COGNITIVE-BEHAVIORAL TREATMENT REVIEW

& CCI News

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Results of Moral Reconation Therapy (MRT®) Utilization in the Las Cruces, New Mexico Juvenile Drug Court

By Ann Wallace, Drug Court Coordinator

The Juvenile Drug Court Program in the 3rd Judicial District of New Mexico began during December 1997. The goal of the Juvenile Drug Court is to help adolescents become productive members of society. This is an innovative team approach to treat teenagers involved with the legal system due to substance abuse. The Program has been operational long enough for us to begin looking at our treatment approaches and some resulting outcomes. Preliminary data below summarizes the number of referrals to the District Attorney for individuals since their graduation from this program.

We had our first graduate from this program in May 1998. Between May 1998 and May 2001, we have had 79 graduates—14 females and 65 males. Based upon an NCIC check of all graduates over a three-year period (May 1998 to May 2001), our overall recidivism rate has been 30%; in other words, 70% of those individuals who have graduated from our Juvenile Drug Court Program have not had a subsequent referral to the Office of the District Attorney. This includes all those juveniles who turned 18 and might have been referred to the Adult Criminal Justice System.

In February 1999, our drug court elected to use Moral Reconation Therapy (MRT). We believed the progressive steps involved in this cognitive-behavioral program were the most appropriate approach for this population of offenders. Since September 1999 (7 months after the MRT began), we have had 40 graduates. Of these 40 graduates, there have been 7 referrals to the Office of the District Attorney, or a 17.5% recidivism rate among our graduates who were exposed to MRT.

When we examined our initial data, we were extremely proud of the 30% recidivism rate among our

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youth. However, when we reviewed our recidivism rate of *17.5%* since we began using MRT we were ecstatic!

Overall (1998-2001), 14% of the females who graduated have reoffended. Since the MRT has begun there have been no female recidivists to date (14% without MRT *vs.* 0% *with* MRT). When we look at data concerning males in the program, overall, 34% reoffended. Since the MRT has begun there have been 7 male reoffenders to date (48% without MRT *vs.* 21% *with* MRT).

For the youth in our program, MRT has made a significant difference in their involvement with the criminal justice system. What is even more striking is that in the 16 months prior to MRT being offered, there were 39 graduates and 17 who reoffended, a 44% recidivism rate *compared with 17.5%* since we began using MRT.

For additional information, you may contact Ann Wallace at the Las Cruces Drug Court, 201 W. Picacho, Suite A, Las Cruces, New Mexico 88005. Phone (505)523-8287/Fax(505)523-8290/ Email: lcrdamw@nmcourts.com.

Table 1: Recidivism Rates Among Juvenile Drug Court Graduates in the Third Judicial District Court Without MRT vs. With MRT

79 Total Juvenile Drug Court Graduates (65 Males/14 Females)	Overall Percentage Recidivating Among Graduates May 1998-May 2001	Percentage Recidivating Among Graduates May 1998-September 1999 Without MRT	Percentage Recidivating Among Graduates September 1999-May 2001 With MRT
All Participants	30.0% (24/79)	44.0% (17/39)	17.5% (7/40)
Males	34.0% (22/65)	48.0% (15/31)	21.0% (7/34)
Females	14.0% (2/14)	25.0% (2/8)	0.0% (0/6)

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- ✔ Use communication skills to develop positive relationships with others.
- ✔ Practice skills in leadership, teaching others, and providing assistance to peers in the class setting.
- ✔ Understand your unique abilities and goals and develop realistic, specific and measurable action plans.

Social Responsibility Training® for MRT® Facilitators

Certified MRT® facilitators can utilize the Social Responsibility Training® Curriculum upon completion of a two-day training that covers all aspects of the curriculum and implementation. Trainees will receive the SRT® Facilitator's Guide with class outlines for the full-year curriculum, discussion guides, and class evaluation tools. Cost of the two-day training for certified MRT® facilitators is $ 250. Please call 901-360-1564 for information about upcoming trainings.

