

Treatment Alternatives for Mentally Disordered Offenders: A Literature Review

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Over the last few decades, a considerable amount of research has been devoted to mentally disordered offenders (MDOs), with both theoretical and empirically validated treatments permeating the literature. Due to the recent onslaught of treatment options for MDOs, a synthesis of this literature seems immediately relevant to the field of forensic psychology. The authors review the current status of the treatment literature for both sentenced and nonsentenced MDOs in both inpatient and outpatient settings. An exhaustive search of the available literature on MDO treatment options was conducted. Ten treatment modalities, both theoretical and empirically validated, were summarized, including their theoretical underpinnings, interventions, empirical support, and strengths and weaknesses. Issues surrounding future research are also discussed.

Keywords: Mentally Disordered Offender, Empirically Validated Treatment, Evidence Based Treatment, Forensic Psychology

Introduction

The moniker “evidence based” has become synonymous with the acceptable standard of psychological care in facilities that maintain and treat mentally disordered offenders (MDOs). Despite the widespread recognition of evidence based treatments, there is a shocking lack of empirical research on which psychological treatments work best for this complex population. This major gap in the research is particularly troubling given the large number of MDOs in correctional and forensic facilities throughout the world. In 2004, one of the authors set out to conduct a meta-analysis on evidence based treatments for MDOs, and found only a handful of research studies suitable for quantitative analysis (Welsh, Ashby, Glassmire, Love, Tavaglia, & Warke, 2004). Most of the existing studies were either poorly controlled, did not report sufficient statistical information to conduct a meta-analysis, or did not adequately define the treatment or treatment population. Nevertheless, three treatments were identified that had a weak to moderate evidence base—behavioral therapy, cognitive therapy, and therapeutic community. Since then, there has been additional research conducted on interventions for MDOs, and new promising treatments have emerged. Thus, we provide an updated review of the aforementioned treatments, and discuss new and emerging treatments that hold particular promise for MDOs.

Mentally Disordered Offenders

Mentally disordered offenders (MDOs)—defined broadly in this article as individuals with a serious Axis I mental disorder or Axis II personality disorder being treated in an inpatient or outpatient correctional or forensic facility—are an exceedingly complex population to conceptualize and treat. Such individuals present for treatment with a dizzying array of target concerns, including psychiatric diagnoses, substance abuse histories,

unique offense characteristics, and high risk and potentially dangerous behavior (Rice & Harris, 1997).

The treatment needs of MDOs are largely governed by their legal status, which statutorily defines their goals for treatment. For example, the treatment needs of an insanity acquittee are notably different from a defendant receiving competency restoration treatment—the chief concern for the court in the insanity acquittee is suitability for outpatient treatment and risk management, whereas the goal for the defendant remanded for competency restoration is trial competency. Mentally disordered offenders also have treatment needs that are related to their offense characteristics—a patient in treatment for domestic violence will have different treatment needs than a patient who is a serial arsonist. Finally, the treatment goals for MDOs will differ with respect to their broad range of psychiatric diagnoses—the review conducted by Welsh and colleagues (2004) yielded widely discrepant psychiatric diagnoses among MDOs. As an example, an acutely psychotic patient will have different treatment needs than a depressed patient with a substance abuse problem.

In spite of this heterogeneity, many forensic institutions adopt evidence based treatments for MDOs that are validated on other populations (see, e.g., Hodel & West, 2003; Hoffman & Kluttig, 2006), leaving forensic psychologists unsure about which treatments are appropriate for MDOs (Rice & Harris, 1997). A comprehensive literature review, therefore, is currently necessary to provide forensic clinicians with an understanding of what is available in the field. In our article, we attempted to accomplish this objective in four ways. First, each MDO treatment was summarized, including theoretical underpinnings and interventions. Second, the empirical support of each treatment was reviewed to better understand current research in the field. Third, the strengths and weaknesses of each treatment were discussed. Finally, directions for future research were offered.

Method

A review of the literature was conducted to locate the available treatment options for MDOs. In our search for research, we took a liberal approach, defining MDOs as individuals who have a serious Axis I mental disorder or Axis II personality disorder and are being treated in the context of an inpatient or outpatient correctional or forensic facility. We found that much of the European and Canadian literature classified personality disorders under the MDO rubric. Thus, our goal was to cast a net as widely as possible to include treatments that are used worldwide with individuals who are classified as MDOs. However, we fully realize that including personality disorders might potentially capture the vast amount of correctional treatment literature in which the participants are primarily diagnosed with antisocial personality disorder. Because of the breadth of this existing literature, we intentionally excluded empirical research focused solely on criminal populations diagnosed with antisocial personality disorder. In a similar vein, we did not include treatment literature that focuses exclusively on sex offender treatment, substance abuse treatment, or competency restoration treatment—these areas are adequately covered in other literature reviews.

We located treatments through several electronic databases of journal articles, including *PsycINFO*, *ProQuest*, and the *Social Sciences Citation Index*, as well as journals, abstracts, and reference sections of review articles. Treatments were included if they offered a clear and specific treatment option with detailed interventions for MDOs. Both empirically validated and theoretical treatments were identified and included in the present review. Unpublished papers and doctoral dissertations were excluded.

Results

In the following section, we provided an overview of the ten treatments located within the MDO literature, specifically focusing on the theoretical underpinnings, interventions, empirical support, and strengths and weaknesses of each treatment.

