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Quality of life of violent and sexual offenders in community-based forensic psychiatric treatment

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Subjective well-being is a common outcome measure in the evaluation of treatment in general psychiatry, but not yet in forensic psychiatry. The impact of quality of life, defined in terms of objective indicators and subjective well-being, on criminal recidivism is unknown. Several criminological theories, such as Ward's good lives model, point at a possible relationship. In a study of male forensic psychiatric outpatients suffering from personality disorders, the quality of life of sexual and violent offenders was compared, using the Dutch version of the Lancashire Quality of Life Profile. The results indicated that although sexual offenders and violent offenders hardly differed on objective indicators of quality of life, their judgments of their subjective well-being differed significantly. Sexual offenders were more satisfied in general and in particular with their family relationships, safety, and health. For both groups, different objective and subjective indicators correlated with global well-being. Assessment of domain-specific objective and subjective issues and global well-being, at the beginning of treatment, may improve the effectiveness of treatment and the quality of life of the forensic patient.

Keywords: quality of life; community-based forensic psychiatry; Lancashire Quality of Life Profile; sexual offenders; violent offenders

Introduction

Following the good lives model (GLM; Ward, 2002), it can be hypothesised that reductions in criminal offending can be established by creating more fulfilling and meaningful lives for offender populations, including those with mental disorders. In theories of quality of life (QoL), striving for the good life is regarded as the most important goal in life (e.g., Diener & Suh, 1997;

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King, 2001; Oliver, Huxley, Bridges, & Mohamad, 1996). Although several criminological theories emphasise aspects of this good life notion (e.g., Agnew, 1992; Rovers, 1998), it is far from clear what empirical relationship exists between criminal behaviour and subjective well-being. In the GLM, offenders are seen as active agents striving for the highest level of well-being through achieving human goods (Ward & Brown, 2004). Their criminogenic needs are considered obstacles to the achievement of these primary goods. According to the GLM model, rehabilitation should focus both on reduction of risk factors and on promoting the attainment of human goods. This theory has not yet received a great deal of empirical support due to a lack of research, other than two unpublished studies mentioned by Ward, Mann, and Gannon (2007) and one experiment evaluating different treatment approaches based on the GLM (Mann, Webster, Schofield, & Marshall, 2004). There is little empirical knowledge on the subject of the well-being of offenders (Ogloff & Davis, 2004); neither has there been much attention to QoL in forensic psychiatry (Van Nieuwenhuizen, Schene, & Koeter, 2002). The current study is an attempt to fill a part of this gap.

The concept of quality of life

Diener and Suh (1997) mention three philosophical approaches to the good life resulting in three different groups of indicators: economic, social, and subjective. This division of QoL indicators into three categories is generally accepted in QoL research (Farquhar, 1995; Glatzer & Mohr, 1987; Goodinson & Singleton, 1989; McCall, 1975). A broad definition using indicators in a wide range of life domains is also accepted in psychiatry (Lehman, 1983; Oliver et al., 1996; WHOQOL Group, 1998). There is a debate regarding whether to solely focus on subjective indicators or to include both objective and subjective indicators in the study of QoL; this has not been resolved (Goodinson & Singleton, 1989; Lehman, 1983; Orley, Saxena, & Herrman, 1998; Simmons, 1994). In the current research, both types of indicators were used to measure global QoL. This choice was made because a combination of these indicators best reflects treatment goals in community-based forensic psychiatry.

Quality of life in forensic outpatients

Four studies have examined the QoL of forensic psychiatric outpatients, and one studied sexual offenders in a correctional community centre or 'halfway house'.

Draine and Solomon (1992) studied clients with or without an arrest history, mainly suffering from schizophrenia (85%), attending a community mental health centre. The patients with an arrest history were more dissatisfied with their current living arrangements, with how they spent

their time, and with their personal safety. These patients more often lived in non-independent housing and had smaller social networks than patients without an arrest history.

In another study of QoL, Draine and Solomon (2000) explored the role of anxiety, depression, and continued involvement with the criminal justice system in psychiatric patients suffering from depression, mania, or schizophrenia, on probation or parole. They concluded that the 'quality of community life for persons with a mental illness can have a significant impact on affective symptom course' (p. 44), and could therefore have an impact on criminal recidivism.

Gerber et al. (2003) explored objective and subjective QoL in forensic patients ($n = 15$), mainly diagnosed with schizoaffective disorder and on Disposition Order specifying conditional discharge, and general psychiatric outpatients ($n = 48$). They reported that the forensic outpatients were more satisfied with their family relationships, with work/school, in the legal and safety domain, and with their global QoL. They seemed less satisfied in the financial domain.

Chung, Cumella, Wensley, and Easthope (1998) compared the subjective QoL of mentally disordered offenders in a court diversion scheme with normative data from a general population. A small proportion (4.6%) of the outpatients suffered from a personality disorder. Six months after entering the program, half of the offenders lived at home, whereas the others lived in hostels (20%), prison (22%), or a psychiatric hospital (9%). The mentally disordered offenders scored lower on all domains than the general population. This difference could be explained by living arrangements, because patients living at home or in hostels tended to have similar scores to the general population.

