Understanding Resistance in Correctional Therapy: Why Some Clients Don't Do What They Should, and What to Do About It

Joseph A. DaGrossa
U.S. Probation Officer, District of New Jersey

AT A RECENT federal reentry court session held in the District of New Jersey, five program participants were provided with an introduction to financial literacy. As a homework assignment, the participants were each instructed to call or visit three local banks and ask a series of brief questions related to opening checking accounts. The participants were given two weeks to complete the task, which would earn them "credits" that could be applied to an early termination of supervised release. When the reentry court reconvened two weeks later, none of the participants had completed the assignment.

We've all been there. A probation officer gives a client instructions designed to help the client. The client then fails to perform the assigned task. The probation officer considers the client to be behaving in a difficult manner and becomes frustrated. Rather than simply regarding clients as being obstinate, however, practitioners would do well to recognize that any number of scientific explanations could adequately explain why clients resist treatment directives. Understanding the dynamics of resistance may provide us with clues to effectively managing it.

Assigning clients tasks to complete (i.e., "homework") is a key component of cognitive-behavioral therapy and effective correctional treatment generally (Andrews & Bonta, 2010; Beck, 1995). In fact, research has demonstrated that therapy programs which make use of homework are more effective than those which do not (Morgan, Kroner, & Mills, 2006; Morgan et al., 2011). As such, probation officers, therapists, and other professionals who work with clients in a correctional setting would do well to employ therapeutic approaches that incorporate homework assignments.

However, whenever therapy involves the use of homework, there exists the possibility that the client will resist completing it (Goldfried, 1982). Understanding and appropriately addressing resistance is an important yet frequently overlooked component of effective therapy. In recent years in the field of correctional treatment, researchers have developed specific conceptualizations of how services are most effectively applied; often missing from these approaches, however, are techniques designed to recognize and address resistance to treatment on the part of those under supervision. One example is the formulation of the Risk-Needs-Responsivity (R-N-R) model, which outlines three central components of offender treatment. Whereas risk assessment is concerned with ascertaining which offenders are most likely to recidivate in the future (and are therefore more likely to benefit from treatment specific to their individual risk factors) and needs assessment focuses on determining a given individual's particular criminogenic needs, responsivity is concerned with making use of the most effective treatment approaches and matching treatment to a given offender's particular circumstances (Andrews & Bonta, 2010). Offender willingness to comply with treatment directives would conceptually appear to be directly related to responsivity; understanding the etiology of resistance and effectively dealing with it would logically increase offender responsivity.

It is noteworthy, though, that some scholars have argued that the R-N-R model inadequately conceptualizes responsivity. They state that the model overemphasizes the importance of risk and needs while paying too little attention to responsivity, thereby potentially leading practitioners to focus on assessing risk and addressing needs while giving minimal regard to appreciating the ability and motivation of offenders to engage in treatment (Ward, 2002; Ward & Stewart, 2003). In light of such criticism and in an effort to bring greater awareness of the issue of resistance in probation officer/offender relationships, in this article I review what is known about why clients in such relationships may fail to adhere to instructions to perform prosocial tasks and offer suggestions as to how probation officers can increase compliance with homework assigned as part of correctional therapy. Understanding resistance and effective ways to address it is particularly important given the current emphasis on the development of reentry and other problem-solving courts.

In this article, reasons for resistance are categorized as falling into four broad categories. First, I discuss possible reasons for resistance based in *social* explanations. For our purposes, these are defined as explanations rooted in the nature of interactions with others and include,

for example, how living in certain social environments may impact decision-making and behaviors at the individual level. *Psychological* explanations are those which, although possibly shaped through social experiences, are considered to be micro-level, client-centered factors. These include explanations for behavior based on personal characteristics, such as how one's financial circumstances may affect decision-making and perspectives of time. Next, I discuss *biological* explanations for resistance; these are explanations for resistant behavior grounded in physical abnormalities, such as problems in brain functioning or chemical imbalances. Finally, I briefly treat the hybrid category of *bio-social* explanations. These are based on the complex interplay between biological and social factors, which may act upon each other to culminate in noncompliant behavior.

