend these trainings with other entities.

**Supervision.** Participants discussed engaging in supervision as well for training. Linda shared that she valued supervision time. She stated that, "I feel like I have to have supervision, um, because that's part of my decompression and making sure that I'm still doing the right thing you know." Nancy shared that she receives monthly supervision from her branch manager which goes toward her becoming a certified addictions counselor. Natalie's noted that her supervision, "…is separate from our clinical staffing (which is held weekly)."

Cathy and Geoff are currently supervisors. Cathy expressed that her supervisors did not help her when she was a counselor at all. As a supervisor, she strives to help her supervisees with facilitating groups and documentation for clients. Geoff uses supervision to talk to his team about ethics and boundaries as he knows that can be a problem area for people in the field. Geoff stated his areas of focus during supervision, for example, "I put a lot of training of ethics and boundaries and that kind of stuff because of the field we in. A lot of people can get, you know, caught and have inmate relations or either get manipulated."

**Theme 2: Team Spirit**

All study participants worked as part of a team to provide clinical services for the treatment program. Participants shared primarily positive experiences working with their current peers. Their current teams were strong and worked together. Geoff stated, "I think we got a great staff there that works together and that's the main thing. Once you work together and understand you can't do it by yourself."

Natalie reported that here team works well to together. She shared:

> This is the best support system because I have counselors that I work with that are likeminded like myself.… So, I have counselors that are that go above and beyond you know. We're supportive we work together. We pull each other up. We share caseloads. We, when there is a disagreement, we are able to come together and fix it before we take it out to the community because they, they [*sic*] can sense when there is distension, so we make it a point to avoid that.

Nancy shared that even though interactions can be minimal during the day, when the team comes together, they talk about a client or an issue that has come up.

Deborah expressed that she worked with a great group of people who she could turn to for help. A team atmosphere was exemplified by:

> If I'm having a problem there isn't a single person in this building I can't go to to [*sic*] talk to, talk it out, or come up with come [*sic*] fresh ideas. Um. We help each other out. Um. Fill in for each other so we get you know good taste of what of what is going on on [*sic*] the different wings here. Um. We do we do [*sic*] our…class which is mix of all the different guys from here. So, uh, we work we work. It's just great working here.

Steven's team was similar to Deborah's. Steven stated, "I mean I think that we all try to pull together as a team and get done what needs to be done."

Subthemes within this theme are: (a) Barriers working with the team, (b) Support from supervisors; and; (c) Learning from others.

**Barriers with working with the team.** Two counselors referenced barriers in working with their team. Veronica shared the "excessive turnover" of counselors at her site was often a result of a struggle with keeping boundaries. One of her observations was the females' clothes were not appropriate. She reported:

> The counselors we have at our place wear tight, tight clothes. You can see the crack in their behind. They wear tight t-shirts. They wear their hair [*sic*]. They look like hookers on 8th avenue. That's what they look like. And they keep telling

> them, 'You can't dress like that. You can't dress like that,' but they keep dressing like that and what is that saying to the guys (the clients)?

She shared that she knew that some people are not appropriate to work in the environment but shared about her need to train and help people who did stay and work.

Ronald shared about the team cliques and how that creates a dynamic in the office. He described how it created a barrier by sharing:

> Unfortunately, like any work environment okay, you have certain people who don't get along with certain people. And there are little cliques who are more into drama than production and uh I am too old to play those games anymore. So, of course, I don't, which of course bothers the popular girl clique to no end.

It appears, in these two instances, that the actions of others are influencing the team significantly regarding staff and work environment.

**Support from supervisors.** Participants primarily provided positive feedback about their supervisors. Their supervisors were available for questions and to assist with problem solving. Participants felt as though they had significant support from management. Caroline shared about her supervisor:

> I mean, of course everybody is so busy and pressed, but I have to say, I've known him for a long time and you know I call him and he gets back with me, and we brainstorm ideas, and he gives me some teaching moments that is um [*sic*]. He is very accessible to set up appointments.

Caroline also reported that sometimes her supervisor and other colleagues do Zoom conferences to engage in problem solving for program issues. Geoff shared that his

supervisors come to the facility as least bi-monthly and were accessible by email or phone for questions.

Some supervisors were characterized as providing encouragement. Matthew stated that his supervisor is there if he needs help and allowed him to take his ideas and, "run with them." Matthew stated he was able to use appropriate resources with clients without issue. Ronald shared his supervisors used "positive reinforcement," which he described as, "They tell me what I am doing right, and they expect me to do it more often."

**Learning from others.** Participants shared that they learned what to do and what not to do from observing others. They knew that they had to find their own style as a counselor. In observing others, they took what they believed would work with their style and disregarded what they did not like. Ronald acknowledged, "Everybody there has a different approach. Everybody there is a master of their different approach. And I couldn't begin to tell you how much good stuff I have learned watching other counselors work with other counselors."

Steven reported, "I think we kind of all see if we see another counselor doing something that we think is a good practice." He has obtained multiple group ideas from observing the group activities of his peers and tailored it for his group. Geoff described himself as being a "sponge" with moving around and observing others and applying his observations to his own practice. Deborah shared that she has struggled with being stern but has learned how to do it more from others. For example, she stated, "You know if I

need to put my foot down a little stronger, you know, I can. I've learned how to do that from, you know, watching other people's groups or asking advice from them."

One participant attributed the TC to the uniqueness of each counselor that is observed. Janice shared:

> But one thing I like about TC is that you can bring yourself to [*sic*]. You can bring yourself to it and it will create something. So, like I have a poetry slam. So that was like kind of my thing that I brought. So, respecting our differences I think is huge. We bring different things to the table and running with that.

Cathy shared two experiences in which she learned what not to do from observing others. In observing another counselor, she witnessed:

> I had this one counselor that was very in your face, the offender's face. She would be very aggressive, and I thought I could try it a little bit and I did and that's not me. That's not my personality.

Her second experience was:

> With another counselor, she had them doing work the whole time they she was here. She never let them have any free time. They never really got to think for themselves…. So, during that time, while I observed her I realized I didn't want to be like her because it seemed like she didn't really allow the offenders to think. She was thinking for them.

In observing these counselors, she was able to identify the type of counselor she did want to be and work towards that.

**Theme 3: Behind the Walls: Working within a Correctional Facility**

Study participants worked in a therapeutic community treatment program in a correctional setting. Participants primarily shared working in a correctional facility had its challenges but made no indication they disliked working in the environment. Caroline described it as, "Satisfying, but challenging." Geoff described it as, "Never a dull moment. I can tell you that. Keeps you on your toes." Veronica described working in a correctional facility as, "Stressful. Not necessarily the inmates, but the staff. They hire too many staff members that don't know anything about criminal justice. They don't. They've never been in prisons before. They don't know the dynamics."

Some participants expressed that they liked working in the correctional environment. Veronica also shared that working in corrections is an opportunity. She stated:

> I tell people all the time like I liked working in a correctional facility because, you know, I mean, obviously it can be dangerous at times, but it's being able to work with those guys being able to help them before they hit the streets.

Steven expressed he worked in corrections as he believed:

> I think I'm [*sic*]. I think this where I'm needed. I think this is where I can can [*sic*] make a difference if that makes sense. I don't really do this for the money. I do it for the for the percentage that I can help or save.

It appears some participants found it a rewarding place to work despite the challenges.

Subthemes I identified with this theme are: (a) Working with DOC staff; (b) Working with Offenders-Frustrations and; (c) Working with Offenders- Successes

**Working with DOC staff.** Participants spoke about finding balance between being security and treatment oriented. Caroline shared that it is important to build connections and demonstrate consistency and stability when working in corrections. She expressed:

> You have to build those connections and they have to trust you and know that you know you're going to talk to them and you're not on an island. Uh and that you do believe that security is the most important thing. And I think once you prove that and I think that we've done that as an agency.

