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Cognitive-Behavioral Treatment of Offenders: A Comprehensive Ten-Year Review of MRT® Outcome Research- Part 2

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(Editor' Note: This is the second part of an article that was originally published in the newsletter, *Addictive Behaviors Treatment Review* , Volume 2, number 1, 2000. It is reprinted with the permission of the author.)

Summary — Outcome research from 65 published reports investigating the effects of MRT on offender populations are reviewed. These reports include 13,498 MRT-treated individuals and 72,384 individuals forming control and comparison groups. Twenty-eight studies have evaluated the effect of MRT on inmate recidivism. All of these found that MRT leads to lower rearrest and reincarceration rates for time periods up to a full 10 years after treatment and release. Other outcome research consistently indicates that MRT leads to reduced disciplinary problems in participants. Perhaps the most significant research resulted from an independent cost-benefit analysis from Washington State showing that MRT produces the greatest cost-benefit savings of any offender treatment. For each $1 spent on MRT treatment, the cost savings in criminal justice related costs was $11.48. The next best program (job placement) showed a savings of $4.

MRT Program Completion & Attrition Research

Table 5 summarizes MRT studies on program attrition and completion rates. A total of 9 published studies have addressed this issue. Four of these reported essentially the same research data (Little & Robinson, 1988; Freeman, Little, Robinson, & Swan, 1990; Robinson, 1994c; Robinson, 1994b) based upon the initial MRT implementation at the Shelby County Correction Center's prison therapeutic community (TC) in Memphis, TN. During the 4-year period preceding MRT implementation, the TC program completion rate for all participants (N = 424) was 30%. The program completion rate (N = 180) during the initial 2-year

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TABLE 5
MRT PROGRAM COMPLETION & ATTRITION RESEARCH

Reference	Site	N MRT	N cont.	Outcome
Little & Robinson, 1988	prison TC	180	424	Increase from 30% to 50%
Freeman, Little, Robinson, & Swan, 1990	*			
Robinson, 1994c	*			
Robinson, 1994b	*			
Waggoner, 1994	Okla. DOC	600	NA	50% of trained staff started groups
Hobler, 1995	Del. DOC	138		84% completion rate
Fann & Stapleton, 1995	parole/prob.	72	NA	78% "success rate"
Fann & Stapleton, 1998	parole/prob.	283	NA	98.8% of successful discharges completed 5 or more MRT steps
Grandberry, 1998	WA DOC	109	101	Females and those completing >5 MRT steps most successful

period of MRT's use in the program was 50%. During this time period the completion rate for minority participants doubled from the prior rate.

Waggoner (1994) reported on staff implementation of MRT following training as possible MRT group facilitators in the Oklahoma Department of Correction. Oklahoma began a system-wide implementation of MRT in 1993. In 1994, about 50% of the 250 trained staff voluntarily began MRT groups following their training session. These staff operated 90 separate MRT groups in state facilities and had 600 offenders participating. Waggoner reported that potential group participant waiting lists had been established at correctional facilities in the state.

Hobler (1995) reported the first data from the Delaware Department of Correction's system-wide MRT implementation through the educational department's Life Skills Program. The Delaware implementation of MRT in its four prisons has received considerable national attention due to its success. Teachers trained as MRT facilitators conducted MRT groups as part of a comprehensive offender treatment curriculum. Results showed that during the first 4-month "instructional cycle" of the program, 84% of the 138 participants completed the program.

Fann & Stapleton (1995; 1998) reported on offender completion of a community corrections-based (probation/parole) MRT program. Results showed that 78% of all participants managed to complete the restrictive program. A unique analysis of successful participants indicated that 98.8% of them completed at least 5 MRT steps while 62.4% of those who were "unsuccessful" (terminated, absconded, violated) completed less than 2 MRT steps.

Grandberry (1998) reported on the system-wide implementation in the Washington State Department of Correction begun in 1994 and continuing to the present. Comparisons of the 109 initial MRT participants to 101 controls showed that the MRT participants began with a higher severity of problems including drug usage and prior failures to conform to supervision requirements. Female MRT participants tended to reduce drug usage more than males and those who completed more than 5 MRT steps were the most successful.

Summary. Data on MRT attrition and program completion is scant. Only the initial implementation of MRT included an analysis of client attrition and program completion rates after MRT implementation with a comparison to similar data prior to MRT. Those results showed that MRT greatly facilitated minority participation and modestly increased program participation by Whites. Observations published from Oklahoma and Washington appear to support this finding with the formation of waiting lists of offenders volunteering for the program. Inmate enthusiasm for the MRT program — especially in large, system-wide implementations — has consistently exceeded that of staff. This may be due to the perception that the formation and ongoing responsibility of operating a regular group is simply an added burden to staff. Waggoner (1994) stressed that staff trained in the method should be encouraged by the possible beneficial effects on inmate compliance and reduced recidivism. Many long-term staff in correctional departments have become skeptical of program implementations and see new programs as futile.

