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Mindfulness in Forensic Mental Health: Does It Have a Role?

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Abstract Treatment and rehabilitation in forensic settings have been largely based on cognitive behavioural models and therapies. In the past decade, "third wave" approaches have developed in cognitive behavioural therapy, strongly influenced by spiritual and contemplative traditions such as Buddhism. Mindfulness is the most analysed and researched of such approaches. In this paper, we ask whether mindfulness is relevant to therapeutic work with offenders in forensic mental health and criminal justice services. We review the known criminogenic and other needs of offender groups and discuss whether the psychological processes affected by mindfulness are relevant to reducing risk, alleviating distress and facilitating coping. We conclude that they are. Finally, we address some of the problems that may arise in implementing mindfulness interventions in forensic settings.

Keywords Mindfulness · Forensic · Offenders · Treatment

Introduction

Treatment interventions with forensic mental health and offender populations have, in the past 20 years, been strongly influenced by contemporary models of treatment in clinical psychology. The influential "What Works" movement in offender rehabilitation, for example, has been largely based on dominant cognitive behavioural models of the causation of problems of general offending (Hollin and Bloxham 2007; Hollin and Palmer 2006; McGuire 1995, 2006; McMurran and McGuire 2005), and of specific types of offending such as violence (Gannon et al. 2007; Howells 2008; Polaschek 2006) and sexual offending (Mann and Fernandez 2006; Marshall et al. 2006; Ward and Maruna 2007). Unsurprisingly, the majority of the treatments delivered have employed cognitive behavioural methods.

Recent accounts of cognitive behavioural models of practice in clinical psychology (Hayes 2004; Williams and Swales 2004) have traced a progression from behavioural methods, through cognitively oriented interventions to the recent "third wave" in which methods influenced by Eastern philosophical and meditative traditions have been incorporated into the cognitive behavioural framework. Hayes et al. (1999) have suggested that these approaches seek to alter the function of private events, rather than primarily their form and frequency, encouraging participants to actively experience particular private experiences that seem to accompany functionally useful overt behaviours. The goal of intervention thus changes from that of assisting clients to control and change particular thoughts or emotions to that of encouraging them to observe and accept rather than react. It has been suggested the inclusion of such methods may help to improve the effectiveness of cognitive behavioural approaches, particularly in situations when the individual reacts too quickly to consciously intervene to change a thought or behaviour (Fehrer 2002), when emotional responses appear to over-ride conscious control of behaviour (Goleman 1995), or when he or she does not have the introspective ability and self-awareness to apply the intervention (Wright et al. 2009).

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It is to be expected that as cognitive behavioural theory and clinical practice changes, forensic practitioners will need to consider developments and decide whether changes need to be made in the treatment approaches that are offered to their clients. In forensic settings, the 'third wave' of cognitive behaviourism has been slow to arrive, with many of the interventions offered to offenders and forensic mental health patients remaining either psycho-educational (Howells et al. 2005), or broadly cognitive in nature. There is an emphasis in those interventions that are commonly offered to serious offenders on changing maladaptive cognitions, or what are commonly referred to as cognitive distortions. This is a term which has become widely used to refer to particular beliefs that are considered to be important causal antecedents to offending (i.e. criminogenic), and have been classified in terms of either primary (self-centred attitudes, thoughts and beliefs) or secondary (blaming others, minimising/mislabelling and assuming the worst of others). The latter are commonly understood in terms of post-hoc rationalisations and justifications of the offending behaviour (see Gibbs et al. 1995).

The purpose of the present paper is to consider the potential relevance to forensic treatments of the developing clinical literature on mindfulness, arguably the most influential and best researched third wave area of clinical practice. In this paper, we will identify those areas of need within forensic populations within which mindfulness might have a prima facie role as a therapeutic strategy and review recent evidence as to the effectiveness of mindfulness training. For the purposes of the present paper, we shall focus on the more serious forms of offending, namely violent and sexual offending. Finally, we will suggest some reasons why a degree of caution, as well as optimism, is necessary in introducing mindfulness into forensic practice.