Janice expressed some of the conflict between DOC and treatment. She reported:

> The unique struggle with that is that you kinda get push back from the institution. They understand security. They understand that, but they don't understand treatment and sometimes those conflict and so things that are appropriate for a counselor to do would look suspicious of what a correctional officer was doing. So, kinda educating them on the differences of that.

Cathy shared that correctional officers support the program 100%, but there are times when they use inappropriate language, such as the "…f-word all the time." Officers are not consistent with sanctions, based on their own beliefs, which causes a problem within the treatment program. She reported about an incident in which 10 clients violated a rule and all, but one, were sanctioned to room restriction. She expressed how the inconsistency of treatment by the officers was affecting the treatment community. She stated, "Well it's causing problems within the community because they feel like he can

get away with murder. They can't even put a piece of paper on the floor without getting wrote up."

Geoff, too, expressed struggles with consistency working with DOC staff. He stated, "It's a give and take. It's a lot of inconsistency and were working on trying to be consistent and it's hard because you got different shifts."

Nancy also shared about correctional staff attitudes that can influence treatment. She stated:

> There are like in any setting you're going to find there are some staff who are very professional and appropriate invested in change and helping the clients to change. There are others who believe in the old school penial system and we are to punish them and kind of the negative that goes along with that. And then by proxy being the person who is providing treatment that judgment that comes with that, these guys aren't changing they are fake. But then there are some staff whether its correctional officers or it's lieutenants, sergeants, captains who some of them are very invested in helping the clients and then of course by proxy they offer support to us.

Natalie and Linda shared challenges of providing treatment services, regarding DOC staff, at times. Natalie expressed:

> You know there is additional rules that we have to abide by first. And it's very important that the correctional staff understand, you know the dynamics. Like when we have a one on one uh you know our office doors can't be locked. You know their fear is that one of these guys may go off on us. They don't understand

> the confidentiality that that we have as counselors. So, their more, *their more* security minded and not treatment minded.

Linda highlighted that building rapport is affected. She reported:

> I have found that has been a struggle or a barrier for me and also just the therapeutic community in general is the rule where institutionally like fraternization develops your relationship with the inmates is absolutely zero tolerance for that.

**Working with offenders: Frustrations.** Participants expressed frustrations working with the offender population. They may not want to engage in treatment at times. Matthew expressed that some of the offenders he encountered found coming to a program as a road block for them getting home. Deborah expressed that it could be stressful and busy working with offenders as, "…we get really sick people in here, so we got a short amount of time to get a lot of work done." The length of the program was not enough time to try to treat all the issues with which a client may present.

Participants shared that working in a correctional facility is challenging for both the staff and clients. Ronald expressed, "A correctional setting is not an ideal location for a counselor. It is difficult to establish therapeutic rapport with a client when I am also having to enforce all the correctional rules and comply with all the correctional bureaucracy." He further commented that:

> Well the big thing is that I am working with clients that most outside, most programs outside of corrections would have turned away as incorrigible… so I

> have bad circumstances to work under and I have clients who have already proven that they are failures in other programs.

Cathy shared that the offenders in the program struggle at her facility because the correctional officers treat them as if it is still general population. Cathy expressed offenders stated, "That they wish that the officers would be more treatment wise instead of custody wise."

Participants shared that part of working with offenders is handling their manipulation. Cathy stated she enjoys working with them, "…even though their manipulative as all get out (laughter)." Daniel shared about the need to understand the offender population and the set of skills it takes to work with them. He reported:

> They can be a very manipulative clientele and it is within the nature of criminality to be manipulative. So, you have to understand that right from the start that it's nothing personal like its life skills for them and how they get by and if you start taking it personal then you're not going to do well. You have to understand how to navigate that. So, I think the biggest challenge is finding that balance between developing the counselor relationship and recognizing the population that we are working with.

**Working with offenders: Successes.** Participants shared about successes in working with the offender population. Veronica shared that working in corrections can be rewarding. She stated, "… hoping that they can be successful and seeing the unity and them doing well is great." Cathy shared about client that contacts to provide reports on his progress, "I have one gentleman. He calls me about every two years and he tells me

that if it wasn't for some of the things I said [*sic*]. Which I turn around him because he wanted to change."

Participants looked at the larger meaning of working with the offender population. Daniel expressed:

> The biggest thing for me is to recognize that we when we do our job right when things change for these guys. We change whole families and whole neighborhoods. You know if we get it right, we send out better fathers, better husbands, better sons, and and [*sic*] the impact of that just echoes across the whole community. And so, when we see those successes particularly when we hear back about the success. Um that's the most rewarding thing. To know that what we do does matter.

**Theme 4: The Therapeutic Community: The Treatment Program**

All study participants worked in a substance abuse treatment program that the treatment modality therapeutic community. Janice stated, "The TC's philosophy is that it's not the addiction. It's not the drug. It's the whole person." Ronald, Nancy, and Daniel shared that the program is designed to address individuals' substance use and criminality. Daniel believed:

> I do fear in criminal justice program that we focus too, too much um on the substance abuse and substance abuse alone. We can end up with sober criminals. And so, we haven't resolved our problem. So, so [*sic*] we really do hound in on the criminality and the substance abuse almost as a co-occurring disorder.

Multiple participants discussed about the ongoing modifications, at some programs, of the TC that have influenced effectiveness. Daniel shared, "You know you hear about all the successful research that support therapeutic community. And you see TCs that are just failing and inevitably you're going to find out that they're not following the model." Veronica based on her experience in "real TCs," felt as though her work site was not a TC and described it as a joke. Linda shared about making sure the TC model is followed:

> Making sure that we are really upholding the model of the therapeutic community because you can say that you are doing TC but if you're really not doing TC the way that its designed and supposed to be done then those outcomes mean nothing.

It appears that programs are not always adhering to the TC model, which can affect the integrity of the program and the outcomes.

The TC structure may challenge the clients' belief system, especially in the area of addressing other people's negative behavior. In the TC, the community is viewed at the agent of change. Janice shared this about the TC:

> I would probably say that so with the therapeutic community it's all about right living. Which is pretty much the exact opposite of prison code. So, I think that the guys struggle with that. They want to change but its they have to figure out where their loyalty lies. Whether is lies with what they were brought up with or their gonna take a new belief system that will help them be successful.

Linda noted:

> In the treatment environment, you're trying to teach them that it's not snitching. It's being able to help each other and to get to help people to grow and to make the environment…safe. And they've turned it into something negative.

Linda expressed how it is hard to combat the correction and treatment culture at times.

**Theme 5: Counselor Experiences with Individuals Who Sell Drugs**

All participants, but Janice, reported working with individuals who sell drugs, who are mandated to substance abuse treatment, but do not themselves use drugs. Participants had mixed experiences about working with this population in treatment. Most of the participants aligned with Veronica's statement, "I take them where they are at." Study participants would assess the individuals who sell drugs to see what they believed their issues were. Nancy found that:

> Those who come and are saying, 'oh I've got a lifestyle problem and not a drug problem,' we challenge them to really look at the truth of it, I guess. And then we find them to be more resistant to treatment at times.

Daniel noted that he worked to remind the individuals who sell drugs when they come to treatment that it is not just about substance use. Daniel explained:

> So, when we get guys in here who don't have substance dependence issue, they like to throw that out. You know, "I don't know why I'm here. I don't even use drugs." kinda thing…. We remind them that our program is a dual program. We're designed to deal with criminality and substance use. So were going to deal with criminality with everyone and that's the benefit that the program is going to bring to you. Along the way, you may or may not understand or identify some kind of

> use issue, but what you will learn is that the way you're living your life is hurting other people so that you can have what you want when you want it and that needs to be explored because you probably don't want to live life that way.

