1995

Staff and resident perceptions of Moral Reconation Therapy at the Butte Pre-Release Center

Sharon R. Clark
The University of Montana

Let us know how access to this document benefits you.
Follow this and additional works at: https://scholarworks.umt.edu/etd

Recommended Citation
Clark, Sharon R., "Staff and resident perceptions of Moral Reconation Therapy at the Butte Pre-Release Center" (1995). Graduate Student Theses, Dissertations, & Professional Papers. 9093.
https://scholarworks.umt.edu/etd/9093

This Thesis is brought to you for free and open access by the Graduate School at ScholarWorks at University of Montana. It has been accepted for inclusion in Graduate Student Theses, Dissertations, & Professional Papers by an authorized administrator of ScholarWorks at University of Montana. For more information, please contact scholarworks@mso.umt.edu.
The University of MONTANA

Permission is granted by the author to reproduce this material in its entirety, provided that this material is used for scholarly purposes and is properly cited in published works and reports.

** Please check "Yes" or "No" and provide signature **

Yes, I grant permission  
No, I do not grant permission

Author's Signature  

Date 6/20/95

Any copying for commercial purposes or financial gain may be undertaken only with the author's explicit consent.
STAFF AND RESIDENT PERCEPTIONS OF
MORAL RECONATION THERAPY
AT THE BUTTE PRE-RELEASE CENTER

by

Sharon R. Clark

Presented in partial fulfillment of the requirements
for the degree of
Master of Arts

The University of Montana

1995

Approved by

Committee Chairman, Professional Paper

Dean, Graduate School

may 16, 1995 Date
Residents and staff at the Butte Pre-Release Center were interviewed to interpret their perceptions of Moral Reconation Therapy (MRT). This is a new program that is being used in prisons and pre-release centers around the country to try and educate clients in the use of positive habits and values based upon high levels of moral judgement. According to Little and Robinson the originators of Moral Reconation Therapy, it is reported to be very effective in reducing recidivism with this population. This study is about the staff and residents perceptions of the MRT program as evidenced by their responses to personal interviews. The staff and residents have many favorable attitudes toward the program and feel it is worthwhile.
# TABLE OF CONTENTS

<table>
<thead>
<tr>
<th>Section</th>
<th>Title</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>I</td>
<td>Introduction</td>
<td>1</td>
</tr>
<tr>
<td>II</td>
<td>History Pre-Release Centers</td>
<td>1</td>
</tr>
<tr>
<td></td>
<td>History of Pre-Release Programs</td>
<td>2</td>
</tr>
<tr>
<td></td>
<td>Pre-Release Centers Today</td>
<td>3</td>
</tr>
<tr>
<td></td>
<td>The Butte Pre-Release Center, Inc.</td>
<td>3</td>
</tr>
<tr>
<td></td>
<td>Current Rehabilitative Programs</td>
<td>5</td>
</tr>
<tr>
<td>III</td>
<td>Moral Reonation Therapy</td>
<td>6</td>
</tr>
<tr>
<td></td>
<td>History</td>
<td>6</td>
</tr>
<tr>
<td></td>
<td>The MRT Program</td>
<td>10</td>
</tr>
<tr>
<td></td>
<td>Treatment Elements</td>
<td>12</td>
</tr>
<tr>
<td></td>
<td>Research on Moral Reonation Therapy</td>
<td>15</td>
</tr>
<tr>
<td></td>
<td>Perceptions of MRT</td>
<td>17</td>
</tr>
<tr>
<td></td>
<td>Resident Interviews</td>
<td>19</td>
</tr>
<tr>
<td></td>
<td>Interviews with Facilitating Staff</td>
<td>23</td>
</tr>
<tr>
<td></td>
<td>Interviews with Other Staff</td>
<td>25</td>
</tr>
<tr>
<td>IV</td>
<td>Conclusions</td>
<td>26</td>
</tr>
<tr>
<td>V</td>
<td>Recommendations</td>
<td>29</td>
</tr>
<tr>
<td>VI</td>
<td>References</td>
<td>31</td>
</tr>
</tbody>
</table>
**Introduction**

The purpose of my professional paper is to study Moral Reconation Therapy, a rehabilitation program that has become popular in prisons and pre-release centers. My study took place at the Butte Pre-Release Center where I am currently doing an internship. This paper is divided into three sections. The first is an explanation of how pre-release centers have evolved into the complex system we see being used today. The next section deals with Moral Reconation Therapy's development and use, and the third part explains the study that I have conducted with the cooperation of the residents and staff at the Butte Pre-Release Center.

**History of Pre-Release Centers**

**A Brief History of Half-way Houses**

Modern pre-release centers are structured on the basic premise of helping prisoners return to life on the outside through some form of structured guidance. Originally most places providing such services were called half-way houses and were run by church affiliated groups. Their history actually goes back to the middle of the first century, where St. Leonard had convicts released into his custody, brought them into a monastery in France, and provided a place for them to adjust to life in the outside world.