Many analyses have focused on the number of MRT steps completed and client success. All of this research indicates that the more steps completed, the greater the odds of client success in completing the program as well as showing lower recidivism. Data from community corrections and prison-based implementations have shown that completion of MRT steps 5 or 6 represents a significant "break point" indicating probable success.

Post-MRT Moral Reasoning Changes

Pre- and post-test research on moral reasoning level changes as a result of MRT participation have been reported in 8 studies. Table 6 summarizes these results. All of these studies have utilized the Defining Issues Test (DIT), an objective measure of the percentage of reasoning employed on 5 of Kohlberg's 6 levels. The test comes from the University of Minnesota Center for Ethical Research.

Four of these reports (Little & Robinson, 1988; Little & Robinson, 1989a; Little & Robinson, 1989c; Freeman, Little, Robinson, & Swan 1990) documented DIT results in drug offenders and DWI offenders who participated in MRT at the Shelby County Correction

Center in Memphis, TN. Results from these studies showed that both felony drug offenders and multiple-DWI offenders showed significant increases in reasoning in Kohlberg's higher reasoning levels and significant declines in the lower (hedonistic) levels of reasoning after an average of 6 months MRT participation. One-year DWI recidivism of released MRT participants was significantly correlated to Kohlberg's highest moral reasoning level. Results showed the lower the individual's level of reasoning in stage 6 (universal-ethical, principled reasoning) the greater the odds of a new DWI arrest during the first year following release.

TABLE 6
MRT MORAL REASONING RESEARCH

Reference	Site	N	Outcome
Little & Robinson, 1989a	prison TC/DWI unit	39	moral reasoning sig. increased
Little & Robinson, 1989c	DWI's	115	DWI rearrests sig. related to moral reasoning
Freeman, Little, Robinson, & Swan 1990	*		
Little & Robinson, 1988	*		
Grandberry, 1998	WA DOC	37	MRT increased moral reasoning
Gilreath, 1995	residential/females	65	54% increase in principled reas.
Sandhu, 1999a	residential/females	27	NS increases in principled reasoning and rule orientation
Sandhu, 1998	OK prison	266	NS increase in principled reas.; sig. increase in rules orientation

Grandberry (1998) reported on the DIT pre- and post-test scores of 37 Washington state offenders participating in MRT. Only 13 post-tests were available for analysis. The percentage of principled reasoning increased from 31 to 35 after MRT participation but a statistical analysis was not performed.

Gilreath (1995) and Sandhu (1999a) evaluated moral reasoning changes in females participating in MRT in a specialized residential program designed for drug abusing mothers. Gilreath reported a 54% increase in principled reasoning in 65 program graduates. Sandhu reported on pre- and post-test moral reasoning results in 27 females in the same program. Moderate — but nonsignificant — increases in moral reasoning were found in principled reasoning and Kohlberg's level 4 (rule orientation).

Sandhu (1998) also conducted a large study on 266 male inmates participating in MRT in an Oklahoma prison. Pre- and post-test DIT results showed a moderate — but nonsignificant — increase in principled reasoning and a significant — and moderately large — increase in rule orientation reasoning.

Summary. Moral reasoning changes following MRT participation have been reported in 8 studies containing 549 participant subjects. All of the reported data show decreases in the lower stages of moral reasoning with increases in higher stages following MRT participation. These findings are consistent with MRT's stated focus: to increase moral reasoning levels. Most of these studies report statistical significance, however, even in those reports showing nonsignificance, the data consistently trends strongly in the expected and desired direction. In summary, it can be stated that MRT does, in fact, increase levels of moral reasoning.

The most consistent problem cited in these studies is the collection of invalid DIT results. Programs relying on clients to correctly complete the tests on their own — and then using computer scoring — tend to obtain a high percentage of invalid tests. Grandberry (1998) observed that the average reasoning level of Washington state inmates who completed valid tests was at the high school level. However, half of all tests were incomplete and invalid. Lack of testing supervision was cited as the most likely explanation for this finding. Those wishing to utilize objective tests on drug abusing populations should understand that staff supervision and support should be utilized during all testing procedures.

MRT Effects On Personality Variables: Self-Esteem, Life Purpose, Anger

Eleven published reports have evaluated the effect of MRT on a number of personality variables. Table 7 summarizes the results from this research. Little & Robinson (1988, 1989a) and Freeman, Little, Robinson, & Swan (1990) reported significant increases in the Purpose In Life (PIL) questionnaire following MRT treatment in both DWI and felony drug offenders. A correlational study on 115 DWI offenders' post-release DWI rearrests (Little & Robinson, 1989c) showed that MacAndrew pretest scores were significantly related to post-release rearrests. Sensation Seeking (SS) scores approached significance but no correlation was found between PIL scores and DWI rearrests.