Williams (2003) quantitatively and qualitatively explored the QoL of 23 male sex offenders participating in sex offender treatment in a community correctional setting, or 'halfway house', as part of their parole or probation agreements. There was no control group. No data on offenders' psychiatric diagnoses were reported. Results from the quantitative part of the study indicated that the participants were neither satisfied nor dissatisfied with their living situation, total QoL, leisure, social relationships, and access to medical care. They were dissatisfied with their finances and satisfied with their family relationships and health. Combining the quantitative and qualitative parts of the study, the author concluded that QoL for sex offenders may be primarily related to degree of freedom, interpersonal relationships (especially with family), and positive emotions.

The vast majority of patients treated in forensic outpatient facilities in the Netherlands are male and suffer from a personality disorder (Hildebrand & De Ruiter, 2004; Plemper, 2001). Patients with personality disorders (PD) have generally been found to have lower global subjective well-being than patients with psychotic disorders (Lehman, 1999; Swinton, Oliver, &

Carlisle, 1999) or the general population (Narud, Mykletun, & Dahl, 2005). Co-morbidity of a PD with a major mental disorder also seems to lead to lower subjective QoL (Draine & Solomon, 2000; Masthoff et al., 2006). However, in most of these studies (Draine & Solomon, 2000; Lehman, 1999; Masthoff, Trompenaars, Van Heck, Hodiamont, & De Vries, 2006; Narud et al., 2005), a large percentage of the samples consisted of women. Previous studies have demonstrated significant differences in subjective well-being between male and female psychiatric patients (Slade et al., 2004; Van Nieuwenhuizen, 1998), with men reporting a higher QoL. Furthermore, the difference between forensic psychiatric patients and other groups could be influenced by living circumstances (see Draine & Solomon, 1992; Williams, 2003): patients living in non-independent housing display lower levels of subjective well-being than patients living in independent circumstances (Chung et al., 1998).

Quality of life of different types of offender

It is unknown whether forensic patients with non-sexually aggressive behaviour and those patients who have committed a sexual offence perceive their lives differently, and consider different life domains important. Ward et al. (2007) reported that the absence of three types of human goods – agency, inner peace, and relatedness – was strongly associated with sexual offending. Swinton, Carlisle, and Oliver (2001) noted that sexual offenders, especially child molesters, might define a good QoL differently from violent offenders, due to different life goals and (unmet) needs.

Due to these presumed differences between male and female patients, between patients with a psychotic disorder and patients with a PD, and between patients living in non-independent housing and patients living in independent housing, we compared two groups of adult male personality-disordered forensic outpatients who differed only in terms of type of offence. The two groups comprise sexual and violent offenders. The results of this study could provide information for treatment planning by identifying those aspects of a patient's life which can be considered problematic, using objective social indicators and subjective assessments by the patient. Following risk–needs–responsivity principles (see Ogloff & Davis, 2004), the results may aid clinicians in establishing treatment relationships with patients, which can form a starting point for addressing criminogenic needs.

Method

Setting

Patients were recruited from four forensic psychiatric outpatient treatment centres throughout the Netherlands. In total, the four outpatient facilities

have 11 locations in large (population approx. 500,000) and midsize (population approx. 100,000) cities, each with a regional service function. Most of the patients have a court order which requires them to participate in treatment to reduce the risk of re-offending. Treatment generally consists of psychotherapy, psychiatric consultation, pharmacotherapy, and social assistance by a psychiatric nurse or social worker. In some cases, art therapy or social skills training is offered. These forms of therapy can be given either individually, in groups, or in a couple format.

Participants

The inclusion criteria were: male gender; 18 years or above; IQ higher than 70; and suffering from a PD or PD traits (DSM-IV-TR; American Psychiatric Association, 2000) without a predominant Axis 1 disorder. Co-morbidity with an Axis 1 disorder was allowed as long as the Axis 1 disorder was not primarily a mood, anxiety, or psychotic disorder. Patients had to have contact at least once a month with a clinician from the forensic treatment centre.

A sample of 214 patients were contacted by their therapist or the first author and handed a leaflet containing basic information about the present study: 79 did not want to participate (36.9%), and 135 agreed to participate. All gave informed consent. On average, these patients had been in treatment for almost two years (644 days, $SD = 636$), ranging from a patient just entering treatment to a patient who had been in treatment for over eight years. Patients who did not participate did not differ from patients who consented with regard to age, substance abuse, the presence of paraphilic disorder (DSM-IV-TR diagnoses), or on most criminal history variables (ever convicted, ever incarcerated, violent or sexual offence). Patients who did not participate had co-morbid Axis 1 disorders more often (41.6% vs. 21.5%; $\chi^2[1] = 9.64$; $p = .002$), and had less often been arrested before the age of 16 (6.9% vs. 28.5%; $\chi^2[1] = 13.03$; $p = .000$) than patients who participated. For five patients, it was impossible to make a second appointment; file information was used to score the Level of Service Inventory–Revised (Andrews & Bonta, 1995). More than half of the patients (57.8%) had displayed violent behaviour for which treatment was recommended; 28% were in treatment because of sexually violent behaviour; 13% had committed a property offence and 6% had committed arson; two patients showed both aggressive and sexually violent behaviour. Of the sexual offenders, 66% had molested children. Patients who had committed arson or a property offence were excluded, unless they had also exhibited aggressive or sexually violent behaviour. The patients with both aggressive and sexually violent behaviour were also excluded from the study, which led to a final sample of 76 patients with violent behaviour and 36 patients with sexually violent behaviour.