Stemming from a 1816 prison riot in Pennsylvania, the first formal recommendation for the establishment of a half-way house in the United States was made the following year. It was recommended that a small building be erected to help ex-convicts until they were able to find suitable housing and employment. The proposed legislation, however, was not carried out due to fear of alarming the public (McCarthy and McCarthy, 1991, p.210).
Churches and clergy continued to render help to convicts until 1954, when the Reverend James G. Jones, Jr., an Episcopal priest founded the first U.S. half-way house in Chicago, and dedicated the facility to St. Leonard. Shortly afterward Reverend Charles Dismas Clark founded a second half-way house in St. Louis. As in the U.S., many of Canada's half-way houses also have their foundations in the church.

**History of Pre-Release Programs**

Originally, all pre-release programs were operated and housed within prison structures themselves, but in recent years they have been moving out into communities. As prison over-crowding increases more ideas for some sort of solution have evolved. In the 1950's the American Prison Association began looking at the need to prepare prisoners for release and to supervise them once they were released. They found that the highest percent of recidivism was occurring within the first ninety days after release, and saw the need to develop programs to help the prisoners to adjust to outside life. With help in finding employment and a place to live, perhaps they would have a better chance of staying out of trouble. It was thought that with help in making decisions and dealing with daily pressures, prisoners would have less trouble adjusting to life on the outside, and learn to adapt more easily.

In 1961 Robert F. Kennedy, then Attorney-General of the United States, combined the ideas behind both half-way houses and pre-release programs and established three Pre-release Guidance Centers (James, 1968, p. 148-9). Shortly after that a pre-release system was started at six federal correctional institutions. The programs were modeled after transitional
programs developed for World War II veterans who had difficulty in adjusting to civilian life after leaving the structured environment of veteran's hospitals.

Three main principles developed in these programs are still used today. The first is to provide inmates with information that will help them to carry out their release plan. The second is to provide inmates a chance to voice their fears about what will happen when they are released and the third is to provide a system to evaluate how well the pre-release plan works (Callison, 1983, p.146).

**Pre-Release Centers Today**

Today pre-release centers are well established and serve as a valuable part of the prison system. They function to not only provide food, clothing and shelter for the transition back into the community but to meet other needs as well. Each pre-release center has programs designed to help the residents find jobs, complete their education and go through self-help programs. Residents are encouraged to seek counseling as needed, and to attempt to solve some of their personal and family problems. As they are able to handle more responsibilities, they are granted more freedoms and extended passes (Callison, p.154).

**The Butte Pre-Release Center, Inc.**

The Butte Pre-Release Center, Inc., is a private non-profit organization located in Butte, Montana. It has a ten-member, volunteer Board of Directors, and was established to provide pre-release and other transitional help for adult felons. It is supported by contracts with the Montana State Department of Corrections and the Bureau of Prisons. Residents are
required to contribute monies from their earnings to subsidize their living expenses. The Center is capable of housing approximately 75 male and 25 female residents at a time.

It is a flexible program providing several alternative programs for the residents, depending on their needs. Some of the residents may need the program to aid in their adjustment back into society, while others go to the pre-release center because they need more supervision than probation can offer. The environment is less structured than that found in prison, and residents are expected to make many of their own decisions. Residents are given a starting point to build on. As it states in the *Staff and Resident Guidebook for the Butte Pre-Release Center* "Programs don't change people, people change themselves."

The first step in becoming a resident at a pre-release center is by referral or application. Candidates should be within a year of parole eligibility or release. All applicants are screened for various qualities that indicate success in the program. At most centers they are screened for family and community ties, their potential for employment and special skills, mental health, physical condition, level of motivation to seek and hold employment, desire to succeed and level of savings (McCarthy and McCarthy, 1991, p.214).

At the Butte Pre-Release Center the residents must be at least 18 years old and non-violent offenders. Residents with chemical dependency problems are withdrawn from drugs and from alcohol, and those who are emotionally disturbed receive intensive treatment before they are considered. Preference is given to people from the area or those planning to relocate in the area. Those with a minimal criminal history are given preference, as well as those who have good institutional and employment records. Institutional recommendations count heavily in the screening. All applicants have to sign a Residency Contract, House Rules
Acknowledgement and fill out the application form.

Each resident who is accepted into the program must go through orientation which consists of a complete search and inventory of possessions. They are then given a breath alcohol detection test, urinalysis and personal search. They receive a tour of the facility and are assigned a room. Residents must complete an Orientation Mutually Agreeable Plan (MAP).

Each resident does a "Life Plan" and personal autobiography in orientation. These are honest descriptions of what has happened in their life, so far, leading them to where they are currently and suggest what they can do to change their life for the better. Within two weeks most residents have their MAP completed and with the help of their primary counselor have started to work in the program.

Current Rehabilitative Programs

There are several therapeutic groups available to help residents. World of Work is designed to assist in finding employment. Residents learn to design a resume' and are taught simple job hunting skills such as what to wear and how to act during an interview. They participate in mock interviews that are videotaped and critiqued by their training group. Residents are taken on a tour of the area to learn the bus routes they will need when they head out in search of jobs, and are required to work on computers and complete a set job training program as part of their stay.

For those with chemical dependency problems there are groups offered within the facility and they are required to attend outside groups as well. If a resident needs mental
health counseling they are encouraged (some are required) to seek and pay for help in the community.

In some ways the pre-release center seems like a prison, with room searches, urinalysis and the residents having to be accountable for where they are at all times, but the freedom of being able to go out and work and spend time doing ordinary things such as shopping, attending church, participating in leisure activities and enjoying family visits makes the situation workable.

