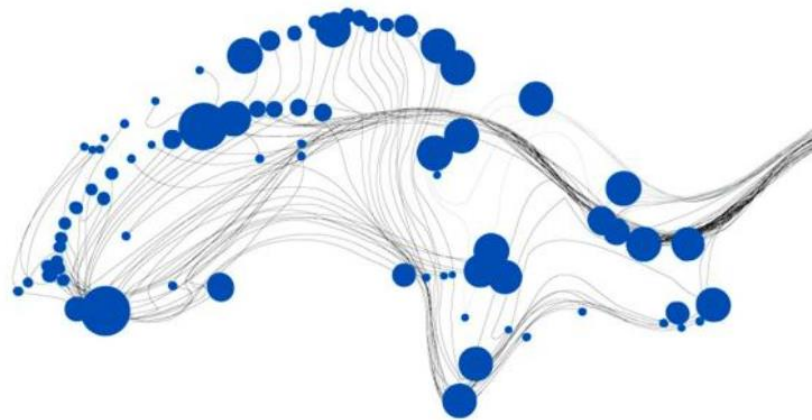


Exploring Acute Dynamic Risk Factors in Forensic Psychology: An Interview Study



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Abstract

Background: In forensic psychology, risk factors are essential for assessing recidivism risk and creating treatment strategies to address individuals' needs. However, existing risk assessment instruments often overlook acute dynamic risk factors (ADRFs), which address short-term changes in risk. This oversight may stem from a lack of clear conceptualization, complicating the integration of ADRFs within research, existing instruments and practice.

Objective: This study aims to develop an initial taxonomy of ADRFs that can be used in risk assessment and treatment by researchers and practitioners in the field of forensic psychology.

Methods: The study employed a qualitative approach, conducting 27 semi-structured interviews with researchers and practitioners working in forensic psychology. The participants were selected from four countries: the Netherlands, Belgium, Australia and New Zealand. Participants were diverse in years of experience, age and gender. Inductive thematic analysis was employed to identify and categorize ADRFs.

Results: The findings revealed five overarching types of ADRFs: Psychological, Behavioral, Contextual, Interpersonal and Physical ADRFs. These five types encompass 16 sub-categories, including Psychological Distress, Substance Abuse, Proximal Stressors, Major Life Events, Influence from Harmful Peers, and Poor Sleep.

Discussion: These ADRFs often seemed to be interconnected, suggesting the potential presence of an individual risk factor network that collectively influences recidivism risk. Limitations of this study include the unclear conceptualization of ADRFs, which may have led to inconsistencies in participant responses. To conclude, the results of this study present an initial taxonomy that could be used by researchers and practitioners in the field of forensic psychology to improve risk assessment and treatment. Furthermore, it provides a starting point for future research into the understanding of ADRFs in forensic psychology.

Keywords: risk factors, acute dynamic risk factors, dynamic risk factors, forensic psychology, forensic psychiatry, risk assessment, risk assessment instruments, risk assessment tools, short-term risk assessment.

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Introduction

Forensic psychology focuses on understanding psychological issues related to criminal or transgressive behaviours (for example sexual aggression) and on treating patients involved in the legal system. The main aim of treatment is to reduce recidivism, meaning the reoffending of a patient. Effectively addressing recidivism is a global challenge, yet it is critical for ensuring patient safety, protecting potential victims, reducing incarceration rates, and minimizing related costs. Reconviction rates for recidivism range from 20% to 63% within two years (Yukhnenko et al., 2019). To prevent recidivism, forensic professionals must understand why patients recidivate. This is where risk assessment is used to monitor patients. The goal of risk assessment is to identify factors that heighten the risk of reoffending in a systematic manner (Brown & Singh, 2014). As Lamberti (2007) explains, individuals possess certain factors, specific elements within environmental, social, or psychological domains that, when active or present, may contribute to recidivism by influencing their criminal behaviour. These factors, when present, become the focus of assessment and treatment, offering valuable insights into recidivism prevention. Risk assessment instruments help identify and monitor these individual factors and behaviours that may lead to recidivism (Expertisecentrum Forensische Psychiatrie, 2019; Ward & Beech, 2015). However, no current risk assessment instrument predicts recidivism optimally (Graham et al., 2021; Yang et al., 2010).

Most risk assessment instruments primarily focus on static and stable dynamic risk factors (SDRFs), which predict long-term recidivism risk factors (Nitsche et al., 2022). Static risk factors, such as family history, gender, and past offences, are rigid and cannot be altered through treatment. However, they provide insights into a patient's history and can potentially worsen if, for example, another crime is committed. While these factors are associated with recidivism risk, relying solely on static risk factors fails to provide a comprehensive understanding of an individual's overall risk profile. Their utility in predicting recidivism is

limited (Yukhnenko et al., 2020). SDRFs, while changeable, unfold over longer periods (years/months) and are often referred to as “skill deficiencies” (Freestone et al., 2017). These factors provide valuable guidance for treatment, as stabilising SDRFs is an aim of treatment. Examples of SDRFs include alcoholism or personality disorders (Davies et al., 2023; Freestone et al., 2017). However, as noted by Yang et al. (2010), current risk assessment instruments like the PCL-R or the HCR-20 lack precision in predicting recidivism. Emphasizing that decisions about patients should not rely solely on these instruments, while static risk factors and SDRFs provide valuable insights into long-term risks, they fail to capture immediate risks essential for timely interventions. This limitation reduces the effectiveness of current instruments in predicting recidivism.

To improve the accuracy of risk assessment instruments, and thereby improve tailored treatment for patients, multiple studies have highlighted the importance of incorporating acute dynamic risk factors (ADRFs) alongside static factors and SDRFs (Eisenberg et al., 2019; Nitsche et al., 2022; Vasiljevic et al., 2017). ADRFs predict short-term risk and can change rapidly (within weeks, days, or even hours), offering critical insights into recidivism timing and proximity (Freestone et al., 2017; Yukhnenko et al., 2020). Examples of ADRFs include intoxication, a negative emotional state, or access to potential victims. So, unlike static risk factors and SDRFs, ADRFs are associated strongly with the timing of recidivism. This stronger association with the timing of recidivism enhances their predictive value, enabling more timely and targeted intervention options (Freestone et al., 2017; Heffernan & Ward, 2017). Currently, the use of ADRFs is not fully optimized in existing risk assessment instruments designed for measuring acute dynamic risk. Moreover, there is no comprehensive overview of potential ADRFs available to support professionals in the field of forensic psychology during assessment or during treatment.

At present, risk assessment research and instruments predominantly focus on static factors and SDRFs. Limiting insights into patients' recidivism risk and potential treatment options. One of the main reasons for ADRFs being used less is because of the lack of a unified understanding of ADRFs, resulting in debates about their precise role in risk assessment and their differentiation from SDRFs and triggers (Ward & Beech, 2004, 2015). For instance, within research and practice, ADRFs are frequently conflated with SDRFs under the broad category "dynamic risk factors", which could be said to obscure their distinct contributions to recidivism prediction (Babchishin et al., 2023; Mann et al., 2010; Seto et al., 2023; Thornton, 2002). This study distinguishes SDRFs from ADRFs, emphasizing the timing of the risk factors in relation to recidivism. Some studies also equate ADRFs with triggers, which are sometimes described as "super acute risk factors", further complicating the conceptualization of ADRFs (Freestone et al., 2017; Stone et al., 2023). Within this study ADRFs and triggers are seen as two separate concepts. This lack of consensus restricts their inclusion in studies which withholds the making of a clear overview of ADRFs, which further limits the possibility of effectively integrating ADRFs into risk assessment instruments.

