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Assessment of protective factors in clinical practice☆

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ABSTRACT

Protective factors safeguard against undesirable outcomes such as violence, sexual violence and criminal behavior in general. While a growing body of theoretical and empirical literature has identified plausible protective factors and explored their underlying mechanisms and additional value to risk factors, little has been written concerning clinical assessment of protective factors. A challenge faced by clinicians working in correctional and forensic settings is how to translate emerging knowledge into applied approaches to assessment and treatment. The current paper explores the clinical assessment of protective factors. Within often time-pressed legal and clinical practice environments, feasible assessment methods are needed that add value to the current predominantly risk-focused assessment practice. The valid and reliable assessment of protective factors should aid in risk-management decision-making and help inform strengths-based treatment efforts. This paper aims to demonstrate ways to bridge the gap between theoretical and empirical knowledge regarding protective factors and their clinical applicability, and to highlight the added value of assessing protective factors. Several protective factor assessment tools are described and short cases are used to exemplify how consideration of protective factors can enhance clinical practice.

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1. Introduction

Prevention of aggression and violent or sexually violent behavior is the primary task of clinicians working in forensic and correctional settings. It is the main purpose behind legal decision-making regarding security classifications, permission for leaves and early release or parole. It

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is also the prime consideration in risk assessments contained within psychological and psychiatric reports informing the best approach to intervention for specific individuals. Most importantly for clinicians – and ultimately the communities to which their clients are discharged or released into – violence prevention is the ultimate goal in forensic psychology and psychiatry treatment efforts. Taking a wider perspective, prevention of harmful behavior is a primary driver for many interventions outside of correctional and forensic settings as well. In general psychiatry, the prevention of aggression is a major concern for patient and staff safety. In dealing with children with severe behavioral problems in schools, aggression is a pressing issue and the prevention of oppositional behavior is often the prime target of intervention. Sound evaluation of the likelihood of aggressive behavior is however extremely difficult. In forensic and correctional settings, mental health professionals try to find the right balance between ensuring maximum freedom for the client and guaranteeing safety as much as possible. That is, the safety of the individual, of the direct environment, such as fellow clients or treatment staff, and of society in general. Overestimating violence risk can lead to unjustified long and costly interventions, while underestimating violence potential leads to unacceptable risks (Miller, 2006). Thus, careful assessment of the likelihood of violent behavior is of critical importance within clinical decision-making.

Until recently, the practice of assessing risk for future aggression and violence has taken a predominantly deficits-based approach. Typically, clinicians rely on actuarial and/or structured professional judgment (SPJ) tools that assess empirically derived risk factors to arrive at an overall risk classification, or judgment. Commonly used tools include the HCR-20^{V3} (Douglas, Hart, Webster, & Belfrage, 2013) to assess risk for violence, and the (Y)LS/CMI (Andrews, Bonta, & Wormith, 2004; Hoge & Andrews, 2006) to assess risk for general offending and guide case management. There are also tools available for more specific types of violence, such as sexual violence (e.g., STATIC-99, Hanson & Thornton, 1999; STATIC-2002, Hanson & Thornton, 2003; STABLE-2007, Fernandez, Harris, Hanson, & Sparks, 2012) or domestic violence (e.g., the B-SAFER, Kropp, Hart, & Belfrage, 2005), and tools for specific populations, such as females (e.g., FAM, de Vogel, de Vries Robbé, van Kalmthout, & Place, 2012) or juveniles (e.g., SAVRY, Borum, Bartel, & Forth, 2006). With few exceptions, these tools focus on psychological problems or individual deficits (e.g., self-regulation difficulties, lack of insight) and past harmful behavior (e.g., number of prior convictions/arrests).