**Moral Reconciliation Therapy**

**History**

Reconciliation Therapy was developed by Robert W. Wood and Richard S. Sweet for the rehabilitation of narcotic addicts. Its use was initiated in a psychiatric hospital to try to instill self-motivated, positive, goal-directed behavior into the patients. The first treatment program to use Reconciliation Therapy was a Drug Offender Rehabilitation Program at the Shelby County Correction Center in Memphis, Tennessee, and it is currently very popular in prisons and pre-releases centers across the country. The history of this program starts with the word *Reconciliation*, which comes from the term "conation, derived from Descartes' idea of the point where mind and body fuse to create consciousness" (Little and Robinson, 1988, p.136). "Conation refers to the process of how we direct our behavior and decisions" (Little and Robinson, 1986, p.42).

Behavioristic methods were used early on in treatment to try to curb impulsive behavior. Impulse control was facilitated primarily by using reinforcement and punishment early in treatment, and group formats focused on forcing the clients to reevaluate beliefs and
personal perceptions about controlling impulsive behavior. The approach was adapted, as explained in the following section, for use in prison drug-treatment programs and was quite effective in reducing recidivism among DUI offenders. Participants in the program experienced fewer arrests for all offenses and spent less time incarcerated. The program had flaws though and one of the biggest was that many clients did not complete the program. In 1985 Little and Robinson noticed that one reason that clients did not finish the program was due to their inability to make moral decisions. The program needed to be changed to attract and retain as much of the treatment population as possible. Reconation Therapy thus evolved into:

Moral Reconation Therapy which is a fusion of treatment methods aimed at effecting clients' moral reasoning with behavioristic, group and individual processes and it is designed to foster functional behavior, identity and impulse control and responsible behavior. The step-by-step approach to increase clients' moral level and behavior addresses these issues (Little and Robinson, 1988, p.138).

Moral Reconation Therapy (MRT) is a simplified personality theory taught to residents through lecture, individual discussions, and workbook exercises. The personality theory behind MRT contends that over time people develop their personalities through a gradual buildup of beliefs, attitudes and habits, thus forming the "Inner Self or essential essence which is described as all of a person's positive potential as a human being" (Little and Robinson, 1986, p.29). As people's personality develops, their potential becomes increasingly unconscious and hidden, and when one's potential is not utilized, internal conflict increases. When the personality fails to reach its potential, high tension occurs, resulting in the development of defense mechanisms.
MRT personality theory assumes that an individual's personality resists change through the development of such defense mechanisms. As a result, they may have a weak sense of identity and are generally unhappy, anxious and depressed. Those with a strong sense of identity may possess a false or inappropriate identity—they do not see a real need to change and do not believe they can change.

MRT stresses that people must develop a sense of happiness to survive. The approach adopts a simple definition of happiness for the people it serves "...we are happy in our lives to the same degree that we accomplish the right things in the right ways" (Little and Robinson, 1986, p.106). This is explained by how the personality or a person's belief, attitudes and behavior work with the moral needs and standards expressed by the "Inner Self." People learn what is right and wrong and the "Inner Self" (or conscience) can push a person to do what is right. The "Inner Self" allows people to learn to set appropriate goals and come up with a reasonable way of attaining them. Participants in MRT do this by going through a series of steps and tasks which build upon each other and lead to higher levels of moral reasoning.

The theory combines elements from Erikson and Loevinger's ego development theory, which was drawn from studies done about identity and how identity develops through the life cycle (Little and Robinson, 1988, p.139). In MRT, the "Inner Self" is similar to the ego in Erikson and Loevinger's work. Both the "Inner Self" and the ego develop in stages over time through a gradual build up of beliefs, attitudes and habits which allow individuals to progressively move from self-centeredness to altruism.
In a similar way, the theory is also based upon Kohlberg's (1980) six stages of moral reasoning. Kohlberg's theory contends that as a person grows older they develop more sophisticated moral principles such as justice, equity and respect of other's rights. People become more aware of other's needs and become less selfish. Kohlberg's stages of moral development are as follows: Stage 1: Punishment and obedience (pleasure and pain); Stage 2: Instrumental Relativist (backscratching); Stage 3: Interpersonal Concordance (seeking approval); Stage 4: Law and Order (the rules are the rules); Stage 5: Social Contract (what is best for society) and; Stage 6: Universal-Ethical-Principle (following one's conscience) (Little and Robinson, 1989, p.85).

Little and Robinson's original application of MRT was with alcoholics where they saw a great need to develop a therapeutic approach that would improve their client's sense of morality. Little and Robinson took the basic principles of Kohlberg's stages of moral development and built them into the MRT steps with specific exercises and tasks. As a result, as persons advance through the steps of MRT they work through Kohlberg's stages of moral reasoning.

The theory also contains aspects of Piaget's belief that children grow cognitively by taking the simple concepts they learn early in their development and integrating them into more advanced reasoning ability. For example, Moral Reconciliation Therapy explains this as the way children develop by learning that when they cry they are answered and receive what they need and as time goes on they learn this as a form of manipulation. Piaget's stages of cognitive development similarly contends most people's thinking abilities are physiologically determined. Little and Robinson feel that for some reason some people do not develop normally and still have childish behavior as adults.
Elements of Carl Jung’s teachings are also incorporated into the theory. These include the importance of analysis of current problems, as opposed to dwelling on the past and childhood conflicts in adult treatment (Little and Robinson, 1988, p. 139). MRT uses this to show that each person has problems from their past but they must not dwell on them but have to get on with their lives and use the past to improve the future.