As of now, there are some ADRF risk assessment instruments on the market, for example, the Acute-2007 or the DRAOR. And while these instruments do focus on several ADRFs there is a lack of an instrument that wholly captures ADRFs. This is supported by a study of Serin et al. (2016), which compared four different ADRF risk assessment instruments: The START, IORNS, SPIn, and the DRAOR. The study found that there was only one ADRF included in all four of the risk assessment instruments. None of the other mentioned ADRFs were found in all instruments, underlining that current risk assessment instruments do not present a full picture of ADRFs. So, within practice, there is a need for a risk assessment instrument that portrays a full picture of a patient by assessing all risk factors and include all known ADRFs. However, due to the limited theoretical consensus surrounding

ADRFs, there is no clear overview of ADRFs that could be used by professionals in the field to score ADRFs.

This qualitative study seeks to explore perspectives from researchers and practitioners in forensic psychology about ADRFs, to develop a preliminary taxonomy of ADRFs for use in risk assessment and treatment. The main research question is: “What types of acute dynamic risk factors are identified by researchers and practitioners in the field of forensic psychology?” Additionally, a sub-question will explore: “What differences exist between researchers and practitioners in the types of acute dynamic risk factors mentioned?”

Methods

Participants

The target group for this study consisted of researchers and practitioners with substantial expertise in forensic psychology. Practitioners were deemed eligible if they were actively involved in the treatment of forensic patients, working as a psychologist, healthcare psychologist, clinical psychologist, or nurse practitioner, and trained in the use of one or more risk assessment instruments. Researchers were included if they were engaged in scientific research on ADRFs within the context of forensic psychology.

Participants were selected using purposive sampling and snowball sampling. The latter has a limitation of a maximum of four participants per institution. Potential participants were contacted through multiple channels. Managers of forensic mental health institutions were approached to provide contact information for suitable practitioner participants. Information about the study was also shared on the platforms LinkedIn and KNAPP (a community platform for professionals working in forensic mental healthcare). Researchers were primarily contacted via email, with direct invitations to participate.

In total 34 participants were contacted, of whom seven declined participation due to lack of time or unknown reasons. Leaving the final sample of the present study to $n = 27$. Within this sample, data saturation was reached when the last two interviews did not provide new data or meanings, stopping the recruitment of new participants (Curry et al., 2009; Fusch & Ness, 2015; Rahimi & Khatooni, 2024). The sample included six researchers, 17 practitioners and four with experience in both, from four countries: Netherlands ($n = 13$), Belgium ($n = 5$), Australia ($n = 5$), and New Zealand ($n = 3$). Further demographic variables were collected in ranges. Starting with age, the youngest are in the 21-25 range ($n = 1$), 26-30 ($n = 4$), 31-35 ($n = 5$), 36-40 ($n = 5$), 41-45 ($n = 4$), 46-50 ($n = 5$), the oldest being in the 66-70 range ($n = 1$), and two participants who have not disclosed their age. Lastly, years of experience in the field of forensic psychology, with $n = 8$ for 0-5 years, 6-10 ($n = 8$), 11-15 ($n = 3$), 16-20 ($n = 2$), 21-25 ($n = 4$), and the most experience 26-20 years ($n = 2$).

Materials & Procedure

The data in this study were collected via semi-structured interviews, which are often used in thematic analysis to focus on a research topic and identify themes relating to the topic (Joffe, 2011). The interviews were conducted by one researcher between November 2023 and March 2024, in Dutch and English. Having one interviewer increases the consistency within interviews and provides a more uniform data collection process (Coleman, 2022). Two interview schemes were developed by a team of five researchers, one for researchers (Appendix A) and one for practitioners (Appendix B). Both interview schemes had the same structure: introduction of the research, introduction of the participant, conceptualization of dynamic risk factors, the difference between SDRFs, ADRFs and triggers, and lastly, use in treatment. An example question is: 'How would you explain the term 'dynamic risk factor' to a patient?' The schemes allowed for probing questions to clarify responses. The average interview duration for researchers was 51.67 minutes, with a range of 26 to 78 minutes ($SD =$

16.80). For practitioners, this average was 54.59 minutes, with a range of 40 to 64 minutes ($SD = 7.40$). For those with experience in both the average was 56.50, with a range of 50 to 70 minutes ($SD = 9.15$). Participants were sent an e-mail with information (Appendix C) about the study, including the goal of the study, the estimated duration of the interview, and the informed consent form. Some interviews were in-person, but most were via Teams. Before the start of each interview, the informed consent form had to be filled in and returned to the researcher.

Notably, this study is part of a broader research into the conceptualization of risk factors and their application in treatment. As a result, the interview scheme was not exclusively designed for this study.

Data analysis

The interviews were audio-recorded and transcribed verbatim. ATLAS.ti 24 version 24.1.1 was used to iteratively analyse the data using an inductive thematic analysis approach. Inductive thematic analysis was employed to identify patterns and overarching themes within the dataset that directly aligned with the research questions (Kiger & Varpio, 2020).

After the data were collected and transcribed, a single researcher began by reading through the transcripts to familiarize themselves with the subject matter. During this familiarization process, the researcher marked all data relevant to the research question. From these initial observations, a preliminary coding scheme including concept themes was developed. The coding scheme was applied to three interviews as a test and then reviewed and revised based on insights gained from the data. Subsequently, the updated framework was applied to an additional five interviews, after which it was reviewed and adjusted again. After refining and applying the coding scheme to another five interviews it was reviewed again. Then this revision led to applying the coding scheme consistently to all interviews in the dataset. After all interviews were coded, the concept themes were made definitively. To

minimize bias, the proposed coding scheme and the identified themes were reviewed with supervisors during the whole analysis process. In refining the finalized coding scheme, ensuring mutual exclusivity and collective exhaustiveness was a priority. This process involved revising code titles for clarity and merging overlapping codes to streamline the final framework. The finalized framework was subsequently reviewed with supervisors.

Results

In Table 1 an overview of the occupation per participant is presented. After analysis, five ADRF types emerged, with a total of 16 sub-categories, which are presented in Figure 1. An overview of the coding scheme is presented in Table 2. Data on the number of unique mentions per occupation and the total number of mentions per occupation are presented in Appendix D. For an overview of all the unique examples mentioned, see Appendix E.

The identified types offer a structured perspective on the specific factors associated with ADRFs. This addresses the main research question “*What types of acute dynamic risk factors are identified by researchers and practitioners in the field of forensic psychology?*” Additionally, to sub-question “*What differences exist between researchers and practitioners in the types of acute dynamic risk factors mentioned?*” is addressed.

Table 1

Occupation per participant (n=27).