Up to this point, there has been little examination of resistance in therapeutic relationships from these perspectives. In fact, in the psychological literature, researchers on resistance have thus far given little attention to the reasons for it, instead being concerned primarily with strategies for addressing resistance. Where people have attempted to explain the etiology of client resistance, those of various psychological perspectives have disagreed as to its causes, with psychodynamic, behavioral, and cognitive schools of thought all offering their own distinct explanations (Beutler, Moleiro, & Talebi, 2002). Clearly, considerable disagreement exists within the psychological community as to the causes of resistance. Given this, a detailed examination of these varying perspectives is outside the scope of this article. Rather, I offer some explanations for resistance not widely considered in the traditional psychological literature but grounded in research and holding the promise of explaining a variety of (frequently dysfunctional and sometimes criminal) human behaviors. In some cases, the connections to particular schools of psychological thought will be obvious to readers with training in psychology and counseling; in other cases, less so. When needed, I will suggest specifically how many of these explanations for assorted behaviors also have utility in explaining resistance to treatment.

Social explanations

Many explanations for human behavior may be found in social influences. In fact, a substantial body of literature has suggested that not only behaviors but also beliefs and attitudes may be learned from others. Much of this work has been criminological in nature.

In proposing his theory of differential association, for example, Sutherland (1939) suggested that competing cultures—criminal and conventional—vie for people's attention and whether an individual succumbs to criminal or conventional influences depends on which culture exerts a greater influence in his or her life. Sutherland's theory grew out of earlier work done by Clifford Shaw and Henry McKay, who contended that criminal activity would be more prevalent in areas of a city in which social disorganization led to the formation of antisocial values. Akers (1977) subsequently expanded on Sutherland's work to develop a theory of social learning. In doing so, he explained specific processes by which people may learn criminal behaviors and attitudes. Akers proposed that people may, for instance, learn criminal behavior by imitating conduct which is modeled for them. Once this is done, they may continue to engage in such conduct if it is rewarded in some way. Similarly, people may continue to participate in criminal activity if they see others rewarded for doing so, a process psychologists refer to as vicarious reinforcement.

How might resistance to treatment interventions be shaped by one's social environment? Several possible explanations are offered. For one, distrust of authority figures may be an attitude learned in certain communities and this distrust may lead some people under supervision to view treatment directives with skepticism. Second, a depressed sense of self-efficacy may develop in people who live in communities where examples of efficacious behavior are limited. Each of these concepts is examined in this section.

In some cases, resistance may be rooted in a client's mistrust of the therapist and his or her motives, especially when treatment is being applied in a correctional setting (Morgan et al., 2007). Some explanations for why clients may distrust practitioners are socially-based. A growing body of research, for instance, suggests that in dealing with authority figures, people largely form their views of the authorities based on their perceptions of whether or not they believe the authorities act in a fair manner. These perceptions of fairness shape views on the legitimacy of authority; people are more likely to comply with directives if they view the authority as being legitimate (Mazerolle et al., 2013; McCluskey, 2003; Sunshine & Tyler, 2003; Tyler, 1990; Tyler, 2004). Perceptions of the legitimacy of law enforcement officials may form even in the absence of direct contact with such officials (Tyler, 1990; Tyler & Huo, 2002). Views of the criminal justice system may be shaped, for example, by witnessing the imprisonment of a family member or being exposed to media accounts of alleged police brutality. Weakened views of the legitimacy of law enforcement may lead people under supervision to distrust the motives of probation officers, thereby creating apprehension about complying with treatment directives (DaGrossa, 2014).