The MRT Program

MRT describes several stages of personality development: disloyalty, opposition, uncertainty, injury, nonexistence, danger, emergency, normal and grace. Little and Robinson explain that most people are in the normal stage but that the population MRT is oriented toward is not. To reach the normal stage they have to pass through the lower stages by doing certain tasks and exercises.

The lowest stage is disloyalty.

It is characterized by the behaviors of lying, cheating, stealing, blaming others, taking revenge and victimizing others. People in disloyalty experience a series of negative emotions characterized by anger, hatred, jealousy, resentment, and depression (Little and Robinson, 1988, p. 141).

People in this stage are mistrustful of others and make decisions based on pain/pleasure and reciprocity.

In the opposition stage, people tend to blame others, the rules or the system for all their problems. Their inability to adapt to new situations lends to problems with relationships in that they are full of hostility, instigate confrontations and conflicts, and tend to be very manipulative. They often make decisions based on pleasure/pain and reciprocity.
In the *uncertainty* stage persons have difficulty with decisions, lack discretion and have poor insight. They seldom commit to goals, believing they are not possible for them to attain. They are distrustful of others, unpredictable, and are never sure how they feel about other people. In trying to please others they often make decisions based on pleasure/pain and reciprocity.

Those people in the stage of *injury* are increasingly aware of the pain they are inflicting on themselves and others. This stage is characterized by feelings of low self-esteem, guilt, and behavior that degrade the self and others. Those moving through this stage usually know they are the source of the problem, and tend to base judgements on what would please others.

People in the stage of *nonexistence* have little sense of identity and feel out of control. They do not feel that their life has a purpose, feel alienated and seldom commit to any goals. Decisions are very difficult for them to make and they often rely on others to do their decision-making for them. The decisions they make are based on pleasure/pain and pleasing others.

People in the stage of *danger* make commitments to long-term goals and feel compelled to fulfill those goals, but think they will fail. Their decisions are based primarily upon societal values and law and order. Deciding to please others or make decisions based on pleasure/pain or reciprocity puts them at risk; thus making them lose self-esteem and feel anguish.

The *emergency* stage is when people feel a sense of urgency to fulfill goals, usually because they are not just personal goals but have the potential to negatively effect others.
Decisions are usually based on society and ethical principles. People in emergency occasionally make a poor judgement, and feeling a strong sense of guilt, bring it into the open and rectify the problem.

The normal stage is when people can successfully fulfill their goals without extreme effort. They are happy and satisfied with their abilities and decisions are based on social considerations and ethical principles.

The stage of grace is rare. In this stage the people are committed to doing the right thing and have a concern for societal issues. They want to do things for the right reasons and in the right way, and base those decisions on their ethical principles.

Treatment Elements

Moral Reconciliation Therapy was developed to:

...raise clients from relatively low levels of personality/identity/moral development (e.g., disloyalty) to higher levels of development. The therapy is designed to combine behavioristic methods with a systematic (12 or 16 steps) step-by-step treatment approach aimed at impacting personality and behavior (Little and Robinson, 1988, p. 144).

MRT was developed in an alcohol treatment unit where the success of some other therapeutic step programs such as Alcoholics Anonymous helped the originators to design the program. These programs are similar in the aspect that one is expected to try to improve in such areas as staying out of trouble, not breaking rules and laws and being responsible for their own behavior. The MRT program is much more confrontational than most twelve-step programs but the popularity and basis of such therapeutic step programs helps to formulate the process for MRT treatment. In such step programs the participants are
expected to help those who are in the steps below them and receive help from those in the steps above them. The programs are usually set up so that the steps increase in difficulty as the program progresses. The programs are based on helping the person to succeed and build a sense of confidence and trust. (Nowinski, 1992)

Methods used with Moral Reconation Therapy differ with the clientele in different treatment settings such as pre-release centers, prisons or alcohol treatment facilities. Each facility has special needs to address and for instance community service in prison has to be done with helping other prisoners while in the pre-release setting the person may do a wider variety service. All of the programs have a basic focus on certain personality/behavioral elements. (Little and Robinson, 1988, p.144)

1) "Confrontation and assessment of self (beliefs, attitudes, behavior and defense mechanisms)." In the early stages of treatment (Steps 1, 2, 3 and 4) the therapist identifies weaknesses and strengths in the client and tries to help them to be aware of these. Communication and involvement with peers are an important element in these steps. In the first step the resident is introduced to the program and has to present their reason for being at the facility to their peers. Many residents do not do this step as honestly as they must and do not pass. Step 2 talks about learning trust for the program and learning to trust at least one person in the group. Step 3 deals with learning to accept the responsibility for one's actions by looking at worries, wants and needs. This step is repeated every time a person has a write-up. It helps the person realize why they made mistakes, rectify them and not repeat mistakes. Step 4 teaches the resident time management. They must record everything that they do in a week's time period and they must be very specific. It usually amazes them when
they realize how much time they sit idle.