Definitions and Conceptualisations of Mindfulness

The number of scientific reports relating to mindfulness has been estimated to have risen from 90 in 1996 to 200 in 2006 (Brown et al. 2007a). However, definitions of mindfulness vary somewhat. Brown and Ryan (2003) define mindfulness as "a receptive attention to and awareness of present events and experiences" (page 823). Such events include sensations associated with the senses, body events, proprioceptive stimuli and mental events such as thoughts, memories and emotions. Bishop et al. (2004) describes mindfulness interventions in the following way:

> The client …..attempts to maintain attention on a particular focus, most commonly the somatic sensations of breathing…whenever attention wanders from the breath to inevitable thoughts and feelings that arise, the client will simply take notice of them and let them go, as attention is returned to the breath….in a state of mindfulness, thoughts and feelings are observed as events in the mind, without over-identifying with them and without reacting to them in an automatic, habitual pattern of reactivity. This dispassionate state of self-observation is thought to introduce a space between one's perception and response….thus mindfulness is thought to enable one to respond to situations more reflectively(as opposed to reflexively) (page 231).

In effect, mindfulness concerns awareness of, and attention to, all events experienced in the ongoing stream of consciousness. Mindfulness implies particular qualities of this awareness and internal observation, notably 'bare attention'; a simple non-judgemental noting of phenomenological events. A mindset of 'acceptance' and non-judgemental noticing is encouraged, as is a focus on the present moment. Thus, thought sequences about the past and future, which constitute a major part of normal everyday thinking are seen as mere thoughts and distractions from the task of remaining present centred.

Mindful states are likely to occur naturally for many people but the mind requires training in the sense that such states are infrequent and not sustained. The typical mind state of everyday life appears to be one of rapid change and some confusion, with a succession of sensations, images, memories, plans, emotions and habitual thoughts passing though consciousness. Mindfulness training creates an awareness of such states and a method for producing more focus, greater mental clarity and control. Meditation on the breath in mindfulness training is meant to develop the art of concentration and to serve as a reference point, to increase awareness of ongoing distractions and automatic mental events. It is clear that mindfulness is a multi-faceted phenomenon.

There have been three major clinical areas in which mindfulness training has been applied: Mindfulness-based Stress-Reduction (MBSR) Programmes (Kabat-Zinn 1990); Mindfulness-based CBT (MBCT), particularly depression relapse prevention (Kuyken et al. 2008; Williams et al. 2008); and Mindfulness *skills* within Dialectical Behaviour Therapy (Linehan 1993). Brown et al (2007a) have produced an extensive review of the utility and impact of mindfulness training in all three of these areas as well as of mindfulness effects in experimental social psychology. Our present comments are based largely on their more detailed evaluation of previous studies. The Brown et al. review (2007a) highlights a number of studies in which mindfulness, either as a trait (some individuals are high, others low in mindfulness) or a state (for example, where mindfulness has been induced in a study) has been investigated. Such

studies appear to reveal a positive association between mindfulness and states of mental well-being and a negative association with states of distress, anxiety, depression and overall negative affect

In addition, controlled treatment studies (including RCTs) of MBSR have demonstrated greater reductions in stress and distress for those undertaking MBSR, compared with waiting-list controls (Grossman et al. 2004). Similarly, for MBCT, RCTs have demonstrated reductions in relapse rates for patients with three or more previous episodes of depression (Kuyken et al. 2008; Teasdale et al. 2000; Williams et al. 2008). There is also evidence that mindfulness alters both brain processes and immune function in a positive direction (Davidson et al. 2003).