It is not difficult to see why some people under supervision are reluctant to trust authority figures, especially if they have grown up in neighborhoods that have historically embraced views of law enforcement which are less than positive. But distrust also extends into relationships with other private citizens, especially among residents of low-income, high-crime neighborhoods. Sociologists have identified a concept known as *collective efficacy*, defined as "social cohesion combined with shared expectations for social control" (Sampson, 2012, p. 27). One element of collective efficacy is trust among the people who live in a neighborhood. Low levels of collective efficacy have been found not only to result from—but also to cause—increased rates of crime (Sampson, 2012; Sampson, Raudenbush, & Earls, 1997). Relatedly, I am reminded of a conversation that took place while teaching a job readiness class several years ago for a group of ex-offenders under supervision. In the course of discussion, one participant in the group stated, "I have friends, but they don't know where I live. I don't let them come over to my house because they may not be my friends someday." The notion that even friends are kept at a safe distance because they may one day turn into violent foes may be foreign to many probation officers, but feelings of distrust are all too palpable among residents in many poor, crime-ridden communities.

Distrust of others may therefore result not only from direct and indirect interactions with authority figures but also from simply residing in areas that are low in social cohesion and collective efficacy. This distrust affects relationships not only with law enforcement but with other private citizens, as well. A client's difficulty trusting others may create an unseen barrier between the treatment provider and client, leading to resistance, especially if the treatment is being "coerced," such as in a correctional setting.

Additionally, treatment efforts may be

impeded when clients do not believe they have the ability to change their situation. Martin Seligman and colleagues developed the concept of *learned helplessness* in a series of famous psychological experiments in the 1960s. Simply stated, learned helplessness is a perception of powerlessness people develop, often following a traumatic event or repeated exposure to aversive stimuli which one cannot escape (Seligman & Maier, 1967). Those experiencing learned helplessness believe that they cannot control their circumstances, are likely to avoid or withdraw from treatment, and are prone to becoming depressed.

Much like distrust of others, learned helplessness may not be a function of one's particular circumstances alone, but also those of the larger, surrounding environment. Upon analyzing national-level surveys and census data, Boardman and Robert (2000) found that high rates of neighborhood unemployment and public assistance were associated with low levels of *self-efficacy* reported by individuals, where self-efficacy was characterized according to Bandura's (1986) definition: "people's judgments of their capabilities to organize and execute courses of action required to attain designated types of performances" (p. 391). The authors suggested that neighborhood socioeconomic status may influence individual-level self-efficacy in two ways. First, spatial constraints may affect the flow of resources into a community. As such, someone living in an area of low socioeconomic status may have fewer institutional resources on which to rely, which could degrade the person's perception of his or her ability to complete tasks. Second, someone who lives in an area of low socio-economic status may report a lower level of self-efficacy simply because he or she has less exposure to other individuals engaged in efficacious activities. The result is that people with low levels of self-efficacy may not fully engage in treatment directives if they believe that their efforts will have little effect on ultimately changing their circumstances.

Psychological explanations

For our purposes, psychological explanations of resistance to treatment are considered to be those that originate and operate at a much more individual level than the social explanations presented above. Discussed are ways in which clients' perspectives on finances and orientation toward time may affect their compliance with treatment directives, as well as personality traits, the importance of personally-held perceptions about the value of treatment, religious beliefs, and even potential embarrassment about engaging in assigned therapeutic tasks.

A growing body of research suggests that views of one's personal financial circumstances may influence how decisions are made. In particular, experiencing poverty may adversely impact cognitive functioning through a process known as *attentional capture*; in other words, being poor may cause people to become preoccupied with budgetary concerns, interfering with their ability to make decisions and focus on tasks at hand (Mullainathan & Shafir, 2013). Mani et al. (2013) demonstrated this in an experiment in which fairly wealthy and poor subjects were presented with scenarios designed to induce varying degrees of financially-related pressure. After being presented with scenarios describing "low" financial pressures, the poor subjects did not perform any differently than the wealthy subjects on a test of cognitive abilities. However, after being presented with scenarios detailing "high-cost" financial problems, the poor subjects performed much worse on the tasks than the wealthy subjects. The authors suggest that the high-cost financial scenarios served to distract the poor subjects from the task at hand. They add that the demands on attention and cognitive abilities generally which are created by poverty may help to explain why poor citizens are less likely to engage in preventive health care practices (Katz & Hofer, 1994), are less productive workers (Kim, Sorhaindo, & Garman, 2006), and even tend to be more likely to show up late for and miss scheduled appointments (Neal et al., 2001).