2) "Assessment of current relationships." In this phase (Step 5), the client looks honestly at what he/she has done to damage relationships and what relationships are damaging to him/her, considering which ones should be terminated. This step is called best of times and worst of times. Each person looks at five times that were good and five times that were bad and analyzes them. They have to present these in group and the second part of this step is drawing pictures that show the most important relationships in the resident's life. The third part looks at relationships and how the resident has damaged this relationship and what their goals for the future are. The third part is not shared with the group and is only shared with the counselor.

3) "Reinforcement of positive behavior and habits designed to raise awareness and moral responsibility." The idea behind this, as well as all other steps, is that the more responsible a person becomes the more freedom they gain. This responsibility is attained through work, forming positive habits and learning concern for others, by doing such things as community service.

4) "Facilitation of positive identity formation through exploration of the Inner Self and goals." This is the exploration of the Inner Self and the types of defense mechanisms that have been developed over time. In these steps clients also work to attain appropriate goals. (Steps 7, 8, 11 & 12.) Many of the residents have never learned how to make appropriate goals and carry them through. These steps also teach them how to look back at their mistakes and use them as learning experiences.

5) "Enhancement of self-concept through ego-enhancing activities and exercises."
Several steps work on this problem, which is attempting to improve how one thinks of one's self. By working on personal relationships in treatment and performing community service for no personal gain, clients can build up self-concept. (Steps 6 and 10.) All residents have to perform community service hours and are encouraged to keep this up even after they have fulfilled the required amount of time.

6) "Decrease the hedonistic orientation of clients by the development of delay of gratification expectations." One basic reason for this program is to make clients aware that many of their past decisions were based on pleasure/pain. Clients are required to participate in activities that only offer internal gratification, thus learning about delayed gratification through the progression of the steps in the program. In learning to work for a paycheck and do community service the residents become more aware of delayed gratification.

7) "The development of higher stages of moral reasoning." Increasing levels of moral reasoning is essential to every step in the program. It is hoped that by increasing moral reasoning, moral behavior will increase as well. Making the program mandatory for all clients is necessary for this to work (Little and Robinson, 1988, p.144).

Research on Moral Reckoning Therapy

In their first study in 1985, Little and Robinson introduced Moral Reckoning Therapy into the drug abuse program at the Shelby County Correctional Center in Tennessee. Clients completed the first seven steps of the program while incarcerated, and steps 8-12 were meant to be used in after-care. After six months of full treatment implementation, enrollees were given Rest’s (1986) "Defining Issues Test." This is a paper-and-pencil test that assesses
individuals' moral reasoning. The test is based on Kohlberg's six stages of moral development mentioned earlier. Most research interest on this test has been about the degree of "principled" thinking. People who make their decisions based on principled thinking tend to be guided by concerns of justice, equality, and basic human rights. Little and Robinson found that those who had been in the program longer scored higher on the test.

The same study also looked at changes in moral reasoning occurring over the course of treatment. The "Defining Issues Test" was used again with a pre-test, post-test application. Residents were tested upon entry into the program and retested at the completion of Step 7. They found significant pre- to post-test changes.

Another part of this study involved the administration of Hablas and Hutzell's (1982) "Purpose In Life" questionnaire to residents upon enrolling in the treatment program and after six months of full implementation of Moral Reconation Therapy. The reason for doing this was to see if test scores increased as a client progressed in the program. The results showed that those who were more advanced in the MRT program scored higher. Another group who had spent the same amount of time in the program without being in MRT were given the test. They did not show higher scores on the "Purpose of Life" test. Therefore, the conclusion was that being enrolled in the MRT program did make a difference on achieving a higher score which reflected that those in MRT had improved their moral reasoning and had better perceptions of purpose in life. (Little and Robinson, 1989, 86-87).

In three consecutive studies, Little and Robinson (1990, 1991 and 1993 with Burnette) conducted computer searches of Shelby County arrest and conviction reports looking for the 115 treated clients and 65 control subjects. These were all persons that had
been incarcerated at the Shelby County Correctional Center. The control subjects were persons who had not been enrolled in MRT. When the data were collected the results showed that those clients who had been in MRT had fewer arrests for all offenses and had been incarcerated for fewer number of days than the control group. The studies also showed that those who completed a greater number of steps and attended after-care had less arrests and less incarceration of any kind. The studies clearly showed that those clients who participated more in the program seemed to avoid arrest and incarceration up to five years after the initial MRT program. In all of the studies there does seem to be proof that participation in the MRT program does effect behavior.

There are several weaknesses with the evaluation research on MRT. The first is that it was conducted by the people who created MRT. At present there is no data available to duplicate or dispute the results of these studies. Additionally the journal they are published in is not peer reviewed. The evaluation provides some of the theoretical basis of Moral Reconciliation Therapy, the discussion is extremely vague and the reader has to guess which part of each theory matches with specific concepts in MRT. One other weakness is that in the research articles they name two tests used to measure the effectiveness of MRT: the "Purpose of Life" test and the "Defining Issues Test" but they do not include any information to tell whether these are considered valid and reliable.

