Tri-County Batterer Intervention Provider Network Meeting Minutes June 9, **2015**

Present: Jacquie Pancoast (Eastside Concern), Rachel Smith (Portland State University), Krystal Duff (Bridges 2 Safety), Matt Johnston (Domestic Violence Safe Dialogue), Jacob Hunt (Eastside Concern), Diana Groener (Allies in Change/Sunset Counseling/A Work in Progress), Sand Rorick (Multnomah County DCJ-DV Unit), Samantha Naliboff (VOA Home Free), Linda Castaneda (Manley Interventions), Guruseva Mason, Shannon Barkley (Clackamas County Community Corrections), Chris Huffine (Allies in Change)

Minutes by Rachel Smith, edited by Chris Huffine

Topic: Presentation on Moral Reconation Therapy DV specific curriculum (MRT-DV)

Presentation by Krystal Duff. Please refer to the attached PowerPoint presentation for additional information. Shannon Barkley has also attended a training on MRT-DV and contributed significantly to this discussion.

MRT is very similar to cognitive behavioral therapy (CBT) in terms of changing the way people think about themselves and the world. MRT was developed by Greg Little and Kenneth Robinson in 1985 for substance abuse issues in prisons. MRT-DV was developed in 1994 and revised in 2000. The newest program that the MRT developers are working on now is related to trauma/childhood trauma, which is basically a CBT program for criminal justice offenders. MRT is based on the Stages of Development framework (Erikson) wherein achievements are required to move through stages of development.

The curriculum has been translated for use with Spanish-speaking groups, and has been implemented in Puerto Rico.

“Reconation” is a made up word. It is intended to refer to changing the way a person makes their decisions.

The goal is to advance a client's level of moral reasoning from more hedonistic (e.g., pleasure vs. pain) to concern for the greater social good.

The evidence of effectiveness is based on the general MRT curriculum, not the DV specific version.

Discussion

One of the biggest criticisms of MRT is that very little, if any, *independent* evaluation research has been conducted regarding evidence of MRT's effectiveness.

Another major criticism is that the curriculum is supposed to be implemented without any variation or modification. For example, so long as the BI participants write in the acceptable

answers on the homework according to the curriculum, then it is a correct answer and cannot be challenged. This makes it easier to “fake good”—give the “correct” answers without necessarily believing them or applying the underlying principles in one’s actual life. There are issues with the rigidity presented in the training specific to facilitators' roles (e.g., pass/fail approach), which presents some behaviors that facilitators here would actually discourage among their clients, let alone engage in those behaviors themselves. There’s no room for responsivity—which appears to contradict the RNR (risk/needs/responsivity) model which is now being more heavily promoted in general.

While MRT people say the curriculum is in line with BIP standards, in reality it likely is not in every state. It is not fully in line with the Oregon state standards, for example.

The general consensus of those present, who were also able to review the manual/curriculum is that MRT-DV appears to be based on traditional anger management concepts and stereotypes and not particularly well informed about domestic violence. For example, there appears to be a (false) assumption that DV perpetrators are also substance abusers.

It makes several claims that are not backed by evidence (despite it being "evidence based") and perpetuates several problematic myths that ultimately present hefty barriers to this work. It is also specific to criminogenic needs, which is not necessarily the only populations we serve.

The claim stated in the curriculum that "All DV is illegal" is a bit misleading, given that, in fact not all behaviors that fall under the definition of intimate partner abuse are technically illegal, and the illegality of intimate partner abuse is not consistently enforced. Also, what the curriculum calls "pre-violence" is actually a part of the core pieces of abuse.

On page 42 of the curriculum states that "99% of DV acts occur out of a fit of anger", which contradicts one of the core underlying theories of cause among BI providers.

The curriculum does not seem to necessarily encourage changing behaviors via clients' own intrinsic motivations. When clients do not do their homework, they just stay longer. How can group members educate each other and grow as a group if they cannot challenge each others' core beliefs, etc.? There seems to be a focus on the rules rather than on thinking and on core beliefs that drive abusive behaviors.

The publication they provided for distributing to survivors may be problematic. Chris suggested a 2-pager for survivors of abuse from men adopted from the Emerge program.

The dynamics of abuse are so much more complex than what is represented in this curriculum. As facilitators, it is our responsibility to make observations about where our clients are and work with them where they are at, rather than pushing them through to a next level that they are not ready for yet. Being curious and inquisitive, rather than making demands and directives, as the MRT curriculum appears to advocate. Ask genuine, rather than authoritative, questions that help facilitators understand what's keeping clients from doing the work.

The earliest DV programs (e.g., Duluth, Men's Resource Center in Portland, and others) typically started with a traditional anger management approach. However all of these programs had two other key factors in common (which MRT-DV does not)—they talked with and listened to the abused partners and also consulted with DV advocates. As a result these programs realized, back in the 80's, that a traditional anger management curriculum was not adequate for working with abusive partners. The MRT-DV curriculum does not appear to have realized this or adequately drawn on the collective wisdom and experience of abused partners, their advocates, and programs that have been working with abusive partners for decades—and it shows.

It was mentioned that a similar curriculum that has empirical support for working with a non-DV population and has been quickly, superficially, and ignorantly adapted to work with a DV population is the DV version of Acceptance and Commitment Therapy (i.e., ACT-V). On the surface it appears to be a strong curriculum, but it does not address power and control and gender-based issues. Both MRT-DV and ACT-V are being aggressively marketed as DV specific curriculums even though it's apparent they haven't really done adequate program development for these specialized curriculums.

The curriculum may have issues, but the way they talk about the group setting and facilitators role may be beneficial in our work. Also, the MRT training itself was very beneficial and much of the content is beneficial to this work, but it is likely not a good standalone program.