Meta-Analysis of MRT Recidivism Research on Post-Incarceration Adult Felony Offenders

By
Gregory L. Little, Ed.D., LPC, NCP

Study Summary

Over the past decade, cognitive models have become the preferred treatment approach for offender populations (Little, Robinson, & Burnette, 1998). In general, offender treatment outcome evaluations have been based on the assumption that all cognitive-behavioral approaches are "equivalent," however, more detailed analyses have shown this is not the case. Substantial differences exist in the method of programming, content, and outcome among the various cognitive methods utilized in the criminal justice system. For example, the *Reasoning & Rehabilitation* program (Ross & Fabiano) is delivered in educational style classes to enhance "cognitive skills." A few short-term recidivism outcome evaluations have generally shown a modest beneficial effect using this approach, however, other studies have shown a negative effect. A Colorado Division of Criminal Justice evaluation (Pullen 1996) of Reasoning & Rehabilitation found that juveniles exposed to the program showed a 15% *higher* recidivism rate than controls. In addition, a 70-item pre- and posttest attitude measure yielded unexpected results that were in line with the increased recidivism rate: "As measured by this instrument, attitudes among offenders in the experimental group changed in the opposite direction than was expected—meaning that they got worse—on all 14 of the composite scales for the experimental group, and changed in the opposite direction in 12 of the 14 scales for the control group" (p. 37).

Another cognitive skills program (*Youth Crossroads*) has yielded results similar to those obtained from *Reasoning & Rehabilitation*. A few studies have found slightly lower recidivism following treatment, but other research has found significantly increased recidivism in treated groups (Leiber & Mawhorr, 1995).

The most widely utilized and researched cognitive behavioral approach in criminal justice is probably Moral Reconation Therapy (MRT®). The approach was gradually developed and tested during 1979 to 1982 within the Federal Bureau of Prisons. The model was subsequently refined and fully implemented in a county operated, prison-based drug therapeutic community in 1985 (Little & Robinson, 1988). It is currently employed in over 40 states and in several countries.

A recent review of MRT outcome research (Little, 2000) identified 65 published reports on the approach. The studies included 13,498 MRT-treated individuals and 72,384 nontreated controls. Since that report, an additional 10 studies have been published raising the number of MRT-treated subjects to 14,464 with 72,809 comparison controls. Approximately one-third of the reports evaluated changes in moral reasoning, self-esteem, and various other personality variables. Virtually all of these resulted in outcomes in the expected directions with the majority indicating significant beneficial changes in treated offenders. About half of the studies tracked posttreatment recidivism (rearrests and reincarceration) in drug offenders, DWI offenders, domestic violence perpetrators, violent offenders, juvenile offenders, and in drug court participants. Treatment venues included prisons, jails, community correction facilities, parole and probation sites, schools, and boot camps. Virtually all studies indicated that MRT treatment led to significantly lower recidivism for time periods up to 10 full years after treatment and release into the community. Of the 75 studies, more than half were conducted independently from the developers of MRT. The majority of MRT research has focused on adult offenders.

MRT was initially developed as a treatment method that could be employed primarily with incarcerated, adult offenders. Although substantial research has been completed in other venues, the majority of outcome data comes from the postrelease outcomes of incarcerated adults and probationers. This study reports results from a meta-analysis conducted on recidivism of adult offenders treated with MRT during incarceration. Since the most common timeframe utilized in criminal justice recidivism research is one year after release, the present study focused on MRT recidivism reports using that timeframe.

Sample of Studies

Of the 75 MRT studies identified, seven reported recidivism rates in MRT-treated and nontreated controls at one year of release. All of these were adult offenders who were treated during incarceration or confinement and subsequently released. The only variable reported in this analysis is recidivism after one year of release. Recidivism was defined as a new arrest or actual reincarceration. The developers of MRT conducted only one of these studies.

Little, Robinson, Burnette, & Swan (1999) reported one-year reincarceration rates of 1,052 MRT-

treated offenders and 329 nontreated controls at the Shelby County Correction Center in Memphis, TN (the original MRT implementation site). The treated group showed an 8.4% reincarceration rate as compared to 21% in nontreated controls.