Perceptions of MRT

In preparing to interview the staff and residents at the Butte Pre-Release Center, I attended MRT groups for several months, attempting to learn more about the program and
become acquainted. I requested permission from management to conduct interviews and assured them that all interviews would be anonymous. I showed them what questions would be asked and explained that I was not interested in personal information that could be harmful to the residents or the employees. I also explained that if anyone wished to refuse or terminate an interview, they could do so at any time. Both staff and residents are aware that a copy of my professional paper will be available to read at the end of this study.

My interviews were gathered through a convenience sample by going to the MRT group and asking the residents to answer questions. Each counselor asked their MRT group if it would be acceptable for me to attend and to interview them. All of the groups were very cooperative, so most of the resident interviews were done in this manner. I only had a few residents who refused to participate. In the group setting, I would ask a question and then work my way around the room writing down responses. A few residents were interviewed individually as they had completed the program and I wanted their insights also. In all I interviewed 17 female and 18 male residents, 7 facilitating staff and 6 other staff members. The staff interviews were done on a one-on-one basis. It was not always easy to catch these people as they worked varying schedules, but this setting seemed the most conducive to getting the information I needed. After watching how the program worked it seemed best to base my study on the personal interviews I conducted with the staff to find out their individual styles and feelings about the MRT program. I felt that a few residents were just saying what they thought I wanted to hear but for the most part their answers were honest and open. This is an honesty program and the residents had no reason to lie to me. They would not gain anything from it. The facilitators were not present at all times and it did not
seem to change the residents' responses. In the Butte Pre-Release the residents learn that if they make a mistake and admit it they will do much better than lying about it. Lying is also a violation of the center rules. Most of the residents answered the questions in MRT group and their peers will not let them get away with lying. This population would probably not fill out a written questionnaire unless it was mandatory.

Interviewing the staff and residents at the Butte Pre-Release Center gave me many insights into their perceptions of MRT. I interviewed the residents who were currently participating in the program and some who had completed the program. The staff interviewed were facilitators of the program and other staff who work with the residents on a daily basis. All interviews were anonymous and everyone was assured that their answers would in no way hurt their program or job status.

**Resident Interviews**

I asked the residents three basic questions: "How do you feel MRT helps you, if it does?", "Would you have done the MRT program if it were not mandatory?" and "What step do you feel was the most important to you?" Answers varied with the respondents' progress in the program, and men and women perceived the program differently. Even though there are three times as many men at the center as women, I interviewed about equal numbers for my study. The women I observed in the group seemed more open than the men. They tended to be able to show their feelings more, especially when discussing their personal relationships. The men were much more reserved in showing their feelings, and seemed to internalize a lot of the program's ideas. They are willing to admit that the program has helped
them but have difficulty in describing how this has happened. An example of some basic differences between the males and females was in their description of Step 5. In this step the residents discuss the best of times and worst of times. Women tend to talk about the great emotional value of experiences or traumas they have had. Men on the other hand described their best and worst of times in more gain and loss terms. If men had a best time it was when they acquired things, including wives and children. Women describe all of their steps more emotionally. This may be due to having to present in front of their peers and males in our society are taught not to show any weakness, especially in this setting. The staff seems to feel that the female residents take the program much more seriously than the male residents. I cannot describe specific incidents of my observations of the differences between males and females because what happens in MRT group is considered confidential and does not leave the group room. A very important part of all of the group process is trust, confidentiality and peer honesty.

To the question "How do you feel MRT helps you, if it does?" the responses indicated that the program made them look at the past honestly, understand what they were responsible for, and plan for the future. In many instances the respondents who were farther into the program said that they had learned to acknowledge that they are responsible for their own behaviors. For some it has helped to improve family relationships, learn honesty and to take a hard look at themselves. Residents in the later steps are better able to set realistic goals. The residents in the more advanced steps talk more about what they can do in forms of living within a budget and with actual jobs they are holding. They also discuss saving money and how they have learned to think before acting on impulses to just spend money. If going on
to school is their goal some of the people in the first steps say they are going to go to college without thinking out the steps it takes. Those in the more advanced steps have learned they must first have certain requirements fulfilled such as a high school diploma or its equivalent. MRT has helped some residents become more aware of their inner self and to learn to live a gainful life. For many residents as they progress along the steps, deeply buried episodes from their past come up and must be dealt with before they are able to become emotionally stable enough to advance with their plans. Residents learn patience and not to expect immediate gratification, as evidenced by their working and having to wait for a paycheck and knowing that if they follow the rules they will be free. Numerous references were made to learning anger management and learning to better control their emotions. Sometimes the residents have learned how important it is to help others and how good it can make them feel about themselves. This increase in self-esteem shows in all aspects of their life, including work and personal relationships.

There are some residents who feel the program has not helped them at all and that it is a waste of their time. In their responses they indicated their time would be better spent out working or doing as they pleased. One respondent who had felt like this originally said that if a person stops fighting the program, eventually they may get something out of it. Since it is mandatory they really have no choice and might as well do it.

The next question I asked, "Would you have done the MRT program if it were not mandatory?" had some interesting responses. Some respondents answered affirmatively but qualified their answers by stipulating that they would have done so only if their stays could have been shortened. Most of the female residents said they would, because word of mouth
describes it as such a good program. Many male residents said they would not, but about a third of them who were at higher steps in the program said they would because they had come to realize how much it had helped them.