Behavioral Therapy

According to Spiegler (1983), behavioral therapy focuses solely on behaviors that can be directly observed, emphasizing psycho-education, self-control skills, and action. There are a plethora of behavior therapies, including positive reinforcement, modeling, cognitive restructuring, shaping, systematic desensitization, and stimulus control (Spiegler, 1983). Overall, behavior therapists are interested in changing overt behavior, and tend to de-emphasize internal processes (Spiegler, 1983).

Behavioral therapy applied to MDOs can take on many forms, including social skills training, social learning programs, and token economy programs (Rice, 1983). As an example, both Rice and Chaplin (1979) and Rice (1983) describe social skills training programs for MDOs that include behavior rehearsal, modeling, coaching, instructions, feedback from group members and therapists, and homework assignments. A common focus among these programs seems to be the improvement of interpersonal skills.

Goodness and Renfro (2002) implemented a social learning

program at a maximum-security forensic unit, which included applying social learning principles to staff-patient interactions and observing patient activities to identify both interaction problems and useful dangerousness management strategies. Furthermore, modeling, reinforcement, shaping, overlearning, and generalization were utilized in the program, with *tokens* used to increase pro-social behaviors (Goodness & Renfro, 2002).

Regarding token economy programs, Rice, Quinsey, and Houghton (1990) suggest they should be designed to shape offender behavior so as to increase pro-social behavior and decrease antisocial behavior. One of the characteristics of token economies is for patients to be rewarded, or reinforced, when they exhibit good behavior by increasing their privileges (Rice et al., 1990). Conversely, fines may be administered when patients misbehave, taking the form of decreased privileges (Rice et al., 1990). Ultimately, token economy programs rely on positive and negative reinforcement to promote change among offenders.

In terms of the treatment efficacy of behavioral therapy with MDO populations, numerous studies have demonstrated its utility in teaching social skills (Rice, 1983; MacKain & Streveler, 1990). Moreover, evidence based treatment manuals for MDOs have emerged that emphasize problem solving skills (Ross, Fabiano, & Ewles, 1988). Although many studies have examined the efficacy of behavioral interventions for MDOs, to the authors' knowledge, no meta-analyses have been conducted. Further research is needed in order to understand the overall efficacy of behavioral interventions for MDOs.

When examining the strengths of behavioral therapy for MDOs, it becomes immediately clear that a focus on the behavior of offenders is important. With this being the case, one of the strong suits of behavioral therapy is its focus on tangible and concrete behavioral changes through interventions such as social skills training and token economies. Antisocial behavior must be changed in order for MDOs to better deal with conflict in society. With a focus on measurable behaviors, behavioral therapy allows clinicians the opportunity to see progress, and research can be conducted that clearly measures its efficacy. To date, behavioral therapy is one of the most researched MDO treatment options (see Rice, 1983; MacKain & Streveler, 1990), which improves its position among the established MDO interventions.

Among the weaknesses of behavioral therapy is that it has been mainly applied to civil populations—only in the last few decades has behavioral therapy emerged as an intervention for MDOs. As such, the heterogeneity of MDO populations is not addressed as thoroughly as with some of the other forms of MDO treatment (e.g., therapeutic community, assertive community treatment). And although behavioral therapy focuses on salient offender issues such as social skills and problem solving, it may lack a more comprehensive approach in that it fails to address idiosyncratic demographic variables such as type of criminal act committed and disorder. Nevertheless, overall, behavioral therapy appears to be a solid intervention with well-established efficacy for MDO populations.

Cognitive Behavioral Therapy

According to Steiman and Dobson (2002), cognitive behavioral therapy (CBT) is a blanket term for both cognitive and

behavioral interventions. These therapies share an understanding that cognitions, or thoughts, play a central role in the etiology, maintenance, and treatment of mental illness (Steiman & Dobson, 2002). Steiman and Dobson explain that cognitive restructuring, coping skills therapies, and problem solving therapies all fall under the heading of CBT. Ultimately, the differing CBT interventions vary mainly in their focus on cognitive versus behavioral elements of treatment (Steiman & Dobson, 2002).

Cognitive behavioral therapy is a widely used form of treatment for MDOs. In fact, numerous meta-analyses of CBT for MDOs have emerged over the last few decades (see, e.g., Lipton, Pearson, Cleland, & Yee, 2002). What is more, CBT has been used for a wide variety of offender dysfunctions, including anger management for violent offenders (Renwick, Black, & Ramm, 1997), and coping skills for personality disordered offenders (Clarke & Ndegwa, 2006). Lipton, Pearson, Cleland, and Yee (2002) highlight that CBT is especially useful in addressing recidivistic behavior—MDOs, according to CBT, have learned unacceptable behaviors and have failed to develop important cognitive skills (Lipton et al., 2002). Among the techniques used by CBT for MDOs are problem solving training, social skills training, and pro-social modeling with positive reinforcement (Lipton et al., 2002).

Jones and Hollin (2004) employed a manualized CBT training program for MDOs that focused on the cognitive, arousal, and behavioral elements of anger. Specifically, the program involved arousal reduction techniques, cognitive restructuring, and behavioral skills to respond to cues that previously brought on an aggressive response. Timmerman and Emmelkamp (2005) describe a CBT program for MDOs that incorporated behavioral modification principles such as reinforcement, shaping, modeling, and giving time outs, along with cognitive principles such as challenging distorted thoughts.