Miller (1997) performed an independent evaluation on the Delaware Department of Corrections MRT implementation in prisons. MRT-treated offenders (N = 62) showed an 8.1% rearrest rate after one year of release as compared to 34.9% in randomly selected controls (N=355).

Krueger (1997) reported one-year rearrest rates on offenders who were treated during incarceration in an Ohio jail. MRT-treated offenders (N=401) showed an 11% rearrest rate as compared to 51% for all of the other offenders released from the jail during the same time period (N=6,727).

Godwin, Stone, & Hambrock (1995) reported one-year rearrest rates on offenders who were treated during incarceration in a Florida jail. MRT-treated offenders (N=98) showed an 11.25% rearrest rate as compared to 29.67% for all of the other offenders released from the jail during the same time period (N=5,119).

Grandberry (1998) evaluated one-year rearrest rates in 109 high-risk offenders treated during incarceration in Washington State prisons and compared them to 101 nontreated controls. This was the only study that did not find significantly lower recidivism rates in the MRT-treated group. Treated offenders showed a 44% rearrest rate as compared to 40% in controls.

Hanson (2000) collected one-year rearrest rates in drug offenders treated with MRT during incarceration in a Washington State correctional facility. Random assignment was made to treatment (N=175) and nontreatment conditions (N=96). Treated offenders showed a 19% rearrest rate compared to 29% in controls.

In an independent evaluation of the Oklahoma Department of Correction's massive implementation of MRT, MacKenzie, Brame, Waggoner, & Robinson (1995) compared the one-year postrelease rearrest rates of MRT-treated offenders (N=1,409) to offenders treated in other Oklahoma Department of Correction programs (N=5,222). A monthly survival analysis was performed that allows for a cumulative analysis of recidivism over different time periods. The MRT-treated group showed a one-year recidivism of 12% as compared to 39.6% in offenders treated in other programs. It should be noted that this study also indicated that offenders assigned to MRT treatment had a significantly higher risk of recidivism prior to MRT treatment. That is, Oklahoma assigned the most "risky" offenders to MRT treatment while less risky offenders were assigned to other programs.

Statistical Analysis & Results

A "quality" weighing of the studies included in this analysis was initially considered but then ruled out. Several of these reports were unusual "population" studies, which included the entire inmate population. Four studies attempted a form of randomization or matching, however, given the problems of randomizing within the "real world" of offender treatment, the best that can be stated is that quasi-randomization was achieved in a few. Finally, two of these reports deliberately assigned offenders with the highest risk of recidivism to MRT. Thus, lending more weight to one study or another was deemed inappropriate. Given the general consistency of the obtained data in these studies, and substantially the same findings occurring with more than 20 other reports from probation, parole, and community correction agencies, it was assumed that the quality of all of the research was essentially similar.

A meta-analysis on the difference between proportions was conducted on data from the seven included studies. The studies contained a total of 21,255 subjects. The META program (Kenny, 1999) was utilized with an arcsin transformation. Results showed a significant effect size of .2315 with a transformed effect size of .2295 ($t6 = 3.78$, $p = .01$).

Discussion

Results from the present report indicate that MRT treatment of adult offenders during their incarceration leads to significantly reduced recidivism for the one-year time period after release. In general, MRT treatment leads to a 23-24% decline in expected recidivism during that time frame. However, this reduction is substantial and significant since the expected rates of recidivism are 30-50% during that period. Thus, it can be stated that MRT cuts the expected one-year recidivism rate in half or substantially more.

One of the most serious drawbacks of recidivism research is the timeframe typically employed in collecting data. It is not uncommon in criminal justice literature to have 3-month recidivism rates from programs compared to 5-year recidivism data from another. In addition, few researchers have continued to follow treated groups for extended timeframes following treatment. MRT providers and researchers have provided several studies of 5-year recidivism data as well as 10-year data (Little, 2000). The results indicate that lower recidivism rates persist to at least the 10-year period.