Areas of Criminogenic Need that Might Usefully be Addressed by Mindfulness

What are the common antecedents, and hence criminogenic factors for violent offending? Howells et al. (2008) have identified a number of different factors as potentially important, including those associated with the environment (social learning, triggering external events and situational factors), those related to offender cognition (appraisals, beliefs and information-processing styles, perspective-taking deficits), those associated with emotion and emotional regulation (negative affective states such as anger; inhibitory and self-regulatory deficits) and those which are best understood as broadly as related to the construct of personality (traits, disorders and psychopathy). The list is not exhaustive and the categories clearly overlap. Patterns of cognitive appraisal, for example, overlap with negative affective states and anger overlaps with personality and personality disorders (Howells 2009). Its relevance to the present paper lies in the specification of possible areas of need, that is, *dynamic risk factors*, in offenders and forensic patients. For mindfulness to have value in risk reduction, it would need to reduce either the frequency or intensity with which dynamic risk factors motivate antisocial behaviour.

Mindfulness would appear to have the potential to address a number of psychological processes and states that are clearly relevant to risk of recidivism. Firstly, negative affective states have been identified as relevant to many forms of offending (Day 2009), and the evidence available as to the impact and mediators of mindfulness (see below) suggests it is particularly relevant to the reduction of negative affect. Secondly, self-regulatory breakdown (particularly for negative affect) leading to impulsivity is widely recognised as an important causal influence for many forms of offending (Farrington 2000) and may be particularly important in personality disordered offenders. By its nature, mindfulness is about reducing impulsive responding by increasing awareness of mental states and their role in eliciting automatic and impulsive behaviour. Mindfulness promotes control of mental states and processes (Macicampo and Baumeister 2007). Thirdly, anger is recognised to be a major antecedent for many forms of violence (Novaco 2007; Howells et al. 2007) and mindfulness grew out of a philosophical, psychological and spiritual tradition—Buddhism—in which states of anger have received extended and detailed attention. Within such traditions, anger is viewed as a major "mental affliction" (Dalai Lama and Goleman 2003), and mindfulness has been proposed as a helpful technique in the control of anger and its possible contribution to cognitive behavioural therapy (Wright et al. 2009). Given the limitations of conventional anger management programmes, as currently delivered, for improving anger problems in offenders (Howells et al. 2005) there would appear to be room for increasing the range and sophistication for anger interventions along mindfulness lines.

Problems of negative affective states and poor emotional self-regulation in forensic populations are at their most extreme in offenders labelled as having a personality disorder (Howard 2009). Personality disorders are endemic in offender populations (Fazel and Danesh 2002), particularly among more serious offending groups. Indeed, this observation triggered a major government initiative in England and Wales in 1999 to develop assessment and intensive treatment services for high-risk offenders with severe personality disorders—the so-called Dangerous and Severe Personality Disorder initiative (Howells et al. 2007). Antisocial- (APD) and borderline personality disorders (BPD) are the most common DSM-IV categories of personality disorder in serious offender groups, with some evidence that both are linked, both independently and in combination, to the proclivity for violence (Duggan and Howard 2009), though demonstrating that personality disorder and violence are causally or functionally linked rather than simply correlated remains problematic, both empirically and conceptually (Duggan and Howard 2009). Nevertheless, the putative link between BPD and violence has proven sufficiently convincing to lead to the implementation of dialectical behaviour therapy programmes (Linehan 1993) with offenders with BPD (Hogue et al. 2007; Nee and Farman 2005).

The relevance of such developments is twofold for the present paper. Firstly, scientific investigation of BPD strongly implicates an important mechanism in understanding personality disorder/serious offending links—that of *dysfunctional affective regulation.* Secondly, the most common psychological therapy for BPD—Dialectical Behaviour Therapy (Linehan 1993)—already incorporates a significant module on mindfulness training (Williams and Swales 2004), thus DBT with offenders may offer some insights into the clinical implementation of mindfulness

methods. Unfortunately, DBT is typically evaluated as a "total package", making it difficult to identify the therapeutic impact of the mindfulness component per se.