Instruments

Quality of Life

We used the extended Dutch version of the Lancashire Quality of Life Profile (LQoLP; Van Nieuwenhuizen, Schene, & Koeter, 1998) to measure objective and subjective QoL. This structured interview assesses seven life domains: leisure and social participation (26 items), religion (2 items), finances (9 items), living arrangements (8 items), legal status and safety (8 items), family relations (8 items), and health (16 items). No data on the subjective rating of religion were gathered in the present study. The internal consistency of the Dutch version of the LQoLP is adequate to good (Cronbach's alpha range = .62–.84). The two-week test–retest reliability ranges from .67 to .90 (Van Nieuwenhuizen, 1998).

At the end of the interview, each patient was asked to rate his overall life quality at the moment, by indicating on a 100 mm ladder how he perceives his life on a continuum ranging from 'life at its worst' to 'life at its best'. This is called Cantril's ladder. A score of $\leq$50 mm was regarded as dissatisfaction, and $\geq$51 mm as satisfaction.

The Life Satisfaction Scale (LSS) was also used in the interview: patients were asked to state their satisfaction with 32 subjective items from the six domains, using a scoring system ranging from 1 ('cannot be worse') to 7 ('cannot be better'). A mean domain score of <4 was regarded as dissatisfied, and $\geq$4 as satisfied.

Criminal history

Here we used a section of the Level of Service Inventory–Revised (LSI-R; Andrews & Bonta, 1995, 2000). The LSI-R is a measure of risk and need assessment. It was developed to determine offenders' needs for assistance when reintegrating into society. The interrater reliability of the English version of the LSI-R ranges from moderate (.71 in Austin, Coleman, Peyton, & Johnson, 2003) to good (.80 to .96 in Andrews & Bonta, 1995; .88 in Austin et al., 2003) depending, according to the latter authors, on the degree of training of raters. The interrater reliability of the Dutch version of the LSI-R is good (.87; De Rooy, 2004). The LSI-R in the present study was scored using file and interview data. The interviews were conducted by the first author or by master's-level psychology students as part of their clinical internship. They all were trained in administering the instruments used.

Demographic background

Demographic variables are assessed by the LQoLP. Additional information with regard to psychiatric diagnosis and background was taken from patient files or gathered during the LSI-R interview. Psychiatric classification was

determined by clinicians who were treating the patients, which resulted in Axis 1 and/or 2 diagnoses. These clinicians indicated whether the primary diagnosis related to treatment in the forensic facility was the Axis 1 or the Axis 2 disorder. Patients were included if they were diagnosed with PD traits or with a PD. PD traits are defined as sub-clinical PD, which means the patients show a number of traits of one or more PDs, but do not meet the required number to reach the clinical threshold. Patients with a current mood, anxiety, or psychotic disorder were excluded, as were patients with a lifetime psychotic disorder. Clinicians who performed the assessment were all trained in using the DSM standard as part of their professional education.

Statistical analyses

Student's t tests were used to examine differences between sexual and violent offenders on ordinal or interval variables. Pearson χ^2 was used to examine group differences on nominal variables. Furthermore, Pearson's r was calculated to indicate correlations between scale variables. Significance levels were set at $\alpha \leq .05$. If applicable, a Bonferroni correction was employed.

Results

Demographic background

Violent offenders and sexual offenders did not differ significantly with regard to age, educational level, IQ, or income (see Table 1).

Psychiatric background

Violent and sexual offenders did not differ in terms of prevalence of PD (Table 2). However, the two offender groups had different types of PDs.

Table 1. Demographic characteristics.

	Violent ($n = 76$)		Sexual ($n = 36$)		Pearson's χ^2/t test	
	P or M	*SD*	P or M	*SD*	Value	*p*
Education: none or primary school	39.5		33.3			n.s.
Receiving social benefit	63.2		47.2			n.s.
Average debts, in euros	15,778[a]	18,668	16,944[b]	20,867		n.s.
Income per month, average in euros	1026	594	1101[c]	443		n.s.
Children? If yes: how many?	2.3[d]	1.3	1.9[e]	1.6		n.s.
Average age	37.5	9.1	41.1	12.3		n.s.

Note: P = Percentage of group; M = Mean per group.
[a]$n = 49$; [b]$n = 16$; [c]$n = 34$; [d]$n = 45$; [e]$n = 14$.

Table 2. Clinical characteristics and criminal background.

	Violent ($n = 76$)		Sexual ($n = 36$)		Pearson's χ^2/t test	
	P or M	*SD*	P or M	*SD*	Value	*p*
Reason for treatment: offence*	65.8		86.1		5.04	.025
Framework treatment: mandatory**	31.6		61.1		8.80	.003
Prior psychiatric treatment	72.4		58.4			n.s.
Personality disorder	71.1		66.7			n.s.
Cluster B PD*	28.9		8.3		6.06	.048
Cluster C PD	3.9		13.9			n.s.
Used medication for mental health problems in previous year	52.6		36.1			n.s.
Offence history: ever convicted	75.3[c]		71.4[d]			n.s.
Average number of convictions	3.61	5.23	1.97	4.33		n.s.
Incarceration: yes	46.6[a]		45.7[b]			n.s.
Been accused of crime in previous year**	50.0		22.2		7.79	.005
Judicial charge for violence***	90.4[a]		31.4[b]		40.22	.000
Arrested before age 16*	34.2[a]		11.4[b]		6.27	.012
Same delinquent behaviour before admission*	75.7[e]		54.3[b]		4.97	.026
Criminal family member*	49.3[a]		24.2[b]		5.78	.016
Criminal acquaintances	75.3[a]		67.6[b]			n.s.
Criminal friends	44.4[a]		27.3[b]			n.s.