Occupation	Total Participants	Participant Number
Practitioner	17	2, 7, 9, 12, 13, 14, 15, 16, 17, 18, 19, 21, 22, 23, 24, 25 & 26
Researcher	6	1, 3, 4, 11, 20 & 27
Experience in both	4	5, 6, 8 & 10

Figure 1

Overview of the five ADRF types and the 16 sub-categories

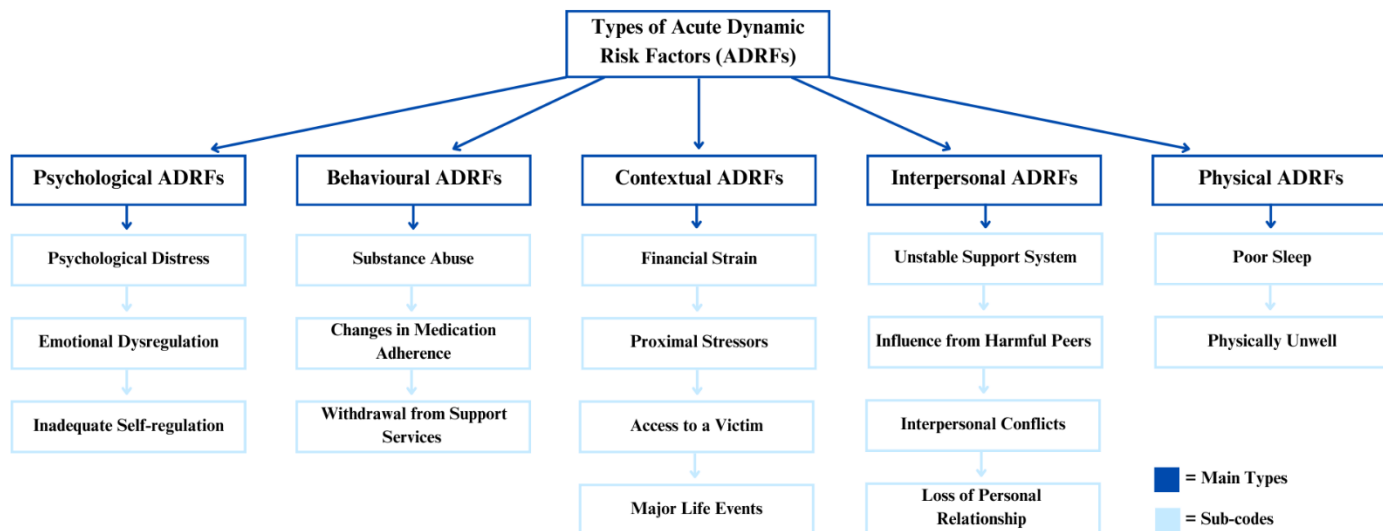


Table 2

Coding scheme including all types, sub-categories, definitions, unique mentions per participant (N_{unique}) and the total number of mentions (N_{total}).

Type of ADRFs	Sub-code	Definition	N_{unique}	N_{total}
Psychological ADRFs		The type encompasses adverse psychological states, such as challenges with rational thinking, decision-making, and managing situations, as well as emotional states, including difficulties in regulating moods and feelings. These states may contribute to recidivism risk through maladaptive thought patterns, mental illnesses and intense emotions such as anger or fear.	25	102
	Psychological Distress	Mental states, for example, maladaptive cognitions, negative beliefs or mental illnesses, that may increase recidivism risk by suddenly or unexpectedly destabilising the patient.	19	40
	Emotional Dysregulation	Intense emotional responses or feelings that may impair judgement.	15	34
	Inadequate Self-regulation	individuals fail to adapt effectively to stress, stressors or sudden maladaptive thoughts due to a lack of adequate internal mechanisms, like coping mechanisms.	13	28
Behavioural ADRFs		Observable actions or routine changes that may signal distress and therefore may contribute to recidivism risk.	23	90

Substance Abuse	Engaging in the use of substances, including current intoxication, substantial changes in usage patterns, relapses, or instances where prior intoxication was identified as a contributing factor to the crime.	22	80
Changes in Medication Adherence	Patients who make unapproved changes to or stop taking prescribed medications that are deemed critical for their stability, leading to increased recidivism risk.	5	7
Withdrawal from Support Services	Instances where patients disengage from professional support services, possibly leading to recidivism risk.	3	3
Contextual ADRFs	Environmental or circumstantial factors that create high-risk contexts or contribute to mental vulnerabilities, leading to recidivism risk in patients.	21	67
Financial Strain	Urgent financial difficulties and severe distress about finances may lead to increased risk-taking.	6	8
Proximal Stressors	External stressors and factors in a patient's surroundings that for example contribute to a patient's stress or temptation, ultimately leading to a heightened recidivism risk.	10	20
Access to a Victim	Situations where a patient comes in any form of contact with either a new or previous victim, leading to recidivism risk.	5	9
Major Life Events	It encompasses examples of losing key resources that support stability, which when lost, can increase acute recidivism risk.	10	30

Interpersonal ADRFs	Social and relational dynamics impacting an individual's mental stability, leading to increased recidivism risk.	20	63
Unstable Support System	The sudden absence of a stable support system or unexpected changes and instability in a social support system may increase recidivism risk	13	17
Influence from Harmful Peers	Instances where exposure to individuals who encourage risky or harmful behaviours heightens recidivism risk.	8	12
Interpersonal Conflicts	Acute conflicts or fights within relationships that escalate stress or distress for patients, potentially contributing to recidivism risk.	10	22
Loss of Personal Relationship	The end of a significant personal relationship, which may lead to recidivism risk.	7	12
Physical ADRFs	Physical health conditions or changes that affect mental stability or increase vulnerability for recidivism.	4	8
Poor Sleep	Inadequate or low-quality sleep directly impacts patients' mental state and decision-making, possibly making them distraught.	2	4
Physical Pain	Acute physical pain or physical illness that negatively impacts mood and behaviour in patients, which may lead to recidivism.	3	4

Psychological ADRFs

Psychological ADRFs was the most mentioned type linked to increased recidivism risk in participant accounts. The type encompasses adverse psychological states, such as challenges with rational thinking, decision-making, and managing situations, as well as emotional states, including difficulties in regulating moods and feelings. These states may contribute to recidivism risk through maladaptive thought patterns, mental illnesses and intense emotions such as anger or fear. There were no major differences between researchers and practitioners regarding frequency or interpretation.

Psychological Distress

The sub-code *psychological distress* was mentioned by 19 participants. It refers to mentions of mental states, for example, maladaptive cognitions, negative beliefs or mental illnesses, that may increase recidivism risk by suddenly or unexpectedly destabilising the patient. Participants emphasised the connection between negative thought patterns and heightened recidivism risk. For example, Participant 27 noted that “stronger negative attitudes towards society or high violence attitudes” correlate with higher risk. Similarly, Participant 8 highlighted severe maladaptive cognitions like “longing for sex with kids”, as directly linked to high recidivism risk. Participant 10 provided a case illustrating this link, describing how a patient believed that people were attempting to steal his money, prompting an immediate reaction in which he threatened to escalate the situation with serious violence. Underscoring the short-term nature of ADRFs. Additionally, Participant 25 underscored the variability of mental states. Where there may be a day-to-day difference in mental state. Noting that when a patient is then “quite labile in their mental state, it could contribute to their violence risk”.

Emotional Dysregulation

The sub-code *emotional dysregulation* was mentioned by 15 participants. It covers examples of intense emotional responses or feelings that may impair judgement. This impaired judgement may lead to patients not thinking clearly and possibly falling back into old patterns leading to recidivism. Participant 22 highlighted emotional dysregulation, where overwhelming feelings like anger or rejection could trigger destructive actions such as self-harm or assault. Furthermore, Participant 14 described how sudden emotional shifts, represent ADRFs, “when she gets angry, within a minute she goes from zero to 100, yelling, screeching, threatening people [...] yes I would describe that as an acute dynamic risk factor”.

