The Role of Acute Dynamic Risk Factors in Forensic Treatment

Samuel Pietsch

Department of Psychology, University of Twente

Faculty of Behavioural, Management, and Social Sciences

Supervisors: Dr. Saskia M. Kelders, Carlijn Serno (Msc)

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Table of Content

Abstract

Risk factors are central aspects of forensic treatment, as they represent contextual, behavioural and psychological characteristics of offenders that influence recidivism risk. Static and stable dynamic risk factors (SDRFs) are well-established and widely used in forensic practice to predict long-term recidivism risk. However, the role of acute dynamic risk factors (ADRFs), which fluctuate rapidly and are useful for short-term risk prediction, is underexplored. This study examines the contemporary role of ADRFs in forensic treatment, by analysing semi-structured interviews with 27 forensic therapists and researchers. By applying thematic analysis, this study explores how ADRFs are addressed across four treatment phases; diagnostics, risk assessment, therapy, and rehabilitation. Findings indicate that ADRFs are considered along the four phases of treatment, however by a minority of participants. ADRFs seem to be more prominent during treatment and rehabilitation, while their role in diagnostics and risk assessment appears comparatively lower. Risk assessment tools predominantly focus on static and SDRFs, with ADRF-specific instruments being used by a minority of participants. Based on the results, practical constraints, such as frequent assessment and resource limitations, seem to influence the limited use of acute-specific instruments. Moreover, addressing ADRFs in forensic treatment appears to be challenging due to their quickly fluctuating nature, suggesting the need for continued improvement in treatment approaches. For future research, it is interesting to explore more efficient assessment and management techniques to facilitate the integration of ADRFs into forensic treatment.

Introduction

Forensic mental health care institutions play a central role in the criminal justice system by providing treatment for offenders, or those deemed at significant risk of offending in the future. Within this population, many suffer from severe mental health or psychiatric disorders such as, psychosis, substance abuse or personality disorders (Howner et al., 2018). Research has demonstrated a strong link between psychiatric disorders and recidivism, the tendency of offenders to reoffend (Maier et al., 2016; Seewald & Fazel, 2012). This underscores the importance of forensic psychiatry, which treats offenders suffering from psychiatric disorders to reduce their risk of recidivism and their reintegration into society (Robertson et al., 2011). The leading framework in forensic treatment to treat psychiatric patients is the Risk, Need and Responsivity (RNR) model (Andrews & Bonta, 2017). Within this framework, firstly, the risk principle states, the higher the risk of a patient to offend, the more frequent and longer the treatment should be, compared to lower risk individuals. Secondly, the need principle indicates that individually relevant risk factors should be targeted by treatment. Thirdly, the responsivity principle indicates that interventions should be tailored to match the needs and abilities of the patients. By studying the effect of these principles on forensic treatment, Andrews & Bonta (2017) found the more principles were applied, the lower the recidivism rates among patients. A long-term study by Bengtson et al. (2019) highlights the effect of forensic treatment on recidivism rates. The study found that mentally ill offenders who received forensic treatment had a recidivism rate of 43%, compared to 51% for those who did not receive treatment. While these findings indicate that forensic treatment can be effective in reducing recidivism, the rates remain high, suggesting a need for continued improvement in treatment approaches. This highlights the ongoing challenge in forensic treatment, in which risk factors stand central to reduce recidivism rates.

Static and Dynamic Risk Factors

Risk factors for recidivism are multifaceted and can be categorized into static and dynamic risk factors (Mulder et al., 2010). Static risk factors, such as age and offending history remain constant over time and are useful for predicting the likelihood of a patient to reoffend (Andrews & Bonta, 2006). However, static risk factors are not changeable and thus,

unsuitable targets for treatment interventions (Beech et al., 2002). In contrast, dynamic risk factors (DRFs) are changeable psychological, contextual, or behavioral features of an offender, such as distorted attitudes or sexual interests, that can be targeted by treatment (Andrews & Bonta, 2006). Moreover, DRFs show a stronger relationship with recidivism than static risk factors (Eisenberg et al., 2019). In the literature, some researchers, not all, distinguish between stable dynamic risk factors (SDRF) and acute dynamic risk factors (ADRF) (Hannson & Harris, 2000). Davies et al. (2023), supported the distinction between these DRFs, finding ADRFs to be more strongly associated with imminent recidivism than SDRFs. To this end, SDRFs refer to DRFs that can change over a long time-period, such as substance use and personality disorders, while ADRFs refer to DRFs that can change more rapidly like intoxication or emotional arousal (Hansson & Harris, 2000). Thus, SDRFs can be used for monitoring long-term changes in the risk of a patient, whereas ADRFs have a more imminent effect and seem to add value to short-term risk prediction. Vasiljevic et al. (2020) support this by indicating that regular monitoring of ADRFs is feasible and adds value to the evaluation of SDRFs, recommending multipoint studies with at least three measurements, to achieve more accurate estimations of change. Nevertheless, ADRFs are often considered unsuitable treatment targets, due to their quickly fluctuating nature, making them more impractical to target compared to SDRFs (Davies et al., 2023). For example, intoxication (ADRF) is more difficult to address in treatment, compared to substance abuse (SDRF). Hence, ADRFs appear to add value to forensic treatment, however, it seems challenging to incorporate ADRFs into forensic treatment. To this end, the momentary role of ADRFs in forensic treatment remains unclear.