Note: P = Percentage of group; M = Mean per group.
[a]$n = 73$; [b]$n = 35$; [c]$n = 69$; [d]$n = 32$; [e]$n = 70$.
*$p \leq .05$; **$p \leq .01$; ***$p \leq .001$.

Over three times more violent offenders were diagnosed with a Cluster B PD (borderline, antisocial, or narcissistic PD) than sexual offenders. Moreover, sexual offenders tended ($p = .06$) to have a Cluster C PD (dependant, avoidant, or obsessive-compulsive PD) more often than violent offenders. No significant differences were found between the two groups with regard to prior psychiatric hospitalisations, mental health treatment, or use of medication.

Criminal history

Most patients treated at the outpatient facilities had a criminal history (Table 2). About three-quarters had previous convictions. Although the same number of violent and sexual offenders had previous convictions, four times more violent offenders than sexual offenders had been convicted three times or more ($F[1] = 11.98$; $p = .001$), with a maximum of 35 convictions. Over a quarter of the patients had been arrested before 16 years of age, including three times more violent offenders than sexual offenders. Nearly half (46%) of the patients had been incarcerated after a conviction as an adult. Twice as many violent offenders as sexual offenders had been accused of a crime during the year prior to the interview. For 41.1% of the patients, the background for

the current treatment was a conditional sentence in combination with mandatory treatment. The sexual offenders' treatment was mandatory twice as often as that of violent offenders. More violent offenders than sexual offenders had a family member with a criminal record. Overall, violent offenders had a more severe criminal history than sexual offenders.

Social indicators of quality of life

Violent and sexual offenders did not differ on objective QoL, as indicated by the average number of positive social indicators (see Table 3). However, the two groups differed in terms of several underlying circumstances. More violent offenders had children, more of them had debts, and more of them were religious, compared with sexual offenders. Sexual offenders more frequently had contact with their family than violent offenders.

Domain-specific subjective quality of life

Overall, sexual offenders were satisfied in more domains than violent offenders (see Figure 1; mean for sexual offenders = 5.2, for violent

Table 3. Social indicators of quality of life.

	Violent ($n = 76$)		Sexual ($n = 36$)		Pearson's χ^2/t test	
	P or M	*SD*	P or M	*SD*	Value	*p*
Work: yes	30.3		47.2		3.06	n.s. (.080)
Been out to watch or participate in sports in the past two weeks	46.1		33.3			n.s.
Average of leisure activities (max. = 4)	3.1	0.9	3.1	0.6		n.s.
Relationship: yes	53.9		36.1		3.11	n.s. (.078)
Children: yes*	59.2		38.9		4.05	.044
Has a friend who will help when needed	69.7		72.2			n.s.
Daily or weekly family contact**	72.4		94.4		7.30	.007
Debts: yes*	67.1		44.4		5.22	.022
Living situation: alone	32.9		44.4			n.s.
Been victim of violence in previous year	25.0		33.3			n.s.
Been hospitalised in psychiatric hospital in the previous year	6.6		5.6			n.s.
Religious: yes**	60.5		30.6		8.78	.003
Average number of positive social indicators[†]	6.6	1.7	6.3	1.9		n.s.

Note: P = Percentage of group; M = Mean per group.
*$p \leq .05$; **$p \leq .01$; ***$p \leq .001$; [†]range = 0–11 (average leisure activities not included).

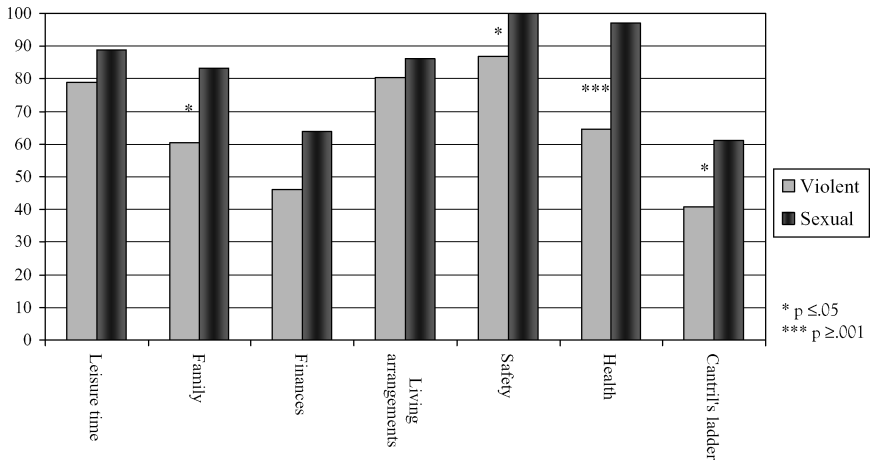

Figure 1. Proportion of satisfied violent and sexual patients per domain and in general.

offenders = 4.2; $F = 14.63$; $p = .000$). Significantly more sexual offenders than violent offenders were satisfied with their family, safety, and health. In the other life domains, the differences were not significant.