Inadequate Self-regulation

The sub-code *inadequate self-regulation* was mentioned by 13 participants. It includes examples where individuals fail to adapt effectively to stress, stressors or sudden maladaptive thoughts due to a lack of adequate internal mechanisms, like coping mechanisms. A lack of coping mechanisms may increase recidivism risk whenever a patient faces a difficult event. Examples of missing/underdeveloped internal mechanisms that were identified by the participants include: poor perception, poor judgement, lack of self-control, low distress tolerance, poor emotion regulation skills, and lack of anger management. Participant 21 emphasised the link between coping and recidivism risk, “If the client has good coping skills, then that works protective. When the client has a high sense of self-control. But when that is not the case, that would be an acute dynamic risk factor”. Furthermore, Participant 23 mentioned that without sufficient coping skills, recidivism risks go up when general life events, such as someone passing away, happen. Additionally, impulsiveness is mentioned by six participants, where Participant 12 highlighted the risk of recidivism by describing “impulsivity fluctuates much faster so that it could have been very decisive at the moment itself”.

Behavioural ADRFs

Behavioural ADRFs emerged as the second most mentioned type for heightening recidivism risk. This type includes observable actions or routine changes that may signal distress and therefore may contribute to recidivism risk. There were no major differences between researchers and practitioners in the frequency of mentioned examples of behavioural ADRFs.

Substance abuse

The sub-code *substance abuse* was mentioned by 22 participants, making it the most frequently mentioned sub-code overall. It encompasses mentions of engaging in the use of substances, including current intoxication, substantial changes in usage patterns, relapses, or instances where prior intoxication was identified as a contributing factor to the crime. Participant 22 illustrated the heightened recidivism risk with the quote “he could see this female, and he was quite interested in her, but he knew when he was drunk that the likeliness rose to sexually assault [her]. Participant 20 highlighted the acute risk posed by a relapse in substance use, especially when such relapses have previously led to criminal behaviour. This relapse could trigger the same harmful behaviours, increasing recidivism risk. Moreover, Participant 7 mentioned the importance of noticing changes in current substance use as this may cause a crisis, “we have a lot of people that always drink, so you could always score them, however, we stop doing that at one point. But when something changes in that [we score them again and are on immediate alert]”.

Changes in Medication Adherence

The sub-code *changes in medication adherence* was mentioned by five participants. It covers examples where patients make unapproved changes to or stop taking prescribed medications that are deemed critical for their stability. This could signal two risks: withdrawal

symptoms that may increase recidivism risk. And a broader instability in the patient's mental state, which may be a warning of distress that may lead to recidivism. Participants 13 and 15 highlighted the risks associated with patients suddenly stopping prescribed medications, such as antipsychotics, as this may cause psychosis leading to recidivism. However, Participant 22 mentioned not only the importance of taking the prescribed medication but also the need to reduce behaviours, such as smoking tobacco, that can negatively affect the medication's effectiveness.

Withdrawal from Support Services

The sub-code *withdrawal from support services* was mentioned by three participants. It includes instances where patients disengage from professional support services. This could result in a disruption of treatment, leading to heightened symptoms and an increased risk of recidivism. Alternatively, it may serve as a warning sign, reflecting a deteriorating mental state that requires immediate attention. Participant 15 described this as patients who "pull back from contact with support services, or in treatment". Participants 6 and 16 also referenced cases of patients failing to attend appointments or uphold treatment agreements, highlighting this behaviour as an ADRF for recidivism.

Contextual ADRFs

The next type of ADRFs identified by participants in relation to heightened recidivism risk is contextual ADRFs. This type includes environmental or circumstantial factors that create high-risk contexts or contribute to mental vulnerabilities, leading to recidivism risk in patients. For this type, relatively more examples were given by researchers.

Financial Strain

The sub-code *financial strain* was mentioned by six participants. It encompasses examples where urgent financial difficulties and severe distress about finances may lead to

increased risk-taking. Participant 13 identified financial strain as a factor driving criminal acts, noting, “Often people commit crimes because they need money, that is why they shoplifted, to get food or whatever”. Participant 2 mentioned, “A patient receives bills which he did not expect, and he is used to solving those with property crimes, so he will steal or mug someone”.

Proximal Stressors

The sub-code *Proximal Stressors* was mentioned by 10 participants. It includes external stressors and factors in a patient’s surroundings that for example contribute to a patient’s stress or temptation, ultimately leading to a heightened recidivism risk. Participants highlighted specific environments that may heighten recidivism risk in patients by being stressors or triggers. Such as places mentioned by Participant 3 “an environment where they were used to using substances, drugs or alcohol” or settings that increase stress and possibly lead to recidivism, such as “an environment that is de-humanizing [an inpatient setting]” (Participant 24). Other examples are factors that provoke stress or temptation, “a person who has experienced sexual abuse in the past, when they later in life watch a movie where something like that happens again” (Participant 17), or “you receive an advertisement from Sinterklaas with children in it” (Participant 8). The focus was placed on external factors for the patient, with the understanding that contact with these factors could lead to recidivism. Notably, practitioners and those with both research and practice experience contributed most of these examples.

Access to a Victim

The sub-code *access to a victim* was mentioned by five participants. It refers to situations where a patient comes in any form of contact with either a new or previous victim, leading to recidivism risk. This ADRF was often mentioned in the context of stalking. For example, Participant 2 described “renewed contact with an ex-partner after a stalking crime”.

Participant 8 provided a broader example, noting a situation where “someone cycles past and the patient thinks, hey, I am going to rape them”. Participant 21 elaborated on the progression of recidivism tied to victim access, “when a patient has stalked the same victim, for years. And in the meantime, has been in treatment for three years and does good. However, the preoccupation of the victim stays, and he succeeds in not harming her. Which is good, but suddenly the patient receives information about the victim. Maybe, his mother visits and tells the patient, that the victim is remarried, and has two kids. Which could form a trigger. The patient may have trouble holding himself back and looks her up on the internet, to later try and re-establish contact”.

Major Life Events

The sub-code *major life events* was mentioned by 10 participants. It encompasses examples of losing key resources that support stability, which when lost, can increase acute recidivism risk. Most examples involve losing a resource, like “losing your housing” (Participant 12) or “losing your job” (Participant 18). Another example mentioned is, “daily activities that fall away” (Participant 15). Participant 10 explained that a patient who was an ex-gang member, however, had his life back on track, “He had support from his parents, a stable job, a stable accommodation and went to the gym. However, he got into an argument with his parents, and they kicked him out. He needed to sleep on friends' couches and didn't show up for work. He then lost his job and could not afford the gym membership anymore. Within two weeks of losing his accommodation, the patient was arrested in a bar for possession of a large amount of meth and a loaded gun, which he attempted to shoot the police with”. The Participant called this a “domino effect”. Participants with the research occupation contributed more examples than practitioners for this sub-category.

Interpersonal ADRFs

The next type mentioned by participants for higher recidivism risk is interpersonal ADRFs. This type includes social and relational dynamics impacting an individual's mental stability, leading to increased recidivism risk. For this type, researchers accounted for a relatively higher number of examples than practitioners.