Specific to CBT for MDOs seems to be the amalgamation of both cognitive (e.g., disputing distorted beliefs, improving cognitive skills) and behavioral (e.g., reinforcement, social learning theory) principles. Although many of the programs adhering to a CBT approach offer program-specific, individually tailored approaches, the fundamental principles of CBT seem to be practiced by most programs that use CBT interventions for MDOs.

Empirically validated research with CBT for MDOs has been consistent in recent years (Hodel & West, 2003; Timmerman & Emmelkamp, 2005). Multiple studies have shown that CBT is efficacious in terms of improved cognitive skills (Hodel & West, 2003) and a reduction in psychopathological symptoms (Timmerman & Emmelkamp, 2005). Additionally, manualized cognitive skills programs have recently been compared to understand the efficacy of CBT for MDOs (Blud & Travers, 2001). Although meta-analyses have been conducted with CBT (Lipton, Pearson, Cleland, & Yee, 2002), more specific research needs to be conducted in order to better understand the heterogeneous needs of MDO populations.

Among the strengths of CBT is its focus on both the cognitive and behavioral components of the offender. CBT offers offenders the ability to ameliorate coping skills and address anger management issues, and provides pro-social modeling and problem solving skills training. Matters surrounding anger, coping, and adaptive and positive social behavior must be ad-

ressed with MDOs. CBT adequately tackles these issues, and helps the offender use effective tools to dispute distorted beliefs and embrace acceptable behavior in an attempt to reduce recidivism. In addition, CBT for MDOs is empirically supported in the literature (Hodel & West, 2003), and familiar among various psychological fields and populations. Overall, CBT provides offenders with tangible and effective tools to address the multiple layers of dysfunction they must ameliorate in order to rehabilitate and prevent recidivism.

Some of the weaknesses of CBT for MDOs surround its lack of a focus on the heterogeneous needs of offenders. Particularly, CBT fails to address issues surrounding the specific type of offense and disorder. For example, although Hodel and West (2003) implemented a cognitive training program for mentally ill offenders with schizophrenia, the specific criminal act committed was not addressed or focused on. As another example, Fleck, Thompson, and Narroway (2001) employed a problem solving skills training program for MDOs that neglected to address the specific crime committed (e.g., arson, sexual offense, murder, armed robbery, grievous bodily harm, and burglary). Along with specific criminal act committed, disorders commonly fail to be a focus of attention within the MDO literature (see Timmerman & Emmelkamp, 2005). Instead, MDOs tend to be lumped together regardless of type of disorder or criminal act committed. Since it is still relatively unknown what the relationship between offense and disorder is, more specific interventions tailored to the idiosyncratic needs of MDO populations must be developed in order to address their heterogeneous needs.

Cognitive Analytic Therapy

According to Pollock and Stowell-Smith (2006), cognitive analytic therapy (CAT) combines concepts from psychoanalytic, cognitive, and personal construct theory, and is a relational form of therapy. Central to CAT are self-processes, which are an internalized system of self-other relationship patterns (Ryle & Fawkes, 2007). Early negative interpersonal events can lead to a negative system of self-other relationship patterns, which CAT calls reciprocal role procedures (RRPs) (Ryle & Fawkes, 2007). Fundamentally, the goal of CAT is to change these negative self-other relationship patterns into more positive internalized experiences.

The application of CAT to offenders can be traced back to the 1990s, when CAT therapists first suggested that the actions of MDOs stem from RRP (Pollock & Stowell-Smith, 2006). The CAT therapeutic process for offenders involves three major phases. First, within the reformation phase, the therapist gets a detailed client history (Pollock & Stowell-Smith, 2006). Also in this phase, a *reformation letter* is created, which is written by the therapist to communicate his or her beliefs about the internal and external processes of the offender and serves as an agreement about the work to be done (Pollock & Stowell-Smith, 2006). Ultimately, the letter helps to communicate to the patient his or symptoms, pattern of relating, and difficulties (Pollock & Belshaw, 1998). Second, within the recognition phase, the therapist and client go over central themes and agree on homework assignments between sessions (Pollock & Stowell-Smith, 2006). Third, within the revision phase, the therapist helps the client to improve his or her thinking, feeling, and behaving (Pollock & Stowell-Smith, 2006). Lastly, termination is worked

towards in the CAT treatment process (Pollock & Stowell-Smith, 2006).

Pollock and Belshaw (1998) note that interventions used for offenders include the analysis of transference and countertransference in order to effectively manage the potential for harm. In addition, helping the offender to identify with the victim (e.g., helplessness, vulnerability) is crucial with certain types of offenders such as murderers (Pollock & Belshaw, 1998).

Multiple studies have examined the efficacy of CAT in forensic populations (Cowmeadow, 1994; Duignan & Mitzman, 1994; Golyunkina & Ryle, 2000; Pollock & Belshaw, 1998). Unfortunately, these studies were either case studies or lacked controlled samples. And although some of these studies reported a significant reduction in symptoms (Duignan & Mitzman, 1994), the empirical validation of CAT through a controlled study is still lacking. In essence, CAT is successful with general psychotherapy, but has not been empirically supported in the forensic literature (Pollock & Stowell-Smith, 2006).

When looking at the strengths of CAT, it becomes immediately apparent that the conceptualization process emerges as a strong point. Heuristics such as reciprocal role procedures (RRPs) allow the clinician to better understand the intrapsychic process and structure of the offender in an attempt to identify the etiology of dysfunction. In addition, CAT focuses on the relationship between offender and victim, which promotes empathy and addresses issues surrounding the prevention of recidivism. Overall, the interpersonal dimension of CAT sets it apart from some of the other MDO treatments, and better helps offenders relate to others in new and positive ways.