Another essential issue in offender treatment recidivism research is cost-effectiveness. This administrative and politically important issue is often posed to treatment providers. If the short-term benefits in costs savings do not exceed the treatment costs, relatively few

criminal justice systems will provide treatment to large groups of offenders. The cost-benefits of MRT have been analyzed in several studies. For example, the Washington State Institute for Public Policy conducted a large, independent evaluation of 18 programs typically employed with adult offenders (Aos, Phipps, Barnoski, & Lieb, 1999). For each $1 spent on MRT treatment, the report determined that $11.48 was saved in eventual criminal justice-related costs. MRT was cited as the most cost-effective program. The next-best program was job counseling/job search programs for inmates about to be released. For each $1 spent on that program, $4 was eventually saved. Other "cognitive" programs did not fare well. While Reasoning & Rehabilitation saved $3.51 for each $1 spent, life skills and cognitive skills approaches actually lost money.

Few offender programs have been scrutinized and evaluated to the extent that MRT has been. Results are consistent across all of the research areas investigating MRT's effects.

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Article Submissions

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EFFECTIVE COUNSELING APPROACHES

For Chemical Abusers & Offenders

By Dr. Greg Little, Dr. Ken Robinson, & Kathy Burnette

A basic understanding of the major counseling theories is essential for the practicing substance abuse counselor and those working with offenders. ***Effective Counseling Approaches for Chemical Abusers & Offenders*** is an indispensable primer covering the most commonly used counseling approaches. Few counselors are familiar with the history and background of the counseling field and the relative short history of substance abuse counseling. This text presents that history as well as showing when each counseling approach is best employed. ***Effective Counseling Approaches*** represents a comprehensive overview of various counseling theories, their underlying personality theory and philosophy, essential terminology for each, and a review of treatment outcomes. Counselors, counselors-in-training, criminal justice personnel, and other mental health personnel will find the book useful. Areas covered in this text include:

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History of Drug & Alcohol Treatment
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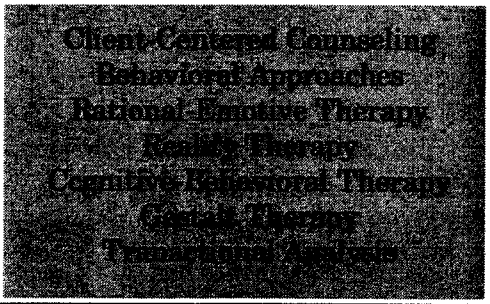
Essential Counselor Skills & Abilities
Background & History of Major Counseling Theories
Philosophy, Personality Theory, Terminology of Each
Counseling Processes
Appropriate Use & Limit of Each Approach
Understanding Defense Mechanisms



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by Dr. Greg Little & Dr. Ken Robinson

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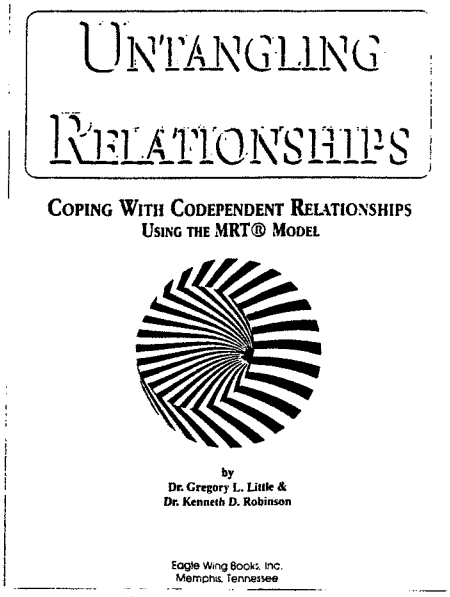

Article Submissions

CBTR is interested in publishing brief reports on cognitive-behavioral implementations, outcome studies, and reviews of cognitive-behavioral materials. Articles should be no more than 6 double spaced pages in length and may be submitted on IBM or MAC disk formats including Microsoft Word, Claris, and Pagemaker. Articles should be submitted to:

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February 11-15, 2002, MRT in Memphis, Tennessee
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March 11-14, 2002, MRT in Kelowna, British Columbia, Canada
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April 15-19, 2002, MRT in Memphis, Tennessee
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A Study of the Effectiveness of the MRT Program at Jefferson County Restitution Center 2

by
Ken Suitt
Life Skills Coordinator/MRT Facilitator.