The different Phases of Forensic Treatment

In forensic treatment, four distinct phases can be identified, namely, diagnostic, risk assessment, therapy, and rehabilitation (Expertisecentrum Forensische Psychiatrie, 2019). Firstly, in the diagnostic phase, the main goal is to explore risk factors that had an influence on the occurrence of the index offense, the primary crime that involved an offender with the forensic mental health system. Thereby psychodiagnostics instruments such as the Psychopathy Checklist Revised (PCL-R) are typically administered to identify offender characteristics and psychological functioning (Weiner, 2002). Also, an offense script is often used to analyse contextual factors as well as behavioural and cognitive patterns that, in form

of DRFs, might had an influence on the index offense (Askola et al., 2020). Secondly, the aim of the risk assessment phase is to identify a patient's risk factors, to ultimately be able to manage and reduce the risk of recidivism (Viljoen et al., 2018). Thereby, the approach of structured clinical judgement is typically applied, combining the use of risk assessment tools with clinical experience of forensic professionals (Baird & Stocks, 2013). A contemporary risk assessment tool that is widely applied is the Historical Clinical Risk Management-20 (HCR-20), incorporating static as well as SDRFs to assess the risk of a patient to violently reoffend (Douglas et al., 2014; Hanson & Harris, 2012). Moreover, risk assessment instruments exist which assess specifically ADRFs, for example the Dynamic Appraisal of Situational Aggression (DASA), assesses short-term risk of aggression with a 24-hour predictive validity (Ogloff & Daffern, 2006). Nevertheless, it is unclear to what degree acute-specific instruments are used in practice.

Thirdly, in the therapy phase, interventions are set in place to address DRFs that are deemed relevant treatment targets to reduce a patient's risk of recidivism (Heffernan & Ward, 2020). Thereby, the main goal is to build awareness and skills in patients to better manage situations involving DRFs in the future, with SDRFs like emotion regulation or antisocial attitudes often being primary targets (Heffernan & Ward). In the rehabilitation phase, a risk management plan is typically developed in collaboration with the patient. (Expertisecentrum Forensische Psychiatrie, 2019). Thereby the main aim is to mitigate the patient's risk of recidivism during and after reintegration into society, by applying a patient-centred approach, including risk management strategies and promoting responsibility and autonomy of patients (Barnao et al., 2014).

Current Study

While ADRFs have the potential to add value across the various phases of treatment, the exact nature of their role remains unclear in the existing literature. This study aims to understand the contemporary role of ADRFs in forensic therapy by examining the perspectives of relevant stakeholders. By interviewing forensic therapists and researchers this research seeks to combine practical and theoretical perceptions to achieve a comprehensive understanding of the contemporary role of ADRFs in forensic treatment. This approach aligns with the need principle of the RNR-model (Andrews & Bonta, 2017), by investigating

to what degree ADRFs are used in forensic practice, and whether they seem to add value to forensic treatment. Semi-structured interviews with forensic therapists and researchers in both in- and outpatient settings will be analyzed to gain insights into how ADRFs are momentarily embedded in forensic practice. Leading to the following research questions:
1) *How are acute dynamic risk factors addressed in the four different phases of forensic treatment, according to forensic therapists and researchers?*

1.1) *How are acute dynamic risk factors addressed in the diagnostic phase of forensic treatment?*

1.2) *How are acute dynamic risk factors addressed in the risk assessment phase of forensic treatment?*

1.3) *How are acute dynamic risk factors addressed in the therapy phase of forensic treatment?*

1.4) *How are acute dynamic risk factors addressed in the rehabilitation phase of forensic treatment?*

Methods

Participants

The target group of this study consisted of forensic therapists and researchers with experience in conducting or researching forensic treatment. To be eligible for this study, forensic therapists must have been employed as a provisional psychologist, clinical psychologist, health psychologist, or nurse practitioner and be trained in at least one risk assessment instrument, to enhance quality of the collected data. Forensic researchers were eligible if they were undertaking scientific study in the domain of SDRFs and ADRFs and had published one or more scientific articles on that subject. Participants were recruited via purposive and snowball sampling (maximum of four therapists per forensic institution). Thereby, several pathways were used to find suitable participants. Firstly, therapists were recruited via forensic institutions and the networking websites LinkedIn and KNAPP (a networking platform for professionals in forensic healthcare). Secondly, to recruit researchers, authors from relevant publications were contacted via email. Lastly, interviewed

participants (both researchers and therapists) were asked to refer other suitable participants.

In total, 34 participants were reached, seven declined due to timely or unknown reasons. As the last two interviews did not produce new information, data saturation within this sample was reached (Rahimi & Khatooni, 2024). Thus, the sample of this study consisted of 27 participants, including forensic therapists in an inpatient (n=10) and outpatient setting (n=7), researchers (n=6) and participants with experience in both (n=4). Further, participants from the Netherlands (n=14), Belgium (n=5), Australia (n=5) and New Zealand (n=3) were recruited, including 16 female and 11 male participants with an age range of 21-70. Years of experience ranged from: 0-5 (n=8), 6-10 (n=8), 11-15 (n=3), 16-20 (n=2), 21-25 (n=4) and 26-30 (n=2).

Materials & Procedure

This study employed a qualitative approach by conducting semi-structured interviews with forensic therapists and researchers. Semi-structured interviews profit from both the consistency of structured interviews and the flexibility of open-ended questions (Kallio et al., 2016). This flexibility contributes to a deeper understanding of the topic, as the experiences and insights can be freely discussed and unclarities can be resolved. The interviews were conducted in English and Dutch, by another researcher (CS), between November 2023 and March 2024. Two interview schemes, one for researchers (Appendix A) and one for therapists (Appendix B), were developed collaboratively by a team of five researchers. Both interview schemes entailed demographic information (i.e., gender, age, job title, working experience in years). The interview schemes were not specifically developed for this research, but for broader research into the concepts of ADRFs, SDRFs and triggers in general, and in the different phases of forensic treatment. For this study, the role of ADRFs was examined across the four phases of forensic treatment, namely, diagnostics, risk assessment, therapy, and reintegration. The interview schemes for researchers differed, by placing greater emphasis on the conceptualization of the concepts, while their role in treatment was examined more broadly. To test and refine the interview schemes, a pilot interview was conducted with one therapist and one researcher.