Some of the weaknesses of CAT for MDOs include its lack of empirical validation. Although case studies and theoretical articles have materialized (see Pollock & Belshaw, 1998), empirically validated CAT interventions for MDOs are still needed. Also, although CAT addresses the interpersonal component of criminal behavior, it fails to emphasize the heterogeneous needs of MDOs. Moreover, usable coping skills appear to be lacking with CAT applied to MDOs. Offenders may benefit from tangible interventions that can be carried over with them into the real world. Overall, CAT offers more of an interpersonal experience, combined with insight, than it does specific tools offenders can use to dispute distorted beliefs and decrease maladaptive behaviors.

Dialectical Behavior Therapy

Dialectical behavior therapy was originally developed as an intervention for women with borderline personality disorder, and has since been applied to other treatment populations (Robins & Chapman, 2004). According to Fruzzetti (2002), the goal of DBT is to help clients create a life worth living according to their own values, which is done by aligning the stages of treatment with the stages of the disorder.

In recent years, DBT has been applied to forensic populations, addressing the high frequency of antisocial behavior among males (Evershed, Tennant, & Boomer, 2003; Wix, 2003). DBT for MDOs also focuses on staff burnout, as well as involuntary and restricted institutional and legal demands (Evershed et al., 2003; Wix, 2003).

With regard to treatment, DBT helps patients to monitor symptoms, behavior, anger, and suicidal thoughts, providing

tools to manage behaviors such as alcohol and drug use or self-injury (Wix, 2003). Throughout treatment, the therapist builds and maintains a positive, interpersonal, validating, and collaborative relationship with the offender (Wix, 2003), helping the patient to develop new skills, address motivational obstacles, and generalize the skills to daily living (Robins & Chapman, 2004). Also, the therapist must simultaneously confront, comfort, and validate the offender (Wix, 2003). Skills training sessions are held weekly, which focus on the four DBT skill domains, including distress tolerance, interpersonal effectiveness, emotion regulation, and mindfulness (Wix, 2003).

Robins and Chapman (2004) explain that DBT has been modified for forensic populations to include behavioral targets such as interpersonal violence and homicide. Furthermore, DBT has been adjusted to incorporate testing skills acquisition of antisocial offenders with exams and role-play quizzes (Robins & Chapman, 2004). McCann, Ball, and Ivanoff (2000) argue that the DBT for forensic populations differs significantly from the original DBT model in that the patients have multiple problems and violent behaviors.

Low, Jones, and Duggan (2001) applied DBT to forensic patients in the United Kingdom to reduce self-harm behavior ($N = 10$). Each MDO was required to attend one skills training session and one individual therapy session every week. Overall, results indicated a significant reduction in self-harm behaviors from the pre-therapy to post-therapy periods (Low et al., 2001). Evershed, Tennant, and Boomer (2003) applied DBT to a group of forensic males ($N = 8$) in the United Kingdom, measuring both violent and parasuicidal behaviors. The DBT program required weekly individual and skills group sessions. Results indicated no significant difference in pre-treatment and post-treatment violent behavior (Evershed et al., 2003).

DBT research with MDO populations appears to be minimal at best (Evershed, Tennant, & Boomer, 2003; Low, Jones, & Duggan, 2001). Although DBT has been shown to be efficacious with borderline women (Linehan, Armstrong, Suarez, & Allmon, 1991), it has rarely demonstrated its efficacy with MDO populations. Authors such as Robins and Chapman (2004) have suggested that DBT has been sufficiently modified for applicability with forensic populations; still, to date, very few outcome studies have emerged. Further research is needed to ascertain the effectiveness of DBT for MDOs.

Among the strengths of DBT for MDOs is its focus on behavior and the promotion of more effective coping strategies. The ability to effectively cope with stressors is an important component to offender rehabilitation. Also, DBT for offenders focuses on treating life-threatening behavior—this is crucial in reducing the prevalence of destructive behavior within forensic settings. Most importantly, DBT for MDOs teaches how to monitor symptoms, behavior, suicidal thoughts, and anger, allowing offenders to manage their own behavior more effectively, which helps to reduce rates of recidivism.

Some of the weaknesses of DBT for MDOs include its lack of a focus on specific MDO populations. For example, Wix (2003) implemented a DBT program for MDOs in a forensic unit, but failed to address their specific disorders. Instead, Wix applied DBT to many different offender disorders (e.g., psychotic, bipolar, major depressive, personality). In addition, the specific criminal acts committed were not addressed. Another weakness of DBT centers on its lack of empirical validation.

Only a handful of studies have addressed the efficacy of DBT for MDOs. Further research is needed to better understand the role that DBT plays in reducing recidivistic and maladaptive behavior among offenders.

Therapeutic Community

According to Lipton, Pearson, Cleland, and Yee (2002), therapeutic community (TC) is a community-based residence with professional staff. McMurrin, Egan, and Ahmadi (1998) suggest that TC is based upon the idea that certain people experience problems because they cannot relate to society. Therapeutic community, therefore, attempts to ameliorate this interpersonal deficit by creating a community in which residents stay about 9 to 18 months (McMurrin et al., 1998).