He finds that sharing this helps with treatment engagement and the development of the treatment plan to meet their needs.

Natalie shared that, “My experiences is that they the light comes on with them when they realize that just even addicted to the lifestyle is an addiction and what it has cost them.” Counselors found it may take time for them to reach this point. Deborah shared the individuals who sell drugs, “They kind of require you to uh, for a lack of a better word, step on 'em just a little bit harder, because they think they are unique.”

Matthew found in his experience, “is that most of the ones, if you were selling, you’re using.” Matthew noted that those who did not use drugs were:

> Honestly, those are some of the harder ones to get through in treatment to realize that they have they have a problem because I mean they'll admit they are just doing it for the money. They're just doing it for the status.

Subthemes I recognized under this theme are: (a) Reasons for Selling Drugs; (b) Demonstration of Superiority; (c) Substance Use; (d) Treatment Engagement; and (e) Addressing Treatment Needs.

**Reasons for selling drugs.** Participants cited being told various reasons why individuals sold drugs. Geoff stated that the individuals who sell drugs reported they sold drugs to make a living and it was not by choice. He stated, “Because for the most part a lot of times the guys that are in there selling drugs they [sic]. It’s not they say it’s not by

choice. It's just that they gotta make a living." The individuals who sell drugs needed to support themselves and their families. For some it was all they were exposed to growing up.

Cathy shared, "Oh definitely because they are so used to, that's their lifestyle. They've been raised in it. They've been around the drugs. They've been around gangs and the shootings and etc." Caroline shared that in completing an assessment and individual reported that his drug of choice was money. He stated, "I was addicted to money. That's why I sold drugs."

Participants, also, based on their interactions with individuals who sell drugs, came to their own conclusions why individuals sold drugs. The reasons included money, power, and peer influence. They like the fast, easy money that is associated with selling drugs. Linda shared, "I think that definitely people are addicted to the lifestyle, to the status, to the money, to the adrenaline rush that brings [*sic*] when they do do [*sic*] a drug deal." Veronica explored the "rap sheet" of individuals who are placed on her caseload and would identify someone as an individual who sells drugs, based on his charges and lack of substance abuse treatment. In doing their assessments, she would gather additional information that would confirm he was a seller. She discovered that individuals who sell drugs:

> They don't want to use drugs. They want to do the crime and they want to make the money. They love the lifestyle and if you're doing drugs you're not enjoying the lifestyle because your high all the time and they don't want that. A good a good [*sic*] drug dealer doesn't use drugs.

Multiple participants noted that some were addicted to the lifestyle that was associated with selling drugs. Steven reported:

> Their addicted to the fast cars. They're addicted to you know the the [*sic*] women they can get or whatever. You know I deal with a male population. I'm sure it's opposite with women, but it, their more addicted to the money and the cars and the clubbing, and the lifestyle that goes along with that.

Linda expressed:

> When your selling drugs to be able to kind of party, you know, that rapper lifestyle. That's kind of portrayed by the media unfortunately. Women, um, a lot of them, significant um relationship problems where they're in a committed relationship however they constantly cheat on their significant others. So that image and status of what it kind of means to be a drug dealer. Um, I think a lot of that comes from the media and unfortunately cultural myths, you know, myths myths [*sic*] and the stereotypes that we put on men.

**Demonstration of superiority.** Participants reported that some of the individuals who sell drugs demonstrated superiority over their peers who were substance users. Deborah reported that some of the individuals who sell drugs comment, "I'm not a user. I'm different from these guys. I just sell it." Cathy found, "They do feel very superior because they're not like junkies." Some of their behaviors when selling indicated that too. Cathy shared about the behaviors of individuals who sell drugs when they were selling. She reported:

> Some people say they made them work in their yard all day long for one thing of the you know make them sweat and they thought it was funny. I heard some drug dealer talking about how this person wanted drugs, so he made him work for like two days for one thing of drugs. And I said, 'That is not right. That's more than. He's working more than what you.' He says, 'Yea, but they want to do it so I'm going to make them do it.'

**Substance use.** There were minimal instances in which individuals who sell drugs reported no substance use at all. Participants found there was a history of some substance use. Steven reported, "And I would have to say probably in that whole time there's been like maybe 2 or 3 that have not also been using as well as selling." Nancy shared:

> We've had some situations where guys are like, 'I don't use at all' and we're like, 'Well then you shouldn't be here,' and they've then kind of changed their stories. And we're gonna, we're gonna [*sic*] meet them where they're at.

Matthew shared about substance use that, "With my experience, I guess, I said I mean, every person that has sold they used one time or another."

Individuals who sell drugs were found to be in denial of the severity of their substance use, if they admitted to substance use. Linda shared about a client who stated he, "I sold cocaine, but you know I drank until I got black out drunk every weekend so from Friday to Sunday. I was drunk all weekend." The individual did not believe he had a problem when he compared himself to those who were using cocaine or heroin.

Steven found, "But primarily their addicted to the lifestyle, but if they tell me that you know, 'Yea, I don't really use that much drugs, but I drink alcohol,' well then I can

help them with some of the alcohol." Daniel has found in his groups that the individuals who sell drugs who deny having a substance use problem get challenged by their peers. He described it as when individuals who sell drugs say, "They just sell or whatever and when that's not accurate. When that's not true the other men will bring that out."

**Treatment engagement**. Participants had mixed experiences in assessing the treatment engagement of individuals who sell drugs, who were mandated to substance abuse treatment. Participants expressed that individuals who sell drugs, for the most part, were able to engage in treatment, although they could be challenging at times while in the program.

Participants found there was a disconnect or a gap between individuals who sell drugs and substance users at the onset of treatment. Caroline noted that individuals who sell drugs, "...start hearing and start relating and start reaching out and start trying to be more honest, um, they being to um relate." This took place over time during treatment. Individuals who sell drugs felt as though they could not relate to those who use drugs.

Steven shared he tried to find ways to help individuals who sell drugs to connect with other people in treatment. He stated, "If I can tie their selling drugs into a lifestyle addiction, then I can really get them to relate more with the other folks." Once the connection is made, Steven found that some of the individuals who sell drugs would participate more in the treatment process. Participants noted that once the individuals who sell drugs were not in denial they were different people. For example, Ronald found, "Once they break the denial barrier every person is very, very different. And again, it doesn't matter if they were a user or a seller or did both."

Participants found that individuals who sell drugs did what they needed to do to complete treatment. Cathy found that individuals who sell drugs can be detrimental and cause more harm than good at times. Cathy stated, "To me the drug dealers are the most tough (pause) population to reach." Cathy stated in her program individuals who sell drugs participated because they do not want to receive "improvement expected" during their 45-day review. They were expected to participate, so they do to avoid negative consequences.

Deborah stated she gets 5 to 6 guys a year that report a primary problem of selling drugs and finds that she needs to be tougher on them. She found that eventually they engage, "…but usually right off the bat their kind of stand-offish." Deborah found that individuals who sell drugs do well in the group process. Once they start talking, they were able to engage and tend to pick up some information during their time in treatment.

Nancy shared, in her experiences, that some of the individuals who sell drugs stated they should not be there or they begin to identify the "ripple effect" that selling drugs has on hurting themselves or others. Nancy stated that the individuals who sell drugs can be resistant to discussion in treatment. Cathy shared similarly that she worked with the clients to help them understand how their behaviors are hurting themselves, their children, and their loved ones. She also targeted their need to change their image and to begin to think about how they are going to support themselves as they had minimal skills and education. She stated, "You can reach them sometimes, (pause) but it's going to be hard for them to change."

Caroline shared that individuals who sell drugs tend to be more difficult to work with. Caroline observed the individuals who sell drugs either, "…don't say too much or they start acting out and complaining…" She has found she needs them look at their behavior and once they get it, they are more open to treatment. She stated:

> I think sometimes after they listen in group and what trauma has been created in that life from using drugs that they sold and profited from um I think that then they really begin to identify, but also really begin to struggle with allowing to forgive themselves and how to get on top of that.