In terms of domain-specific indicators, patients were satisfied with most aspects of their leisure time and social activities, except with their sexual activities. Violent patients were neither satisfied nor dissatisfied with their daily structure, whereas sexually violent patients were significantly more satisfied in this respect. On most of the variables of the family domain the groups did not differ significantly, except for family support: violent patients were on average neither satisfied nor dissatisfied whereas patients who had committed a sexual crime were satisfied. Violent patients were significantly less satisfied with the amount of money they had, their income, and how much money they could spend on leisure activities. Violent offenders evaluated the quality of their housing similarly to sex offenders. On average, both patient groups felt satisfied about their safety. Subjectively, patients who had committed a sexual offence were significantly more satisfied with every aspect of their health, except for the perceived attitude of their doctor towards their mental health problems, compared to violent patients. Violent offenders tended to be neither positive nor negative with regard to their health, while sexual offenders were satisfied with every aspect of their mental and general health.

Global subjective quality of life

Violent offenders were less satisfied with their current life, as measured by Cantril's ladder, than patients who had committed a sexual offence (see Figure 1; $\chi^2[1] = 4.05$; $p = .044$).

Prior to an examination of the relationship between objective and subjective indicators and global subjective well-being, bivariate correlations among the social indicators and among the domain-specific subjective indicators were calculated in order to check for possible multi-collinearity. No correlations of .5 or higher were found between social indicators for the total group, for the group of violent offenders, or for the group of sexual offenders. Subjective well-being with regard to health and with regard to leisure and social participation correlated significantly at .51 for the total group. No correlations higher than the threshold were found among domain-specific subjective indicators for the group of violent offenders. For the group of sexual offenders, the correlations between satisfaction with health and satisfaction with leisure and social participation, and between satisfaction with health and satisfaction with living arrangements, were .74 and .56 respectively. When calculating the correlations between the objective and subjective indicators and global subjective well-being, we therefore applied a Bonferroni correction for these three subjective indicators.

The relationships between objective and domain-specific subjective QoL scores on the one hand, and a global measure of QoL (i.e., Cantril's ladder) on the other, revealed different pictures for violent offenders and sexual offenders (see Table 4). For violent offenders, having paid work and not having financial debts correlated with high scores on Cantril's ladder. For sexual offenders, having a religious faith correlated with lower scores on Cantril's ladder. For violent offenders, the total number of positive objective indicators correlated with Cantril's ladder, indicating that more positive circumstances correlated with higher global subjective well-being.

Of the domain-specific subjective ratings, satisfaction with leisure time and social participation, finances, and health all correlated with Cantril's ladder for both groups of offenders. For violent offenders, satisfaction with safety also correlated with Cantril's ladder; however, this was not the case for sexual offenders. Satisfaction with family was not correlated with the Cantril's ladder score for either group. The total number of domains with which patients were dissatisfied correlated negatively with Cantril's ladder for both groups.

Discussion

This study aimed to compare sexual and violent male forensic outpatients in terms of quality of life and its determinants. Sexual and violent offenders displayed the same objective QoL. Subjectively, sexual offenders were more satisfied with their life in general and with their health, safety, and family relationships, compared to violent offenders. For violent and sexual offenders different indicators were associated with global well-being.

Although violent offenders and sexual offenders did not differ with regard to their total score on objective indicators, they did differ from sexual

Table 4. Bivariate correlations of objective and subjective quality of life measures with scores on Cantril's ladder.

	Violent ($n = 76$)		Sexual ($n = 36$)	
	r	p	r	p
Social indicators[#]				
Relationship	.08		.00	
Work	.29	.012	.23	
Debts	.29	.012	.20	
Been victim of violence in previous year	.15		.14	
Children	−.02		−.12	
Religious	−.08		−.41	.014
Been out to participate in or watch sports in the past two weeks	.14		−.15	
Average of leisure activities (max. = 4)[‡]	.22		.06	
Daily or weekly family contact	.01		−.22	
Has a friend who will help when needed	.10		−.02	
Living situation	.07		−.09	
Been hospitalised in psychiatric hospital in the previous year	.08		.05	
Number of positive social indicators	.29	.010	−.06	
Average life satisfaction on domains				
Leisure time and social participation	.37	.001	.59	.000
Family	.08		.05	
Finances	.42	.000	.41	.014
Living arrangements	.05		.20	
Safety	.32	.005	.16	
Health	.42	.000	.52	.001
Number of domains dissatisfied	−.39	.001	−.54	.001

[#]Lower scores on social indicators imply negative circumstances; [‡]not used for sum of positive social indicators.

offenders on four of the social indicators. Violent offenders had more debts, were more often religious, more often had children, had less contact with family members, tended to be unemployed more often, and tended to be in an intimate relationship more often. Other studies (Hanson, Scott, & Steffy, 1995; Lievore, 2004) have also reported that rapists and child molesters tend more often to be single than other types of offender. However, Craig, Brown, Beech, and Stringer (2006) found that violent offenders were more often single than sexual and other offenders. In line with our findings, Craig et al. (2006) demonstrated that violent offenders more often had a history of school and employment problems than sexual and other offenders. The results of our study with regard to having children are comparable to other studies (see Lievore, 2004). Overall, forensic outpatients in the current sample seemed to have an unfavourable socio-economic position. Compared to the Dutch male adult population (Centraal Bureau voor de Statistiek,

n.d.), our offender groups more often had little education, were unemployed, had financial problems, and did not have an intimate relationship. Only 6.8% of the adult male Dutch workforce has either an unknown level of education or only primary school. Furthermore, 5% of Dutch households have serious financial problems, and 14.5% of the male Dutch population is single.