A small study (Correctional Counseling, Inc., 1993b) reported on personality variable changes in 26 substance abusers in a hospital-based MRT program. Following MRT participation, PIL scores significantly increased and SS scores (an indicator of thrill-seeking) significantly decreased.

A number of studies have investigated self-esteem changes in MRT participants. Hobler (1995) and Miller (1997) evaluated 102 and 591 Delaware MRT-Life Skills participants at entry and completion with the Rosenberg Self-Esteem Inventory. Both studies showed significant increases in self-esteem following MRT

completion. Miller also showed that the MRT participants' anger expression (as measured by the STAIX Anger Expression Inventory) was significantly lower following treatment.

Gilreath (1995) and Sandhu (1999a) also utilized the Rosenberg Self-Esteem Inventory with groups of 65 and 27 female MRT participants in residential treatment. Both studies found significant increases in self-esteem following MRT participation. In addition, these studies reported significant reductions in pre- to posttest results on sensation seeking and Beck Depression scores and significant increases in life purpose.

Sandhu (1999b) evaluated 19 graduates of an MRT-based drug court program. Both Life Purpose and Self-Esteem scores increased following MRT participation. In another study of 266 offenders in a prison based MRT program, Sandhu (1998) reported significant increases in Life Purpose and Self-Esteem scores and near significant decreases in sensation seeking.

Summary. MRT participation significantly enhances self-esteem and perceived life purpose in participants. Depression and anger expression also appear to be significantly lessened although there are few studies investigating these variables. In addition, thrill-seeking is generally lower following MRT participation. In some samples, thrill-seeking is significantly lower (hospital programs and females in residential treatment), however, in male offenders, thrill seeking reductions only approach significance.

TABLE 7
PERSONALITY VARIABLES: SELF-ESTEEM, LIFE PURPOSE

Reference	Site	N	Outcome
Little & Robinson, 1989a	prison TC/DWI	75	PIL scores significantly increased.
Freeman, Little, Robinson, & Swan 1990	*		
Little & Robinson, 1988	*		
Little & Robinson, 1989c	DWI's	115	DWI rearrests sig. related to MAC pretest, SS appr. sig., PIL unrelated.
Correctional Counseling, Inc., 1993b	Hospital Unit	26	PIL sig. inc.; SS scores sig. dec.
Hobler, 1995	Del. DOC	102	Sig. increase in self-esteem
Miller, 1997	Del. DOC	591	Sig. increase in self-esteem
Gilreath, 1995	residential/fem.	65	54% increase in principled reas.
Sandhu, 1998	OK Prison	266	Sig. inc. in self-esteem & PIL.
Sandhu, 1999a	residential/fem.	27	NS increases in principled reasoning and rule orientation
Sandhu, 1999b	drug court	19	NS increase in principled reas.; sig. increase in rules orientation

MRT Effects On Work Release & Employment Success

A few studies have evaluated the success of MRT participants on work release and employment success. Miller & Hobler (1996) and Miller (1997) evaluated the successful completion of Delaware DOC work release in MRT life-skills participants in comparison to other work release participants. They found that MRT participants had a significantly higher work release success rate (75.9% to 51.7%).

Grandberry (1998) found that MRT participants in Washington state's community corrections program were 84% employed compared to a 75% employment rate in controls. Shields (1999) reported on employment success in a community-based MRT offender services program in Oregon. The 40 MRT participants placed in jobs showed a 78% job retention rate after 90 days as compared to an expected rate of 70%.

MRT & Domestic Violence Treatment

MRT has a specialized program designed for perpetrators of domestic violence. The program has been in use since 1995. While many treatment sites have utilized the program, scant outcome research has been published. Fann, & Watson (1999) found a 64% completion rate of the program by domestic violence perpetrators in a community treatment program in Tennessee. A 7.3% rearrest rate was reported for these completers over approximately one year. By comparison, 35% of the noncompleters were rearrested.

Leonardson (2000) reported on outcomes in 175 domestic violence perpetrators referred to the specialized MRT program in Montana. A 60% completion rate was found for perpetrators who also participated in a concurrent chemical dependency program. Only 22.6% of participants who had a restraining order completed the program. One and two-year rearrest rates were reported. MRT program completers showed a 29.4% one year arrest rate (for any offense) and a 48.6% two-year rearrest rate. Dropouts showed a 60% and 74.2% rearrest rate for one and two years, respectively. Untreated perpetrators showed rearrest rates of 50.6% and 58.7%. MRT completers also showed the lowest rearrest rates for domestic violence offenses in both the one and two-year periods (7.8%; 10.8%). Dropouts' rates (13.3%; 22.6%) were higher than completers but lower than the untreated group (19%; 39.1%).