Linda shared that some of the individuals who sell drugs who were high ranking individuals in the drug hierarchy, either were able to engage and become leaders in the program or try to find problems with the program. She also found that some "coast" through the program and do not cause any trouble. She expressed that individuals who sell drugs, "I think they struggle more. They also get caught more often breaking the menial rules."

Veronica noted no issues working with individuals who sell drugs. She stated:

> They want to get work release. That's why they come in. They want to get the work release. They want to be let out. You know they want some of the benefits of what the program has to offer, which is not a lot, but its more than what they would get on the compound. So, they're fine to work with. I have no problem working with them.

Ronald's observation of treatment of engagement was:

> Former dealers who get out of denial are very positive role models…Because they see the full picture and they are not at all afraid to let especially the younger guys understand just what it is a bad thing they are doing.

Geoff shared in his experience, he found the individuals who sell drugs to be, "more calmer [*sic*] and cooler, than the uh stable than the smokers."

**Addressing treatment needs.** Many of the participants shared that they addressed the treatment needs of the individuals who sell drugs primarily by individualizing the treatment plan. Ronald stated he assesses clients to determine what their needs are and creates a plan once he knows. Ronald stated, "I would put down on their individualized plan that they claim to be a seller and do not have a substance abuse problem. I put it there in plain letters." Daniel stated that with the treatment planning, they strived to meet individuals where they are at and would employ motivational interviewing to gauge where they are.

Natalie stated there are multiple techniques she used to address the treatments of individuals who sell drugs such as decisional balance, pros and cons, behavior change, workbooks, and treatment plans with the focus on changing individuals thoughts and identifying steps that need to be taken following treatment. She expressed, "There's always more to it than them just selling drugs."

Steven and Cathy shared they had specific group activities with which they engage the individuals who sell drugs. For one of his groups, Steven shared:

> I do a little thing that we breakdown their money that they have made dealing the drugs over however many years and then I take that and I take out whatever they

> got left asset wise and then I take that. We kinda what it whittles down to when we come to the end, we divide whatever money they still have left from those activities by the number of years if they have to do their back up and most of the time I can make it pretty clear to them that they can make more working at McDonald's than they can dealing drugs.

Cathy shared about an interfere sheet assignment which she may give to individuals who sell drugs for them to identify 20 to 25 people's lives they interfered with by selling drugs. The purpose of the assignment was, "They can see how many lives they have affected by taking their food stamps or whatever."

Steven stated that individual counseling sessions are also his way of addressing the needs of individuals who sell drugs. He stated:

> I think that that individual counseling is [*sic*]. I mean in [*sic*] Sometimes you don't know where those conversations are going to lead and so, I mean, it would be really hard for me to say specifically what do we do differently for those guys. And I would just have to say that are our individual counseling is is [*sic*] more tailored to what they need.

**Theme 6: What Does It Mean to Work with Individuals Who Sell Drugs**

Participants did not report any significant changes in their approach when working with individuals who sell drugs that were mandated to treatment. Their focus was meeting individual needs and providing services to address any issues that may present in treatment.

Ronald shared this his focus is on treating their individual needs. He stated, "Well I try to treat the client according to their individual needs and treat dealers whether there just dealers and users at the same." Daniel found it irrelevant if a client used drugs or not. He shared, "Although we are a substance use program and that is our primary focus, um, were allowed to work from that common issue of criminality at the starting point. And that keeps everything else pretty much balanced.

Linda shared about helping clients to ensure their success upon their release. Linda reported:

> I think that, um, I am able to look beyond the number beyond the charge and and [*sic*] beyond all the things that brought them up to that moment to help kind of find their authentic selves and and [*sic*] really start that journey. And what is that going to look like for them not only progress through the TC but go home you know.

**Discrepant Cases**

Participant Janice stated that all individuals who participated in the therapeutic community program she worked at were voluntary. Janice worked with individuals who sell drugs at her work site, but her experiences may be different as they were not mandated to be in the program. In themes and sub-themes, non-conforming responses from Veronica and Ronald were shared. Some of their responses were of significant variation from other study participants regarding the same topic.

## Summary

Thirteen participants were interviewed to answer the posed research question: What are the lived experienced of counselors working with individuals who sell drugs, who are mandated to substance abuse treatment, but who do not themselves use drugs. Counselors reported being prepared to do their work as a result of their education, DOC training, continuing education training, supervision and learning from others in their work environment. Participants identified trainings that could further enhance their work with clients. Most of the participants had support from their peers and supervisors and DOC in facilitating treatment services at their respective locations.

Participants expressed that working with individuals who sell drugs could be challenging, but overall, they were able to engage in the treatment process. There was criminality component that applied in working with this population in the TC although the primary focus of the treatment was substance use. Participants reported that it was rare for individuals who sell drugs not to have some history of substance use. It was uncovered, during treatment, that there was some substance use in most cases. Treatment plans were individualized to meet the specific treatment need of individuals who sell drugs, who were typically addicted to the lifestyle, money, and status associated with selling drugs. Study participants, in working with this population, attempted to meet them where they were and to use techniques to get them to be aware of their behavior and thinking to bring about change.

In Chapter 5, I will present the interpretation of the findings through the lens of SLT, limitations of the study, recommendations, and implications of the study.

# Chapter 5: Conclusion

My purpose in this qualitative, hermeneutic phenomenological study, was to examine the lived experiences of counselors working with individuals who sell drugs, who were mandated to substance abuse treatment, but who do not report substance use. I interviewed counselors and learned about their experiences and insights in working with this population. This was to provide a clinical perspective about the treatment engagement, treatment needs, and observations of peer interactions of individuals who sell drugs who are mandated to treatment.

I selected a qualitative, hermeneutic phenomenological approach to obtain specific information and detailed accounts about counselors' experiences with individuals who sell drugs. Counselors provided their experiences during semistructured interviews, which will be interpreted via the SLT, to gain insight about individuals who sell drugs, who are mandated to treatment from the individuals who provide the services. The computer software program I used was NVivo to complete the process of coding and data analysis.

I interviewed 13 participants about their experiences working with individual who sell drugs who are mandated to a therapeutic community treatment setting. Key findings included themes and subthemes that participants were prepared for their positions as counselors through their education, DOC training, continuing education training, supervision, job experiences, and observing others; characteristics of individuals who sell drugs; how to treat individuals who sell drugs within the TC; and, although there were challenges, individuals who sell drugs were able to engage in treatment.

In this chapter, I will interpret the findings of this study through the lens of SLT and compare the results of my study to past literature on the topic. I will report the limitations of the study and identify recommendation for further research. I will discuss the implications of this study regarding social change and recommendations for practice.

## Interpretation of the Findings

In this section, I will discuss the key findings of this study. I will describe the ways in which my findings confirm, disconfirm, or extend the knowledge of our profession for this population. I will also interpret the findings through the lens of the SLT. As defined in Chapter 1, SLT assumes that the same learning process can produce conforming and deviant behavior (Akers, 1998, p. 50). The components of the theory are differential reinforcement (behavior is a result of frequency and amount of rewards and punishment), differential association (direct and indirect, verbal and nonverbal communication), imitation (observation and modeling of others' behavior), and definitions (beliefs, attitudes, values that influence the engagement or nonengagement of behavior).

