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Commentary

Forensic Psychotherapy on Mentally Disordered Offenders: Treatability Therapeutic Security and Structured Monitoring

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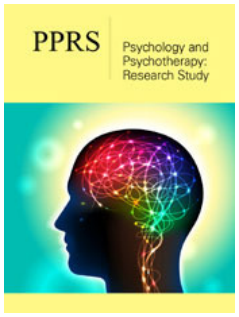

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Introduction

Forensic psychotherapy with mentally disordered offenders requires a substantial redefinition of traditional psychotherapeutic assumptions. In this context, the patient is not only a subject of care, but also a subject of judicial evaluation, social regulation and risk management. This paper conceptualizes forensic psychotherapy as a structured clinical-forensic process integrating treatability assessment, therapeutic use of security, structured professional judgment and longitudinal monitoring. Particular attention is devoted to the use of structured instruments before the initiation of psychotherapy and throughout the therapeutic pathway. We argue that assessment should not be conceived as a preliminary and separate act, but as a continuous process embedded within treatment. A clinically grounded and scientifically informed treatment model is proposed, based on dynamic risk assessment, criminogenic needs, therapeutic engagement, recovery-oriented security and observable forensic outcomes.

Forensic Psychotherapy as a Structured Clinical Process

Psychotherapy with mentally disordered offenders cannot be reduced to a straightforward extension of standard clinical practice. In forensic contexts, the patient occupies a structurally complex position: a subject of psychological suffering, a subject of judicial evaluation and a potential source of risk for others. This triple status transforms the therapeutic setting into an exposed clinical field, permeated by institutional mandates, legal consequences and public safety requirements. As a consequence, some foundational assumptions of psychotherapy-such as voluntary engagement, stable therapeutic boundaries and a non-coercive relational frame-are only partially applicable [1]. In forensic psychotherapy, the therapeutic relationship is therefore never purely dyadic. It is structurally triadic, involving the patient, the clinician and the legal-institutional system that frames the treatment mandate.

Within this context, treatment adherence cannot be taken at face value. Compliance may be formal, strategically oriented toward judicial benefits and not necessarily indicative of genuine therapeutic engagement [2]. Similarly, denial, minimization and externalization of responsibility should not be interpreted solely as defensive reactions. They may constitute relatively stable organizational modes through which the individual maintains a coherent, albeit distorted, relationship with the offense, the victim and the self [3]. From a hermeneutic and clinical-forensic perspective, these distortions can be understood as narrative

constructions that organize meaning and protect identity, rather than as simple absences of truth. In this sense, the clinical task is not to extract a factual confession, nor to reproduce an interrogative logic within psychotherapy, but to progressively destabilize rigid interpretative frameworks and open space for alternative, more reality-based meanings.

This position is consistent with the concept of Herminia, which describes the social, cultural and forensic misunderstandings that may arise when psychiatry is required to communicate complex clinical realities within judicial and public systems [4]. Even the notion of therapeutic neutrality requires reconsideration. In the presence of a concrete risk for others, a rigidly non-directive or ostensibly neutral therapeutic stance may result in a form of clinical disengagement from responsibility. This does not mean that the therapist should abandon clinical understanding or become an agent of control. Rather, it means that forensic psychotherapy must integrate empathic understanding with a specific responsibility toward risk, victims and the social consequences of treatment decisions [5]. These considerations lead to a central issue: . Not all offenders are amenable to psychotherapy and treatability should not be conceptualized as a fixed attribute of the individual, nor as a direct consequence of diagnosis or type of offense. Instead, treatability should be understood as a dynamic construct emerging from the interaction between clinical stabilization, cognitive and emotional capacities, institutional conditions and treatment design [6]. Minimum prerequisites include sufficient organization of thought processes, a basic capacity to represent mental states and consequences and the presence of dynamic risk factors-such as impulsivity, substance misuse, emotional dysregulation, or criminogenic cognitions-that are potentially modifiable through intervention [7]. This has direct implications for selection, timing and intensity of interventions.