MRT & At-Risk Youth

Specialized MRT programming also exists for youthful offenders and youth in educational programs, however, little research has investigated outcomes. Clark

(1995) cited preliminary research showing improved retention in at-risk youth in a vocational training program in Puerto Rico. Two related studies (Petry, Bowman, Douzenis, Kenney, & Bolding, 1992; Petry, & Kenney, 1995) investigated the effectiveness of MRT on treating 218 delinquent males participating in a boot camp. Rearrest rates (37%) were quoted as being low following treatment, however, comparable data was not supplied to the university evaluators performing the study. One significant finding showed that, in those juveniles who did reoffend following treatment, the severity of crime was lessened.

Conclusions

Data presented in this review of MRT research comes from 13,498 MRT-treated individuals and 72,384 individuals forming control and comparison groups. Perhaps the most significant conclusion comes from the independent cost-benefit analysis from Washington State showing that MRT is — by far — the one program that produces the greatest cost-benefit. All other research supports this cost-benefit conclusion. Twenty-eight studies have evaluated the effect of MRT on inmate recidivism. All of these studies have found that MRT leads to lower rearrests and reincarceration rates for time periods up to a full 10 years after treatment and release. Nearly 5,000 MRT-treated offender's post-release recidivism has been tracked by these studies. More than 18 additional studies have shown consistently reduced recidivism in DWI offenders, domestic violence perpetrators, and in community corrections. In addition, research consistently shows that MRT treatment leads to a rapid and significant decline in incarcerated offender misconduct and disciplinary problems. MRT treatment also generally leads to reduced recidivism risk in probationers as well as in lower misconduct rates in some probation groups. Results from research on the effects of MRT treatment on personality variables is also consistent and lends insight into some possible factors leading to MRT's success. MRT leads to significant increases in moral reasoning as well producing as a host of other beneficial changes in personality measures. These include enhanced self-esteem, lower depression levels, lower anger levels, increased life purpose, and lower sensation seeking. Correlational research suggests that the beneficial effect of MRT on offender recidivism is due, in part, on some of these personality variable changes.

Few treatment approaches have been researched as extensively as MRT has been. While it has been established that MRT treatment leads to reduced recidivism, the effects of combining MRT with other programs has been largely unresearched. In addition, research should delineate exactly what types of offenders are most responsive to MRT.

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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:

E. Stephen Swan, Editor, CBTR
Correctional Counseling, Inc.
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The Stages of Change Model with Applications to Moral Reconation Therapy

by Arnold Waggoner, Oklahoma Department of Corrections

A plethora of information exists today regarding the effectiveness of treatment modalities that are designed to target the substance abusing behaviors and criminogenic needs of the adult and juvenile criminal offender. This article will present observations that will identify the hallmarks of the Stages of Change Model that exist in the components of the cognitive-behavioral treatment modality known as Moral Reconation Therapy (MRT).

The Stages of Change

The Stages of Change model is a transtheoretical model of change that systematically integrates the stages of change with processes of change from diverse theories of psychotherapy. (Prochaska, Diclemente & Norcross, 1992). The authors of the Stages of Change Model, James O. Prochaska, John C. Norcross and Carlo C. Diclemente while conducting extensive research projects on smoking cessation became interested in how people change addictive behaviors. They discovered that people who elect to "self change" a negative behavior such as smoking, overeating, alcohol abuse or substance abuse demonstrate some of the same processes as people who change negative behaviors through "therapy change". (Prochaska, et.al, 1992). Six separate stages of change have been identified that people move through when modifying addictive behaviors. The six stages are *precontemplation, contemplation, preparation, action, maintenance,* and *termination.*

Precontemplation is the stage at which there is no intention to change behavior in the foreseeable future. Many individuals are unaware there is any problem. Everyone around them knows that there is a problem and that is often the reason they seek treatment. When the pressure is on to correct their negative behaviors they may demonstrate change, however, when the pressure is relaxed, they may quickly revert to their previous practices.

Contemplation is the stage in which people are aware that a problem exists and they are seriously thinking about overcoming it, yet they have not made a commitment to take action. An important aspect of the contemplation stage is the weighing of the pros and cons of the problem and the solution to the problem. People in the contemplation stage may take action on their problem behaviors within the next six months.

Preparation is the stage that combines intention and behavioral criteria. Individuals in preparation begin to make the effort to change. They may start to reduce the amount of alcohol intake, or the number of cigarettes smoked per day. Even though they have made some demonstrable changes in their negative behaviors, they have not fully reached a criterion for effective action. Individuals in the preparation stage are intending to take action on their negative behaviors within the next month and they have unsuccessfully attempted to take action with the last year.