### Job Preparedness

Participants were prepared for their positions as counselors through their education, DOC training, continuing education training, supervision, job experiences, and observing others. They practiced within the scope of their competency and training to provide treatment services (ACA, 2014). Their education appeared to enhance their ability to assess and have the skills to work with the offender population, which supports the finding that substance abuse counselors with high levels of education have increased

conceptual complexity, cognitive functioning, and moral reasoning (Sia, Lambie, & Foster, 2006). Participants had access and opportunities to attend trainings and conferences that would be applicable to their job roles and the offender population. Participants welcomed training for their professional development and knew it was annual mandatory obligation. The desire of participants to gain knowledge was reinforced as the population presented in treatment with issues outside of substance abuse, such as parenting, PTSD, and other trauma. Sung et al. (2010) noted counselors working with incarcerated offenders may experience challenges because of a substance abuse disorder, mental health disorder, or both.

Participants relied on previous experiences and observations or suggestions from peers to work with clients if they lacked ongoing training and supervision at their work site. There were sites that praised the supervisors and the amount of supervision received. The lack of supervision, at some sites or previous employment, aligns with previous research that supervisors in the field of addiction may be overworked, unprepared, and overburden which influences their ability to provide quality supervision (Schmidt et al., 2013). Participants had experiences which enabled them to problem solve or develop activities to meet the needs of their clients. If they found a technique or intervention that worked, they continued to apply it if the situation allowed it. Participants reflected on their past job experiences to determine what may or may not work in working with offenders. Their associations with the offender population enabled participants to use various techniques to engage clients. They knew when to and when not to challenge and address problematic thoughts and behaviors. Participants knew from past experiences and

listening to their current clients how substance use and criminal thinking and behaviors were initiated and how they progressed. Many of the clients conformed to what they saw taking place around them growing up.

Participants also engaged in imitation. They learned what to do and what not to do regarding working with the offenders from observing their peers and supervisors. They identified what fit their style as a counselor and adopted it. They knew the importance of finding their own style and not imitate something that worked for someone else but did not work for them. Their observations also enabled them to see what was ineffective although someone continued to do it.

The reports of participants were consistent with previous finding that the correctional environment has an emphasis on safety and security (Perkins & Oser, 2014). The Department of Corrections and participants had to learn to work together to ensure safety and security was a priority, but also the integrity and structure of the therapeutic community treatment program. Participants had to demonstrate that they knew and were in support of DOC rules and procedures. Participants desired consistency among DOC staff in enforcing the rule with the clients in the program. Participants shared it took on going communication with DOC to understand the rehabilitation process and to establish trust that participants knew what they were doing as professionals.

Staff deviation from the rules and procedures of DOC would have resulted in conflict with DOC staff, employment termination, or manipulation by the offenders they were treating in the program. These could be factors that contribute to lack of institutional support counselors may experience when working in a correctional facility

(Goodrum et al., 2003). A facility may not want to support a treatment program if the staff hired are not willing to adhere to the rules and procedures of DOC. Participants shared that knowing the dynamics of working in corrections and with offenders was important as people may be coming from community-based environments. Based on their longevity in a correctional setting, the participants of this study learned, observed, and then modeled behaviors that would ensure their safety and boundaries when working in the environment. They wanted other staff to imitate these behaviors to increase their ability to be successful in the environment too.

**Characteristic of Individuals Who Sell Drugs**

The findings of this study support the previous research and contribute knowledge about the population of individuals who sell drugs. The areas I identified were reasons for selling drugs and substance use.

**Reasons for selling drugs.** In chapter two, I noted offenders' reasons for selling drugs as the belief of limited job opportunities, appeal of the lifestyle, and personal substance use (Adler & Adler, 1983; Duck, 2016; Floyd & Brown, 2012; Murphy et al., 1990; Sevigny & Caulkins, 2004; Tunnell, 1993; VanNostrand & Tewksbury, 1999). Participants of this study acknowledged that it was the individuals who sell drugs own social learning that encouraged them to sell drugs. Study participants had their own definitions about the reasons for selling drugs, which were the lifestyle associated with selling drugs and personal substance use. They wanted to obtain the reasons for selling directly from the individuals who sell drugs and not just assume. Participants sought to understand the clients' history and events that led to their drug selling history.

Participants appeared not to want to group clients in the program into categories that would potentially influence how clients would be treated. This understanding influenced counselors' treatment interventions and the application of TC principles to encourage individuals who sell drugs to engage in treatment and initiate behavioral and behavioral change.

The beliefs of individuals who sell drugs were that selling drugs was a way to support themselves and their families due to being raised in that lifestyle and seeing the benefits of selling such as money, possessions, and power. The easy money encouraged them to engage in the behaviors despite the potential for negative consequences. Participants obtained this information which allowed them to understand why the individuals who sell drugs became involved and continued the behavior through the process of differential association. Participants identified that through differential reinforcement that individuals continued to sell drugs. The money gained outweighed the consequences of incarceration. Individuals who sell drugs reported to the counselors that they thought they were doing good the longer they avoided being arrested and not getting caught. This added to the participants' definitions of the individuals who sell drugs believing they were superior. Participants then used this information to challenge individuals who sell drugs to begin to identify their skills and use their efforts to find legal ways to earn an income versus returning to selling drugs on release.

**Individuals who sell drugs do use drugs.** Individuals who sell drugs may sell to support their own substance use. The findings of this study were, in the counselors' experiences, that individuals who report a primary problem of selling drugs did have a

history of substance use. It was rare to find someone who sold drugs who did not use drugs. This is a new contribution to the literature about this population.

Participants definitions regarding individuals who sell drugs, were that substance use was a part of the lifestyle for a drug seller. Participants knew there was a significant amount time spent around drugs, other people using drugs, and women, which led to sexual activity and substance use, that was taking place based on the stories told by individuals who sell drugs. They knew, at times, that an addiction to substances was a result of the ongoing engagement in the above activities. The selling of drugs shifted from making money to supporting their own addiction. This supports previous literature that individuals sell drugs to support their own substance use (VanNostrand & Tewksbury, 1999).

Individuals who sell drugs minimized their substance use to maintain their image of power and control. Study participants typically did not believe individuals who sell drugs denial of substance use, due to their experiences. The definitions of, and association with, the population of individuals who sell drugs compelled the counselors to challenge the statements of denial. The participants understanding of behavior, observation, and interactions caused them to persist using clinical techniques to help individuals who sell drugs move beyond denial. The other clients who were in treatment, would also challenge the drug seller's denial and ultimately the drug seller would disclose substance use. Those individuals who sell drugs own definitions about using drugs caused those individuals appear to be superior. Individuals who sell drugs did not want to be placed in the same category as the users who they referred to as "junkies" and

who were willing to do what it took to obtain their drugs, such as working for drugs sellers or committing other crimes. This supports other research findings that individuals who sell drugs can avoid certain acts, like robbery and theft, to maintain their substance use and reduce their own harm and risk (Moyler & Coomber, 2015).

**The Therapeutic Community**

This study's findings confirmed previous research about the research individuals who sell drugs were mandated to treatment. According to participants, individuals who sell drugs were referred to treatment to address their reported substance use, whether actual or false, and to address criminal behavior and thinking. This is consistent with the findings that individuals were referred to substance abuse treatment to address substance abuse, criminality, and recidivism (Gerstein, 1990; Hkansson & Berguland, 2012; Parhar, Wormith, Derkzen, & Beauregard, 2008; Severson, Burns, Veeh, & Lee, 2011; Tiger, 2011).

Individuals who sell drugs may be slow to embrace the components and structure of the TC. As they progress through the phases, study participants found that some of the individuals who sell drugs were some of the higher functioning clients in the facility. These individuals who sold drugs were able to be leaders among their peers. Several participants stressed the TC component, *View of Right Living*, to encourage participants to see the value in change, taking personal accountability, and to become involved in making the treatment environment a place for learning and growth. Some of the participants noted that their treatment programs were separate from the general correctional population, which helped to encourage a treatment orientated environment.

This supports previous findings that the programs in a correctional facility had living conditions that were better and safer and the potential to change a person' lifestyle (Wexler et al., 1988).