Additionally, people who live in poverty may find themselves choosing to engage in activities that bring immediate, short-term reward instead of those that may result in more beneficial, long-term gains, but gains that are not immediately realized. For instance, in the book *Evicted: Poverty and Profit in the American City*, Matthew Desmond (2016) recounts the story of a poor, recently-evicted woman searching for a new place to live who spends virtually her entire allotment of food stamps on a single, extravagant lobster dinner. Throughout the book she displays a tendency to make sizable purchases whenever she has a little extra money, rather than putting the money aside for when she may eventually need it. Her friends and family regard her behavior as irresponsible. To her, however, these decisions are guided by a certain logic; viewing digging herself out of poverty as a long-term and seemingly insurmountable task, she opts to enjoy more immediate, short-term luxuries in life now and again.

This example illustrates what we know about the link between socioeconomic status and *time perspective*. Time perspective is a measure of how one's thinking is motivated by considerations of the past, present, and future (Guthrie, Butler, & Ward, 2009; Zimbardo & Boyd, 1999). People who are present-oriented are more likely to engage in behaviors that have immediate, short-term benefits, even if those behaviors may be disadvantageous in the long-term. A present-oriented time perspective has been found among drug abusers (Petry, Bickel, & Arnett, 1998), compulsive gamblers (Hodgins & Engel, 2002), risky drivers (Zimbardo, Keough, & Boyd, 1997), homeless people (Pluck et al., 2008), and people of lower socioeconomic status (Guthrie, Butler, & Ward, 2009; D'Alessio, Guarino, DePascalis, & Zimbardo, 2003; Epel, Bandura, & Zimbardo, 1999).

Additionally, in a 2009 study, Guthrie, Butler, and Ward asked participants to answer a series of questions, drawn from the Zimbardo Stanford Time Perspective Inventory, that were specifically designed to measure fatalistic perspectives of time. In the words of Guthrie et al., these items are designed to "reflect a lack of personal influence and a feeling that other forces are more powerful in determining events" (p. 2146). Examples are statements such as "Since whatever will be will be, it does not really matter what I do," and "Fate determines much in my life." Subjects with less formal education and those who held non-professional positions were more like to endorse these statements than those who enjoyed higher socioeconomic status.

The literature is replete with qualitative work that points to the prevalence of the fatalistic time perspective among the offending population. For instance, in his seminal work *Code of the Street*, Anderson (1999) documents the existence of this fatalistic view by recounting conversations with several young, inner-city men who state, "life is bound to be short for the way I'm living," and "when my time is here, it's here, and there's nothing I can do about it" (pp. 136-137). Similar stories have been recounted in work by Matza (1964), Bush (1995), Larson (2000), and Maruna (2001), among others.

Not only may the research on the relationship between poverty and decision-making and time perspectives help explain why some

people choose to engage in criminal conduct, it may also help explain resistance to treatment. Clients experiencing poverty may be particularly prone to choosing to engage in pleasurable tasks that provide immediate gratification rather than devoting time to homework assignments, the benefits of which are often less tangible and not immediately obvious. Those who embrace a fatalistic time perspective may resist treatment directives if they feel powerless to eventually change their circumstances. As such, when encountering client resistance, treatment providers would benefit from considering these possible explanations.

Some previous work has attempted to identify personality traits of clients likely to resist treatment. Upon studying a sample of college undergraduates, Dowd and Wallbrown (1993) found resistant clients more likely to be "aggressive, dominant, defensive and quick to take offense, and autonomous. They also tend not to affiliate with others and neither seek support from others nor support them… Thus, a picture emerges of a person who is dominant and individualistic, a loner who lacks strong relations with others" (p. 537). Of course, resistance to treatment might be rooted in a variety of factors that may more easily be addressed than personality traits. Clients may, for instance, resist treatment because they are not personally invested in the task at hand. In the case of the banking example, one participant told program administrators that he simply didn't see the need for a bank, explaining that for years he used check-cashing agencies to cash his paychecks and kept whatever cash available on hand (this despite the fees charged by such businesses). He added that everyone he knew in his community did the same thing, despite the fact that there are several local banks in the area. As such, clients may resist treatment if they simply don't see the value in it. Proper use of cognitive therapy to educate the client on the potential benefits of the homework assignment may alleviate this obstacle.