The Effectiveness of Mindfulness Training with Forensic Populations

Although it would appear that mindfulness is plausible as a treatment in forensic settings, few controlled intervention studies have been reported. There have, however been reports, mainly single case, multiple baseline experiments, of mindfulness applied to reducing aggressive behaviour in individuals with developmental disabilities and mental illness and conduct disorders, using a self-regulation rationale (Heppner et al. 2008; Singh et al. 2003, 2006, 2007a, b, c, 2008a, b).

A large-scale evaluation of MBSR in Massachusetts' correctional facilities has been reported by Samuelson et al. (2007). This study demonstrated large pre–post differences on measures of mood disturbance, hostility and self-esteem though the value of these findings is limited by the absence of a strictly matched control group in this study. Controlled outcome studies in forensic settings, including both correctional and forensic mental health settings are clearly desirable.

Mindfulness in Forensic Settings?

There are a number of cautions to be noted before advocating mindfulness training in forensic work. There are significant problems with the diversity of definitions of mindfulness, stemming in part from differences in conceptualisation in the psychological and contemplative traditions. The measurement of the mindfulness construct also remains inadequate, with unresolved problems of construct, external and criterion validity (Singh et al. 2008b). This makes the measurement of improvements in mindfulness in clinical settings difficult. Additionally, it is desirable that mindfulness be integrated within a more general formulation of the criminogenic and other needs of the person (Teasdale et al. 2006). Such an approach will also assist in anticipating and dealing with problems that may arise in mindfulness practice, including self-focusing leading to the participant being overwhelmed by negative rumination or memories (Williams and Swales 2004).

There are also potential difficulties relating to the cultural acceptability (for patients, offenders, professional staff and the institution or service) of the language and concepts underlying mindfulness, taken as they are from other, Eastern, cultures, notwithstanding the rapid and continuing expansion of Buddhism in the West and its increasing expression in a more Western form. Inwardness, reflection and introspection (all aspects of mindfulness), intuitively, are not widely valued or practiced in many Western societies and may meet resistance, particularly within criminal justice environments in which psychological practice is underpinned by values that are punishment-oriented (Day and Casey 2009). More optimistically, and contrary to this assumption, however, is the widespread existence and apparent popularity of meditation and similar groups within the prison system (see, for example Samuelson et al. 2007) and the successful delivery of mindfulness within programmes such as dialectical behaviour therapy in forensic settings (Nee and Farman 2005).

Arguably, the most important amongst unresolved issues are those relating to the roots of mindfulness within spiritual, contemplative traditions such as Buddhism. As utilised in psychological and psychiatric interventions, mindfulness has been largely severed from its fundamental roots and treated in relative isolation from the extensive, deeper and sophisticated philosophical, spiritual and psychological system which generated it (Brazier 2003; Dalai Lama and Goleman 2003; Rosch 2007). To take just one example relevant to the previous discussion, the understanding and modification of anger minds within Buddhism is much broader than mindfulness, including consideration of "self-cherishing", and of the need to cultivate minds incompatible with anger-loving kindness, compassion and equanimity (Wright et al. 2009). Anger similarly needs to be understood in the context of fundamental ideas such as the "Three Marks of Existence": impermanence (anicca), egolessness (anatta) and suffering (dukkha) (Brazier 2003; Rosch 2007). The dangers of isolating mindfulness from this rich source have been powerfully described in a recent paper by Singh et al. (2008b):

> We are in serious danger of reducing mindfulness meditation to a technological model for treating psychopathology, thereby losing its historical essence as an approach to transformation of self…….The end point of mindfulness meditation is not in the alleviation of psychological and physical distress. At its core it is about gaining insight into the nature of our own minds, thereby enabling each of us to differentiate between the conditioned and unconditioned self. It provides a method for enlightenment, the summum bonum of existence (page 663).

On the other hand, it might be argued that the scientific and experiential testing and validation of both mindfulness and these broader insights can proceed in parallel, without one excluding the other from attention.