Eligible participants received an email with relevant information about the study, such as purpose, nature, informed consent (Appendix C), and duration of the interview. The

interviews were held via Microsoft Teams or in person, by another researcher (CS). Interviewees who participated via teams were asked to send back the informed consent before the interview took place. For interviewees who participated in person, a copy was signed before the interview. For researchers, the average interview duration was 51.67 minutes (*SD* = 16.80), ranging from 26 to 78 minutes. For therapists, the average duration was 54.59 minutes (*SD* = 7.40), with a range of 40 to 64 minutes. Participants with experience in both roles had an average interview duration of 56.50 minutes (*SD* = 9.15), ranging from 50 to 70 minutes. Probing questions were asked during the interviews when topics required further clarification, contributing to more rich and detailed data (Robinson, 2023).

Data Analysis

The interviews were audio recorded and transcribed verbatim, via Microsoft Teams. The automated transcripts were then scrutinized and edited independently by several researchers, to ensure their correctness. After data collection and transcription, a thematic analysis using Atlas.ti was applied by a single researcher (SP). First, the data on ADRFs across the four phases of forensic treatment were deductively coded to align with the research questions. Following this, an inductive thematic analysis was conducted to identify, analyse and report emerging patterns in participants' experiences, within each treatment phase (Braun & Clarke, 2006; Braun & Clarke, 2012). After familiarizing with the data, an initial coding scheme was developed based on 6 interviews. This scheme was reviewed by two supervisory researchers, refined based on feedback, and then tested on 10 interviews. Iterative revisions followed, adjusting the coding scheme two more times. Once all 27 interviews were coded, themes were finalized and reviewed to ensure clarity, coherence, and non-overlapping categories. The coding scheme and themes were regularly reviewed with supervisors throughout the analysis.

Results

The following table presents all main and sub-codes identified from the interviews, categorized into the four phases of forensic treatment. The results are structured by main codes, with the corresponding sub-codes integrated.

Treatment Phase	Main Codes	Sub Codes	Definitions	Total[A]	Therapists[B]	Researchers[C]
Diagnostics				17 (18,49%)		
	ADRF Exploration		Therapists initially exploring factors that contribute to a patient's ADRFs, such as mental health conditions or contextual factors	7	9	3
		Conversational Diagnostics	Exploring patients background and mental health conditions, such as the influence of delusional states on ADRFs, through therapist-patient conversations.	4	2	2
		Observational Diagnostics	Exploring internal influences on ADRFs, such as narcistic personality structures, through therapists observing patient behaviour.	3	2	0
		Offense Script	Therapists analysing ADRFs, such as victim access, that influenced the occurrence of the index offense, through communication with the patient.	10	5	1
Risk Assessment				15 (16,87%)		
	Risk Assessment Instruments		Application of risk assessment tools, such as the Acute-2007, to identify ADRFs.	9	5	2
	Conversational Risk Assessment		Enhancing understanding of ADRFs, by inventorying contextual information, such as family relations, through therapist-patient conversations.	6	4	1

Therapy			44 (40,45%)		
	ADRF Monitoring	Application of risk assessment instruments, such as the DASA, to assess the trajectory of patients ADRFs over time.	12	3	3
	Insight Development	Therapeutic strategies aimed at enhancing patients' self-awareness and understanding of their behaviours, ADRFs, and emotional responses.	23	11	2
	Reflective discussions	Therapist-patient conversations aimed at exploring and understanding patients' thoughts, emotions, and behaviours to build insight into patients ADRFs	13	7	1
	Psychoeducation	Therapists educating patients on the connections between their behaviours, ADRFs, and underlying issues to enhance self-awareness and self-management.	6	2	1
	Role Play	Therapist-patient performing behavioural scenarios, such as peer influence on drug use, to develop client insight into behaviours, ADRFs, and interpersonal interactions.	4	4	0
	Interventions	Interventions designed to target specific areas that can influence ADRFs, such as aggression regulation or coping skills	9	4	4
	Virtual Reality	Practicing coping skills in situations involving ADRFs, through Virtual Reality	1	0	1

	Collaborative Analysis	Therapist and patient collaboratively analysing situations that involve ADRFs and discussing strategies for effective ADRF management	4	2	1
	Role Play	Therapist-patient collaboratively enhancing coping skills, or aggression regulation in situations involving ADRFs, through role play	2	0	2
	Breathing Exercises	Patients practicing breathing exercises in high stress-situations outside of treatment, to enhance ADRF management	2	2	0
Crisis Management		Strategies and actions used, such as involvement of other professionals, across all phases of forensic treatment to respond to and prevent the escalation of ADRFs.	11	3	1
	Immediate Referral	Immediate involvement of external or internal professionals, such as law enforcement or psychiatrists, to address crisis situations, such as suicidality, requiring immediate intervention.	4	2	0
	Immediate Action	Direct action by forensic therapists to support a patient during a crisis, such as sudden eviction	7	3	1
Crisis Tools		Structured tools, such as crisis or signaling plans, designed to recognize, manage, and respond to crises, helping patients and professionals prevent escalation and ensure safety.	12	8	1
	Crisis Plan	Structured plan with strategies to manage an active crisis	4	2	0