The third question to the residents was: "Which step or steps were most helpful?" As well as indicating a step choice, most residents also told me why their choice was the most helpful. Step 4 was overwhelmingly mentioned the most often. In this step the residents have to write down everything they do for an entire week and show exactly how they spend their time. It is a tedious process and was difficult for many of them, but they were amazed at how much time they wasted and what they could do to change their habits. Many of the new residents noted that Step 1 helped them realize that they must own up to what they have done because they have to testify in front of their peers and give an honest accounting of themselves. Many of them do not pass this step the first time and have to repeat it. Steps 2 and 3 are often listed along with Step 1 as being the most important, because there is a feeling that once they are past these three steps they have started the climb up. Step 5 was mentioned by some of the residents as difficult because they had to look at their best times and worst times and analyze each situation in front of their peers. For many of the residents Step 7 is also very important because they have never learned how to set reasonable goals for themselves. Many of the residents feel that the steps that forced them to do community service are necessary because often they have done things only for themselves and for their own personal gain.

Those who had completed the program had differing opinions. When I asked them if they thought that MRT would be useful, some responded that they still find themselves
thinking about what they learned in MRT. Residents who have completed the program and receive a write-up while still at the Center have to repeat some MRT steps. Some of my respondents were currently doing this at the time of my interviews.

**Interviews with the Facilitating Staff**

In my interviews with the facilitating staff I asked what training was necessary to run MRT groups. They explained that they had to attend a 40-hour course designed and implemented by the originators of the program, Little and Robinson. There are eight staff at the Center trained to do MRT and currently there are three counselors who hold groups along with other facilitators who help or fill in when they are gone. Each of the three counselors has at least two groups that meet twice a week. The counselors each have different styles but follow the MRT program closely. Residents choose or are assigned to MRT as their schedules will allow. MRT is very confrontational, so it takes a very strong person to facilitate the groups.

One of the most interesting questions that I asked the staff was "Why is MRT effective with this population?" The staff feel that it works with this population because it is cognitive and most of these people have problems with not being able to make moral decisions. MRT works for anti-social persons by working on the inner self, which for many reasons never developed quite right in this population. They know the differences between right and wrong but often choose to do wrong and blame others. The staff feels that it makes the residents stop and take time to be aware of their past behavior and appreciate how they can move on from there. The majority of the facilitators feel that if the residents want to
really "work the program" they will benefit from it. It teaches responsibility for their own behaviors and teaches them that they are not victims. It is effective because the residents have to be honest or the group and counselors will not pass them on to the next step. On steps that have to be presented to the group, residents often are grilled during the question and answer phase and if the group feels the person is being dishonest or has not done the step properly they will flunk them.

Another question I asked the facilitating staff was: "Do you see a lot of difference in residents as they advance in the program?" Most of the facilitators feel that as the residents work through the program they begin to see a change in attitude but this also relates to their commitment to change and the program. In the male residents the staff feel that these changes are very difficult to see but through their homework and testimonies in group some changes become evident over time. Some counselors also realize that the residents may be just conning them. Homework can be bought and the residents may only be saying what they feel the counselor wants to hear in groups and one-on-ones. The basic answer to this question was, "if the resident wants to change then the program will help them to do this."

The other question I asked the facilitators was "What steps do you feel are the most important or is each resident different?" The facilitators feel that Step 4 is one of the most important because the residents have never looked at how their time is spent and what they could be doing with their time. It is also at this step that residents complain the most. Step 1 is also one of the more difficult steps to get over for residents, as they are brand new to a group of strangers and have to stand in front of their peers and talk about themselves honestly. Step 8 is very difficult also because many of these people have never made realistic
goals and plans for life that they can stick to. One of the facilitating staff said that Step 1 is very beneficial because residents have to go back and redo several of the previous steps and it is amazing the differences that show up. One facilitator told me that flunking a step can be very beneficial, since residents learn that they cannot get away with anything and have to be honest.

The facilitators also talked about the differences in women's and men's views of MRT. Women tend to get very emotional and men get very nervous during some of the steps they have to present in groups. The women relate many of their steps more toward family and relationships, while the men gravitate toward work, then family and then personal relationships. The men do not participate as openly as the women and sometimes responses have to be dragged out of them. The facilitators feel that most of the men do not take the program as seriously as the women but still benefit a great deal from having to do it.

**Interviews with Other Staff**

In talking to the staff who do not facilitate MRT, but work with the residents daily, I asked whether residents' participation in MRT seems to change their behavior at the Center. In most cases the staff said that they were aware of changes as time went by but this could be due to the resident becoming used to the program, getting a job or accepting their situation. In some cases there were obvious changes that they could attribute to the resident being in MRT, but usually these residents were also doing other things to help to improve their lives. I asked the staff if they were aware of what step the residents were on. It seemed
the most obvious one was when they had to do community service hours for MRT because they would have to arrange for this and the staff would know where they were. Otherwise, the staff does not pay particular attention to MRT status. I also asked the staff if the residents talked about MRT with them and some said the residents do discuss what they have to do at times and ask for help but the staff cannot really help them because they are untrained other than helping them to spell on their homework.

In talking to staff that do other programs such as chemical dependency counseling it is interesting to note that there seem to be steps in MRT that help to make doing the chemical dependency program easier. Chemical dependency goes better for those residents who have completed Steps 1, 2 and 3, in one counselor's opinion, just because they have had to deal with becoming open, honest and trustworthy. They have learned to trust a group a little better which carries through to their chemical dependency groups as well.