With regard to TC for offenders, Ogloff, Wong, and Greenwood (1990) describe TC as an environment wherein offenders can learn to take responsibility for their behaviors through positive interactions with peers and staff. One of the main characteristics of TC is the use of work in the community. Kennard (2004) explains that TC serves as a "living-learning situation" for residents to learn alongside other residents and staff—the residents of TC are involved in the administration, food preparation, and maintenance of the facility. Additionally, TCs are organized in a hierarchical fashion, with a clear chain of command—newer residents usually start with a lower status and have to move up in rankings (Kennard, 2004). The main intervention in TC is the daily group meeting (Ogloff, Wong, & Greenwood, 1990), with the group functioning as a place for therapy and the development of unit rules. Over time, a group culture develops, acting as a positive experience for the residents, who provide support, feedback, affirmation, and instruction to one another (Lipton et al., 2002; Ogloff et al., 1990).

Van Stelle and Moberg (2004) carried out a TC program for dually diagnosed forensic patients with substance abuse and mental health disorders ($N = 212$). The program had two phases—the orientation phase and four two-month residential treatment program phases. Offenders participated in community meetings, treatment groups, and social activities each weekday during the treatment phases. Also, each offender participated in mental illness and substance abuse treatment groups, individual sessions with staff, social activities, daily living skills groups, and health, anger management, and relapse prevention groups (Van Stelle & Moberg, 2004).

Ogloff, Wong, and Greenwood (1990) employed a TC treatment program for male offenders ($N = 80$) that included nurses, a social worker, a psychologist, and a psychiatrist. The treatment involved a large therapeutic group, which met on weekdays for two hours (Ogloff et al., 1990). During the group, the patients were encouraged to share their personal problems with patients and staff, and constructive confrontations between members were supported (Ogloff et al., 1990). In addition, smaller groups were used to focus on specific problems and goals (Ogloff et al., 1990).

To date, only a handful of empirical studies have been conducted on TC for MDOs (Greeven & De Ruiter, 2004; Messina, Burdon, Hagopian, & Prendergast, 2004; Ogloff, Wong, & Greenwood, 1990; Peters, LeVasseur, & Chandler, 2004; Rice, Harris, & Cormier, 1992). Although promising, further research is needed to evaluate the efficacy of TC programs for mentally disordered offenders.

Strengths of TC applied to MDOs include its real world feel and applicability. TC allows offenders the opportunity to experience an environment in which they can learn to take responsibility for their behaviors. It is essential for offenders to learn how to positively interact with their environment in a way that will reduce the likelihood of recidivism. TC applied to MDOs allows for positive peer group influences, which may help offenders learn to better deal with stressful life circumstances and social situations. Ultimately, TC does an effective job of addressing the larger issues (e.g., positively interacting with society, healthy confrontation) that the offender must face in society.

Weaknesses of TC include its minimal amount of empirical validation. Furthermore, although TC has addressed specific types of disorders such as co-occurring disorders (e.g., mental illness and chemical abuse), and has yielded promising results in reducing criminal activity (see McKendrick, Sullivan, Banks, & Sacks, 2006), further research is needed to better understand more specific offender populations. Moreover, although TC provides offenders with a healthy real world experience, it does not emphasize specific tools to address criminal behavior. Whereas other forms of treatment such as CBT provide usable tools to offenders, TC offers more of a corrective experience through interactions with others.

Assertive Community Treatment

Lamberti, Weisman, and Faden (2004) maintain that assertive community treatment (ACT) was developed to help those with chronic mental illness who are at risk of hospitalization or homelessness function in their communities. Parker (2004) describes ACT as a community treatment team of mental health professionals that is responsible for the care of patients with severe psychiatric illnesses in their home environments, with the ACT team functioning like an inpatient treatment team—regular team meetings, a multidisciplinary staff, team responsibility, direct services, continuous availability, and a low client-to-staff ratio. Udechuku, Olver, and Hallam (2005) suggest that the main features of ACT include low caseloads (8 to 12 patients per worker), multidisciplinary teams, less than 20% part-time staff, 24-hour availability, and input from a psychiatrist.

In recent years, authors have applied ACT to MDO populations (Lamberti, Weisman, & Faden, 2004; Parker, 2004). In 2004, Lamberti and colleagues located 16 national programs that apply ACT to MDOs in an attempt to prevent recurring arrest and incarceration. Overall, ACT for MDOs seems to function in the same way as it does for mentally disordered civil populations.

With regard to ACT research, only a handful of studies have examined ACT with forensic populations (Lamberti, Weisman, & Faden, 2004; Parker, 2004). Although Parker (2004) found that ACT with a forensic population showed promising results, a control group was absent. Instead, most studies have focused on ACT with mentally ill civil populations (Burns & Santos, 1995).

Among the strengths of ACT applied to MDOs is its focus on meeting the needs of the offender wherever he or she is located with mobile services. Moreover, ACT provides around the clock mental health services, which is one of its key strengths. Finally, ACT helps to reduce recidivism by offering a compre-

hensive form of treatment, meeting the needs of the offender in the community by way of a multidisciplinary team.

One of the weaknesses of ACT for MDOs pertains to its lack of empirical validation, with Parker (2004) noting that, to date, there have been only three published reports on ACT for forensic populations. Although ACT offers services in a way that other forms of treatment do not, it lacks clear efficacious research to substantiate its utility in reducing recidivism. Additionally, ACT resembles more of a case management team than a form of treatment guided by a clear theoretical orientation. With this being the case, ACT lacks the specific interventions and therapeutic tools that other MDO treatments offer. Ultimately, ACT applied to MDOs appears to be a relatively new phenomenon within the forensic literature. Additional ACT programs for MDOs must be examined in order to better understand its usefulness in rehabilitating offenders and reducing recidivism.