	Signaling Plan	A structured plan to help patients identify early warning signs of an impending crisis, including first steps to manage the crisis	7	6	0
	SOS Card	Portable card containing emergency contacts and concise guidance on managing a crisis	1	0	1
Rehabilitation			24 (24,1%)		
Risk Assessment Instruments		Therapists or forensic specialists administering acute-specific risk assessment as a standardized way to monitor the trajectory of ADRFs.	5	2	2
Reflective Check- ins		Therapist-patient collaboratively reflecting on challenging situations during leave periods, such as leisure activities in society, to assess patient progress and monitor fluctuations in ADRFs.	8	5	1
Chain Partners		Integration of chain partners, such as parole officers or family support, to support the patients during reintegration into society	11	4	2

[A]*Number of text fragments per code that were found in all interviews* [B]*Number of Therapists mentioning the code* [C]*Number of Researchers mentioning the code*

Diagnostic Phase

The primary purpose of the diagnostic phase is to explore potential ADRFs that might be manifested in patients.

ADRF Exploration

According to six participants, a first impression of a patients relevant ADRFs is created in the diagnostic phase. Participants mentioned different approaches to explore relevant ADRFs. Four participants described that through ***conversation*** with the patients, therapist try to achieve a first understanding of the patient. By inventorying about the patient's background, their social relationships or mental health conditions, therapists can make first inferences about ADRFs that could influence the patient towards criminal behaviour. For example, a delusional patient might be at acute risk of becoming violent through distorted perceptions, as participant 24 described:

„Because somebody who has delusions, delusions that my wife Camille is from a different planet, that planet is in Netherlands, but she's come from Netherlands to meet in Australia so that we can get married […] so in that case, that is the acute dynamic risk factor, to become violent."

Another method mentioned by three participants is ***observation***, by observing how patients behave and respond, additional inferences about ADRFs can be made. These observations are typically conducted by the treating therapist. However other staff involved with the patient might contribute to gathering observational information, as one participant described. According to participants, this observational information can be about personality structures, such as a patient behaving narcissistic or autistic. While these structures might be indirectly connected to ADRFs, participants did not specify about this relationship. Additionally, participants mentioned apllying diagnostic and risk assessment instruments, however, the focus lies on static and SDRFs, ADRFs do not seem to be assessed by such instruments at this stage.

Lastly, the ***offense script*** was mentioned by six participants. According to participants, the offense script involves a comprehensive examination of all available information related

to the committed crime, such as crime scene details, immediate lead up to the offense (encompassing ADRFs) and an offender's criminal history. To construct a holistic understanding of the circumstances surrounding the offense, therapists often engage in step-by-step discussions of the crime with the patient. This process enhances the therapist's insight into behavioral patterns and psychological factors that are important to consider when planning further treatment. Six participants mentioned that relevant ADRFs quickly become apparent, by analysing the days, hours and minutes before the occurrence of the index offense. An ADRF that could be present in such a timeframe is emotional arousal, that was triggered by a comment of another person, as a participant noted. Another participant mentioned acute financial problems or sudden eviction as possible ADRFs that can play a role in the immediate lead up to an offense. One participant explained that while the immediate lead up to the offense is considered, the broader context of the weeks and months before the occurrence of the crime is more decisive for treatment planning, focusing on SDRFs. This participant argued that SDRFs are more decisive due to their long-term influence on recidivism making them important treatment targets.

Risk Assessment Phase

The main goal of the risk assessment phase is to identify relevant ADRFs.

Risk Assessment Instruments

In the risk assessment phase, a minority of participants indicated administering acute-specific risk assessment instruments to identify ADRFs that contribute to a patient's risk of criminal behaviour. Five participants mentioned using the Static/Stable/Acute, that includes the subscale Acute-2007, which assesses seven different areas of short-term risk, including victim access, emotional collapse, and substance abuse. However, two of the five participants mentioned excluding the Acute-2007 subscale, arguing that ADRFs are generally less relevant in the initial stages of treatment. as Participant 1 stated:

"We focus more on stable factors because, if I look specifically at our department for sexual offenders, we only use the static/stable, and the acute is only used once they start moving towards release or reintegration. That's when we need to assess whether it's feasible, and that's when we use the acute factors. So, I think we mostly focus on stable dynamic factors again."

Four participants reported using the HCR-20, which does assess ADRFs however with a limited scope compared to static and SDRFs.

Conversational Risk Assessment

Additionally, five participants mentioned therapist-patient communication for deepening the understanding of ADRFs. Through conversations, therapists gather additional information about patients' behavioral patterns and perspectives on their offenses, complementing insights from formal risk assessments, as participant 25 described:

"A very central role to understand what they [ADRFs] are. Um, and you know where they come from? Why did the person develop those particular risk factors? Um and how those acute factors sort of play out in their life?"

Participants reported to consider and remain vigilant to identified ADRFs, for example through informal check-ins in therapy sessions, as one participant explained. However, no participant reported directly incorporating ADRFs in the treatment plan, participants emphasized that ADRFs become more important in the later stages of treatment. One participant argued that in the inpatient setting there are less opportunities for offending, which is why ADRFs become more important towards rehabilitation, when patients start to have leave periods.

Therapy Phase

The main purpose of the therapy phase is to monitor and manage a patient's ADRFs.