Action is the stage in which individuals modify their behavior, experiences or environment in order to overcome their problems. Modifications of the addictive behavior in the action stage tend to be the most visible. Individuals are classified in the action stage if they have successfully altered their behaviors for one day to six months. Successfully altering the addictive behavior means reaching a particular criterion, such as abstinence.

Maintenance is the stage in which people work to prevent relapse and consolidate the gains attained during action. Maintenance is a continuation, not an absence of change. (Prochaska and DiClemente, 1984) For some behaviors maintenance can be considered to last a lifetime.

Termination is the ultimate goal for all changers. In this stage the former addiction will not present itself as a problem. The negative behavior will never return. In essence, people in termination see themselves as a "new" person that never experienced the problem of the unwanted negative behavior.

Moral Reconation Therapy

Moral Reconation Therapy (MRT) is a systematic, step-by-step treatment system designed for "treatment resistant clients"(Little & Robinson, 1988). The system is designed to alter how offenders think, and how they make judgments and decisions about what is right and wrong with their behaviors and attitudes. As a cognitive behavioral intervention, MRT begins with simple tasks and progresses to more difficult and complex tasks. Participants of MRT can complete the required steps in 12 or 16 sessions. The sessions typically last from 1-2 hours. All work is done in the group setting. The group setting is open-ended and this feature of MRT causes those participants who have progressed to higher steps to "pull-up" new participants by relating their own experiences and resolved resistance with the group participants. There is an observable and measurable change in the behaviors of new participants as they are "pulled-up" by those who are higher in their steps. This program format is utilized to build a therapeutic community atmosphere (Little & Robinson, 1988).

The system assumes that clients enter treatment with low levels of moral development, strong narcissism, low ego/identity strength, poor self-concept, low self-esteem, inability to delay gratification, relatively strong defense mechanisms, and relatively strong resistance to change and treatment (Little & Robinson, 1988).

A total of nine personality/behavioral stages are used in MRT (Little & Robinson, 1988). Depending upon the individual's moral level and identity, people are characterized into one or more of the descriptive personality stages.

Disloyalty is the lowest moral and behavioral personality stage in which a person can function. Disloyalty is characterized by blaming others, cheating, stealing, lying, taking revenge and victimizing others. Anger, hatred, resentment and depression may characterize the emotions displayed in stage. People in this stage tend to mistrust other people and make judgments based upon pleasure/pain, & reciprocity.

Opposition is the stage in which people are generally more honest than those in disloyalty. People in opposition tend to blame other people, the rules, or the system for their problems. (Little & Robinson, 1988).

Uncertainty is characterized by indecision, lack of direction, and little use of insight. Commitment to goals and direction are absent in uncertainty, as a matter of fact they are unsure that appropriate goals are even possible for them to attain.

Injury is the stage that is characterized by an increasing awareness of the injury that a person inflicts upon self and others. People in the injury stage begin to understand that when they hurt themselves and others, that they are the source of the problem. People in this stage continue to be motivated by pleasure/pain reciprocity, and they begin to base their judgments on what would please others.

Nonexistence is the stage in which people begin to feel little purpose in their lives, yet they begin to feel responsible for their condition. People in nonexistence do not feel fully connected to the world. Commitment is still absent in this stage. Decisions are made from the "law" and "order" stage. (Little & Robinson, 1988).

Danger is the stage in which people have made commitments to long-term goals and they feel an urgency to fulfill their goals. They have communicated their goals to others and they feel the risk of failure. Decisions are based primarily upon societal values and law and order. However, because of the ongoing "risk" and "danger" that one experiences in this state, in certain situations, they will make decisions based upon pleasing others, reciprocity and pleasure/pain.

Emergency is the stage in which people feel a sense of urgency to fulfill their goals. They begin to feel connected to the world and they take pleasure in setting and reaching goals. They are usually, open, honest and reliable. Decisions are based primarily upon social considerations, but a strong element of idealized ethical principles influences judgment. When a "slip" is experienced, they have a strong sense of guilt and they want to bring the problem out into the open and correct the situation.

Normal is the stage in which people experience success in fulfilling their goals with what appears to be little work and effort. This occurs because they do not see their life's work as work; rather they tend to see it as a mission and purpose. People in normal are relatively happy, content people who are convinced that they have chosen the right goals for themselves and that they are

fulfilling them in the right manner. Decisions are generally based about half-and-half upon social considerations and ethical **principles** (Little & Robinson, 1988).

Grace is the stage reached by few people. People in this state have great concerns for social issues and they are committed to do the right things for the right reasons, and in the right way. They place a great amount of value on human life, diversity and freedom. The great majority of their decisions are based upon their ethical principles.

Integrating the Stages of Change Model and Moral Reconation Therapy

With a basic theoretical framework established for the tenets of the Stages of Change Model and Moral Reconation Therapy, an examination of the similarities in the stages of change and the personality/stages of MRT are applied to the processes involved in the stages of change and the essences of the steps of Moral Reconation Therapy.