Additionally, cultural or religious beliefs may interfere with clients' willingness to engage in treatment. One of the reentry court participants, a devout Muslim, explained to the program administrators that various features of the traditional banking system (e.g., interest payments and certain loan practices) are contrary to Shari'ah, the Islamic teachings. He stated that after consulting with a religious leader, he was advised to avoid activity at conventional banks and that he should limit banking activity to banks that operate in accordance with the teachings. In these types of scenarios, therapists would do well to be mindful of potential religious conflicts and work with the client to fashion an acceptable treatment plan.

Finally, clients may be resistant to treatment simply because they either are too embarrassed to follow directives or just don't understand the instructions provided. Although none of the reentry court participants specifically stated that they were too embarrassed to go into a bank and ask questions about the terms and benefits of having a checking account, this possibility must be considered. Accordingly, it is advisable that when developing homework tasks, practitioners ask clients about any anxiety or concerns they may have about homework assignments. Similarly, when working with clients to develop homework tasks, practitioners will want to avoid assigning tasks that are too complex and will want to check with clients about their perceived ability to complete assignments. If clients feel overwhelmed or unsure of exactly what they need to do, they may become easily discouraged and fail to perform the assigned tasks. To avoid this problem, the therapist may work with the client to break an assignment down into a series of smaller, more-easily accomplished tasks, an approach known by learning theorists as "chunking" (Domjan, 1993). For example, rather than simply directing a client to go to the local Department of Motor Vehicles and obtain a re-issued driver's license to replace one that was misplaced while the client was incarcerated, the client may be tasked with gathering each of the required documents, one step at a time. The client may begin by going to the local municipal offices to obtain a replacement birth certificate and bringing it to the therapist the following week. During the second week, he may be instructed to file an application for a replacement Social Security card. The seemingly complex task of obtaining a replacement driver's license is therefore accomplished in a series of smaller, more manageable goals with specific deadlines. Of note, each of these intermediate steps may need to be broken down into even smaller tasks; for example, if the client is unsure of where to obtain or how to fill out the paperwork needed for a birth certificate, the therapist may need to provide assistance.

Biological explanations

Biological explanations for noncompliant conduct are generally given much less attention by criminal justice professionals than social explanations. In recent years, however, a quickly-growing body of scientific research has focused on how one's brain functioning and chemical make-up may contribute to criminal activity. In 2005, Terrie Moffitt identified over 100 studies that examined the link between genetics and antisocial behavior, and meta-analyses have concluded that approximately 50 percent of the variation in the population's involvement in such conduct may be accounted for by genetic influences alone (Miles & Carey, 1997; Rhee & Waldman, 2002). A genetic basis for criminal behavior may help explain why fewer than 10 percent of the families in a given community have been found to account for approximately 50 percent of the community's criminal activity (Rowe & Farrington, 1997).

A lack of impulse control rooted in brain functioning is perhaps the most widely-cited biological explanation for criminal and other noncompliant activity. Much of this work (Dalley & Roiser, 2012; Krakowski, 2003; Stanley et al., 2000; Walsh, 2012) has specifically linked a lack of the brain chemical serotonin to impulsive behavior. Similarly, imbalances in the amount of dopamine or gamma aminobutyric acid as well as improper functioning in the prefrontal lobes of the brain have also been implicated in impulsiveness (Boy et al., 2011; Dalley & Roiser, 2012). Much in the way that poverty affects attentional capture, impulsivity rooted in bio-chemical factors may interfere with clients' ability to complete homework assignments by distracting them from the tasks at hand.