In conclusion, many of the needs identified as important to any assessment of risk in offender populations (negative affective states, anger, deficiencies in emotional regulation, borderline features and impulsivity) can be understood as psychological states which can be addressed by mindful-

ness interventions. There would, in our view, appear to be a prima facie case that mindfulness has a role to play in risk management interventions for offenders and forensic patients, although further empirical trials of the technique are clearly needed. Of course, it is also the case that reduction of risk is only one indication of successful treatment in forensic mental health services, and as such the benefits that mindfulness can bring to mental health and well-being alone should not be overlooked or under-estimated.

References

Baer, R. A. (2007). Mindfulness, assessment and transdiagnostic processes. *Psychological Inquiry, 18*, 238–242.

Bargh, J. A. (1997). The automaticity of everyday life. In S. R. Wyer (Ed.), *The automaticity of everyday life: advances in social cognition, vol 1* (pp. 1–61). Mahwah NJ: Erlbaum.

Bishop, S. C., Lau, M., Shapiro, S., Carlson, L., Anderson, N. D., Carmody, K., et al. (2004). Mindfulness: a proposed operational definition. *Clinical Psychology: Science and Practice, 7*, 230–241.

Brazier, C. (2003). *Buddhist psychology*. London: Constable and Robinson.

Brown, K. W., & Ryan, R. M. (2003). The benefits of being present: mindfulness and its role in psychological well-being. *Journal of Personality and Social Psychology, 84*, 822–848.

Brown, K. W., Ryan, R. M., & Cresswell, J. D. (2007a). Mindfulness: Theoretical foundations and evidence for its salutary effects. *Psychological Inquiry, 18*, 211–237.

Brown, K. W., Ryan, R. M., & Cresswell, J. D. (2007b). Addressing fundamental questions about mindfulness. *Psychological Inquiry, 18*, 272–281.

Cavell, T. A., & Malcolm, K. T. (Eds.). (2007). *Anger, aggression and interventions for interpersonal violence*. Mahwah, NJ: Erlbaum.

Conklin, C. Z., Bradley, R., & Westen, D. (2006). Affect regulation in Borderline Personality Disorder. *Journal of Nervous and Mental Disease, 194*, 69–77.

Dalai Lama, & Goleman, D. (2003). *Destructive emotions*. NY: Bantam.

Davidson, R. J., Kabat-Zinn, J., Schumacher, J., Rosenkranz, M., Muller, D., Santorelli, S. F., et al. (2003). Alterations in brain and immune function produced by mindfulness meditation. *Psychosomatic Medicine, 65*, 564–570.

Day, A. (2009). Offender emotion and self-regulation: implications for offender rehabilitation programming. *Psychology, Crime and Law, 15*, 119–130.

Day, A., & Casey, S. (2009). Values in forensic and correctional psychology. *Aggression and Violent Behavior, 4*, 232–238.

Day, A., Bryan, J., Davey, L., & Casey, S. (2006). Processes of change in offender rehabilitation. *Psychology, Crime and Law, 12*, 473–489.

Day, A., Nakata, M., & Howells, K. (Eds.). (2008). *Anger and indigenous men*. Sydney: Federation.

Duggan, C., & Howard, R. C. (2009). The 'functional link' between personality disorder and violence: A critical appraisal. In M. McMurran & R. C. Howard (Eds.), *Personality, personality disorder and violence* (pp. 19–38). Chichester: Wiley.

Farrington, C. J. (2000). Individual differences and offending. In M. Tonry (Ed.), *The handbook of crime and punishment* (pp. 241–268). Oxford: Oxford University Press.

Fazel, S., & Danesh, J. (2002). Serious mental disorder in 23, 000 prisoners: a systematic review of 62 surveys. *The Lancet, 359*, 545–550.

Fehrer, F. C. (2002). *The awareness response: A transpersonal approach to reducing maladaptive emotional reactivity*. Unpublished doctoral dissertation. Institute of Transpersonal Psychology. Palo Alto: California.