Within this framework, security assumes a central therapeutic meaning. Contemporary forensic psychiatry, particularly within the Italian community-based model following the closure of forensic psychiatric hospitals, has emphasized the need to integrate treatment and security rather than oppose them [8,9]. The concept of therapeutic security prevents security from being reduced to restriction or custody. When appropriately calibrated, security may function as a condition enabling therapeutic work: it creates a sufficiently containing environment in which patients may tolerate the emergence of responsibility, guilt, shame and awareness of interpersonal consequences without resorting immediately to acting out or rigid defensive strategies [10]. A further step concerns the systematic integration of structured assessment tools both before the initiation of psychotherapy and during its course. Prior to treatment, instruments such as the HCR-20 Version 3 provide a structured framework for violence risk assessment, while tools such as Dundrum-1 support triage decisions and the allocation of patients to appropriate levels of therapeutic security [11,12]. These instruments contribute to defining not only the level of risk, but also the conditions under which psychotherapy can be meaningfully and safely undertaken. During treatment, assessment must evolve into longitudinal monitoring. Structured professional judgment provides a methodological framework that integrates empirical evidence with clinical expertise, avoiding both purely intuitive decision-making and rigid actuarial reductionism [13]. Within this perspective, Dundrum-3 and Dundrum-4 allow clinicians to monitor programme completion, readiness for progression and forensic recovery over time [12,14]. The Italian validation of the Dundrum Toolkit further supports its use within the Italian forensic treatment model, especially in relation to the appropriateness of placement, levels of therapeutic security and longitudinal evaluation of treatment progress [15,16].

At the same time, the assessment of criminogenic needs, consistent with the Risk-Need- Responsivity model, provides treatment targets directly linked to recidivism risk [7]. Process variables should also be monitored. Brief feedback instruments such as the Outcome Rating Scale and the Session Rating Scale, although not forensic risk tools, may support the continuous evaluation of patient-perceived outcome, therapeutic alliance and engagement, thereby operationalizing dimensions that are central to psychotherapy but often remain clinically implicit [17,18]. This integrated use of instruments transforms assessment into an ongoing process embedded within psychotherapy. Evaluation is no longer a preliminary phase, but a dynamic component of treatment. It supports clinical decision-making, communication with judicial authorities, adjustment of therapeutic strategies and documentation of change in a language that is both clinically meaningful and institutionally usable.

From this perspective, the goal of forensic psychotherapy is not necessarily rapid or deep personality transformation. Rather, it is the achievement of observable and forensically meaningful changes: reduction of criminogenic cognitions, increased recognition of the impact on victims, improved emotional regulation, better adherence to treatment and greater predictability of behaviour. These outcomes are directly relevant to risk management, judicial decision-making and the construction of individualized therapeutic pathways [19]. On this basis, we propose an integrated forensic psychotherapy pathway based on three sequential but interdependent phases. First, a pre-treatment assessment phase should define risk level, criminogenic needs, treatability, therapeutic security and responsivity. Second, a targeted psychotherapeutic phase should address motivation, denial, responsibility, emotional regulation and relational functioning within calibrated security conditions. Third, a longitudinal monitoring phase should use structured professional judgment and repeated assessment of dynamic risk, recovery indicators, therapeutic alliance and engagement. The innovative element of this model is that assessment is no longer external to Psychotherapy: it becomes one of its clinical regulators. This model requires shared clinical frameworks across mental health services, forensic facilities and judicial authorities. It also requires longitudinal data collection, periodic reassessment and the development of common protocols capable of making psychotherapeutic change observable, communicable and accountable.

Ultimately, the maturity of forensic psychotherapy lies not in its capacity to promise universal transformation, but in its ability to construct scientifically grounded, observable and responsible

treatment pathways. The central question, therefore, is no longer only whether the patient can change, but whether forensic systems are able to create, monitor and document the conditions under which change becomes clinically possible, legally meaningful and socially responsible.