Unstable Support System

The sub-code *unstable support system* was mentioned by 13 participants. It includes examples where the sudden absence of a stable support system or unexpected changes and instability in a social support system may increase recidivism risk. A stable support system is seen as crucial for patient stability, so the “lack of support” (Participant 18) or “a support system that has suddenly collapsed” (Participant 24) were identified as ADRFs because they remove a critical safety net. In some cases, a patient may have a support system, but it could be a “criminogenic network” (Participant 11), which further elevates recidivism risk. Additionally, family conflicts, such as “family drama, and that sort of thing” (Participant 9), were also highlighted as contributing factors.

Influence from Harmful Peers

The sub-code *influence from harmful peers* was mentioned by eight participants. It includes instances where exposure to individuals who encourage risky or harmful behaviours heightens recidivism risk. This sub-category highlights cases where patients, despite having an overall healthy support network, are suddenly negatively influenced by a criminogenic peer, prompting engagement in risky or criminal behaviour. For example, a patient might have “a few bad friends who gave them a firearm” (Participant 2) or encounter strangers that influence them into recidivism, “people around you are drunk” (Participant 27) may induce relapse, possibly leading to recidivism. These influences may also arise in clinical settings

where patients are “exposed to other people or other patients who are influencing them” (Participant 24), or as Participant 27 noted, an old friend who tries to come back into your life.

Interpersonal Conflicts

The sub-code *interpersonal conflicts* was mentioned by 10 participants. It includes examples of acute conflicts or fights within relationships that escalate stress or distress for patients, potentially contributing to recidivism risk. These conflicts range from minor disagreements, like “not getting along with other patients” (Participant 25) or “conflict within a relationship” (Participant 27) to incidents involving perceived mistreatment or discrimination, such as “being treated disrespectfully or unjust” (Participant 2). Additionally, conflicts may be one-sided, where only one person in the interaction sees it as a conflict. Such as disputes over medication with staff, mentioned by Participant 25. Or when other individuals express anger at the patient, however, the patient does not feel anger, but it may still induce distress, as mentioned by Participant 27. Notably, in comparison, researchers more often mentioned the sub-category than practitioners.

Loss of Personal Relationship

The sub-code *loss of personal relationship* was mentioned by seven participants. It captures instances where the end of a significant personal relationship, possibly leads to recidivism risk. Two main types of relationship loss were identified: first the end of a romantic partnership, such as “having a partner leave” (Participant 3) or “someone loses his relationship” (Participant 15). Secondly, the death of a loved one was mentioned as the “passing of a family member” (Participant 8) or “a best friend who suddenly passes” (Participant 6). Showing that both losing a significant romantic partnership, and the death of a loved one may increase recidivism risk. This loss may cause intense emotions or remove once

provided stability for a patient. Researchers accounted more for this sub-category than practitioners.

Physical ADRFs

The last type identified by participants for heightening recidivism is physical ADRFs. The type includes mentions of physical health conditions or changes that affect mental stability or increase vulnerability for recidivism. This type was mentioned nine times, across five unique participants. The type was not identified by researchers.

Poor Sleep

The sub-code *poor sleep* was mentioned by two participants. It includes examples where inadequate or low-quality sleep impacts patients' mental state and decision-making, leading to recidivism. Participant 5 started by describing that poor sleep causes patients to be distraught, which shortens their "fuse" and causes the "bomb" to "explode" sooner. They further observed that "the fact that someone has slept badly for a couple of nights. Those are factors that often, for example in our clinic, have a lot of influence on the behaviour of the patient". Participant 8 further noted that a single bad night's sleep can make a patient more irritable or on edge.

Physical Pain

The sub-code *physical pain* was mentioned by three participants. It includes examples where acute physical pain or physical illness negatively impacts mood and behaviour in patients, which may lead to recidivism. Participant 22 noted that pain can make patients feel "quite low, desperate and quite irritable". This was also mentioned by participants 25 and 5, who observed that patients may be more likely to go over the edge and fall into recidivism "when they are feeling unwell" or they are in "pain". Participant 5 emphasised the possibility of a lowered threshold for recidivism caused by pain.

Discussion

In this study, the focus was on finding types of ADRFs mentioned by researchers and practitioners in the field of forensic psychology. The findings revealed a taxonomy of five overarching types of ADRFs: Psychological, Behavioural, Contextual, Interpersonal and Physical. Together they encompass 16 sub-categories as shown in Figure 1. Between researchers and practitioners, there were differences found in the frequency of mentioning types and sub-categories. Researchers more often mentioned the types Contextual ADRFs and Interpersonal ADRFs. However, the type Physical ADRFs was only mentioned by practitioners or participants with experience in both.

Network

The findings suggest the idea that ADRFs are interconnected. Where multiple ADRFs often co-occur and influence each other. For example, within the sub-category of major life events, one participant described a sequence where ADRFs impacted each other. This influence spans different sub-categories as well, such as how poor sleep may relate to inadequate self-regulation, or interpersonal conflicts may lead to emotional dysregulation. These interconnections support the concept of a risk factor network, proposed by Van den Berg et al. (2020). They propose the importance of considering patients more holistically, in which professionals should acknowledge that multiple different, interacting risk factors may be present in each patient.

Given the complexity of such a network, professionals could prioritize creating personalized networks of risk factors. Ward and Beech (2015) suggest that this approach improves risk assessment and treatment. Kroner and Yessine (2013) highlight the need to focus on the most relevant risk factors when constructing such networks. Within these networks dynamics between different risk factors should be taken into account, which may differ for each individual. For example, ADRFs could activate SDRFs or static risk factors,

and vice versa. For instance, relapse or intoxication could ‘activate’ alcohol addiction as a SDRF. However, as noted by Thornton (2016), the exact relationship between these risk factors remains unclear, and future research should focus on better understanding these dynamics. The proposed taxonomy and insights from studies like Van den Berg et al. (2024) could inform more personalized risk assessments, where practitioners and patients collaborate regularly to identify and address their risk networks.

Existing Instruments

This study identifies gaps in the understanding of ADRFs, as current research lacks a clear and consistent definition. ADRFs are often conflated with SDRFs and/or triggers (Freestone et al., 2017; Nitsche et al., 2022; Yukhnenko et al., 2020), complicating research efforts. ADRFs individualistic, complex, and resource-intensive nature may have contributed to limited attention in research and in the field. This ambiguity was reflected in this study, where participants frequently confused the terminology. Consequently, existing ADRF assessment instruments may be incomplete. Serin et al. (2016) found variability among four ADRF assessment instruments, with almost no sub-category consistently recognized across them. Similarly, in this study, no sub-category was universally acknowledged, and most were mentioned by only half of the participants. Within this study, some participants may have relied heavily on existing ADRF assessment instruments, potentially taking away from a broader understanding. These findings suggest that knowledge about ADRFs varies among professionals, shaped by individual experience and workplace context.

Reaching consensus on ADRF terminology is necessary for the development of effective ADRF risk assessment instruments. Participants do see the value of using ADRFs in their risk assessment and treatment for patients. Future research should prioritize establishing a shared understanding to create a solid foundation. Building on this, innovative approaches to ADRF assessment could be explored. Given the dynamic nature of ADRFs, assessment

instruments must be applied more frequently than traditional instruments, which are typically used once or twice a year. For example, app-based monitoring, as suggested by Van den Berg et al. (2024), could offer practical solutions for improving the frequency and accuracy of ADRF assessment.