Psychoanalytic Therapy

Auld, Hyman, and Rudzinski (2005) suggest that the underlying assumption of psychoanalytic therapy is that individuals suffer from neurosis because of conflict and repression. Ameliorating this conflict involves reducing the strength of drives, strengthening defensives, and undoing repression (Auld et al., 2005). Overall, psychoanalytic therapy involves uncovering unconscious mental processes, identifying transference, free associating, and using interpretation as the central curative ingredient (Auld et al., 2005).

According to Hoffman and Kluttig (2006), the recent emphasis on empirically validated treatments for MDOs has reduced the prevalence of psychoanalytic approaches in forensic settings. Hoffman and Kluttig assert that manualized treatments have made it easier to measure treatment progress, with psychoanalytic approaches being “stifled” because of their lack of a systematic, manualized approach. Still, Hoffman and Kluttig (2006) maintain that group psychoanalysis overlaps considerably with therapeutic community treatments—among both interventions, the offender must interact with the whole community in order to change. In addition, Hoffman and Kluttig argue that team members focus on transference issues in an attempt to understand the inner world of offenders.

One of the goals of psychoanalysis with MDOs is to help them to view their criminal acts as overstepping boundaries, which involves assisting the offenders in having an accurate picture of themselves, their interactions with others, and with their current life situations (Hoffman & Kluttig, 2006). Also, the offender internalizes his or her positive, supportive experience with the therapist so as to ameliorate the shame of his or her painful affect (Hoffman & Kluttig, 2006). Moreover, the therapist helps the client to recognize triggers for violence or assault, which reduces the likelihood of recidivism (Hoffman & Kluttig, 2006). Finally, Adler (1982) suggests that Winnicott’s *holding environment*, which simply refers to a place of safety originally experienced within the caregiver-infant dyad, can be applied to offenders, who may use the correctional system as a form of containment they cannot find elsewhere.

With regard to research, there appears to be no empirical studies done on psychoanalytic interventions with MDOs. Instead, manualized treatments have replaced psychoanalysis (Hoffman & Kluttig, 2006). Although no empirical studies exist

with psychoanalytic therapy for MDOs, psychoanalytic therapy has added to and strengthened empirically validated MDO treatments such as TC and CBT (Hoffman & Kluttig, 2006). Overall, psychoanalytic concepts such as the holding environment and countertransference can be effectively applied to work with forensic patients in order to promote change.

Among the strengths of psychoanalytic therapy for MDOs is its conceptualization of offenders. Conceptualizing offenders in terms of impulsiveness and destructiveness, both psychoanalytic terms, allows the clinician to better interpret and understand MDOs. Additionally, concepts such as Winnicott’s *holding environment* provide clinicians with an awareness of the type of environment that may need to be created for a successful therapeutic encounter with the MDO. Moreover, focusing on the inner world of the offender may allow for additional insight that can help to promote change. Finally, understanding and addressing transference and countertransference issues that take place within the therapeutic relationship may be beneficial for both the MDO and therapist.

Weaknesses of psychoanalytic theory applied to MDOs include its lack of a standardized, structured intervention that can be applied with confidence to MDO populations. Although psychoanalytic concepts allow for an understanding of MDOs, they fall short in terms of their efficaciousness. While other forms of MDO interventions such as CBT have manualized treatments (Blud & Travers, 2001), psychoanalytic therapy tends to offer only theory. Although Hoffman and Kluttig (2006) assert that psychoanalytic therapy should be reconsidered in treating forensic populations, it simply lacks the empirical validation and convenience that other treatment options provide.

Attachment Therapy

According to Holmes (2001), six domains of attachment theory exist—the secure base, describing the caregiver who the child returns to when upset; exploration and enjoyment, which highlights the reciprocal quality of the secure base; loss, which emphasizes the psychological distress the child experiences when either loss or threat of loss is evident; internal working models, which describe the internal representations of the interaction between self and others; and reflexive function and narrative competence, which refers to the ability to talk about the self and self-difficulties. These six areas are used in clinical work to conceptualize the client and promote change, all through the lens of attachment patterns (Holmes, 2001).

Rich (2006) suggests that, to date, attachment theory has solely focused on causal pathways of, and contributing factors to, criminality. Thus, as of yet, a comprehensive form of attachment therapy for MDOs has not been developed (Rich, 2006). Nevertheless, poor childhood attachment experiences serve as a risk factor, defining the developmental trajectory that points to antisocial behavior later in adulthood (Rich, 2006).

Regarding treatment, Rich (2006) explains that working with offenders means seeing them through the lens of attachment theory, including the mental images of self and others and beliefs about social interactions. Renn (2002) identifies several phases of attachment treatment—the initial assessment, which involves viewing the offender through an attachment heuristic, and the therapeutic intervention, which consists of ameliorating the internal working model of the offender. Included in this

phase is the disclosure of childhood trauma, which may be cathartic for the offender (Renn, 2002). Overall, Rich (2006) suggests that forensic clinicians use attachment theory as a framework for treatment, rather than solely as the treatment itself.

In terms of empirical research for attachment therapy for MDOs, to date, studies have not examined attachment theory directly as a therapeutic agent. Rather, current studies in the literature have focused on attachment representations of offenders (Timmerman & Emmelkamp, 2006; Van Ijzendoorn, Feldbrugge, Derks, De Ruiter, Verhagen, et al., 1997). Although these studies help to elucidate the correlation between attachment representations and criminality, additional studies are still needed that examine the efficacy of attachment therapy in reducing violent behavior and recidivism.