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Conflict of Interest

The authors declare that the research was conducted in the absence of any commercial or financial relationships that could be construed as a potential conflict of interest. This research did not receive any specific grant from funding agencies in the public, commercial, or not-for-profit sectors.

References

1. Ward T, Maruna S (2007) Rehabilitation: Beyond the risk paradigm. Routledge, UK.
2. McMurran M (2011) Motivational interviewing with offenders: A systematic review. Legal and Criminological Psychology 14(1): 83-100.
3. Maruna S (2001) Making good: How ex-convicts reform and rebuild their lives. American Psychological Association, Washington, DC, USA.
4. Carabellese F, Parente L, Kennedy HG (2024) Reform of forensic mental health services in Italy: Stigma and blaming the messenger: Hermenoia. International Journal of Offender Therapy and Comparative Criminology 68(15): 1505-1524.
5. Skeem JL, Manchak S, Peterson JK (2011) Correctional policy for offenders with mental illness: Creating a new paradigm for recidivism reduction. Law and Human Behaviour 35(2): 110-126.
6. Douglas KS, Skeem JL (2005) Violence risk assessment: Getting specific about being dynamic. Psychology Public Policy and Law 11(3): 347-383.
7. Andrews DA, Bonta J (2017) The Psychology of Criminal Conduct. Routledge (7th edn), p. 470.
8. Carabellese F, Felthous AR (2016) Closing Italian forensic psychiatry hospitals in favor of treating insanity acquittees in the community. Behavioural Sciences & the Law 34(2-3): 444-459.
9. Carabellese FF, Parente L (2025) The Italian general psychiatry and forensic psychiatry treatment model: A unique story. CNS Spectrums 30(1): e1.
10. Kennedy HG (2018) Therapeutic uses of security: Mapping forensic mental health services by stratifying risk. Advances in Psychiatric Treatment 8(6): 433-443.
11. Douglas KS, Hart SD, Webster CD, Belfrage H (2013) HCR-20V3: Assessing Risk for Violence: User Guide. Burnaby, BC: Mental Health, Law, and Policy Institute Simon Fraser University, Canada.
12. Kennedy HG, O'Neill C, Flynn G, Gill P, Davoren M (2016) The Dundrum Toolkit V1.0.30. Trinity College Dublin, Dublin, Tara, Ireland.
13. Douglas KS, Hart SD (2010) Structured professional judgment. In: Otto RK, Douglas KS (Eds.), Handbook of Violence Risk Assessment. Routledge, New York, USA.
14. Davoren M, Dwyer SO, Abidin Z, Naughton L, Gibbons O, et al. (2012) Prospective in-patient cohort study of moves between levels of therapeutic security: The dundrum-1 triage security, dundrum-3 programme completion and DUNDRUM-4 recovery scales and the HCR-20. BMC Psychiatry 12: 80.
15. Carabellese F, Parente L, Tegola DL, Rossetto I, Franconi FF, et al. (2022) The dundrum toolkit, Italian version, and its potential use in the Italian forensic treatment model. Italian Criminology Review 16(4): 271-282.
16. Parente L, Fulvio C, Seclì E, Rutigliano M, Tegola DL, et al. (2025) Structured professional judgment in the new Italian forensic treatment model: The validation of the Italian version of the dundrum toolkit. Italian Review of Criminology 19(1): 48-64.
17. Miller SD, Duncan BL, Brown J (2003) The outcome rating scale: A preliminary study of the reliability validity and feasibility of a brief visual analog measure. Journal of Brief Therapy 2(2): 91-100.
18. Duncan BL, Miller SD, Sparks J, Claud DA, Reynolds LR, et al. (2003) The session rating scale: Preliminary psychometric properties of a "working" alliance measure. Journal of Brief Therapy 3(1): 3-12.
19. Olver ME, Wong SCP (2011) Treatment programs for high-risk sexual offenders: Program and offender characteristics, attrition, treatment change and recidivism. Aggression and Violent Behaviour 16(4): 309-320.