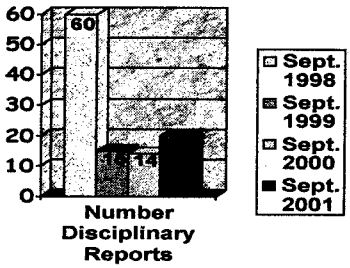
Jefferson County Restitution Center #2 is an all-male facility for felony offenders. We have a bed capacity of sixty (60) men, and we currently have a staff consisting of thirteen (13) Residential Supervisor 1's, one (1) Residential Supervisor 2, a Secretary, a Bookkeeper, an Employment Specialist, two Probation Officers, a Life Skills Coordinator/MRT Facilitator, and the Director. The residents who are assigned to the Restitution Center stay for a mandated minimum of three (3) months to a lifetime maximum of twenty-four (24) months. In that time they are required to pay rent, pay restitution to the victims of their crimes, pay probation fees, and pay any other fines or fees required by their Probation Officers. They do this by working in the community at regular jobs and releasing their pay to the Center for disbursement. They are subject to intensive supervision and programming to help ensure their continued compliance and to reduce the recidivism rate.

In mid 1998, the Restitution Center became aware of a study done by Dr. Ed Latessa in which he discussed "What Works in Community Corrections". In the study he discovered that programs which addressed the criminogenic needs of offenders were more successful than those that didn't. It was also discovered that Cognitive Behavior Programs that focused on changing offender behaviors were related to a lower recidivism rate than those programs which had no cognitive programs in place and/or were education based. As a result of this literature, we began studying available cognitive behavior programs. We assessed "Moral Reconation Therapy" and elected to try MRT both for content as well as the fact that groups are open ended. In September 1998, we sent both of our Probation Officers and the Residential Supervisor 2 to training for Moral Reconation Therapy to assess its effectiveness and to research its compatibility with our current program. They returned with a positive review of the program, but with questions as to how it would be implemented into our current program. As a result of this feedback, we formed a process team to consider implementing MRT into our program. Initially, it was decided to form a pilot group to familiarize the new facilitators with MRT as well as evaluating its effectiveness on actual program participants. This pilot group formed up in February of 1999. As seen in the accompanying graphs, we noticed an immediate result even with a limited number of residents in a pilot program.

Encouraged by these results, we began a team to design our program with MRT as the core principle. After much trial, error and debate, on September 1, 1999 we implemented a new program designed around MRT. As part of the new program, our residents would be required to remain unemployed for the first 4 weeks of their stay here to take advantage of extensive Life Skills programming, community service, and, most importantly, MRT. They would attend 2 MRT groups a week, and after much debate and study, they would be required to complete a minimum of the first 4 steps. The Probation Officers would also consider MRT when doing their assessments if they saw a need for continued participation in group.

We immediately saw a need for additional groups after the new program be-

Number Of Disciplinary Reports: September 1998-September 2001



- September 1998: no cognitive program in place.
- September 1999: MRT program begins, mandatory for all new residents, with minimum Step 4 requirement.

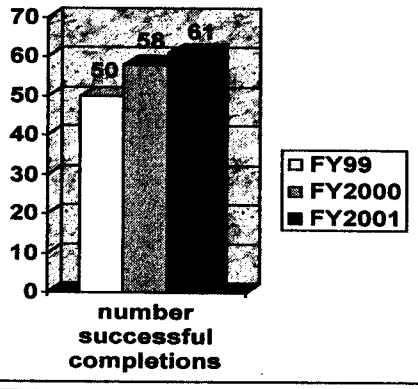
gan, so we initiated a night group and a morning group to better meet the needs of our working residents who either wanted or were required to attend additional groups. Due to the amount of residents volunteering to continue, we have recently started a second night group.