This study's findings contributed new knowledge of how to treat individuals who sell drugs who are mandated to substance abuse treatment. The participants believed that their treatment program could assist the individuals who sell drugs with changing their behavior. Their programs were designed to address substance use and criminality. Participants had to engage in the process of differential association to gain information from individuals who sell drugs. They sought to meet the clients where they were in their readiness to change and to individualize a treatment plans and assignments and individual sessions to meet their needs and identify problematic behaviors and thinking. Participants collaborated with the clients to determine what areas would be addressed during treatment. The treatment plan did not focus only on substance abuse. Participants found that they could not use the same techniques and interventions with all clients as each client's needs were different. Participants were willing to use their program resources as well as use what they learned from their experiences and peers to assist their clients in changing their thinking and behaviors.

Most of the time participants received positive feedback and engagement for their efforts, which reinforced their desire to maintain the process. They knew increasing engagement would reduce resistance. This information is a new a contribution to the research literature as it demonstrates how to begin to identify and address the treatment needs of individuals who sell drugs who are mandated to substance abuse treatment.

**Treatment Engagement**

This study's finding supported previous research that noted working with offenders can be challenging due to their defensiveness, opposition, and comorbidity (Marshall & Serran, 2004; Sung, Mellow, & Mahoney, 2010). Their disorders, (substance use and mental health), and manipulation created challenges for counselors in trying to provide treatment in a short period of time. Some offenders did not view the program as an opportunity to prepare for successful reintegration back into society to avoid recidivating. At times, participants found that offenders did not want to engage in treatment as it was a hinderance to them returning to society or that they were mandated to complete. This supports previous research findings that mandated or coerced treatment in custodial settings are ineffective (Parhar et al., 2008).

Specifically, with individuals who sell drugs, this study's findings extended the knowledge this population's treatment engagement. Participants identified challenges with this population that were consistent with findings of individuals who sell drugs may not be appropriate for substance abuse treatment (Peters, 1992). Individuals who sell drugs struggled with relating with substance users, but in some cases, this was only an initial struggle. Participants attempted to engage the clients in the treatment program despite the clients' demonstrated resistance. Participants believed the ultimately a parallel process would begin to take place. Participants' definitions encouraged them to role model positive behaviors, challenge the behaviors and thinking of all clients, and maintain the structure of the therapeutic community. Participants would intervene with techniques to assist individuals who sell drugs with treatment engagement and encourage

them to find similarities and not differences among their peers. This contributes new information as it identifies what counselors are doing to attempt to engage individuals who sell drugs in treatment. Counselors did not settle to let them be disruptive in the treatment environment or immediately terminate without applying interventions.

In keeping with SLT, participants encouraged clients to engage in the TC community and group process to address the whole person and not just one problem or issue. The other treatment clients and counselors would be promoting conforming behavior. If the individuals who sell drugs see the benefits of this behavior, they might begin to see that the program was not only about substance use, but also about changing addressing problematic thinking and behavior, and start to engage in treatment. Participants believed that clients who were looking to change would be a positive influence for individuals who sell drugs to reflect inwardly and to initiate change.

**SLT**

The theory I selected to interpret my findings is the SLT. As defined in Chapter 1, SLT assumes that the same learning process can produce conforming and deviant behavior (Akers, 1998, p. 50). I will examine how my research supports and confirms pervious research. I will also examine how SLT explains the results of this study.

**SLT: Past Research**

My research study findings support and confirm the application of the SLT. One area is the application of SLT in predicting and explaining substance use because of peer influence (Mui et al., 2014). Mui et al. (2014) found that thoughts, motivations, expectations, and environment influenced the socialization to substance use. Participants,

of this current research, shared that individuals who sell drugs started using drugs after being around other using drugs as a part of the lifestyle of selling. Their use sometimes escalated to selling drugs to support their own substance use. The individuals who sell drugs were also using drugs were imitating what they saw around them which aligns with the findings that substance use can be influenced by peers (Akins et al., 2010).

My research study findings also support and confirm the non-substance use application of SLT and it use as a general theory of crime. This research also demonstrated how person-environment interactions can influence anti-social behavior (Yarbrough et al., 2012). Individuals who sell drugs were influenced by their peers to engage in selling drugs. The money and possessions appealed to them as they believed opportunities to support themselves and their family were limited. They also liked the fast, easy money. This study further confirmed that peer associations and definition are influential in the engagement antisocial behavior (Yarbrough et al., 2012).

**SLT: Current Study**

The findings of this research support the SLT. The key findings were interpreted through the lens of the SLT. Counselors and DOC must foster an environment that promotes and reinforces positive behavior change. Participants shared about their positive collaborations with DOC and their barriers working with them and in a correctional setting. Participants used differential reinforcement, differential association, imitation, and definitions to understand the population of individuals who sell drugs, who were mandated to treatment, within the TC program. The TC structure and counselor and peer treatment interventions had the ability to influence prosocial thinking and behaviors in

individuals who sell drugs. Individuals who sell drugs began to engage in conforming behaviors as of a result of being in treatment and shift from deviant behaviors. This conforming could have been to ensure treatment completion or internalization of information and tools presented while in treatment. Those who did not conform were removed from the program or their disruptions minimal that they did not cause the individuals to be removed.

## Limitations of the Study

I identified multiple limitations in conducting this study. The first limitation was participation criteria. The population I interviewed was very specific, especially with the education and length of experience. I contacted multiple facilities and was informed there was no current staff that had a master's degree. It was not required for employment as counselor per DOC or the company for which he or she worked. People also who reported they were just starting their employment and did not meet the six months of experience in working in a correctional based TC.

The second limitation was that only individuals who were currently working in a corrections-based TC were interviewed. This was due to me directly contacting facilities to screen and obtain participants since my postings on ACA Connect and Walden Participant Pool did not yield any participants. This could have influenced responses, because it was the participants current employment and they could have feared retaliation or been incentivized for their involvement in the study and responses by supervisors or peers. The study criteria I developed allowed for potential participants to be a part of the

study if they had experiences, within the last two years, of working with individuals who sell drugs in a correctional setting. It did not have to be their current employment.

A third limitation was the ages of the participants interviewed. The average age of the 13 participants was 52 years old. Many of the participants were older and have significant years working in the field of counseling or with offenders. This could have influenced their interview responses as they have had various jobs throughout their career and their skill set may be more advanced, due to experience, than younger counselors.

A fourth limitation was that I conducted all interviews via Skype. I conducted no no in-person interviews based on the geographical location of myself and the facilities I contacted and through which I was able to obtain participants. I was not able to travel to conduct the interviews. In-person interview could have positively or negatively effects the dynamics of the interview.

## Recommendations

I have recommendations for future research to learn more about counselors working with individuals who sell drugs who are mandated to treatment. One recommendation is to alter the criteria of this study to include individuals who have a bachelor's degree. Although saturation was reached in this study, adjusting the criteria of participants could increase the diversity, regarding race/ethnicity and age, of participants interviewed. The educational requirements for counselors working in correctional based TC programs should be reviewed to assist a researcher in determining the criteria.

A second recommendation is for the researcher to learn about and complete, when applicable, the state's DOC research proposal submission process to potentially increase

the number of states represented in the study. In conducting my research, I learned there are states with multiple facilities that have TC programs, but staff are not allowed to engage in research without approval. Although saturation was reached in this study, there were people who wanted to participate, but did not want to experience repercussions for doing so.

Another recommendation for further research is to explore what specific groups, activities, or information provided helped individuals who sell drugs to respond well to in treatment and address their behavior of selling drugs. Several of the study participants identified some groups or activities they used with individuals who sell drugs, but it could be explored further to determine what is effective with this population in the treatment setting. The researcher could also explore what components of the TC are effective as well.