Additionally, recent research has suggested that abnormal electrical activity in the brain may be characteristic of people with antisocial personality traits (Bauer & Hesselbrock, 2003; Peskin et al., 2013). In particular, research into the event related potential P300 (simply, electrical activity in the brain) indicates that lower amplitudes of P300 and greater delays in the time between a stimulus and P300 response as measured by electrocardiograms are common among non-psychopathic people with antisocial personality traits (Gao & Raine, 2009; Stanford et al., 2007). These findings may indicate impaired attention in people with antisocial tendencies. Again, the implication is that a reduced ability to concentrate and focus on tasks at hand may interfere with the completion of homework.

Biological conditions may also cause an assortment of mental health problems that could interfere with a client's ability to

complete tasks, such as various psychotic disorders including schizophrenia and related syndromes, impulse-control disorders such as attention deficit/hyperactivity disorder, and mood disorders such as bipolar disorder. Depression may also, of course, affect one's ability to make decisions and take affirmative steps toward improving one's lot in life. Many psychologists consider depression to be frequently undiagnosed; in fact, as much as 25 percent of the U.S. population may suffer from a depressive episode that warrants a clinical diagnosis at some point in their lives (American Psychiatric Association, 2013). It is important to note that people may suffer from depression to varying degrees; while some people may experience debilitating episodes of major depression and may exhibit symptoms that are relatively noticeable (such as depressed speech and facial expressions, decreased appetite or a disheveled appearance), others may experience *dysthymic disorder*, a low-grade but long-lasting period of depression. In such cases, practitioners may not easily notice that the client is depressed and mistake resistance to treatment efforts as being due to some other cause, when in reality the client lacks the physical and/or mental energy required to complete tasks.

Bio-social explanations

Bio-social explanations for human activity essentially hold that biological and environmental factors interact with and upon each other to influence behavior. These types of explanations have recently been used to account for criminal behavior. Perhaps the strongest evidence in support of this view with regard to criminal conduct is found in adoption studies, the most famous of which is that published by Mednick et al. (1984). Upon collecting data on over 14,000 adoptions in Denmark, the researchers noted that 14 percent of the adopted children who had neither biological nor adoptive parents with criminal records went on to be convicted of crimes. However, this percentage increased to 15 percent when only the adoptive parents had a criminal record, 20 percent when only biological parents had a criminal record and 25 percent when both adoptive and biological parents had a criminal record. The implication is that children who are exposed to both inherited biological and environmental criminogenic influences are more likely to engage in criminal conduct than children who have neither or only one type of criminal influence.

Gajos, Fagan, and Beaver (2016) explain that two different models have been proposed to explain gene-environment interaction: the *diathesis-stress* and *differential-susceptibility* models. The diathesis-stress model suggests that a negative environment facilitates antisocial behavior in people who have a psychological or genetic predisposition to such behavior (Belsky & Pluess, 2009; Zuckerman, 1999). The differential-susceptibility model, on the other hand, suggests that genetic polymorphisms which have previously been identified as "risk alleles" are better characterized as "plasticity genes," and increase vulnerability to environmental factors. As such, while some people may, on one hand, respond more poorly to harsh environmental conditions, they may also be more likely to respond affirmatively to treatment efforts (Belsky & Pluess, 2009). As Gajos, Fagan, and Beaver (2016) have suggested, this model comports with what we know about the usefulness of matching treatment to offender risk levels. Individuals who present greater risk of reoffending are more likely to benefit from rehabilitative efforts compared to individuals who present lower levels of risk (Lowenkamp & Latessa, 2006). According to the differential-susceptibility model, this may be because the behavior of higher-risk individuals is more "malleable" and more easily shaped by environmental influences.

For a specific example of how environmental stressors may have physiological impact, we can consider studies examining the effect of poverty on brain functioning. For instance, upon analyzing a series of magnetic resonance imaging scans taken on over 300 children, Hair et al. (2015) found that children in low-income families displayed systematic structural differences in the frontal (an area responsible for impulse control) and temporal lobes of their brains as well as the hippocampus (responsible for learning and memory) and less grey matter generally. Not surprisingly, these children performed less well than their financially-stable counterparts on a series of academic tests. The authors attribute this finding to the adverse impacts of growing up in poverty; children who grow up in poor families experience disproportionate amounts of stress owed to overcrowded homes, family strife, and neighborhood violence. They are also more likely to subsist on diets of poor nutritional value, further affecting brain development (Gomez-Pinilla, 2008; Kruman et al., 2005; Stangl & Thuret, 2009). When viewed within the context of this research, resistance to treatment efforts may be the result of decreased cognitive ability, which in turn is a result of the impact of environmental stressors on brain development and functioning.