Gannon, T. A., Ward, T., Beech, A. R., & Fisher, D. (Eds.). (2007). *Aggressive offenders' cognition: theory, research and practice*. Chichester: Wiley.

Gibbs, J. C., Potter, G. B., & Goldstein, A. P. (1995). *The EQUIP program: Teaching youth to think and act responsibly through a peer-helping approach*. Champaign, IL: Research Press.

Goleman, D. (1995). *Emotional intelligence*. New York: Bantam.

Gross, J. (2002). Emotion regulation: affective, cognitive and social consequences. *Psychophysiology, 39*, 281–291.

Grossman, P., Niemann, L., Schmidt, S., & Walach, H. (2004). Mindfulness-based stress reduction and health benefits: a meta-analysis. *Journal of Psychosomatic Research, 57*, 35–43.

Hanson, R. K., & Harris, A. J. R. (2000). Where should we intervene? Dynamic predictors of sexual assault recidivism. *Criminal Justice and Behavior, 27*, 6–35.

Hayes, S. C. (2004). Acceptance and commitment therapy and the new behavior therapies: Mindfulness, acceptance and relationship. In S. C. Hayes, V. M. Follette, & M. M. Linehan (Eds.), *Mindfulness and acceptance: expanding the cognitive–behavioral tradition* (pp. 1–29). New York: Guilford.

Hayes, S. C., Strosahl, K. D., & Wilson, K. G. (1999). *Acceptance and commitment therapy: An experiential approach to behavior change*. New York: Guilford Press.

Heppner, W. L., Kernis, M. H., Lakey, C. E., Campbell, W. K., Goldman, B. M., Davis, P. J., et al. (2008). Mindfulness as a means of reducing aggressive behaviour: dispositional and situational evidence. *Aggressive Behavior, 34*, 486–496.

Hogue, T. E., Jones, L., Talkes, K., & Tennant, A. (2007). The Peaks: a clinical service for those with dangerous and severe personality disorders. *Psychology, Crime and Law, 13*, 57–68.

Hollin, C. R., & Palmer, E. J. (Eds.). (2006). *Offending behaviour programmes: development, application and controversies*. Chichester: Wiley.

Hollin, C. R., & Bloxham, C. A. J. (2007). Treatments for angry aggression. In T. A. Gannon, T. Ward, A. R. Beech, & D. Fisher (Eds.), *Aggressive offenders' cognition: theory, research and practice* (pp. 215–229). Chichester: Wiley.

Howard, R. C. (2009). The neurobiology of affective dyscontrol: implications for understanding 'dangerous and severe personality disorder'. In M. McMurran & R. C. Howard (Eds.), *Personality, personality disorder and risk of violence* (pp. 157–174). Chichester: Wiley.

Howard, R. C. & Duggan, C. (2010). Mentally disordered offenders: personality disorders. In G. Towl, & D. Crighton (Eds.), Forensic psychology. Oxford: Blackwell, in press

Howard, R. C., Huband, N., Mannion, A., & Duggan, C. (2008). Exploring the link between personality disorder and criminality in a community sample. *Journal of Personality Disorders, 22*, 589–603.

Howells, K. (2008). The treatment of anger in offenders. In A. Day, M. Nakata, & K. Howells (Eds.), *Anger and indigenous men*. Annandale NSW: Federation.

Howells, K. (2009). Angry affect, aggression and personality disorder. In M. McMurran & R. Howard (Eds.), *Personality, personality disorder and risk of violence* (pp. 191–212). Chichester: Wiley.

Howells, K., & Day, A. (2006). Affective determinants of treatment engagement in violent offenders. *International Journal of Offender Therapy and Comparative Criminology, 50*, 174–186.

Howells, K., & Day, A. (2007). Readiness for treatment in high risk offenders with personality disorders. *Psychology, Crime and Law, 13*, 47–56.

Howells, K., Day, A., & Wright, S. (2004). Affect, emotions and sex offending. *Psychology, Crime and Law, 10*, 179–195.