I would also recommend exploring the specific drugs and patterns of use for individuals who sell drugs. Through this research, I found that although substance use was not a primary problem, most individuals who sell drugs ultimately admitted to using drugs too. Based on interview responses, the number of people who reported selling drugs and not using them was minimal.

## Implications

In this section, I will describe how the findings of this research could influence positive social change of the referral and treatment of individuals who sell drugs and who are mandated to substance abuse treatment. My purpose for this research was to learn about the lived experiences of counselors working with individuals who sell drugs and

who are mandated to substance abuse treatment, but do not have a substance use history. The findings indicated there was a substance use history, but substance use was not the identified primary problem. In learning more about this population in a treatment setting, counselors and their programs can continue to find additional ways to assist these individuals in treatment to address their addictions, which may not include substance use.

**Social Change**

The findings indicate that researchers need to examine the assessment process for treatment placement. At time, offenders were being mandated to treatment based on criminal offenses and false information about substance use, that was provided during assessments. If the TC is addressing substance use and criminality, assessments should not just focus on substance use. It should be clear to the program receiving the referral, the offender's need for treatment is criminality and not have it assumed to be substance abuse.

The findings of this research could increase the need for counselors to identify individuals who sell drugs who may be in their programs. This identification could allow for counselors to track trends in referrals to determine if there is a need for specific treatment groups for this population on an ongoing basis. In bringing attention to the population, counselors could encourage other clients to report they have a problem with selling drugs. This could increase treatment engagement of clients if they feel as though they are addressing multiple problematic areas and not just substance abuse.

These findings could also encourage the need to examine the amount of training provided related to criminality and the population of individuals who sell drugs.

Participants did not identify clinical trainings that focused on the criminality or individuals who sell drugs. Increased knowledge and training could enable counselors to feel more confident in addressing treatment issues beyond substance abuse and for the clients to obtain enhanced treatment services. By increasing the quality of treatment services, offenders may have increased engagement, which in turn could result in increased success upon treatment completion.

### Recommendations for Practice

Counselors should make efforts to engage individuals who sell drugs who are mandated to treatment. Counselors should not assume these clients will be problematic and will not engage in the treatment process. The finding of this study indicated that an initial lack of engagement can be changed once offenders make a connection with peers or admit to substance use. Participants who worked to engage individuals who sell drugs typically found success in gaining treatment engagement even if it was for the individuals who sell drugs to avoid negative consequences. This engagement can reduce the challenges this population can present in treatment and increase their successful treatment completion.

## Conclusion

I created this study because of my wanting to learn more about the experiences of individuals who sell drugs in a correctional based TC. I was able to gain information and understanding about this population from the lived experiences of counselors working with them in that setting. Counselor demonstrated that their education and training allowed them to have longevity in working in a challenging environment and still provide

treatment services. Counselors believed the TC modality of treatment along with individualized treatment planning was effective in addressing the treatment needs of individuals who sell drugs that were mandated to treatment. Although it was not their primary reported problem, individuals who sell drugs, did report substance use that they minimized in comparison to their substance using peers. Counselors sought to challenge these clients to think about their behavior and created ways to enable them to examine how selling drug effects their life outside of incarceration. The counselors' desire to engage and treat the individuals who sell drugs contributed to their clients' treatment involvement. Individuals who sell drugs were able to engage in treatment to lessen or avoid negative consequences, which would allow them to complete the program.

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# Appendix A: Email Correspondence

Greetings (insert company name or company contact)

My name is Natasha Herbert and I am a doctoral student at Walden University. My program of study is Doctor of Philosophy in Counselor Education and Supervision. I am looking for volunteers to participate in my dissertation study which is titled: Individuals Who Sell Drugs Placed in Treatment: The Perspective of Their Counselors. Your organization is one that has been identified as facilitating correctional-based therapeutic community treatment. I am specifically recruiting counseling professionals who have experiences working with individuals who report a primary problem of selling drugs, and were mandated to treatment, but who themselves were not drug users.

I have attached a flyer that can be distributed and posted that identifies the purpose of the study, the participant eligibility requirements, the time commitment of the study, and my contact information.

Thank you for your time in reading my email and considering my request.

Sincerely

Natasha Herbert MS, LCPC, NCC, MAC
natasha.young@waldenu.edu

Appendix B: Recruitment Flyer

# Research Participants Needed

**Purpose of the Study:**

**To learn about the treatment experiences of individuals who sell drugs from the counselor perspective**

**Looking for counseling professionals who have:**

a. **A minimum of an associates degree**

b. **A minimum of two years in the field of counseling**

c. **A minimum of six months of working in a correctional based therapeutic community**

d. **Had direct interaction with individuals who reported a primary problem of selling drugs and not using drugs**

e. **Had experience working with individuals who sell drugs in a correctional based therapeutic community within the last year**

**Study volunteers will be asked to participate in a telephone screening interview and then up to a 90-minute interview, if selected.**

**Please contact Natasha Herbert at natasha.young@waldenu.edu for interest or questions about study participation.**

## Appendix C: Informed Consent

### CONSENT FORM

You are invited to take part in a research study about learning the lived experiences of counselors working with individuals who sell drugs who are placed into substance abuse treatment. The researcher is inviting counselors with a master's degree or higher who have worked with individuals who sell drugs in a correctional based therapeutic community treatment setting to be in the study. When not recruiting face-to-face, add: I obtained your name/contact info via email or telephone. This form is part of a process called "informed consent" to allow you to understand this study before deciding whether to take part.

This study is being conducted by a researcher named Natasha Herbert MS, LCPC, NCC, MAC who is a doctoral student at Walden University.

**Background Information:**
The purpose of this study is to examine the lived experiences of counselors who work directly with individuals who have been convicted of selling drugs, incarcerated, and then mandated to engage in a cognitive-behaviorally based substance abuse treatment program while incarcerated. I will examine the results to gain understanding of how this population engages in treatment from the perspective of the treatment counselors.

**Procedures:**
If you agree to be in this study, you will be asked to:

- To complete an initial phone screening, which will include identifying a location and time to conduct the face to face interview. If the interview is being conduct via an online meeting service, a time will be identified to conduct the interview.
- If you agree to participate beyond the screening, to participate in an interview is allotted for no more than 90-minutes
- To have your interview recorded and later transcribed by the researcher
- If you want to review your transcription upon its completion
- To participate in a15-minute debriefing session about the study outcomes

Here are some sample questions:

- What are your experiences working with individuals who sell drugs in the therapeutic community?
- What are your observations of individuals of who sells drugs engaging with peers who report a primary problem of substance use?
- What do you think the impact is, if any, of individuals who sells drugs on the treatment process of others?

**Voluntary Nature of the Study:**
This study is voluntary. You are free to accept or turn down the invitation. No one at your agency will treat you differently if you decide not to be in the study. If you decide to be in the study now, you can still change your mind later. You may stop at any time. The researcher will inform all volunteers of their selection for the study.

**Risks and Benefits of Being in the Study:**
Being in this type of study involves some risk of the minor discomforts that can be encountered in daily life, such as recalling instances of working in the correctional environment or a challenging client in treatment. Being in this study would not pose risk to your safety or wellbeing. In the occurrence of an adverse event due to study participation, please contact the Substance Abuse and Mental Health Services Administration 24-hours National Help Hotline at 1-800-662-4357 or 911 for immediate care.

This current study seeks to learn about counselors' observations of, and interactions with, individuals who sell drugs while in they are in treatment and to gain insight into whether substance abuse treatment is the appropriate referral based on their primary presenting behavior of selling drugs.