The stages of change represent a temporal dimension that allows us to understand when particular shifts in attitudes, intentions, and behaviors occur. The processes of change are a second major dimension that enables us to understand how these shifts occur. (Prochaska, Diclemente & Norcross 1992). The authors of the stages of change model have identified nine different processes of change, consciousness-raising, social liberation, emotional arousal, self-reevaluation, commitment, reward, countering, environment control and helping relationships. Each of these processes are used in the stages of change to help move people through the stages of change and to eliminate the negative behaviors.

The processes of change are applied to each stage of change such as in the precontemplation stage. People in this stage may lack sufficient information to perceive their problems clearly. The agent of change can then begin to provide information to the changer that will increase their awareness or consciousness about the problem. This demonstrates the process of consciousness raising. Reading, observations, and bibliotherapy may be techniques that are employed to raise consciousness.

Moral Reconation Therapy identifies seven treatment elements that seeks to facilitate a rise in the development of moral reasoning and appropriate behavior. 1) Confrontation and assessment of self (beliefs, attitudes, behavior and defense mechanisims.2) Assessment of current relationships, 3) Reinforcement of positive behavior and habits designed to raise awareness and moral responsibility, 4) Facilitation of positive identity formation through exploration of the Inner Self and goals, 5) Enhancement of self-concept through ego-enhancing activities and exercises, 6) Decrease the hedonistic orientation of clients by the development of delay in gratification expectations, and 7) the development of higher stages of moral reasoning.

Moral Reconation Therapy identifies the **essence** of each step of the program. The essence identifies the fundamental issue that will be addressed by the client through the exercises prescribed for that particular step. The initial essence of step one is honesty. Clients must become openly honest about the negative, dysfunctional things they have done. Exercises such as the Pyramid of Life call upon the client to examine their lives 1, 5, 10 and 20 years ago into "what is" and "what could have been" categories, this step is a powerful demonstration of consciousness-raising, a process used in the first stage of change, precontemplation.

The essences of the steps in Moral Recona-

Table 1. Stages of Change With Application to Moral Reconation Therapy Behavioral/Personality Stages

Stages of Change	Precontemplation	Contemplation	Preparation	Action	Maintenance
MRT Behavioral/ Personality Stages	Disloyalty Opposition Uncertainty	Disloyalty Opposition Uncertainty Injury	Opposition Uncertainty Injury Nonexistence	Nonexistence Danger Emergency	Emergency Normal

tion Therapy addresses issues such as, honesty, trust, acceptance, awareness, healing relationships, helping others, goal setting & identity formation, consistency between short & long-term goals, never giving up, maintaining a positive change, backsliding (slipping or relapsing) & firm commitments, and setting appropriate goals. Further identification of the relationship between the Stages of Change Model and Moral Reconation Therapy can be found in Tables 1and 2.

An extensive amount of research has been conducted regarding the principles of effective treatment and what works for changing substance abuse and criminal behaviors. The stages of change model with the processes of change enhances the tenets of successful behavioral change modalities. Moral Reconation has been empirically validated as an effective treatment model that changes criminal behaviors as well. As new research is conducted, the continued search for successfully changing behaviors seems to be less elusive.

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Table 2. Processes of Change With Application to Moral Reconation Therapy Step Essences

Processes of Change-Stages of Change Model	Consciousness-Raising	Social Liberation	Emotional Arousal	Self-Reevaluation	Commitment	Environment Control	Reward	Helping Relationships
Moral Reconation Therapy Essence of Step	Honesty →							
	Trust →							
	Acceptance →							
				Healing Relationships →				
	Awareness →							
								Helping Others →
						Goal Setting & Identify Formation →		
						Never Giving Up →		
						Maintaining Positive Change →		
						Setting Appropriate Goals →		

CBTR LITERATURE REVIEWS

COGNITIVE-BEHAVIORAL TREATMENT

Cognitive-Behavioral Treatment for Cocaine Addiction: Clinical Effectiveness and Practice Guidelines by P.R. Smokowskie & J.S. Wodarski (1998), *Journal of Applied Social Sciences*, 23, 1, 23-33.

This article examines recent developments in the research regarding various cocaine treatment models. Because of the significant increase in the use of cocaine during the last twenty years, there have been numerous treatment interventions proposed and tried during that period. To date, there is little concensus regarding the effectiveness of those various approaches.

The authors first briefly review several phamacological interventions that have been investigated. These include the dopamine agonist, bromocriptine; antidepressants such as desipramine, imipramine, and fluoxetine; and the opioid anonist/ antagonist, buprenorphine. While some of these have shown some promise, "... no pharmacological agents have been found universally effective for treating cocaine dependency. ...Thus, pharmacological treatment remains an important, yet struggling, adjunct to psychosocial and behavioral interventions."