Suggestions for dealing with resistance

This article has provided a brief overview of some of the many possible explanations for why clients in correctional treatment relationships may resist interventions. These explanations have included: 1) distrust of practitioners stemming from negative views of authority figures either rooted in personal experiences or shaped by one's community; 2) lack of self-efficacy, also possibly formed through influences exerted by the larger social environment; 3) the impact of poverty on decision-making; 4) present and fatalistic-oriented perspectives of time; 5) a client's lack of personal investment in assigned tasks; 6) cultural or religious views that conflict with treatment objectives; 7) embarrassment about performing assigned tasks; 8) lack of knowledge about how to complete tasks; 9) biochemical explanations including chemical imbalances, faulty brain functioning, and mental health disorders ranging from psychotic disorders to mild depression; and 10) bio-social explanations including exposure to a combination of biological and environmental influences that may act upon each other to influence decision-making and resultant behaviors. This list is not intended to be exhaustive; there may be any number of other factors that inhibit a client's ability to complete homework tasks and fully participate in therapy. However, these particular considerations may be especially relevant in explaining treatment noncompliance in the course of correctional therapy, and many of them are also useful in explaining criminal behavior. With this modest list in mind, the following suggestions are offered for enhancing compliance with homework tasks:

1) Perhaps first and foremost, practitioners should remain mindful of the importance of developing a collaborative therapeutic relationship with the client. While this seems obvious, practitioners (especially probation officers and others in positions of authority) may find it difficult to resist the urge to give directions rather than engage the client's input and participation in treatment planning (Clark, 2005). Clients, however, are more likely to comply with directives if they play a role in the correctional process by formulating goals and the treatment agenda. Additionally,

they are more likely to complete tasks if they realize the benefit to them in doing so, rather than simply being told what to do (Christy et al., 2005; Pratt et al., 2013; Skeem et al., 2007). To this end, treatment efforts are enhanced when therapists query clients to ascertain their views of what they consider to be needs important to them and things they believe will lead them to desist from crime.

Probation officers and other service providers may make any number of mistakes in applying treatment; these can include not recognizing a lack of skill on the part of the client, failing to consider the client's fears or inadequacies, or moving treatment along too quickly (Beck, 1995; Freeman et al., 1990). Practitioners can avoid many of these pitfalls by engaging the client in a collaborative relationship. This includes taking inventory of clients' perceptions of their ability to complete tasks as well as potential barriers to completing tasks, whether psychological, physical, financial, or otherwise. Helpful initiatives in this area may include work currently being done at the Center for Advancing Correctional Excellence at George Mason University, which, with funding provided by the Bureau of Justice Assistance, is creating a program called Your Own Reentry System (YOURS). YOURS contains materials designed to encourage clients to identify their personal needs and goals and the steps necessary to achieve them as they collaborate with probation officers and service providers throughout the reentry process.

2) Relatedly, efforts should be made to develop assessment instruments that assist probation officers in determining the source and nature of resistance on the part of offenders. As previously noted, in recent years, substantial gains have been made in developing theoretical models designed to guide treatment application; most notably, the Risk-Needs-Responsivity model. At the same time, progress has been made in developing instruments designed to assess offenders' risks and needs. In the federal probation system, the most notable advancement in this area has been the creation of the Post-Conviction Risk Assessment (PCRA). Unlike previous instruments, the PCRA considers both static and dynamic risk factors for recidivism as well as offender needs. The PCRA also takes account of responsivity factors such as educational and language barriers that may present barriers to treatment. This is an important development, as research has suggested that many offenders are confronted with significant barriers that hinder success under supervision. Examination of a sample of federal offenders by Cohen and Whetzel (2014), for instance, found that nearly one-third had some obstacle to treatment, such as an inability to secure adequate transportation, mental health issues, or lack of a stable residence.