Howells, K., Day, A., Williamson, P., Bubner, S., Jauncey, S., Parker, A., et al. (2005). Brief anger management programs with

offenders: outcomes and predictors of change. *Journal of Forensic Psychiatry and Psychology, 16*, 296–311.

Howells, K., Krishnan, G., & Daffern, M. (2007). Challenges in the treatment of dangerous and severe personality disorder. *Advances in Psychiatric Treatment., 13*, 325–332.

Howells, K., Daffern, M., & Day, A. (2008). Aggression and violence. In K. Soothill, M. Dolan, & P. Rogers (Eds.), *Handbook on forensic mental health* (pp. 351–374). Cullompton, Devon: Willan.

Kabat-Zinn, J. (1990). *Full catastrophe living: using the wisdom of your body and mind in everyday life*. NY: Delacorte.

Kraus, E., Mendelson, T., & Lynch, T. (2003). Childhood emotional validation and adult psychological distress: the mediating role of emotional inhibition. *Child Abuse and Neglect, 27*, 199–213.

Kuyken, W., Byford, S., Taylor, R. S., Watkins, E., Holden, E., White, K., et al. (2008). Mindfulness-based cognitive therapy to prevent relapse in recurrent depression. *Journal of Consulting and Clinical Psychology, 76*, 966–978.

Linehan, M. M. (1993). *Cognitive-behavioral treatment of borderline personality disorder*. New York: Guilford.

Mann, R. E., & Fernandez, Y. M. (2006). Sex offender programmes: Concept, theory and practice. In C. R. Hollin & E. J. Palmer (Eds.), *Offending behaviour programmes: development, application and controversies* (pp. 155–178). Chichester: Wiley.

Masicampo, E. J., & Baumeister, R. F. (2007). Relating mindfulness and self-regulatory processes. *Psychological Inquiry, 18*, 255–258.

Marshall, W. L., Fernandez, Y. M., Marshall, L. E., & Serran, G. A. (Eds.). (2006). *Sexual offender treatment: controversial issues*. Chichester: Wiley.

McGuire, J. (Ed.). (1995). *What works: reducing offending*. Chichester: Wiley.

McGuire, J. (2006). General offending behaviour programmes: Concept, theory and practice. In C. R. Hollin & E. J. Palmer (Eds.), *Offending behaviour programmes: development, application and controversies* (pp. 69–112). Chichester: Wiley.

McMurran, M., & McGuire, J. (Eds.). (2005). *Social problem solving and offending: evidence, evaluation and evolution*. Chichester: Wiley.

Nee, C., & Farman, S. (2005). Female prisoners with borderline personality disorder: some promising treatment developments. *Criminal Behaviour and Mental Health, 15*, 2–16.

Novaco, R. W. (2007). Anger dysregulation. In T. A. Cavell & K. T. Malcolm (Eds.), *Anger, aggression and interventions for interpersonal violence* (pp. 3–54). Mahwah, NJ: Erlbaum.

Patrick, C. J. (2008). Psychophysiological correlates of aggression and violence: an integrative review. *Philosophical Transactions of the Royal Society., 363*(1503), 2543–2555.

Polaschek, D. L. L. (2006). Violent offender programmes: Concept, theory and practice. In C. R. Hollin & E. J. Palmer (Eds.), *Offending behaviour programmes: development, application and controversies* (pp. 113–154). Chichester: Wiley.

Rosch, E. (2007). More than mindfulness: when you have a tiger by the tail, let it eat you. *Psychological Inquiry, 18*, 258–264.

Samuelson, M., Carmody, J., Kabat-Zinn, J., & Bratt, M. A. (2007). Mindfulness-based stress reduction in Massachusetts correctional facilities. *The Prison Journal, 87*, 254–268.

Segal, Z. V., Williams, J. M. G., & Teasdale, J. D. (2002). *Mindfulness-based cognitive therapy for depression: a new approach to preventing relapse*. New York: Guilford Press.