Some of the strengths of attachment theory applied to MDOs include its ability to conceptualize the relationships of the offender via internal working models. This internal working model acts as a template for the offender, which helps the clinician to better understand potentially maladaptive and rigid ways that the offender interacts with his or her environment. In addition, understanding negative early childhood experiences allows the clinician to better comprehend why the offender relates to others in unhelpful ways. For example, poor early childhood experiences may prevent the offender from attaching to others in adulthood. In sum, attachment theory provides a framework for the clinician to conceptualize the interpersonal functioning of the MDO.

Although attachment theory offers a lens through which the clinician can view violent behavior, it falls short as a comprehensive and applicable form of treatment. Unfortunately, within the field of MDO treatments, attachment theory has only been applied theoretically (see Rich, 2006). As a result, research on the efficacy and applicability of attachment therapy to MDOs must be conducted.

Art Therapy

Art therapy has been applied to many different populations and used together with a vast number of theoretical orientations (Rubin, 2001). Case and Dalley (2006) explain that art therapy involves the use of different art media for clients to express and work through the problems and concerns that initiated therapy, with the client and therapist making sense of the artwork together. Sometimes, clients can express themselves through mediums such as artwork in ways they cannot with traditional talk therapy (Case & Dalley, 2006). Many art therapies involve two poles, including creative production and expressive communication (Feder & Feder, 1981).

In prison settings, Case and Dalley (2006) suggest that art therapy can be difficult due to ongoing violent behavior. Still, art therapy in prisons can offer the space to think and reflect, helping offenders to express angry and violent feelings in a safe way (Case & Dalley, 2006). In recent years, art therapy has also been applied to MDO fields (Liebmann, 1998; Smeijsters & Cleven, 2006; Teasdale, 1997). Teasdale suggests that art therapy can be added to group therapy for personality disordered offenders so as to gain insight into emotional experiences and improve communication skills.

Smeijsters and Cleven (2006) highlight that the goals of art therapy with MDOs are self-expression, improving coping

skills, breaking through defenses, exploring the offending behavior, insight into the thoughts, feelings and actions that precipitated the offense, increasing self-control, and developing empathy for the victim. Furthermore, the offender can express feelings to others, and work through painful childhood experiences.

To date, research is non-existent on art therapy for MDOs. Although multiple studies have examined the efficacy of art therapy for offenders (Riches, 1998), no studies are in the literature that measure the efficacy of art therapy for MDOs. Thus, original research is essential in order to better understand the efficacy of art therapy applied to MDOs.

One of the strengths of art therapy is its ability to help the MDO express him- or herself nonverbally. To be sure, offenders may lack the verbal skills necessary to express painful experiences. Art therapy, therefore, provides the offender with a nonverbal outlet in order to express intrapsychic experiences. Moreover, art therapy may allow MDOs to work through difficult childhood experiences. Poor early childhood encounters may prevent the MDO from relating to his or her social environment in a healthy and adaptive manner. Finally, art therapy may help offenders to break through defenses and cope with stressors.

Among the weaknesses of art therapy applied to MDOs is its lack of empirical validation. Moreover, although art therapy may be beneficial as an adjunct to other forms of therapy, it does not appear to have the weight to stand on its own as an intervention for reducing recidivistic and violent behavior. Ultimately, art therapy appears to be an excellent form of self-expression, but does not address some of the more deep-seated problems that must be addressed in working with MDOs, such as antisocial behavior, substance abuse, and lack of impulse control.

Music Therapy

According to Wilson (1990), music therapy in a hospital or community program environment typically involves chorus, band, or chamber groups. Newer forms of music therapy, however, include creative movement, discussion groups, guided imagery, sports, and arts and crafts (Wilson, 1990). Wilson stresses that music therapist interventions are goal-oriented, emphasizing the psychological, behavioral, and social needs of clients. Unkefer (1990) lists music performing, music psychotherapy, music and movement, music combined with other expressive arts, recreational music, and music and relaxation as different music therapies for mental illness. Moreover, Feder and Feder (1981) suggest that music therapy helps to improve interpersonal relationships, promotes self-development, and induces physiological responses.

In the last decade, multiple articles have emerged that focus on music therapy for MDOs (Hakvoort, 2002; Reed, 2002; Smeijsters & Cleven, 2005). Reed (2002) applied music therapy to MDOs in a state hospital setting, which involved playing instruments, listening to music, and singing. According to Reed, music therapy goals for MDOs may include increasing adaptive behavior, enhancing coping skills, increasing self-esteem, and eliminating maladaptive behaviors. One of the main interventions is music listening groups (e.g., rock, soul, gospel), which involves listening to music for 60 to 90 minutes, and helps clients to increase their motivation to participate in groups and to

improve self-expression (Reed, 2002).

Recently, Hakvoort (2002) combined music therapy with an anger management program in an effort to reduce anger in forensic offenders. Hakvoort suggests that music allows offenders to express their anger in a controlled environment, with the goal of minimizing violent behaviors and reducing recidivism. With music therapy, the music therapist must alter the treatment to the specific offender and tailor the treatment to a specific problem area, which helps to explore the behavior and emotions that are associated with the anger (Hakvoort, 2002). Furthermore, there must be a confrontation that takes place within the musical environment, which may involve contrasting, intervening, splitting, and shifting (Hakvoort, 2002). Ultimately, Hakvoort emphasizes that a balance between containment and confrontation is maintained in working with offenders.