Scholars have long sought to find the holy grail of violence risk assessment, from the criminal taxonomy by Lombroso (1887), to the MacArthur violence risk assessment studies by Monahan (1981 and onwards), to revisions of current tools in light of new empirical research (e.g., STATIC-99R; Helmus, Thornton, Hanson, & Babchishin, 2012). Over the last two decades however, researchers have increasingly focused not solely on what factors predict violence, but turned their attention to why and how people stop behaving violently (the study of *desistance* from crime, e.g., Maruna, 2001), and more generally what decreases the likelihood of crime and inspires prosocial functioning and successful living. *Protective factors* can interact with risk factors and have a risk-reducing effect on violence (de Vogel, de Ruiter, Bouman, & de Vries Robbé, 2009). Accurately identified, they should improve the predictive accuracy of risk assessments, while additionally offering valuable insights to treating clinicians. More specifically, recognition of protective factors extends the focus of forensic and correctional rehabilitation beyond simple risk reduction to promoting productive, meaningful and prosocial lives. Consistent with the *Positive psychology* approach regarding the value of optimism and achieving happiness (Seligman, 2002), according to Ullrich and Coid (2011) the positive approach of protective factors emphasizes hope for change, making interventions not only more engaging but potentially more effective (e.g., Farrall & Calverley, 2005).

What do protective factors look like? They can be internal resilience factors (such as coping), community reintegration factors (such as work or leisure activities), treatment related factors (such as motivation for change or medication), social factors (such as peer support), or environmental factors (such as supervised housing). Literature reviews, for example Lösel and Farrington's (2012) review on protective factors for youth violence, point to the empirical evidence for the protective effect of good functioning on different life domains, such as school or work, family, friends or the living environment. In the sexual offending literature, a series of studies found that men leaving prison who had somewhere to live, had relationships with prosocial people, had employment plans and pro-social goals for the future were less likely to reoffend than their counterparts with poorer release planning across these domains (Scoones, Willis, & Grace, 2012; Willis & Grace, 2008, 2009). For women, positive factors related to family and social network (including motherhood) and community participation (including work, leisure activities and financial situation), as well as willingness or motivation to change and a sense of agency, have shown to have a particularly protective effect (Rodermond, Kruttschnitt, Slotboom, & Bijleveld, 2016).

Drawing from the contemporary *Good Lives Model* (GLM) of rehabilitation (e.g., Ward, 2002), protective factors can be conceptualized as prosocial means or strategies to achieve one or more *primary human goods*, also referred to as common life goals (Yates & Prescott, 2011). Primary human goods are states of mind, experiences and outcomes that all humans are naturally inclined to seek, and include relatedness, belonging, mastery, peace of mind and happiness/pleasure (e.g., Laws & Ward, 2011). The GLM is based on the basic idea that every individual aims to accomplish a 'good life' by fulfilling these primary goods. Offending can be understood as a maladaptive attempt to attain one or more primary human goods. Indeed, for some individuals, offending may be the easiest or most familiar way for them to acquire primary goods.

The GLM poses that assisting people in finding prosocial alternatives to accomplish desired outcomes ('primary human goods') while concurrently addressing those causal factors associated with offending will make offending less desirable (e.g., Laws & Ward, 2011). Many general treatment efforts focus on strengthening personal or environmental factors, such as vocational training, development of work skills, seeking life goals, involvement in leisure activities, improvement of social integration, pharmacological treatment, or development of individualized aftercare programs. All of these elements offer new opportunities for success in life, and promising potential for positive change. The GLM provides a framework for identifying how extra-therapeutic resources such as vocational training and cultural activities might be best suited to individual clients, through matching these activities to their prioritised primary human goods, strengths and interests.

There is growing theoretical and empirical attention for the positive influence of specific protective factors and treatment efforts invested in the building of strengths in different life domains. Surprisingly however, efforts to practically incorporate these protective factors into assessment methods have been sparse (de Ruiter & Nicholls, 2011). Thus, the current challenge is not only to uncover new potential factors that protect against aggressive or violent behavior and contribute to prosocial living, but also to find clinically feasible ways to incorporate these protective factors into risk assessment and strengths-based treatment. Sound assessment of protective factors can provide the link between theoretical and empirical knowledge regarding the desistance enhancing effect of protective factors and practical strengths-based treatment approaches and risk management efforts in forensic and correctional settings (e.g., Rennie & Dolan, 2010).

Although most protective factors included in assessment in forensic practice are measured in the light of the prevention of (further) offending, actually most of these protective factors are likely to promote general well-being, which leads to increased life satisfaction and successful living in general. In turn, subjective well-being itself is also related to decreased recidivism (Bouman, Schene, & de Ruiter, 2010). Thus, most protective factors first and foremost contribute to attaining good life goals and life satisfaction, which is true for resilience factors as