ADRF Monitoring

According to six participants, ADRFs are monitored to evaluate changes in risk, during the therapy phase. Two participants reported periodically reassessing DRFs, though they did not specify the time frame and which instruments are used. Three participants mentioned using the Acute-2007 instrument. While one of the three participants noted that the Acute-2007 is administered weekly, to monitor changes in acute risk, the other participants did not state the assessment frequency. The goal of repeated scoring is to monitor progress during treatment, as one participant explained. Additionally, one participant reported using the DASA which is valid for 24 hours and assesses risk of inpatient violence. This

participant emphasized that addressing ADRFs should precede working on SDRFs, as a prominent ADRF can sabotage the process of working with SDRFs, ultimately interfering with treatment progress. However, the participant did not specify in greater detail how a prominent ADRF would interfere with SDRFs..

Insight Development

During treatment, thirteen participants highlighted insight development as crucial for improving ADRF management. According to participants, insight development makes patients become more aware of behavioural patterns linked to ADRFs, enabling them to recognize situational risks and apply strategies effectively**. *Reflective discussions*** were identified as the most common approach, with regular check-ins during therapy sessions providing opportunities to collaboratively explore recent situations involving ADRFs. By informally exploring how an ADRF posed an influence on a patient's behaviour, patients' understanding of relevant ADRFs can be enhanced, as participant 26 described:

"One of the guards spoke to me really rudely at breakfast this morning. OK, how did you deal with that? What was going on in terms of your thoughts, your emotions? How did you respond to that kind of thing? So we're kind of we're checking at the start of the session."

In addition to reflective discussions, participants also mentioned ***psychoeducation*** as a method to increase patient insight. Unlike reflective discussions, which focus on collaborative exploration, psychoeducation involves therapists explaining ADRFs contributing to certain behaviours and how they manifest in patients. One patient mentioned 'Minddistrict', a website providing psychoeducation and guided treatment modules, for enabling patients to expand their knowledge independently outside of sessions. Additionally, extreme situations involving ADRFs can be useful in educating a patient of the interconnections between ADRFs and resulting behaviours, as Participant 9 delineated:

"A crisis is actually an exaggeration of the problem. And you try to explain that to the patient as well, saying; Now you're behaving extremely. You don't always do that, but this is what's happening. That helps patients better understand their behavior and what triggered it because it's more intense and extreme, making it easier to remember and providing more information from the patient. Whereas if it's not a crisis, a mild situation, the patient might say, "What are you talking about? There's no problem. I didn't do anything,"

Lastly, ***role play*** was mentioned by four participants to develop behavioural insight. Participants stated that besides reflective discussions and psychoeducation, role play allows patients to directly experience how ADRFs influence their behavioural responses, providing a practical understanding of the interconnection with ADRFs. However, no specific examples were mentioned.

Interventions

According to eight participants, interventions address ADRFs by targeting situational risk factors to improve patients' ability to manage their behaviours and emotions effectively. These interventions are tailored to specific needs of patients, such as aggression regulation or impulse control. One participant mentioned the use of ***Virtual Reality (VR)*** to simulate high-stress scenarios in a controlled environment, allowing patients to practice managing anger and emotional arousal without putting other at risk. Two participants stated that ***breathing techniques*** are taught in sessions, while patients are encouraged to practice applying these skills in high-stress situations outside of therapy. Three participants mentioned ***collaborative analysis*** utilizing real-life scenarios, to explore strategies for regulating heightened emotions through communication, as explained by Participant 13:

"Your relationship has ended, and you're very angry, so we can practice with that and also look to the future, like suppose something like that happens again, and you get into a relationship again, and it becomes difficult again, how will you handle it? So that would be nice to work on during therapy, but I think if there isn't really an acute situation to practice with, then it's very broad to talk about."

Likewise, social, - or coping skills are addressed during therapy sessions when deemed relevant for the patient. Two participants mentioned ***role play*** as a method to practice social skills, such as learning how to interact with old acquaintances associated with drug use, in a controlled environment. Contrary to role play that is used in insight development, the aim is to develop skills in managing ADRFs. Enhancing patients' reactions to situations involving heightened emotions or stress, contributes to a learning process of managing ADRFs more effectively. However, one participant explained that therapists require a high level of behavioural therapeutic skills to adequately address ADRFs through role play, without going into specifics why this is so challenging. Seven participants mentioned focusing especially on SDRFs during treatment, with two arguing that resource constraints makes addressing

ADRFs challenging. Three of the seven participants argued that ADRFs can be indirectly targeted through SDRFs, as Participant 24 described:

"By targeting the stable dynamic risk factors, indirectly you are also targeting the acute dynamic risk factors because control underlayer you control the top layer."

Moreover, another participant described SDRFs as necessary basis for handling situations involving ADRFs, arguing that the ability to handle long-term stress also improves short-term stress management. This participant did not further elaborate on the mechanisms behind this. Likewise, one participant explained that ADRFs can be useful for monitoring changes in SDRFs, arguing that the extremity of ADRFs indicates how strongly SDRFs currently manifest in a patient.

Crisis Management

According to a minority of participants, crises can occur across all four phases of forensic therapy, making crisis management relevant throughout treatment rather than being confined to a single phase. According to four participants, ADRFs often contribute to crisis situations that require ***immediate referral***. In extreme situations, external agents can be involved when the crisis exceeds the institution's capacity to manage it, as reflected by these participants. For example, one participant noted that law enforcement may be involved when a patient poses a high risk of violence to himself or others. However, urgent action may also include engaging an institutions internal resources in cases of suicidality, as explained by Participant 2:

"If someone is suicidal, someone who has stalked or is still stalking… I might not even finish the entire risk assessment, but instead, I'll already schedule an appointment with the psychiatrist… preferably tomorrow so that they can be seen, and we can make a plan for how to handle it. So maybe medication or perhaps they need to live somewhere else for a while. So, you move more into action."