In general, the majority of the sexual offenders were satisfied, while most violent offenders were dissatisfied. Most violent and sexual offenders were satisfied with their leisure time, social participation, living circumstances, and safety. Both groups were neither satisfied nor dissatisfied with their financial situation. Violent patients were neither satisfied nor dissatisfied with their family relationships and their health, while sexual offenders were satisfied. Sexual offenders were also more satisfied with a number of other domains, such as general and mental health. Compared to the findings of Williams (2003), the sexual offenders in our study were more satisfied with their living arrangements, leisure time, social relationships, and finances. The sexual offenders in Williams' study resided in a halfway house, and might therefore have been more limited in their autonomy with regard to leisure time and social relationships, and thus have been less satisfied with their living arrangements.

Comparing objective social indicators with domain-specific subjective well-being, the patients in our sample seemed to be relatively satisfied with their circumstances, despite their relatively unfavourable social position. This might reflect a different set point or benchmark for satisfaction. Patients seem to adapt to less positive circumstances by redefining their situation, and altering their ideals towards more realistic goals (also called response shift; Schwartz & Sprangers, 2000).

When we explored the relationships between the objective and subjective indicators of QoL and global well-being, different pictures emerged for violent offenders and sexual offenders. For sexual offenders, having a religious belief correlated negatively with global subjective well-being. For violent offenders, financial situation and employment status correlated significantly with Cantril's ladder, as did their overall objective situation. The two groups did not differ significantly on many domain-specific subjective indicators. However, among violent offenders, subjective assessment of safety correlated significantly with Cantril's ladder, which was not the case for sexual offenders. Living arrangements and family do not seem to play an important role in these offenders' current lives; the objective and subjective indicators in these areas did not correlate with their overall well-being. The relationship between religion and global well-being for sexual offenders is somewhat counter-intuitive. However, the strong values regarding sexual behaviour generally advocated by religions may prompt sexual offenders to feel bad about their lives because they have broken the rules set by their religion.

Sexual offenders were more satisfied with their lives in general than violent offenders. What could account for this difference? Do sexual offenders have different belief systems; are their expectations different from those of violent offenders? Violent offenders were diagnosed with a Cluster B PD more frequently than sexual offenders. Patients with a Cluster B PD report lower QoL (Chen et al., 2006) and, more specifically, patients with antisocial PD characteristics have been found to be more dissatisfied than patients without such traits (Sareen, Stein, Cox, & Hassard, 2004). Furthermore, violent offenders tend to have a more chaotic lifestyle than sexual and general offenders (Craig et al., 2006). In combination with the fact that violent offenders more often were diagnosed as suffering from a Cluster B PD, violent offenders could be more prone to strain as a result of interpersonal conflict and a chaotic lifestyle than sexual offenders. According to Agnew (1992), strain leads to negative affect and negative affect has been found to influence subjective QoL negatively (Baker & Intagliata, 1982; Diener & Suh, 1997).

The good lives model (GLM; Ward, 2002; Ward et al., 2007) offers a framework for constructing treatment for sexual offenders, based on positive psychology. Clinicians can try to motivate offenders to pursue more socially acceptable goals as personally meaningful and valuable through insight into the value of alternative ways of living (Ward & Brown, 2004). Several cautionary remarks should be made here. First, a treatment approach solely focussing on positive psychology can lead to inattention to criminogenic needs, which caused the original criminal behaviour. Second, sexual offenders demonstrate higher subjective well-being than seems plausible, based on their objective circumstances. Sexual offenders are known frequently to deny and minimise their offences (Ward, Hudson, & Marshall, 1995). This tendency may also be present in their subjective QoL assessment. Third, the set of goods used in the GLM may reflect a set of values based on a particular subset of the general population. Patients seem to come from lower SES groups, whereas the goods used in the GLM may be applicable to a middle class population and may not be as relevant to individuals from other socioeconomic or cultural groups.

One of the weaknesses of this study is that only a small group of sexual offenders participated. In order to explore more fundamentally the concept of QoL in this group, it would be useful to study a larger sample of sexual offenders, preferably differentiating between child molesters and rapists. The objective of this study was to explore the QoL of a sample homogeneous with regard to mental disorder. Diagnostic procedures can influence the reliability and validity of psychiatric diagnoses; however, although the clinicians who diagnosed these patients did not use standardised interviews, all had been trained in diagnostic interviewing during their formal education.

When a patient enters treatment, one of the primary objectives is to create a situation where treatment can have a positive effect on the patient's life. For forensic patients, this often means creating order in the chaos.

Violent patients seem to be more aware of the problem areas in their lives than sexual offenders. After assessing the objective problem domains, these can be addressed in treatment. According to Slade et al. (2004), the QoL of psychiatric outpatients can be influenced by assessing the unmet needs formulated by patients. For violent patients, forensic treatment programs tend to focus on impulse control and anger management, which are legitimate and logical treatment targets. However, our study shows that by administering a more general QoL measure at intake assessment, other problem domains, which also require attention, may surface. For instance, finances seem to be problematic for a large proportion of violent offenders.