General Understanding

The lack of consensus on the definition of ADRFs, as highlighted above, is evident in this study's findings. Notably, no single sub-category was universally identified by all participants. However, this may be due to the fact that there were no further probing questions to deepen a participant's understanding of a category or probe for more information about other categories. This may have led to relevant information being overlooked.

Moreover, before this study, there were a lot of unknowns. About the consensus of the definition of ADRFs, but also about what examples of ADRFs are. So, the creation of a preliminary taxonomy has added a starting point for research. Furthermore, the results of this study provide more insight into the possible underrepresentation or absence of certain factors that do represent an ADRF. A possible example is the underrepresentation of neurobiological factors like poor sleep. Despite extensive research linking the biopsychosocial model to mental health issues and recidivism, it seems to be often overlooked (Blankenstein et al., 2024; D'Aurizio et al., 2023; Scott et al., 2021), only two participants identified poor sleep as an ADRF. This oversight is important given that good physical and mental health seems to improve reintegration and lower recidivism risk (Link et al., 2019). To address this gap, future research should involve a wider range of individuals with knowledge about ADRFs or who come into contact with acute situations, for example, patients, probation officers, prison guards, etc. Enabling a broader array of insights and potentially incorporating additional (interconnected) factors into the proposed taxonomy. A recommended approach could be to conduct a Delphi study with a diverse group of experts in the field of forensic psychology to

identify new ADRFs and validate the found factors in this study (Barrett & Heale, 2020). The strength of this method lies in its iterative process, where knowledge is built upon with each round, and participants can review all previous responses.

Limitations

The study has several limitations that need to be considered when interpreting the results. First, the inconsistent use of terminology by participants limited the scope of data interpretation. Examples that participants labelled as triggers or SDRFs were excluded, even when they might have been qualified as ADRFs. This may have led to the oversight of relevant factors. Second, the interview design was not explicitly tailored to explore examples of ADRFs, which may have affected the depth and reliability of responses. Currently, a concept article is being written by Serno et al. (in progress), which should shed more light on the theoretical consensus of ADRFs. This could further provide new leads for future research into ADRFs.

Furthermore, the coding of the data was done by one individual, which according to O'Connor and Joffe (2020), lowers the reliability of the study. Even though the coding scheme was shared with other researchers, the initial coding process was done alone. Therefore, this study does not have genuine interrater reliability, and the results may be only seen as an explorative taxonomy that should be studied in future research by a group of researchers.

Conclusion

The study identifies five main types of ADRFs: Psychological, Behavioural, Contextual, Interpersonal and Physical. The findings emphasize the interconnected nature of ADRFs, supporting the concept of a risk factor network. However, a lack of consensus on ADRF terminology, including confusion with SDRFs and triggers, limits the effectiveness of current assessment instruments. No instrument currently captures all known sub-categories

comprehensively. Participants may not have had the chance to answer their potential about sub-categories, which may have led to the underrepresentation of factors or the absence of factors. Some of these underrepresented factors are known in the literature to be important, such as neurobiological influences like poor sleep.

Future research should prioritize establishing a consensus on ADRF terminology, potentially through a Delphi study involving a wider range of knowledgeable individuals. Subsequent studies could investigate the relationship between ADRFs and other risk factors within the network. The taxonomy proposed here offers a foundation for developing innovative ADRF assessment methods, paving the way for more tailored treatment.

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Appendices

Appendix A: Interview Guide Researcher

In order to effectively process the data, I would like to record the interview. Only the researchers involved in the project have access to the recordings, and the recordings are deleted after transcription. You can find more information on the confidentiality of the information you share in the informed consent form, as well as on the option to withdraw from participation if you feel uncomfortable. Please read the form carefully. You can sign it if you agree. If you have any questions, please let me know.

Introduction

First of all, thank you for agreeing to participate in this study. To provide context about this study: We are seeking clarity on the concepts of acute dynamic risk factors and triggers.

These concepts appear to play an important role in the treatment of forensic patients, but we are curious about how these concepts are perceived and used by therapists and researchers. To explore this, I will first ask you some conceptual questions about acute dynamic risk factors and triggers. I am also interested in how these concepts are integrated in treatment according to you. We have allocated an hour for this interview, and I would like to cover all the topics. Therefore, I may interrupt you occasionally and move on to the next question. Do you have any questions for now?

Introduction participant

To begin with, could you tell me something about yourself? What kind of work do you do, and how long have you been doing it?

Conceptualisation

1. How would you define the term ‘dynamic risk factor’? Is this the term you use?
2. Are you familiar with the distinction between stable and acute dynamic risk factors?
 - a. *If no:* Generally, stable dynamic risk factors are seen as factors that can change over longer periods of time and are associated with long-term recidivism, usually weeks to months. On the other hand, acute dynamic risk factors can quickly change and are associated with short-term recidivism, ranging from minutes to weeks before the offense. How do you view this?
 - b. *If yes:* How do you perceive this?

If using the distinction:

3. Can you provide examples of both types?
4. How do stable and acute dynamic risk factors relate to each other, in your opinion?

If against the distinction:

5. Can you further explain why you don’t use this distinction?
 - a. According to you, are there different types of dynamic risk factors?
 - i. If so, which types do you distinguish and can you provide examples?
 - ii. If not, do you distinguish between different factors/variables within dynamic risk factors?
 1. *If not:* Why do you not?
 2. *If yes:* Can you elaborate on this? Can you give examples?

Follow up questions on quickly changing factors in the minutes to weeks prior to offending behaviour, e.g., “Can these factors/variables [pick two examples] be distinguished based on how quickly they change?”, “If you would place these

factors/variables [pick two examples] on a timeline, would some generally speaking be closer to the offending behaviour than others?”.

Now, I would like to move on to the concept of trigger and its relationship with acute dynamic risk factors. In the literature, the concepts of trigger and acute dynamic risk factors are often used interchangeably. However, sometimes they are considered distinct concepts.

1. How do you view the relationship between acute dynamic risk factors and triggers?

In case they are viewed as separate concepts:

2. How would you define ‘trigger’? Which terms or synonyms do you use?
3. Can you give examples of triggers? (*e.g., intern, extern*).

Follow-up questions about differences between mentioned triggers, e.g. internal vs external triggers

4. If you think about the previous examples, what are, according to you, similarities between acute dynamic risk factors and triggers?
5. In what ways are acute dynamic risk factors and triggers different, according to you?
Can you provide examples?

In case they are viewed as the same concept:

6. Would you say that the terms could be used interchangeably? Which term do you prefer and why?

Use in Treatment

In the second part, I would like to learn more about the use of acute dynamic risk factors and/or triggers in risk assessment and therapy.

7. To what extent are you familiar with the use of these concepts in treatment?

8. First a general question: according to you, what is the role of acute dynamic risk factors and triggers in treatment?
9. In order to zoom in on this topic, I want to go through the different phases of treatment. One could identify four phases: Diagnostics, risk assessment, therapy, and rehabilitation. Are you familiar with those phases?

If yes:

- a. Do you see it the same way?

If no:

- b. In brief, the goal of diagnostics is to map the patient's personality in light of their social and (inter)cultural context. Risk assessment is focused on estimating the patient's risk for recidivism. Further, the aim of therapy is to reduce the risk of recidivism and reduce the (effects of) the disorder, and finally, rehabilitation is about preparing the patient for life after treatment.