One of the benefits of having MRT available was when a resident committed a rule infraction that related to any of the steps of MRT, he would likely be reassigned to one of the additional groups offered. The group would then confront the resident about his behavior, rather than allowing the resident to reflect on the punishment he received for the infraction and seeing himself as a victim. He would then either be instructed to continue through a certain step or even for the duration of his stay in the Center. This has served the purpose of meeting the needs of the problem residents with a positive, proactive continuation of the principles of MRT that directly related them to real life.

Resident Anthony Moore has been an active MRT participant since entering the program, and he has really been living the principles espoused by MRT. When asked what he has learned from MRT, he states: "My MRT group has helped me recognize my mistakes and showed me what I need to do to change my ways to be a better man. It has also helped me maintain a positive attitude, and has given me the opportunity to put a new perspective in my future. I plan on completing my MRT group with hopes of changing my life for the better."

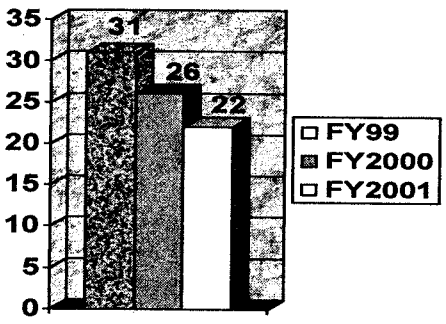
The implementation of MRT proved to be a successful change in our program. We continue to be surprised at the number of residents who elect to continue in the MRT program voluntarily, and exit interviews routinely cite MRT as the catalyst for change in successful resident completions. As reflected in the accompanying graphs, we have seen positive results almost immediately after implementation, and continue to see positive results to date.

Number of Successful Completions before and after MRT program



- These figures compare the number of successful completions in FY 1999 with the numbers achieved after MRT was implemented FY 2000.

Number of Unauthorized Absences FY 1999-FY 2001



- This graph represents the number of Unauthorized Absences beginning with FY 1999, continuing through FY 2000 when MRT was implemented and through FY 2001.

How MRT Is Implemented:

MRT® is a trademarked and copyrighted cognitive-behavioral treatment system for offenders, juveniles, substance abusers, and others with resistant personalities. The system was developed in the mid-1980s and has had substantial outcome research published in the scientific literature showing that recidivism is significantly lowered for ten years following treatment. MRT® is performed in open-ended groups typically meeting once or twice per week. Clients complete tasks and exercises outside of group and present their work in group. The MRT-trained facilitator passes clients' work according to objective guidelines and criteria outlined in training. ***Programs using MRT® must supply clients with a copy of an MRT® workbook that can be purchased from CCI for as little as $25 per copy.*** MRT® formats are in use for general offenders, juveniles, perpetrators of domestic violence, and others. MRT® trainings are held routinely across the United States and monthly in Memphis. Accredited CEUs for MRT training are offered from Louisiana State University at Shreveport for participants who complete training. Training dates and a registration form can be found on the prior page. Feel free to call or write for more details.

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e-mail ccimrt@aol.com

— MRT® Trainers —

CCI staff conduct each training session. Trainers may include Dr. Ken Robinson (a co-developer of MRT®), Kathy Burnette, M.S. (CCI's Vice President of Clinical & Field Services), E. Stephen Swan, M.Ed. (CCI's Vice President of Administrative Services), Patricia Brown, LADAC, or a regional CCI licensee.Dr. Robinson has over 25 years direct experience in criminal justice programming. Ms. Burnette has over 15 years direct criminal justice and substance abuse treatment experience and was involved in the initial implementation of MRT®. Mr. Swan has 30 years in counseling and correctional administration. Those interested in being licensed as exclusive providers of MRT® in regions should call Dr. Ken Robinson.