**Conclusions**

The majority of the staff and residents of the Butte Pre-Release Center have positive perceptions of MRT. Overall the staff and residents seem to agree that MRT is a useful program for helping residents to build honesty, and allowing them to understand what they can do to change their lives and to learn how to think before acting. Some of the residents who have been through other programs while incarcerated say it is one of the better ones they have been involved with because it addresses the needs of the adult criminal population.

MRT at the Butte Pre-Release Center is used as a tool for therapy and also as a means of discipline. When a resident receives a "write-up" and has to repeat certain steps, it helps
him/her to understand better what he/she did wrong. They have to talk about what they did in group, in front of their peers and hopefully this will help them to think about their behavior.

This study found that Moral Reconation Therapy helps residents to understand that they have learned to make incorrect moral decisions and, as a result, their actions are wrong and sometimes illegal. They learn that they are manipulative of others because they are starved for some form of security. The residents also learn that the only gratification they understand is either avoiding punishment or gaining pleasure. They live in a world where backscratching or "you scratch mine and I'll scratch yours" is all they can understand.

MRT residents work through the walls and prisons they have built in their minds, especially the wall between the self and reality. It teaches them that they cannot blame others for their own problems and that they alone are responsible for their behavior. It also looks honestly at the past, but unlike some other forms of therapy it does not let them dwell there. The resident has to move on, try to change and leave their excess "baggage" behind. They have to develop healthier attitudes toward family, friends and authority figures.

The most difficult obstacle for the residents was admitting having a problem. In some cases the resident may insist that they are not a criminal, even though they will admit to having done criminal acts. They may get in trouble on a weekly basis but still fail to see that they are not getting anywhere and let the program work.

There are some people, however, who insist that the program is useless and seems to hold residents back. In the Butte Pre-Release Center the residents who are there for Federal crimes do not always finish the program because they only serve a certain amount of time and
cannot be held for extra time to finish the MRT program. If they are there for a short time it is fairly certain they will not finish the program, but they are the only ones who do not. All other residents must complete MRT as part of the treatment program in order to be released from the Center. Residents cannot be forced to participate and may do the steps as slowly as they wish. They are encouraged by the counselor and the group to complete treatment but some residents refuse and just come because they are required. It is hoped that sooner or later these individuals will realize the benefits of the program and finish.

Some residents do not take the program seriously but do the steps and manage to be passed by their peers through the program. As with all things in life you get out of MRT what you put into it.

Conceptually and theoretically, MRT seems to suffer from some missing pieces. In certain instances there are parts that have been derived from other sources that the originators fail to mention. There are parts of the therapy that show a strong resemblance to Rational Emotive Therapy (RET) and this is not even acknowledged. RET has been practiced for almost thirty years. Its main goal is for the clients to achieve a new philosophical outlook. After the client has been confronted by their own irrational ideas, a distinct confrontational therapeutic attitude is used. RET teaches troubled individuals to think before acting. In RET terminology they learn to understand and employ the "logico-empirical method" of thinking, feeling and behaving (Ellis, 1962). This sounds a lot like MRT, especially in the literature about re-thinking and changing to enhanced moral reasoning. There is one difference: RET has primarily been used with psychotherapy and MRT was developed for the adult criminal population.
Another general criticism of the MRT program is that Little and Robinson tend to view everything in behavioral terms. From a sociological perspective, there are significant social factors this program does not address. Little and Robinson ignore social factors that have been associated with criminality. For example, they do not take into account socio-economic status, gender, ethnicity or family background. Since there have been numerous studies that demonstrate that these have an impact on criminality. There should be some mention of these factors in their research or theories.

**Recommendations**

MRT has been in use at the Butte Pre-Release Center for two years and there has been some discussion surrounding its success, however, at this time there are no data to show the program's effectiveness. Some recommendations for an evaluation of the program would be to follow Little and Robinson's example and look at arrest rates and number of days incarcerated for people that have completed the MRT program. A control population would need to be found, perhaps in a pre-release center that does not use MRT. If the evaluation research were done without a control group, perhaps a partial study could be done repeating Little and Robinson's study which looked at whether completion of MRT is associated with fewer arrests and number of days incarcerated.

Evaluation also must be done of the use of MRT as a disciplinary device. Residents often have to repeat steps for disciplinary purposes. Effectiveness could be measured by frequency of program rule infringement. In this study there were several cases where the
residents repeated Step 3 more than five times. Such a study would involve considering why certain residents do not seem to improve after they have completed MRT.

The present study found marked differences in how males and females view MRT. This finding suggests possible differences in program effectiveness between the males and females. These differences could be explored through a variety of measures such as differences in program completion rates, differences in active group participation and differences in post-treatment arrest rates.

MRT could also be evaluated by considering whether completion of MRT has an effect on social adjustment as measured by rates of gainful employment and whether they have improved their lifestyle on the outside. Such evaluation is important because even though those who complete MRT may not have been arrested or incarcerated, they may not be living productive lifestyles. In a similar way, participants and those who complete MRT could be assessed in terms of improved personal and family relationships. MRT is supposed to help a person with all aspects of life. As can be seen, the evaluation studies that have been done in the past were rather narrow in their scope.
References