The authors point out two significant struggles in the treatment of cocaine addiction: getting the users into treatment and keeping them in treatment. Several studies are cited that provide empirical evidence that positive contingency contracting is more effective in retaining clients in treatment than negative contingency contracting. In addition, they point out that cognitive-behavioral groups can serve as a therapeutic and supportive aid because group members become therapeutic agents for one another and reinforce each others' prosocial efforts.

The authors conclude that "...preliminary results for the use and effectiveness of cognitive-behavioral treatment in cocaine addiction are encouraging. Behavioral methods have been shown to produce results superior to several other treatment modalities."

ANTISOCIAL PERSONALITY

The Contagious Nature of Antisocial Behavior by M.B. Jones and D.R. Jones (2000) *Criminology* , 28, 1, 25-43.

This article puts forth the premise that there is evidence that contagion plays a role in the development of antisocial behavior. "The greater the preva-

CBTR LITERATURE REVIEWS

lence of antisocial behavior in a family or community where a boy (especially) is growing up, the greater the risk that the boy will be affected. " The authors point out that the contagion theory is compatible with the known epidemiology of antisocial behavior. They cite research studies that have found that delinquent boys tend to have as associates other delinquent boys as friends, that delinquent acts are not usually committed by lone individuals but rather by two or more boys acting in concert, and that poor supervision by parents or other adults consistently precedes the development of antisocial behavior

They also discussed the concept of critical levels of antisocial behavior within communities. The authors point out that prosocial forces are also present within a given community. They hypothesize that as long as these prosocial forces are stronger than the current contagion pressure, antisocial behavior will remain at low levels. When the contagion pressure is greater than the forces of social control, antisocial behavior spreads throughout the susceptible population. Studies of teenage childbearing and dropping out of school are discussed as supporting the idea of critical value. It was found that migration of prosocial forces out of a community was the most likely reason for higher levels of teenage childbearing and dropping out.

The authors maintain that "... the most useful consequence of the contagion hypothesis may be that levels of antisocial behavior in a community are controlled by equilibrial processes. If prosocial forces are concentrated in such a way to drive a high level of antisocial behavior below a critical value, a process may be set in motion that will continue to lower the level of antisocial behavior with no further commitment of social resources, as the process moves to a new and lower equilibrium of its own accord. " In order to effectively use these equilibrial processes, more specific knowledge is needed regarding the measurement and control of critical values. With such knowledge, prosocial resources could be marshaled to minimize the level of antisocial behavior.

SUCCESSFUL COGNITIVE-BEHAVIORAL PROGRAMMING IN COUNTY PROBATION

by Rex Lynch, Anderson County Executive

In the fall of 1998, I met with General Sessions Judge Don Layton to see if the County Executive Office could assist in improving Misdemeanor Probation Services in Anderson County. Those initial meetings evolved into an initiative creating a new probation department that is now recognized as one of the most innovative and efficient county-run programs in the state. General Sessions Judges Ron Murch and Don Layton deserve most of the credit because of their insistence on developing quality probation services.

I have recently held meetings with the Anderson County Probation Director Alan Beauchamp to evaluate and possibly expand community service programs. The most rewarding aspect of this department's achievement is the number of quality programs that have been implemented within the past 12 months. Anderson County Probation Services is now managing seven different educational and rehabilitation programs under the supervision of Director Beauchamp and Programs Coordinator Willie Golden.

Classes are now available in Anger Management, Moral Reconation Therapy (MRT®), Financial Responsibility, AA, NA, Driver's Safety School, and GED classes. Many of these programs are offered at the jail. We are also working with other community agencies to place individuals in rehabilitation programs through grants and other independent sources. Everyone with an alcohol or drug conviction is getting an alcohol and drug assessment that helps our staff to determine appropriate program placement.

The past five months have seen us introduce Community Service Programs that are making a significant contribution to the welfare of Anderson County. Community Service Projects are used as an alternative to incarceration. Tjese projects have saved county taxpayers thousands of dollars this year and self-supporting through probation and program fees. Programs have helped to construct a playground in Claxton, raked leaves at area schools, picked up litter, cleaned county buildings and helped non-profit groups in their work to serve the community. We are now working with the Anderson County Chancery Court to provide parenting classes that are required by the state of Tennessee after January 1, 2001.

Dag Hammarskjold, Former Secretary General of the United Nations, wrote in his biography, "The burdens we carry in our life only weigh us down when the only burdens we carry are our own." We hope our County Service Programs are helping to build a greater sense of community through the sharing of those burdens in a constructive way.

For additional information about the programs of the Anderson County Probation Services, please contact Mr. Willie Golden, Programs Coordinator at (865)220-0118.