FOR CLIENTS IN NEED OF PROGRAMMING FOR

ANGER MANAGEMENT

COPING WITH ANGER:

A Cognitive-Behavioral Workbook

Coping With Anger is a 49 page cognitive-behavioral MRT® workbook designed for eight (8) group sessions. The groups are conducted in an open-ended fashion where clients can enter at any time and progress through eight sequential modules where each client processes his or her homework and exercises in the group. Already in use in several probation-based sites, *Coping With Anger* is ideal for use with violent offenders, argumentative or oppositional clients, and with those who have trouble expressing anger feelings. Based on the highly successful MRT® method, *Coping With Anger* is a important treatment option that can complement other programming already in place. Each client copy of the workbook is $10. A simple facilitator's guide is available for only $5. See page 19 for ordering details.

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A Cognitive-Behavioral Approach for Sex Offender Relapse Prevention

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11. *Sense of Program Membership Scale*
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17. *Michigan Alcoholism Screening Test (MAST)*
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see page 19 for order form

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The juvenile version of *How To Escape Your Prison* is available. Programs and institutions with trained MRT facilitators may order copies of this 117 page workbook. ***Juvenile MRT*** is written on a lower reading level but retains the basic flow of MRT concepts and exercises **and is very user-friendly.** The book is appropriate for delinquents and juveniles in chemical abuse/conduct disorder programs as well as those in offender programs. An order form is on page 19 of this issue. For credit card orders, please call CCI at 901-360-1564.

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- ✱ The Healthy Family

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- • Substance Abusers With Children
- • Parents Experiencing Problems
- • Parents Seeking Understanding

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CBTR LITERATURE REVIEWS

Emotion in Criminal Offenders with Psychopathy and Borderline Personality Disorder by S.C. Herpetz, U. Wert, G. Lukas ,et.al. (2001) *Archives of General Psychiatry*, 58, 737-745.

While there are a number of studies that have looked at the emotional responses of psychopaths to pleasant and unpleasant stimuli, this article aims to examine not only criminal offenders with a diagnosis of psychopathy but also offenders with a diagnosis of borderline personality disorder (BPD). The authors intent was to compare emotional processing in psychopathic subjects and subjects with BPD.

In this study, 75 subjects were screened for participation (50 male inmates-25 with a clinical diagnosis of psychopathy and 25 diagnosed with borderline personality disorder) and 25 noncriminal male controls with no history of psychiatric diagnosis or treatment. From these groups, 18 subjects with BPD, 25 psychopaths and 24 controls were actually included in the study.

Each subject was shown a series of 24 slides selected to provoke a range of various qualities of negative and positive emotions. Physiological measurements of skin conductance and EMG activity were recorded as well as measurements of the startle reflex.

The findings of this study confirmed the authors' hypotheses. "Compared with controls and offenders with BPD, psychopaths showed decreased electrodermal responses to emotional slides and a higher percentage of psychopathic subjects failed to show any startle reflex... Criminal offenders with BPD exhibited a response pattern very similar to that of controls,ie, they showed no electrodermal hyporesponsiveness and an adequate emotional modulation of startle response. The authors concluded "... hypoemotionality in psychopaths may predispose them to violence, because it prevents them from experiencing emotions that naturally inhibit the execution of violent impulses."

The Relation Between Exposure to Violence and Social Information Processing Among Incarcerated Adolescents by A. Shahinfar, J.B. Kupersmidt, and L.T. Matza (2001) *Journal of Abnormal Psychology*, 110, 136-141.

The purpose of the study was to examine the influence of exposure to community violence on patterns of social cognition in a group of incarcerated juvenile offenders. The subjects were "serious and violent" male juvenile offenders between the age of 13 to 17 years (M= 15.6 years). The racial demographic was 63% African-American, 26% Caucasian, 7% Latino and 2% Asian, and 2% Native American. The authors "... predicted that higher levels of victimization by violence would be related to social-cognitive processes that have been shown to be related to aggressive behavior development, namely, the misattribution of cues, maladaptive social goals, greater endorsement of the use of aggressive tactics in interpersonal situations and perceived positive outcomes to aggression."