**Payment:**
There will be no payment of any form for participants participating in this study.

**Privacy:**
Reports coming out of this study will not share the identities of individual participants. Pseudonyms will be provided when presenting the results of the data. Details that might identify participants, such as the location of the study, also will not be shared. The researcher will not use your personal information for any purpose outside of this research project. Data will be kept secure by the researcher. Paper documents will be kept in a locked box by the researcher. All electronic documents will be kept on the researcher's personal computer which is password protected. The data will be backed up on a flash drive, which will also be stored in the locked box. Data will be kept for a period of at least 5 years, as required by the university.

**Contacts and Questions:**
You may ask any questions you have now. Or if you have questions later, you may contact the researcher via email at Natasha.young@waldenu.edu or telephone at 240-418-449. If you want to talk privately about your rights as a participant, you can call the Research Participant Advocate at my university at 612-312-1210. Walden University's approval number for this study is Walden University's approval number for this study is 02-09-18-0236072 and it expires on February 8, 2019

As this consent is being completed via email, please print or save this consent form for your records.

**Obtaining Your Consent**

If you feel you understand the study well enough to make a decision about it, please indicate your consent by replying to this email with the words, “I consent.”

# Appendix D: Phone Screen Protocol

## Phone Screen Protocol

1. Review of informed consent
2. Review of confidentiality
3. Review of role my as doctoral student and researcher and credentials
4. Background of the study
5. Participant Criteria confirmation
    a. Minimum of master's degree
    b. Minimum of two years in the field of counseling
    c. Minimum of six months of working in a correctional based therapeutic community
    d. Had direct interaction with individuals who reported a primary problem of selling drugs and not using drugs
    e. Experience working with individuals who sell drugs in a correctional based therapeutic community within the last year
6. If criteria are met, an agreement to participate in semistructured interview
7. Identification of interview time and location

# Appendix E: Interview Protocol

## Interview Protocol

Name:

Age:

Race/Ethnicity:

IQ1- What is it like working as a counselor in a correctional setting? What are positive experiences and what some challenges you have faced?

IQ2- How did you learn that an individual had a primary problem of selling drugs and not using drugs?

IQ3- What are your experiences working with individuals who sell drugs who are mandated to treatment in the therapeutic community, but do not report a primary problem of substance abuse?

IQ4- How did you and the program address the needs of the population of individuals who sell drugs and are mandated to treatment, but do not report a primary problem of substance abuse during the treatment process?

IQ5- What are your observations of individuals who sell drugs engaging with peers who report a primary problem of substance use?

IQ6- How do individuals who sell drugs participate in the psychoeducational and small therapy group process?

IQ7- What is the impact, if any, of individuals who sells drugs on the treatment process of others?

IQ8- What training have you received to enable you to work with this population? What are your training needs at this time? What type of support do you receive from peers and supervisors?

IQ9- What does is it mean to be a counselor who works with individuals who sell drugs in a treatment setting?

Appendix F: Human Participants Training Certificate

**Certificate of Completion**

The National Institutes of Health (NIH) Office of Extramural Research certifies that **Natasha Herbert** successfully completed the NIH Web-based training course "Protecting Human Research Participants".

Date of completion: 05/28/2017.

Certification Number: 2405052.

## Appendix G: Phone Screen Protocol Updated

### Phone Screen Protocol

1. Review of informed consent
2. Review of confidentiality
3. Review of role my as doctoral student and researcher and credentials
4. Background of the study
5. Participant Criteria confirmation
    a. Minimum of masters' degree
    b. Minimum of two years in the field of counseling
    c. Minimum of six months of working in a correctional based therapeutic community
    d. Had direct interaction with individuals who reported a primary problem of selling drugs and not using drugs who were mandated to treatment
    e. Experience working with individuals who sell drugs in a correctional based therapeutic community within the last year
6. If criteria are met, an agreement to participate in semistructured interview
7. Identification of interview time and location

Appendix H: Informed Consent Updated

CONSENT FORM

You are invited to take part in a research study to learn about the lived experiences of counselors who work with individuals who sell drugs who have been arrested for selling drugs, but do not report a primary issue of using drugs, but who are referred to substance abuse treatment. The researcher is inviting counselors with: (a.) a minimum of a master's degree, (b.) a minimum of two years in the field of counseling, (c.) a minimum of six months of working in a correctional based therapeutic community, (d.) had direct interaction with individuals who reported a primary problem of selling drugs, but were not using drugs who were mandated to treatment, and (e.) had experience working with individuals who sell drugs in a correctional based therapeutic community within the last year to be in the study. Study participants will be asked to share their experiences working with individuals who report a primary problem of selling drugs, who are mandated to a substance abuse treatment program, but who themselves do not use drugs. This form is part of a process called "informed consent" to allow you to understand this study before deciding whether to take part.

This study is being conducted by a researcher named Natasha Herbert MS, LCPC, NCC, MAC who is a doctoral student at Walden University.

**Background Information:**
The purpose of this study is to examine the lived experiences of counselors who work directly with individuals who have been convicted of selling drugs, incarcerated, and then mandated to engage in a cognitive-behaviorally based substance abuse treatment program while incarcerated. I will examine the results to gain understanding of how this population engages in treatment from the perspective of the treatment counselors.

**Procedures:**
If you agree to be in this study, you will be asked to:

- To complete an initial phone screening (maximum 15 minutes), which will include identifying a location and time to conduct the face to face interview. If the interview is being conduct via an online meeting service, a time will be identified to conduct the interview.
- If you agree to participate beyond the screening, to participate in an interview that is allotted for no more than 90-minutes and will be audio recorded. The audio recording will be transcribed by this researcher.
- As needed, participate in member checking (15-30 minutes) for clarity in responses provided following transcription

Here are some sample questions:

- What are your experiences working with individuals who sell drugs in the therapeutic community?
- What are your observations of individuals of who sells drugs engaging with peers who report a primary problem of substance use?
- What do you think the impact is, if any, of individuals who sells drugs on the treatment process of others?

**Voluntary Nature of the Study:**
This study is voluntary. You are free to accept or turn down the invitation. No one will treat you differently if you decide not to be in the study. If you decide to be in the study now, you can still change your mind later. You may stop at any time. The researcher will inform all volunteers of their selection for the study.

**Risks and Benefits of Being in the Study:**
Being in this type of study involves some risk of the minor discomforts that can be encountered in daily life, such as recalling instances of working in the correctional environment or a challenging client in treatment. Being in this study would not pose risk to your safety or wellbeing. In the occurrence of an adverse event due to study participation, please contact the Substance Abuse and Mental Health Services Administration 24-hours National Help Hotline at 1-800-662-4357 or 911 for immediate care.

This current study seeks to learn about counselors' observations of, and interactions with, individuals who sell drugs, who are mandated to treatment, to gain insight into whether substance abuse treatment is the appropriate referral based on their primary presenting behavior of selling drugs.

**Payment:**
There will be no payment of any form for participants participating in this study.

**Privacy:**
Reports coming out of this study will not share the identities of individual participants. Pseudonyms will be provided when presenting the results of the data. Details that might identify participants, such as the location of the study, also will not be shared. The researcher will not use your personal information for any purpose outside of this research project. Data will be kept secure by the researcher. Paper documents will be kept in a locked box by the researcher. All electronic documents will be kept on the researcher's personal computer which is password protected. The data will be backed up on a flash drive, which will also be stored in the locked box. Data will be kept for a period of at least 5 years, as required by the university.

**Contacts and Questions:**
You may ask any questions you have now. Or if you have questions later, you may contact the researcher via email at Natasha.young@waldenu.edu or telephone at 240-418-4749. If you want to talk privately about your rights as a participant, you can call the Research Participant Advocate at my university at 612-312-1210. Walden University's approval number for this study is 02-09-18-0236072 and it expires on February 8, 2019.

As this consent is being completed via email, please print or save this consent form for your records.

**Obtaining Your Consent**

If you feel you understand the study well enough to make a decision about it, please indicate your consent by replying to this email with the words, "I consent."