Further, ***immediate action*** by therapists may be required in certain crisis situations, as noted by five participants. While three participants did not specify these situations, two participants indicated that in cases of sudden job loss or eviction, immediate support is offered to help mitigate the ADRF for the patient. However, the participants did not elaborate on the specifics of such support.

Crisis Tools

According to nine participants, intervention tools such as SOS cards, crisis or signalling plans are created to provide the patient with a concrete plan how to behave when a crisis, typically involving ADRFs, is occurring. Participants explained that the aim is to provide immediate support to assist the patient in the moment, facilitating ADRF management. A ***crisis plan*** is a structured crisis management tool that outlines step-by-step strategies, key contacts, and intervention measures to systematically manage and de-escalate high-risk situations. While ***a SOS card*** provides similar information, it is usually more concise and in form of a portable card, for patients to always carry with them, as participants reported. A ***signaling plan*** helps patients recognize early warning signs of distress, often using a traffic light system to indicate dynamic risk levels and reflect on appropriate actions to take, as participant 17 described:

„It's a plan where—yes, it's a bit similar to the 5G worksheet, but they use colors: green means everything is okay; how do people see that I'm okay, and how do I see it myself? Orange means things are getting a bit worse; how do people see that, how do I notice it in myself, and what can I do about it? And red means that things aren't going well at all, and the risk of relapse is high."

Rehabilitation Phase

The primary goal of the rehabilitation phase is to monitor changes in ADRFs and develop a management plan to effectively address ADRFs during rehabilitation and reintegration into society.

ADRF Monitoring

During rehabilitation, ADRFs often become more prominent due to the differences between the controlled inpatient environment and the complexities of everyday life, as reflected by a participant. ADRFs that were absent during inpatient care may resurface under these new circumstances. To address these challenges, four participants mentioned the use of ***risk assessment instruments*** to monitor fluctuations in ADRFs during leave periods. One participant mentioned the use of the Acute-2007, which is scored weekly when patients start to have leave periods. Another mentioned scoring the DRAOR, that assesses violence risk during rehabilitation, without specifying the assessment frequency. Also, collaboration with

forensic clinical specialists was mentioned by one participant. These specialists conduct risk assessments in the community to monitor changes in ADRFs during rehabilitation. However, it was not specified which risk assessment instruments are widely applied, nor which type of forensic specialists are consulted.

Lastly, four participants mentioned ***reflective check-ins*** during therapy sessions target to support the patient in challenging situations involving ADRFs. These discussions provide a structured space to prepare for and reflect on real-life situations, such as planned leave, returning to work, or engaging in resocialization activities, as reflected by participants. Through therapist-patient conversation, patients' risk-levels are regularly assessed and specific situations potentially involving ADRFs are collaboratively explored. Ultimately, developing strategies to handle these challenges effectively, as participant 13 stated:

"The leave is supposed to be for resocialization, so okay, I'm in yellow or red, you're angry, you're tense, okay, what do you want to do outside? Yes, walk in the woods. Okay, what would happen if you meet people? Maybe I'll behave well, but I don't really feel like talking or something. Could you indicate that? How would you indicate that? So, with that, you can practice very nicely."

Chain Partners

According to a minority of participants, managing relevant ADRFs is another important aspect during rehabilitation. With encountering ADRFs more frequently, the learned strategies and techniques to manage ADRFs are challenged. Six participants mentioned chain partners, such as socio-therapists, autism coaches or probation officers to be involved in the rehabilitation process. These chain partners are usually provided with background information from treatment, to support patients during this phase. Participant 17 highlighted the importance of reinforcing therapeutic learning beyond formal treatment, emphasizing the role of continued support in helping patients apply skills in real-life settings:

"It often happens that we bring in our colleagues from home visits, who go by once a week to work with the person. That's more support than treatment. It's about applying the things the person has already learned in therapy."

Discussion

This study aimed to examine how ADRFs are addressed across the four different phases of forensic treatment. Thereby two main methods emerged in which ADRFs are consistently addressed. First, risk assessment instruments assessing ADRFs appear across several phases, except diagnostics. Thereby, risk assessment instruments are used to identify and monitor fluctuations in ADRFs, however by a minority of participants. A majority of participants view SDRFs as more suitable treatment targets, due to their long-term influence on recidivism. Second, therapist-patient communication emerged as a key-method in which ADRFs are addressed across all four phases of forensic treatment. Generally, with the idea to complement risk assessment instruments by inventorying about contextual information of ADRFs. In diagnostics and risk assessment to identify ADRFs, in therapy and rehabilitation to monitor and manage situations involving ADRFs. Additionally, ADRFs appear in other treatment methods as well. In diagnostics, ADRFs appear in the offense script, by analysing the immediate lead up to the offense, however a majority of participants emphasizes SDRFs over ADRFs. In the therapy phase ADRFs are more actively targeted by awareness and skill development in patients, however by a minority of participants. In rehabilitation, a minority of participants monitor and manage ADRFs by chain partner involvement. Lastly, half of participants reflected that ADRFs often play a role in crisis situations across all phases of forensic treatment. However, ADRFs seem to be rather retrospectively addressed, as ADRFs appear difficult to grasp when not actuely present.