Study participants were given questionnaires concerning exposure to violence and measures of social information processing. There were four measures of violence exposure created from 2 sets of scores: victimization by mild violence, witnessing mild violence, victimization by severe violence, and witnessing severe violence. They also assessed four parts of the social information-processing model of children's social adjustment- endorsement of aggressive beliefs, causal attributions, social goals, and perceived outcomes of aggression.

The authors found a statistically significant relationship between exposure to violence and social information processing. "As predicted, victimization by severe violence was significantly related to three of the four social information-processing measures: approval of aggression ($r=.24, p\leq.05$), hostile attribution bias($r=.19, p\leq.05$) and social goals($r=.19, p\leq.05$)...It was found adolescents who reported greater witnessing of severe violence indicated greater confidence that violence would effect a positive outcome." Their findings..."suggest that social cognition may serve an important mediating function between exposure to violence and aggressive behavior."

The Effects of Social Ties on Crime Vary by Criminal Propensity: A Life-Course Model of Interdependence by B.R.E. Wright, A. Caspi, T.E. Moffit, P.A. Silva (2001) *Criminology*, 39, 321-351.

This article proposes a new hypothesis to explain the transition to criminal behavior from juvenile criminal propensity: Life-course interdependence. This hypothesis has two predictions. First that prosocial ties that deter crime should deter crime most strongly among those already prone to crime. This phenomenon is termed a "social-protection" effect. The second is that antisocial ties that promote crime should promote it most strongly among those same persons already prone to crime. This phenomenon is termed by the authors as a "social-amplification" effect.

CBTR LITERATURE REVIEWS

In order to test their hypothesis, the authors used data from the Dunedin Study, a longitudinal study gathering measures of low self-control, social ties and crime that began in Dunedin, New Zealand with subjects born in 1972 and 1973. The subjects (N=1037) began participating in the first follow-up assessment at the age of three and were re-interviewed every 2 years through the age of 15 followed by assessments at the ages of 18 and 21.

Based on the data analysis, the authors found empirical evidence supporting their hypothesis of life-course interdependence. "... Prosocial ties deterred crime, and antisocial ties promoted crime, most strongly among the low self-control study members. The evidence ...proved robust, holding up across different measures for self-control, social ties, and criminal behavior."

Their conclusion was the findings provide optimism because "... data show that it is possible for severely crime-prone youth to be successfully deterred from crime by strong, prosocial ties."

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How To Escape Your Prison — The MRT® workbook used in criminal justice, 138 pages, 8.5 X 11 perfect bound format, with all relevant exercises — by Drs. Greg Little & Ken Robinson; $25.00.

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Lecture, discussion, group work, and individual exercises comprise MRT® training.

Monday	Tuesday	Wednesday	Thursday	Friday
8:00 a.m. to 5:00 p.m. *(Lunch-provided in Memphis)* Introduction to CBT. Treating and understanding APD and treatment-resistant clients. Background of MRT® personality theory.	8:00 a.m. to 12:30 p.m. *(Lunch - on your own)* Personality theory continued. Systematic treatment approaches. MRT® Steps 1 - 2. About 2 hours of homework is assigned.	8:00 a.m. to 5:00 p.m. *(Lunch - on your own)* MRT® Steps 3 - 5.	8:00 a.m. to 12:30 p.m. *(Lunch - on your own)* MRT® Steps 6 - 8. About 2 hours of homework is assigned.	8:00 a.m. to 2:00 p.m. *(Lunch - provided in Memphis)* MRT® Steps 8-16. How to implement MRT®. Questions & answers. Awarding completion certificates.

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February 11-14, 2002, MRT in Casper, Wyoming
March 11-14, 2002, MRT in Kelowna, British Columbia, Canada
March 18-22, 2002, Domestic Violence in Memphis, Tennessee
April 15-19, 2002, MRT in Memphis, Tennessee
May 6-10, 2002, MRT in Memphis, Tennessee
June 10-14, 2002, MRT in Memphis, Tennessee

Please check our website at www.ccimrt.com for additional training dates.

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