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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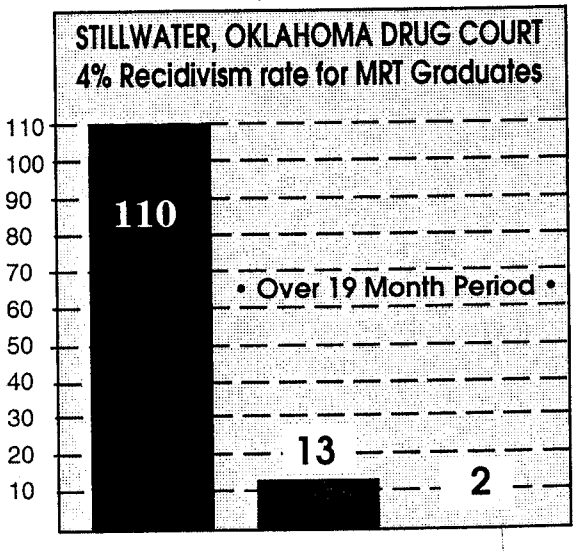

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Imaginary Time Out (audio cassette)	$8.95		
Family Support (CBT workbook)	$9.00		
Job Readiness (CBT workbook)	$9.00		
Simply Spiritual Book + Workbook	$15.95		
Spiritual Reflections Book + Tape	$18.95		
An Introduction To Spirituality book	$12.00		
The Joy Of Journaling	$11.95		
Psychopharmacology: Basics for Couns.	$24.95		
Coping With Anger (workbook)	$10.00		
Coping With Anger (Spanish workbook)	$10.00		
Coping With Anger Facilitator Guide	$5.00		
Making Changes Sex Offender Workbook	$18.00		
Making Changes Facilitator Guide	$10.00		
Untangling Relationships Workbook	$10.00		
Staying Quit (workbook)	$10.00		
Staying Quit Facilitator Guide	$5.00		
Staying Quit Audiotape Set	$50.00		
Staying Quit Group Starter Kit	$140.00		
Responsible Living workbook	$10.00		
Thinking For Good workbook	$10.00		
Thinking For Good Facilitator Guide	$5.00		
Character Development	$20.00		
Character Development Facilitator's Guide	$20.00		
RAPPORT	$25/$85/$375		
Objective Tests & Measures Book I.	$105		
MRT ***Materials below can only be ordered by trained MRT facilitators***			
MRT Counselor's Handbook	$10.00		
MRT Poster (Freedom Ladder)	$10.00		
How To Escape Your Prison (cassette tapes)	$59.95		
How To Escape Your Prison	$25.00		
How To Escape Your Prison (In Spanish)	$25.00		
How To Escape Spanish (cassette tapes)	$59.95		
Juvenile MRT® - How To Escape Your Prison	$25.00		
Domestic Violence (Must take Dom. Vio.)	$25.00		
Domestic Violence ***Facilitator's Guide***	$10.00		
Filling The Inner Void	$25.00		
Discovering Life & Liberty...	$25.00		

Ordering Instructions

To order materials, clip or copy coupon and send with check, money order, or purchase order. All orders are shipped by UPS — no post office box delivery. Include $5.00 per item shipping for all orders of single items. Bulk orders should call CCI at (901) 360-1564 for UPS shipping, insurance, and handling charges. Orders are typically shipped within 5 working days of receipt.

Materials below the line stating "MRT Materials..." can only be ordered by persons or agencies with trained MRT® facilitators. Call for details if you do not understand or have any questions.

CREDIT CARD ORDERS: (901) 360-1564

ORDER COUPON

Name: _____

Agency: _____

Address: _____

City/State/Zip: _____

Phone: _____

Send form and payment to:

Correctional Counseling, Inc.
3155 Hickory Hill • Suite 104
Memphis, TN 38115

Grand Total = _____

Memphis MRT Training Daily Agenda

This schedule is for Memphis trainings only. Regional times and costs vary. Lunch served in Memphis only.
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.

MRT® Or Domestic Violence For Your Program
Training and other consulting services can be arranged for your location. For information call Dr. Ken Robinson: 901-360-1564.

2001 MRT® AND DOMESTIC VIOLENCE TRAININGS

February 12-16 — MRT in Memphis, TN
March 1-4 — MRT in Conyers, GA
March 19-23 — MRT in Memphis, TN
March 19-22 — MRT in Albuquerque, NM
March 26-29 — MRT in Chicago, IL
April 2-5 — MRT in Newark, NJ
April 5-8 — Domestic Violence in Conyers, GA
April 9-12 — MRT in Augusta, ME
April 10-13— MRT in Concord, CA
April 23-27 — Domestic Violence in Memphis, TN
May 7-11 - MRT in Evanston, WY
May 7-11 - MRT in Memphis, TN
June 11-14 — MRT in Yakima, WA

CBTR
3155 Hickory Hill
Suite 104
Memphis, TN
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