While the PCRA's strengths appear to lie in risk and needs assessment, it is somewhat limited in its ability to gauge offender responsivity to treatment. The presence of barriers such as lack of education or housing may be fairly obvious to ascertain. Less obvious, however, is the offender's perception of the importance of those barriers, what is needed to address them, and how easy (or difficult) they may be to overcome. In short, the instrument is not designed to assist officers in understanding offenders' perceptions of those obstacles and therefore provides a somewhat incomplete accounting of responsivity factors. Moreover, while the PCRA contains a single question that asks if the offender is "motivated" or not (an item lacking a clear indicator), the tool does not provide guidance in determining exactly *why* offenders are not motivated. As this article has suggested, offenders may be resistant to treatment interventions for a variety of reasons. The efforts of probation officials would be greatly enhanced if they had at their disposal an instrument (or battery of instruments) designed to assist in determining which—if any—of these factors are contributing to resistance, as well as guidance in formulating appropriate strategies for addressing them.

3) Probation officers should make appropriate use of cognitive-based treatments such as Staff Training Aimed at Reducing Rearrest (STARR). Utilizing the STARR method, officers can work with offenders to identify faulty and antisocial thinking patterns that may interfere with homework compliance and facilitate unhealthy behaviors generally (Alexander, Whitley, & Bersch, 2014).

However, I advise "appropriate" use of cognitive-behavioral treatments because I caution against over-reliance on them. While there is much evidence to suggest that cognitive therapies can be very useful in working with an offender population, they should not be regarded as a panacea or used in a vacuum. Cognitive-behavioral techniques are most effective when paired with other services designed to address criminogenic needs, such as educational and vocational training or substance abuse counseling. While assisting offenders to change the way they think is undoubtedly of value, we must be mindful of the fact that very real structural barriers exist in society that inhibit individual change. These barriers include—but are not necessarily limited to—a lack of opportunities for employment, education, and health care as well as the assorted civil disabilities that attach to a criminal conviction and the harmful effects of living in high-crime, poverty-ridden areas riddled with decay and disorder. Along these lines, Hannah-Moffat (2005) has offered a thoughtful critique of cognitive therapies, stating that such treatments recast broad social problems as individual inadequacies, thereby relieving government of any responsibility to address large social issues. In her words, "This process is a reframing of social problems as individual problems. Manageable criminogenic problems are those that can be resolved through behavioural or lifestyle changes that are seen achievable with a positive attitude…structural barriers conveniently disappear" (p. 43). Mindful of this view, cognitive therapies should be regarded as one of many instruments in a probation officer's toolbox and something to be used in conjunction with—not in place of—other effective programs.

4) Practitioners would do well to make use of strategies that have been shown to be effective in enhancing compliance with assigned tasks. McDonald and Morgan (2013), for instance, studied various homework compliance strategies in a sample of offenders enrolled in a six-month correctional treatment program in Texas. They concluded that participants were more likely to complete assigned tasks when group leaders modeled the tasks and when they were required to publicly affirm a commitment to completing the task. Therapists may therefore find it useful to incorporate some of these strategies when assigning homework, rather than simply providing clients with instructions on what to do.

5) Finally, probation officers and related treatment providers should be aware of the assorted biological factors that may interfere with the ability of clients to complete tasks. While easy detection of abnormalities in brain structure and electrical activity remains currently out of reach, practitioners should be mindful that undiagnosed mental health disorders may be impeding clients from fully engaging in treatment. To this extent, mental (and physical) health evaluations conducted by qualified professionals should be sought when encountering resistant clients, especially if efforts to address resistance through traditional cognitive techniques have been tried

without success. The research into possible biological causes of noncompliance is relatively new but holds much promise for informing our understanding of why people do the things they do. Currently, if nothing else, this work underscores the rich complexity of human behavior and the many challenges inherent in working with people. As this brief article has suggested, the first step toward managing these challenges is to be aware of them.

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