Forensic treatment should target specific life domains which have been found to correlate with the risk of recidivism. Several dynamic factors, such as having an intimate relationship (Odonne-Paolucci, Violato, & Schofield, 2000), work, a stable financial situation (Gendreau, Goggin, & Gray, 2000), and structured leisure activities (for adolescents; Hoge, Andrews, & Leschied, 1996), can protect against future criminal behaviour. Treatment cannot change a criminal history, but it can try to provide a favourable starting point by helping forensic patients to change their objective circumstances and aim towards a better life.

References

Agnew, R. (1992). Foundation for a general strain theory of crime and delinquency. *Criminology*, *30*, 47–87.

American Psychiatric Association (2000). *Diagnostic and statistical manual of mental disorders* (4th edition, text rev.). Washington, DC: Author.

Andrews, D.A., & Bonta, J.L. (1995). *The Level of Service Inventory–Revised*. Toronto, Canada: Multi-Health Systems.

Andrews, D.A., & Bonta, J.L. (2000). *Level of Service Inventory–Revised: User's manual*. Toronto, Canada: Multi-Health Systems.

Austin, J., Coleman, D., Peyton, J., & Johnson, K.D. (2003). *Reliability and validity study of the LSI-R risk assessment instrument*. Washington, DC: George Washington University Institute on Crime, Justice, and Corrections. Retrieved June 21, 2005, from http://www.pccd.state.pa.us/pccd/lib/pccd/stats/lsi_r_final_report.pdf

Baker, F., & Intagliata, J. (1982). Quality of life in the evaluation of community support systems. *Evaluation and Program Planning*, *5*, 69–79.

Centraal Bureau voor de Statistiek (n.d.) [Indices]. Available from Centraal Bureau voor de Statistiek website. Retrieved December 5, 2007, from http://www.cbs.nl/nl-NL

Chen, H., Cohen, P., Crawford, T.N., Kasen, S., Johnson, J.G., & Berenson, K. (2006). Relative impact of young adult personality disorders on subsequent quality of life: Findings of a community-based longitudinal study. *Journal of Personality Disorders*, *20*, 510–523.

Chung, M.C., Cumella, S., Wensley, J., & Easthope, Y. (1998). Quality of life and psychological well-being of mentally disordered offenders after court diversion: A 6-month follow-up. *International Journal of Offender Therapy and Comparative Criminology*, *42*, 164–173.

Craig, L.A., Brown, K.D., Beech, A., & Stringer, I. (2006). Differences in personality and risk characteristics in sex, violent and general offenders. *Criminal Behaviour and Mental Health*, *16*, 183–194.

De Rooy, A. (2004). Risicotaxatie in de forensische psychiatrie: Psychometrische evaluatie van de Level of Service Inventory-Revised [Risk assessment in forensic psychiatry: Psychometric evaluation of the Level of Service Inventory-Revised]. Unpublished master's thesis. Maastricht University, the Netherlands.

Diener, E., & Suh, E. (1997). Measuring quality of life: Economic, social, and subjective indicators. *Social Indicators Research*, *40*, 189–216.

Draine, J., & Solomon, P. (1992). Comparison of seriously mentally ill case management clients with and without arrest histories. *Journal of Psychiatry and the Law*, *20*, 335–349.

Draine, J., & Solomon, P. (2000). Anxiety and depression symptoms and quality of life among clients of a psychiatric probation and parole service. *Psychiatric Rehabilitation Journal*, *24*, 38–45.

Farquhar, M. (1995). Definitions of quality of life: A taxonomy. *Journal of Advanced Nursing*, *22*, 502–508.

Gendreau, P., Goggin, C., & Gray, G. (2000). *Case need review: Employment domain*. Saint John, NB: University of New Brunswick Centre for Criminal Justice Studies.

Gerber, G.J., Prince, P.N., Duffy, S., McDougall, L., Cooper, J., & Dowler, S. (2003). Adjustment, integration, and quality of life among forensic patients receiving community outreach services. *International Journal of Forensic Mental Health*, *2*, 129–136.

Glatzer, W., & Mohr, H.M. (1987). Quality of life: Concept and measurement. *Social Indicators Research*, *19*, 15–38.

Goodinson, S.M., & Singleton, J. (1989). Quality of life: A critical review of current concepts, measures and their clinical implications. *International Journal of Nursing Studies*, *26*, 327–341.

Hanson, R.K., Scott, H., & Steffy, R.A. (1995). A comparison of child molesters and nonsexual criminals: Risk predictors and long-term recidivism. *Journal of Research in Crime and Delinquency*, *32*, 325–337.

Hildebrand, M., & De Ruiter, C. (2004). PCL-R psychopathy and its relation to DSM-IV Axis I and II disorders in a sample of male forensic psychiatric patients in the Netherlands. *International Journal of Law and Psychiatry*, *27*, 233–248.

Hoge, R.D., Andrews, D.A., & Leschied, A. (1996). An investigation of risk and protective factors in a sample of youthful offenders. *Journal of Child Psychology and Psychiatry and Allied Disciplines*, *37*, 419–424.

King, L.A. (2001). The hard road to the good life: The happy, mature person. *Journal of Humanistic Psychology*, *41*, 51–73.

Lehman, A.F. (1983). The well-being of chronic mental patients. *Archives of General Psychiatry*, *40*, 369–373.

Lehman, A.F. (1999). A review of instruments for measuring quality-of-life outcomes in mental health. In N.E. Miller & K.M. Magruder (Eds.), *Cost-effectiveness of psychotherapy: A guide for practitioners, researchers, and policymakers* (pp. 174–181). New York: Oxford University Press.