Risk assessment instruments

Risk assessment instruments appear across the risk assessment, therapy and rehabilitation phases. However, acute-specific risk assessment instruments seem to be used by a minority of participants. The Acute-2007, was the most frequently mentioned acute-specific instrument, which assesses imminent recidivism risk in sexual offenders, covering 7 different areas of ADRFs, such as emotional collapse, substance use, or victim access (Hanson & Harris, 2012). Risk assessment instruments such as the HCR-20 and the FARE, were mentioned by half of participants. These instruments assess general and violent recidivism, focusing on static and SDRFs (Douglas et al., 2014; Van Horn et al., 2016). While participants argued that due to their influence on long-term recidivism, SDRFs are more important treatment targets than ADRFs, resource constraints were also mentioned as a reason why ADRFs receive limited attention. Many risk assessments rely on pen-and-paper questionnaires or structured professional judgment tools, both of which require trained

professionals to administer (Vasiljevic et al., 2017). The high resource demand makes frequent ADRF monitoring impractical, as conducting these assessments on a frequent and continuous basis is both time-consuming and costly (Vasiljevic et al., 2017).

Moreover, according to participant responses, the concept of ADRFs seems not to be clear among all forensic therapists, posing a challenge to practical application. Half of participants do not differentiate between DRFs, suggesting a lack of establishment of ADRFs in forensic practice. This is in line with Ward & Beech (2015), noting that ADRFs lack universal understanding, as they are often conflated with other concepts, such as SDRFs. To this end, when acute-specific risk assessment instruments are used, the most recent assessment is typically considered to assess imminent risk of recidivism (Brown et al., 2009; Handby, 2013). This is in line with data from this study, a participant stated that ADRFs assessments become less interesting when patients mostly score zero on ADRF items each week, indicating that weekly scores are compared with each other. However, ADRFs can change quickly over time within the same individual (Vasiljevic et al., 2017). Moreover, greater variability in acute risk scores is associated with a higher likelihood of recidivism (Davies et al., 2023; Penney et al., 2016). Thus, to adequately assess short-term risks of patients, acute-specific risk assessment instruments need to be frequently (i.e., daily to weekly) administered, and variation scores considered. While one participant mentioned administering the Acute-2007 weekly, none of the participants reflected on considering variation scores in assessing ADRFs. The lack of understanding of ADRFs as well as the difficulty in capturing meaningful change values in ADRFs, highlights one of the challenges that exist in incorporating ADRFs into forensic treatment,

A possible pathway to explore in future research is Experience Sampling Methodology (ESM). ESM prompts repeated measurements in relatively short time intervals, collecting self-reported data from a patient's daily life (Bringmann et al., 2013). On the one hand, repeated daily measurements have the benefit of capturing fluctuations in ADRFs that occur within hours, on the other, self-reported data reliefs ADRF assessment from time- and cost-inefficient methods involving trained personal. A study using Stable-2007 items found that ESM assessment was feasible and acceptable for a patient (Smid & Van den Heuvel, 2023). The Dynamic Appraisal of Situational Aggression (DASA), which has a 24-hour validity on short term risk of aggression, has the potential to be modified to a self-report tool, according to the authors (Ogloff & Daffern, 2006). Incorporating the DASA into an ESM study in forensic practice would provide the opportunity to explore whether ADRF assessment via ESM is feasible for patients. Moreover, through frequent assessment (i.e.,

multiple prompts daily), ESM data could provide variation scores of ADRFs, making assessments more predictive of recidivism. Nevertheless, self-reported data has the disadvantage that social desirability or lack of self-insight of patients could falsify the assessments (Smid & Van Heuvel, 2023). Thus, ESM might not be suitable as a stand-alone tool, but still offers a promising avenue for ADRF assessment in future research.

The Role of ADRFs vs SDRFs

According to participants, informal conversations, aiming to complement risk assessment instruments and providing contextual information on a patient's risk levels, seem to pose an integral part across all phases of forensic treatment. ADRFs seem to be contemplated in these conversations by half of participants, however their role was rather broadly described, without providing specific details. It seems that ADRFs are not considered as standard treatment targets but more as a complementary concept to SDRFs. Additionally, participants commonly view SDRFs as more suitable treatment targets than ADRFs. A reason for this is that SDRFs are easier to target and to monitor due to their slowly changing nature (Vasiljevic et al., 2017). Nevertheless, a minority of participants indicated that ADRFs become increasingly important in the later stages of forensic treatment, as they naturally gain prominence. To this end, participants reported that ADRFs can be better retrospectively addressed, after being naturally prominent in a patient. This may be accounted by the fluctuating nature of ADRFs that can change quickly within hours or days (Lee et al., 2023), making ADRFs more elusive than SDRFs and challenging to target when not acutely present. While situations including ADRFs provide opportunities to target ADRFs, participants also stated that these situations often escalate to become a crisis. In these crisis situations immediate measures need to be taken to ensure the patients- and others safety, typically lacking time to work on ADRFs. These findings highlight a decisive challenge in incorporating ADRFs into forensic treatment.

For future research, it would be interesting to examine whether proactive ADRF management is possible and adds value to forensic treatment outcomes. A possible avenue can be found in Virtual Reality (VR), which provides a unique opportunity to expose individuals to virtual environments, while in a safe setting without endangering others (Renaud et al., 2014; Fromberger et al., 2015). Thus, crisis situations involving ADRFs can be simulated, to support a patient proactively building skills to manage ADRFs in a safe setting. Moreover, VR can elicit the feeling of presence, stimulating the impression of being in a certain environment, while being situated in another (Schuemie et al., 2001).

This creates a feeling of realness of simulated scenarios, enhancing transferability of ADRF management skills to real-life settings. Further, these environments can be fully manipulated, to suit the specific needs of patients (Ticknor & Tillinghast, 2011; Smeijers & Koole 2019). Thus, in line with the responsivity principle of the RNR-model, interventions could be tailored to suit the needs and abilities of patients (Andrews & Bonta, 2017). However, it is important to consider that VR is not suitable for every patient, as symptoms like headeaches, motion sickness or disorientation can emerge (Ticknor, 2018). Nevertheless, VR offers a promising direction for advancing ADRF management in forensic treatment.