With regard to the efficacy of music therapy for MDOs, no empirical studies appear to exist in the literature. And although multiple studies have applied music therapy to MDOs (Cooke & Cooke, 1982; Hakvoort, 2002; Reed, 2002; Smeijsters & Cleven, 2002), these authors relied on case studies rather than empirical support. Further research is needed to address the efficacy of music therapy for MDOs.

In terms of its strengths, music therapy offers the MDO an alternative to more traditional therapeutic interventions, and may help offenders to express themselves through avenues other than talk therapy. In addition, music therapy may help the offender to better relate to others through common interests such as music. Also, music may be cathartic, offering an emotional response other forms of therapy may not be able to provide. Moreover, music may be soothing and calming, which may help offenders to explore anger and frustration in more appropriate ways. Finally, music therapy may provide offenders with a safe way to cope with stressors.

Music therapy applied to MDOs has several limitations. First, music therapy lacks empirical validation as an efficacious treatment for MDOs. Instead, most music therapy literature on MDOs appears to be theoretical, and its use with MDOs seems to be extracted from other populations. Overall, it is currently unclear whether music can reduce the likelihood of recidivism and maladaptive behavior among MDOs. Further research on music therapy applied to specific MDO populations is essential in order to understand its effect on reducing criminogenic behavior and ameliorating mental illness.

Discussion

This article attempted to review all of the treatment options in the forensic psychology literature on MDOs in order to provide practitioners with a cursory treatment guide. The ten treatment options located were summarized to better understand their applicability to MDOs. Also, each treatment was reviewed in terms of empirical research to obtain a clearer understanding of what is currently available in the field of forensic psychology. Lastly, strengths and weaknesses were discussed to better grasp the suitability of each treatment for this heterogeneous population.

Of the ten treatment options found in the literature, only five are empirically validated with MDO populations (i.e., behavioral therapy, cognitive behavioral therapy, dialectical behavior therapy, assertive community treatment, therapeutic commu-

nity). The remaining five treatment options for MDOs are theoretical in nature. In addition, only two treatments discussed (i.e., therapeutic community, assertive community treatment) are tailored to the specific needs of MDOs. Other treatments (i.e., cognitive behavioral therapy, behavioral therapy, dialectical behavior therapy, cognitive analytic therapy), although efficacious and useful, are borrowed from other populations. The remaining treatments (i.e., music therapy, art therapy, analytical therapy, attachment theory) seem to be primarily theoretical, and also tend to be borrowed from other populations.

Although several studies have been conducted on the five empirically validated treatment options for MDOs, only a handful of these studies have emerged with adequately controlled samples (Rice, 1983; Rice & Chaplan, 1979). Rather, many MDO treatment studies either employ case studies to support their claims (Ryle & Fawkes, 2007), or rely on theoretical conceptualizations (Pollock & Belshaw, 1998). Further research is needed with sufficient control groups and empirical validation in order to better understand the efficacy of MDO treatments. Furthermore, four of the reviewed treatments appear to be relatively new interventions for MDOs. Specifically, cognitive analytic therapy, dialectical behavior therapy, assertive community treatment, and attachment theory have only recently emerged as treatments for offenders with mental illness. It remains to be seen just how useful these treatments will be for MDOs. Further research is also necessary to empirically understand these burgeoning interventions.

While the field of MDO treatment has grown exponentially in the last few decades, additional work is needed to better understand the efficacious nature of the differing treatment options for MDOs and strive towards the overarching goal of reducing recidivism. Since MDOs are a complex population—forensic clinicians must consider the disorder, criminal act committed, and location of treatment—emerging treatments must address the vast assortment of treatment variables.

Rice and Harris (1997), in their comprehensive review of treatment considerations for MDOs, conclude that effective interventions must reduce the likelihood of future violent episodes and ameliorate mental illness. Rice and Harris also highlight several clinical problems that regularly occur with MDOs, including aggression, criminal tendencies, institutional management, lagging life skills, substance abuse, social isolation, and psychotic and mood symptoms. New and innovative MDO treatments must take these variables into consideration, and draw from the strengths of existing treatments. For example, behavioral therapy, cognitive behavioral therapy, cognitive analytic therapy, dialectical behavior therapy, therapeutic community, psychoanalytic therapy, and attachment therapy all emphasize pro-social behaviors and interpersonal success, whether through social skills training, problem solving skills, internalizing new reciprocal role procedures, interpersonal effectiveness skills, corrective emotional experiences, or ameliorating internal working models of relationships. In addition, most of the existing MDO treatments heavily emphasize improving mental illness, whether through positive reinforcement, cognitive restructuring, emotion regulation skills, or nonverbal forms of self-expression to achieve catharsis. Finally, many of the existing MDO treatments, in one way or another, address common clinical problems highlighted by Rice and Harris (1997). For instance, music and art therapies help offenders to

express anger in healthy ways so as to reduce the prevalence of aggressive outbursts; therapeutic communities give offenders a chance to learn new life skills, reduce criminal behavior in a real world environment, and socially engage with other members of their community; assertive community treatment de-institutionalizes offenders by bringing services to them in their own home environments; and cognitive behavioral and dialectical behavior therapies provide clients with skills to cope with psychotic and mood symptoms. In sum, future treatments must combine the strengths of existing interventions, address the plethora of MDO treatment variables and clinical concerns (Rice & Harris, 1997), and measure their efficacy via randomized controlled trials.

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