10. Shall we go through each step and see how acute dynamic risk factors and triggers come into play?
 - a. Diagnostics
 - b. Risk assessment
 - c. Therapy
 - d. Rehabilitation

Closing

We have reached the end of my questions.

11. Is there anything you would like to add?

I would like to thank you for your time. After the interview, I will transcribe the recordings.

Would you like to read the transcript before I move onto analysing the data? Do you know anyone else I could approach for an interview?

Appendix B: Interview Guide Practitioner

In order to effectively process the data, I would like to record the interview. Only the researchers involved in the project have access to the recordings, and the recordings are deleted after transcription. You can find more information on the confidentiality of the information you share in the informed consent form, as well as on the option to withdraw from participation if you feel uncomfortable. Please read the form carefully. You can sign it if you agree. If you have any questions, please let me know.

Introduction

First of all, thank you for agreeing to participate in this study. To provide context about this study: We are seeking clarity on the concepts of acute dynamic risk factors and triggers. These concepts appear to play an important role in the treatment of forensic patients, but we are curious about how these concepts are perceived and used by therapists and researchers. To explore this, I will first ask you some conceptual questions about acute dynamic risk factors and triggers. I am also interested in how these concepts are integrated in treatment according to you. We have allocated an hour for this interview, and I would like to cover all the topics. Therefore, I may interrupt you occasionally and move on to the next question. Do you have any questions for now?

Introduction participant

To begin with, could you tell me something about yourself? What kind of work do you do, and how long have you been doing it?

Conceptualisation

1. How would you define the term 'dynamic risk factor'?
2. How would you explain the term 'dynamic risk factor' to a patient?
 - a. What terms, synonyms, or comparisons do you use?
3. In the scientific literature, a distinction is sometimes made between stable and acute dynamic risk factors. Have you heard of this?
 - a. *If yes:* Can you briefly explain what they mean to you? Do you make this distinction?

- b. *If no:* Generally, stable factors are seen as factors associated with long-term recidivism, often weeks to months. They can change over the long term. In contrast, acute dynamic risk factors can change much more quickly and are associated with short-term recidivism, ranging from minutes to a few weeks before the offense. How do you view this? Do you recognize this?
4. Could you provide examples of both types of factors? For example, when you think of a patient, what risk factors are important to them?
 - a. *E.g., SDRFs: addiction, criminal network, antisocial personality*
 - b. *E.g., ADRFs: being intoxicated, access to victims*
5. How do you view the relationship between stable and acute dynamic risk factors? Is it one concept according to you, or can they be distinguished?

Now, let's focus on the relationship between acute dynamic risk factors and triggers. The literature indicates that these terms are sometimes used interchangeably but are also seen as separate concepts.

1. How do acute dynamic risk factors and triggers relate to each other in your view? Are they the same or different concepts according to you?

If they are seen as different concepts:

2. What do you understand by the term 'trigger'?
3. How would you explain the term 'trigger' to a patient? What terms, synonyms, or comparisons do you use?
4. Could you provide examples of triggers?

Follow-up questions about differences between mentioned triggers, e.g., internal or external

5. When you think of the examples of acute dynamic risk factors you mentioned earlier, what are similarities between acute dynamic risk factors and triggers in your view?
6. In what ways do acute dynamic risk factors and triggers differ? Could you provide examples?

If they are seen as the same concepts:

7. Can the terms be used interchangeably in your opinion? Do you have a preference for one term, and if so, why?

Use in treatment

In the second part, I would like to learn more about the use of acute dynamic risk factors and/or triggers in treatment.

1. I'll start with a broad question: what is their general role in treatment? This concerns an overall picture; we'll delve into the different phases later.
2. Next, I'd like to go through the different phases of treatment. I've identified the following phases: Diagnostics, risk assessment, therapy, and reintegration. Do you see it this way, or is it better to adjust it?
3. Shall we go through each step and see how acute dynamic risk factors and triggers are incorporated into them? You can consider a patient and their acute dynamic risk factors and/or triggers in your mind. How do they come into the different treatment phases?

Ask at each step if the interviewee has ideas on how they could be discussed differently or be improved.

4. ...

Probes:

- a. Diagnostics
 - b. Risk assessment
 - i. Which risk assessment tools do you use? Why these?
 - c. Treatment
 - i. Can you tell me about the use of acute dynamic risk factors and triggers in treatment?
 - d. Reintegration
 - i. How do risk factors and triggers generally come into play in the conclusion of treatment?
5. We've now looked at the role of these factors within treatment. Do you advise your patient to do something with their acute dynamic risk factors and/or triggers outside of treatment?
 6. Are there, in your view, opportunities to discuss them more effectively within treatment?

Closing

With this, we've come to the end of my questions.

1. Is there anything you'd like to add?

I would like to thank you for your time. After the interview, I will transcribe the recordings.

Do you wish to read the transcript before I proceed with it? Do you know anyone else I could approach for the interview?

Appendix C: Information Leaflet and Informed Consent Form

Information leaflet for the study ‘The definition and use of dynamic risk factors and triggers’

Purpose of the study

This study aims to map the conceptualization and role of dynamic risk factors and triggers in the treatment of forensic patients. These factors play a crucial role, as they are incorporated in risk assessment tools and guide the treatment of these patients.

In this study, we primarily focus on the concepts of acute dynamic risk factors and triggers. Due to the existing ambiguity surrounding these concepts in both literature and practice, we aim to explore the perspectives of clinicians and researchers. We also examine the relationship between acute dynamic risk factors and stable dynamic risk factors. Additionally, we seek to understand how acute dynamic risk factors and triggers are used in practice according to experts.

By systematically mapping the way in which acute dynamic risk factors and triggers are understood and applied in the treatment of forensic patients, we hope to establish a shared understanding of these concepts. This shared understanding can enhance communication between researchers and clinicians, ultimately contributing to more effective treatment, risk assessment, and risk management for forensic patients.

The results of this study will be used for the publication of a scientific article, by means of which we hope to advance the scientific understanding of this important subject and improve the quality of care for forensic patients.

This study is led by [REDACTED]

What does participation entail?

You are participating in a study in which we will gather information by interviewing you and recording your response via an audio recording. The interview will be transcribed. Any sensitive or private information will be removed from the transcript.

Potential risks of participating

There are no physical, legal, or financial risks associated with your participation in this study. You are not required to answer any questions you do not wish to answer. Your participation is voluntary, and you can withdraw from the study at any time.

Compensation

You will not receive any compensation for participating in this study.

Confidentiality of data

We are committed to protecting your privacy to the best of our ability. Confidential information or personal data about or of you will not be disclosed in any way that could identify you. Before our research is released, your data will be anonymized as much as possible.

In any publication, we will use anonymized or pseudonymized data. The audio recordings, forms, and other documents created or collected as part of this study will be stored in a secure location at the University of Twente and on the secure (encrypted) data storage devices of the researchers.

The audio recordings will be deleted after transcription. The other research data will be stored for a period of ten years. After this period, the data will be deleted. Research data will be made available in anonymous form to individuals outside the research group only if necessary (for example, for a scientific integrity check).

Finally, this research has been reviewed and approved by the ethical committee of the Faculty of BMS (domain Humanities and Social Sciences).