Interconnection of Risk Factors

While a majority of participants emphasize SDRFs over ADRFs as treatment targets, a minority of these participants reflected on an interconnection between these DRFs, arguing that treatment on SDRFs indirectly influences ADRFs. This viewpoint is in line with the network perspective by Van den Berg et al. (2020), indicating that dynamic risk factors do not work in isolation but interconnectedly influence each other. Participants explained that reducing SDRFs can indirectly lower ADRFs as well, arguing that SDRFs build a foundation of recidivism risk in individuals, that can transpose to ADRFs. Accordingly, Polaschek & Yesberg (2017), found that treated patients with low SDRFs and high protective factors had less fluctuations in ADRFs in the following 2 months, supporting the idea of DRFs interconnectedly influencing each other. Moreover, one participant in this study explained that while emphasizing SDRFs as treatment targets, ADRFs can be used to monitor treatment progress on SDRFs. Thereby, the participant argued that the extremity of ADRFs can indicate how strongly SDRFs manifest in patients. Following this line of thought, frequent intoxication (ADRF) could signal that substance abuse (SDRF) is strongly prominent in a patient, requiring increased attention in treatment. In line with the risk principle of the RNR-model, such insights could be used to adjust treatment frequency and intensity to match the risk level of a patient (Andrews & Bonta, 2017). Conversely, one participant explained that ADRFs ideally should be addressed before working on SDRFs, arguing that the prominence of an ADRF can interfere with treatment effectiveness when working on SDRFs. Hence, the occurrence of ADRFs might place an additional burden on the SDRFs active in a patient, overloading the patients' coping abilities. Likewise, in a qualitative study by Serno et al. (2024), participants reported that perfectionism (SDRF) feelings of inadequacy (ADRF) and experiences in one's family (Static) are interconnectedly influencing each other. Suggesting

that static and SDRFs form a certain risk level in a person that can escalate situationally with the occurrence of an ADRF.

Taken together, these findings support the network perspective, suggesting that DRFs should be considered as interrelated, rather than separate risk factors. Van den Berg et al. (2020), explored the network structure of SDRFs using the Static-2007 risk assessment instrument. Impulsivity, cognitive problem solving, and feelings of loneliness were found to be most directly linked to recidivism. Future research could build on this by exploring network structures of acute-specific risk assessment instruments such as the Acute-2007, as well as interrelations between SDRFs and ADRFs. For example, it would be interesting to investigate whether items of the Acute-2007, interact with items of the Stable-2007, providing further insight into possible interconnections of DRFs.

Strengths and Limitations

When interpreting the findings of this study, the following strengths and limitations should be considered. First, separate interview schemes for both researchers and therapists, ensured appropriate questions for each subgroup, facilitating participant responses and thus, enhancing the quality and relevance of the collected data (Doody & Noonan, 2013). Additionally, the interview structure which was organized according to the four phases of forensic therapy allowed a clearer categorization of the results. Thereby, comparisons between phases could be made and differences in ADRF implementation across therapy phases identified. However, in practice the categorization of the four phases is not as linear as reflected in this study. Some elements, such as risk assessment instruments are relevant across phases and the different phases might overlap to certain extends, which may not be fully reflected in the results. Further, researcher and therapists from multiple countries and professional backgrounds were included, ensuring substantial expertise and varied perspectives on forensic treatment. Nevertheless, the qualitative nature of the study, including the limited sample size needs to be considered, reducing transferability to other forensic settings.

While the semi-structured approach in this study benefits from natural communication, it has the disadvantage of introducing variability. The framing of questions or amount of probing used in each interview might be susceptible to researcher bias, and be influenced by own beliefs and interpretations (Lim, 2024). However, through piloting an interview in collaboration with another researcher, objectivity and trustworthiness was enhanced (Kallio et al., 2016). Further, inter-rater reliability requires a team of researchers to

collaboratively discuss and establish consensus on a set of codes (O'Connor & Joffe, 2020). As this study was conducted by a single researcher, this may have limited the verification of coding consistency and led to a higher degree of subjectivity in the data analysis, even though the coding scheme was repeatedly reviewed by supervisors and accordingly adapted. Moreover, thematic analysis inherently involves reflexivity, as the researcher's subjective interpretations influence the coding process and the resulting findings (Freshwater, 2005).

Conclusion

This study highlights a critical gap in forensic treatment, ADRFs seem to be considered across the four phases of forensic treatment, however by a minority of participants. While acute-specific risk assessment instruments exist, they seem to be used to a limited extend. Practitioners predominantly focus on static and stable SDRFs, leaving ADRFs to be addressed mostly retrospectively through informal discussions. The limited application of acute-specific risk assessment instruments points to a broader issue. Existing instruments are often impractical to administer due to resource constraints. Future forensic practice should explore innovative approaches, such as ESM, to explore ways to capture real-time fluctuations in ADRFs, potentially improving application effectiveness and risk prediction. Moreover, retrospectively addressing ADRFs seems to have limited practical value, due to crisis situations hindering interventions to address ADRF management. Thus, new avenues like VR could facilitate proactive ADRF management, potentially addressing ADRFs in a more effective manner. To this end, if ADRFs are to be fully integrated into forensic treatment, practitioners need tools that are both feasible and responsive to the fluctuating nature of ADRFs. Advancing towards more flexible, patient-centered methods will be essential in connecting forensic research and practice.

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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?
    1. *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?

2. *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?
    1. *E.g., SDRFs: addiction, criminal network, antisocial personality*
    2. *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 CS

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:

Signature:

Date: Date:

Name researcher: Signature:

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: _____