Lievore, D. (2004). *Recidivism of sexual assault offenders: Rates, risk factors and treatment efficacy*. Canberra: Australian Institute of Criminology.

Mann, R.E., Webster, S.D., Schofield, C., & Marshall, W.L. (2004). Approach versus avoidance goals in relapse prevention with sexual offenders. *Sexual Abuse: A Journal of Research and Treatment*, *16*, 65–75.

Masthoff, E.D., Trompenaars, F.J., Van Heck, G.L., Hodiamont, P.P., & De Vries, J. (2006). Quality of life and psychopathology: Investigations into their relationship. *Australian and New Zealand Journal of Psychiatry*, *40*, 333–340.

McCall, S. (1975). Quality of life. *Social Indicators Research*, *2*, 229–248.

Narud, K., Mykletun, A., & Dahl, A.A. (2005). Quality of life in patients with personality disorders seen at an ordinary psychiatric outpatient clinic. *BMC Psychiatry*, *5*, 10. Retrieved May 2, 2005, from http://www.biomedcentral.com/1471-244x/5/10

Odonne-Paolucci, E., Violato, C., & Schofield, M.A. (2000). *A review of marital and family variables as they relate to adult criminal recidivism*. Calgary, Canada: National Foundation for Family Research and Education.

Ogloff, J.R.P., & Davis, M.R. (2004). Advances in offender assessment and rehabilitation: Contributions of the risk–need–responsivity approach. *Psychology, Crime and Law*, *10*, 229–242.

Oliver, J., Huxley, P., Bridges, K., & Mohamad, H. (1996). *Quality of life and the mental health services*. London: Routledge.

Orley, J., Saxena, S., & Herrman, H. (1998). Quality of life and mental illness: Reflections from the perspective of the WHOQOL. *British Journal of Psychiatry*, *172*, 291–293.

Plemper, E. (2001). *Ambulante forensische psychiatrie: Onderzoek forensisch psychiatrische poli- en dagklinieken* [Community-based forensic psychiatry: Research forensic outpatient and day-treatment facilities]. Utrecht, the Netherlands: Verwey-Jonker Instituut.

Rovers, B. (1998). Theoretische integratie van Hirschi en Merton [Theoretical integration of Hirschi and Merton]. *Tijdschrift voor Criminologie*, *40*, 151–165.

Sareen, J., Stein, M.B., Cox, B.J., & Hassard, S.T. (2004). Understanding comorbidity of anxiety disorders with antisocial behaviour: Findings from two large community surveys. *The Journal of Nervous and Mental Disease*, *192*, 178–186.

Schwartz, C.E. & Sprangers, M.A.G., (Eds.). (2000). *Adaptation to changing health: Response shift in quality-of-life research*. Washington, DC: American Psychological Association.

Simmons, S. (1994). Quality of life in community mental health care: A review. *International Journal of Nursing Studies*, *31*, 183–193.

Slade, M., Leese, M., Ruggeri, M., Kuipers, E., Tansella, M., & Thornicroft, G. (2004). Does meeting needs improve quality of life?. *Psychotherapy and Psychosomatics*, *73*, 183–189.

Swinton, M., Carlisle, J., & Oliver, J. (2001). Quality of life for patients with a personality disorder – comparison of patients in two settings: An English special hospital and a Dutch TBS clinic. *Criminal Behaviour and Mental Health*, *11*, 131–143.

Swinton, M., Oliver, J., & Carlisle, J. (1999). Measuring quality of life in secure care: Comparison of mentally ill and personality disordered patients. *International Journal of Social Psychiatry*, *45*, 284–291.

Van Nieuwenhuizen, C. (1998). *Quality of life of persons with severe mental illness: An instrument*. Amsterdam: Thesis Publishers.

Van Nieuwenhuizen, C., Schene, A.H., & Koeter, M.W.J. (1998). *Lancashire Kwaliteit van Leven Profiel, uitgebreide Nederlandse versie* [Lancashire Quality of Life Profile, extended Dutch version]. Eindhoven, the Netherlands: Youth Forensic Psychiatric Hospital.

Van Nieuwenhuizen, C., Schene, A.H., & Koeter, M.W.J. (2002). Quality of life in forensic psychiatry: An unreclaimed territory. *International Review of Psychiatry*, *14*, 198–202.

Ward, T. (2002). The management of risk and the design of good lives. *Australian Psychologist*, *37*, 172–179.

Ward, T., & Brown, M. (2004). The good lives model and conceptual issues in offender rehabilitation. *Psychology, Crime and Law*, *10*, 243–257.

Ward, T., Hudson, S.M., & Marshall, W.L. (1995). Cognitive distortions and affective deficits in sex offenders: A cognitive deconstructionist interpretation. *Sexual Abuse: A Journal of Research and Treatment*, *7*, 67–83.

Ward, T., Mann, R.E., & Gannon, T.A. (2007). The good lives model of offender rehabilitation: Clinical implications. *Aggression and Violent Behavior*, *12*, 87–107.

WHOQOL Group (1998). Development of the World Health Organization WHOQOL-BREF quality of life assessment. *Psychological Medicine*, *28*, 551–558.

Williams, D.J. (2003). ''Quality of life'' as perceived by sex offenders on early release in a halfway house: Implications for treatment. *Journal of Offender Rehabilitation*, *38*, 77–93.