Serran, G. A., & Marshall, W. L. (2006). Coping and mood in sexual offenders. In W. L. Marshall, Y. M. Fernandez, L. E. Marshall, & G. A. Serran (Eds.), *Sexual offender treatment: controversial issues* (pp. 109–124). Chichester: Wiley.

Singh, N. N., Wahler, R. G., Adkins, A. D., & Myers, R. E. (2003). Soles of the feet: a mindfulness-based self-control intervention for aggression by an individual with mild mental retardation and mental illness. *Research in Developmental Disabilities, 24*, 158–169.

Singh, N. N., Lancioni, G. E., Winton, A. S. W., Curtis, W. J., Wahler, R. G., Sabaawi, M., et al. (2006). Mindful staff increase learning and reduce aggression in adults with developmental disabilities. *Research in Developmental Disabilities, 27*, 545–558.

Singh, N. N., Lancioni, G. E., Winton, A. S. W., Winton, A. S. W., Adkins, A. D., Wahler, R. G., et al. (2007). Individuals with mental illness can control their aggressive behaviour through mindfulness training. *Behavior Modification, 31*, 313–328.

Singh, N. N., Lancioni, G. E., Joy, S. D. S., Winton, A. S. W., Sabaawi, M., Wahler, R. G., et al. (2007). Adolescents with conduct disorders can be mindful of their aggressive behaviour. *Emotional and Behavioral Disorders, 15*, 56–63.

Singh, N. N., Lancioni, G. E., Winton, A. S. W., Adkins, A. D., Singh, J., & Singh, A. N. (2007). Mindfulness training assists individuals with moderate mental retardation to maintain their community placements. *Behavior Modification, 31*, 800–814.

Singh, N. N., Lancioni, G. E., Winton, A. S. W., Singh, A. N., Adkins, A. D., & Singh, J. (2008). Clinical and benefit-cost outcomes of teaching a mindfulness-based procedure to adult offenders with intellectual disabilities. *Behavior Modification, 32*, 622–637.

Singh, N. N., Lancioni, G. E., Wahler, R. G., Winton, A. S. W., & Singh, J. (2008). Mindfulness approaches in cognitive behaviour therapy. *Behavioural and Cognitive Psychotherapy, 36*, 1–8.

Teasdale, J. D., Segal, Z. V., & Williams, J. M. G. (2000). Reducing risk of recurrence of major depression using Mindfulness-based Cognitive Therapy. *Journal of Consulting and Clinical Psychology, 68*, 615–623.

Teasdale, J. D., Segal, Z. V., & Williams, J. M. G. (2006). Mindfulness training and problem formulation. *Clinical Psychology: Science and Practice, 10*, 157–160.

Ward, T., & Maruna, S. (2007). *Rehabilitation: beyond the risk principle*. London: Taylor & Francis.

Weisner, M., Kim, H. K., & Capaldi, D. M. (2005). Developing trajectories of offending: validation and prediction to young adult alcohol use, drug use, and depressive symptoms. *Development and Psychopathology, 17*, 251–270.

Williams, J. M. G., & Swales, M. (2004). The use of mindfulness-based approaches for suicidal patients. *Archives of Suicide Research, 8*, 315–329.

Williams, J. M., Russell, I., & Russell, D. (2008). Mindfulness-based cognitive therapy: further issues in current evidence and future research. *Journal of Consulting and Clinical Psychology, 76*, 524–529.

Wright, S., Day, A., & Howells, K. (2009). Mindfulness and the treatment of anger problems. *Aggression and Violent Behavior, 14*, 396–401.

Wupperman, P., Neumann, C. S., & Axelrod, S. R. (2008). Do deficits in mindfulness underlie borderline personality features and core difficulties? *Journal of Personality Disorders, 22*, 466–482.

Zamble, E., & Quinsey, V. L. (2001). *The criminal recidivism process*. London: Cambridge University Press.