Voluntary participation

Participation in this study is entirely voluntary. Even when you have decided to participate, you can stop your participation in this study at any time or withdraw your consent to use of your data for research purposes without the need to give a reason. If you decide to discontinue your participation during the study, the data you have provided up to the point of withdrawal will be used in the study. Discontinuing your participation will not have any adverse consequences for you.

Do you wish to discontinue your involvement in the study or have questions and/or complaints?

Please contact the researchers.

X

If you have questions about your rights as a research participant, or wish to obtain information, ask questions, or discuss any concerns about this study with someone other than the researcher(s), please contact the Secretary of the Ethics Committee/domain Humanities & Social Sciences of the Faculty of Behavioural, Management and Social Sciences at the University of Twente by ethicscommittee-hss@utwente.nl. This research is conducted at the University of Twente, faculty of Behavioural, Management and Social Sciences. In case you have specific questions about dealing with personal data, you can contact the Data Protection Officer of the University of Twente via dpo@utwente.nl.

Finally, you have the right to make a request for access, modification, deletion, or correction of your data to the research leader.

By signing this informed consent form, I acknowledge the following:

1. I have been adequately informed about the study through a separate information leaflet. I have read the information leaflet and had the opportunity to ask questions, which have been adequately answered.
2. My participation in this study is voluntarily. It is clear to me that I can discontinue my participation in this study at any time, without giving any reason. I am not obligated to answer a question if I do not wish to.

In addition to the above, it is possible to give consent for specific parts of the study below. You can choose whether or not to give consent for each part. If you wish to give consent for everything, you can do so by checking the checkbox at the bottom of the statements.

3. I consent to the processing of the data collected from me during the

research, as described in the attached information leaflet. This consent also applies to the processing of data related to my perspective on (the use of) dynamic risk factors and triggers in the treatment of forensic patients.

YES NO

4. I consent to audio recordings being made during the interview and my responses being transcribed.

5. I consent to my responses being used for quotes in the research publications.

6. I consent to the storage and use of the research data collected from me for future research and educational purposes.

I consent to everything described above.

Name participant:

Name researcher:

Signature:

Signature:

Date: Date:

I do/do not* wish to receive a copy of the publication of the research. If yes, the researchers will send it to the following email address:

Email address: _____

Appendix D: Numbers/Frequencies Per Occupation

Unique mentions per participant per occupation (N_{unique}) and the total number of mentions per occupation (N_{total}). Researchers, $n = 6$; practitioners, $n = 17$; both, $n = 4$.

Type of ADRFs	Sub-code	N_{unique} researchers	N_{total} researchers	N_{unique} practitioners	N_{total} practitioners	N_{unique} both	N_{total} both
Psychological ADRFs		6	22	15	65	4	15
	Psychological Distress	3	4	13	31	3	5
	Emotional Dysregulation	4	10	8	17	3	7
	Inadequate Self-regulation	4	8	7	17	2	3
Behavioural ADRFs		6	20	14	62	3	8
	Substance Abuse	6	18	13	55	3	7
	Changes in Medication Adherence	1	2	4	5	0	0
	Withdrawal from Support Services	0	0	2	2	1	1
Contextual ADRFs		4	19	15	37	2	11
	Financial Strain	1	2	5	6	0	0

Proximal Stressors	2	3	7	12	1	5
Access to a Victim	0	0	4	8	1	1
Major Life Events	3	14	6	11	1	5
Interpersonal ADRFs	5	24	11	34	4	5
Unstable Support System	3	3	9	13	1	1
Influence from Harmful Peers	2	6	6	6	0	0
Interpersonal Conflicts	4	9	4	11	2	2
Loss of Personal Relationship	2	6	3	4	2	2
Physical ADRFs	0	0	2	3	2	5
Poor Sleep	0	0	0	0	2	4
Physical Pain	0	0	2	3	1	1

Appendix E: List of Unique Examples from the 16 Sub-categories

Psychological ADRFs

Psychological Distress	Unstable mental health, mental health decline, depression, trauma, sexual preoccupation increases, psychosis, delusions, psychotic experiences, unhelpful thoughts, violent ideation, major mental illness, negative attitudes towards society, high violence attitudes, suicidality, homicidally, antisocial cognitions, longing for sex with children, loneliness, thought they were rejected, maladaptive fantasies, thinking they will be abandoned, and low self-esteem.
Emotional Dysregulation	Perceive criticism, anger, feeling rejected, affect, frustrations, stress, heightened emotions, hostility, receiving bad news, anxiety, rising tension, sadness, and feelings of injustice.
Inadequate Self-regulation	Impulsiveness, impulsivity, absence of healthy coping mechanisms, poor emotion regulation, poor perception, poor judgement, degradation of self-control, not having control, lack of self-control, and poor distress tolerance.

Behavioural ADRFs

Substance Abuse	Substance use, intoxication, being intoxicated, relapse, use when bored, use on rainy days, use when walking past dealers, influence of substances, drugs, alcohol, change in use of substances, increase amount of substances, substance use withdrawal, smoking weed, and taking pills.
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Changes in Medication	Not taking medicine correctly, suddenly stop taking medication, and not being compliant with medication use.
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Adherence

Withdrawal from Support Services	Does not show up for appointments, retract from contact with support services, and does not keep to agreements.
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Contextual ADRFs

Financial Strain	Financial trouble, need for money, someone (an authority) does not pay you, and receive a bill.
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Proximal Stressors	Things out of their control, different environment, the opportunity, environment that is de-humanizing, access to weapons, being retained by someone, lunching next to the children's section, receiving a folder from Sinterklaas, seeing a beer, seeing a silver foil, seeing a movie with aspects of your trauma, and carrying a weapon.
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Access to a Victim	Access to a potential victim, access to a victim, renewed contact with an ex-partner, and contact with an old victim.
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Major Life Events Losing stable accommodation, losing employment, sudden change in employment, sudden loss of a job, being fired, being kicked out of your house, change in living arrangement, becoming homeless, losing a gym membership, losing daily activities and purpose.

Interpersonal ADRFs

Unstable Support System Parents that have substance abuse issues, not having the right support around, not having relationships, sudden collapsed support system, isolation, family fights, a criminogenic network, negative social network, loss of social support, not having social support.

Influence from Harmful
Peers Peers that offer [drugs] to them, other patients that are negatively influencing them, exposed to other people who are a negative influence, antisocial peer turns up at your house, old associate who is up to no good comes round to your house, gang environment, someone offers you a drink, people around you are drunk, friends that give you a firearm, group pressure.

Interpersonal Conflicts Conflicts with staff, conflict with people who offer support, not having needs met straight away by staff, not getting your medication straight away, not getting along with other patients, another patient does something they do not like, not liking a staff member, conflict within a relationship, someone making an upsetting comment about you, someone is being aggressive towards you, a discussion with another patient or staff, being treated

without respect, being treated unfairly, having someone threaten you, partners cheating, being discriminated, guards speak to you rudely.

Loss of Personal Relationship Mom or dad passes away, sudden loss of a relationship, having a partner leave, a relationship breaking up, loss of an important person, a best friend who suddenly dies, or someone in his social circle dies.

Physical ADRFs

Poor Sleep Bad night's sleep, sleep troubles, slept badly for a couple of nights.

Physical Pain Pain, feeling unwell, bodily feelings, car accidents
