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An Exploration of Protective Factors Supporting Desistance From Sexual Offending

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Abstract

This article considers factors that support or assist desistance from sexual offending in those who have previously offended. Current risk assessment tools for sexual offending focus almost exclusively on assessing factors that raise the risk for offending. The aim of this study was to review the available literature on protective factors supporting desistance from sexual offending. This article discusses the potential value of incorporating protective factors into the assessment process, and examines the literature on this topic to propose a list of eight potential protective domains for sexual offending. The inclusion of notions of desistance and strengths may provide additional guidance to the assessment and treatment of those who sexually offend. Further research investigations are recommended to consolidate the preliminary conclusions from this study regarding the nature and influence of protective factors in enabling individuals to desist from further offending.

Keywords

risk assessment, sexual offender, recidivism, desistance, protective factors

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Introduction

Modern-day risk assessment schemes tend to predict recidivism better than chance, but there is room for improvement. The major "third generation" assessment frameworks for assessing convicted sexual offenders focus almost exclusively on factors that raise risk for recidivism, for example, the *STABLE-2007* (Fernandez, Harris, Hanson, & Sparks, 2012), the *Structure Risk Assessment* (Thornton, 2002), the *Violence Risk Scale–Sexual Offender version* (VRS:SO; Wong, Olver, Nicholaichuk, & Gordon, 2003), the *Sexual Violence Risk–20* (SVR-20; Boer, Hart, Kropp, & Webster, 1997), and the *Risk for Sexual Violence Protocol* (RSVP; Hart et al., 2003). Consequently, Maruna and LeBel (2003) described the assessment of risks and needs as "deficit focused" and urged those in the criminal justice field to consider balancing such measurement with an assessment of individual strengths.

There are three reasons in particular why it may be important to consider strengths as well as risks in the assessment process. First, to do so could improve the predictive validity of our risk assessment tools. For instance, the combined use of risk factors and protective factors has demonstrated incremental predictive validity over assessments with risk factors alone. A study on a combined violent and sexual offender sample that had been discharged from inpatient forensic psychiatric treatment, showed a significant increase in predictive validity for violent recidivism after treatment when protective factors were added to the risk factors in the assessment (de Vries Robbé, de Vogel, & Douglas, 2013). Second, a one-sided focus on risk can lead to over-prediction of violence risk, and poor risk management and treatment planning. Rogers (2000) argued that risk-only evaluations are inherently inaccurate and implicitly biased, often resulting in negative consequences to forensic populations. In particular, over-prediction (i.e., too many false positives) can lead to pessimism among therapists and unnecessarily long treatment or overly restrictive risk management, which are costly for both society, in terms of financial burden, and for the individual in terms of limited liberties (Miller, 2006). Third, deficit-focused assessments can be stigmatizing for criminal justice clients. In particular, research by Attrill and Liell (2007) among prisoners and ex-prisoners emphasized the feelings of unfairness of the assessors' focus on risk to the exclusion of any recognition for positive accomplishments. For example, one prisoner in their study reported his view that, "From my experience risk assessment isn't fair as it's just pure negatives that people look at, not positives." Such testimony raises the possibility that the emphasis on risks found in most current assessment processes will have a negative impact on the relationship between the assessor and the assessee, and consequently perhaps on the rehabilitation process itself.

These risky aspects of risk assessment may be offset by paying more than lip service to the concept of *protective factors* in assessment work. By this term, we mean factors that enable or assist desistance from (sexual) offending among those that have already offended. In the criminology field, some work has focused on the assessment of protective factors (e.g., Herrenkohl et al., 2003) or individual *strengths* as a way of complementing the deficit-driven focus on risks and needs (e.g., Maruna & LeBel, 2003). Others have sought to subtly shift the focus away from assessing predictors of

recidivism to those factors associated with successful desistance from crime (e.g., Farrall, 2004; McNeill, 2006; Robinson & Shapland, 2008).

Before protective factors can be fully incorporated into sexual offending assessment frameworks, however, we need to (a) identify potential protective factors from exploratory research and the theoretical literature, (b) build theoretical models to explain how the identified protective factors reduce risk, (c) articulate and systematically collect data on these variables and examine their relationship with recidivism, and (d) build and validate tools for the assessment of protective factors for sexual violence. The present article seeks to complete the first of these steps, that is, examine the existing literature to identify and propose potential protective factors for sexual offending.

Conceptualizing Protective Factors

A starting point in seeking to define protective factors for sexual offending might be to mirror accepted definitions of risk factors (e.g., Andrews & Bonta, 2006) by stating that a protective factor is *a feature of a person that lowers the risk of reoffending.* In addition to internal, psychological features, there is a question about whether or not external, environmental, or circumstantial features of an individual's life situation could also be considered to be protective factors. Certainly, criminological research into desistance indicates that an ex-offender's social situation is an important factor associated with desistance. In fact, some desistance researchers would argue that external factors are more important than internal ones (for a discussion, see LeBel, Burnett, Maruna, & Bushway, 2008). This is in line with results from a protective factors study by Ullrich and Coid (2011) in a sample of violent and sexual offenders, which found that protection was primarily related to social network factors. In the case of sexual offending in particular, restrictive external circumstances are frequently imposed on the individual against his preference, such as incarceration, residency restrictions, social isolation, and restricted employment opportunities. If these external circumstances are guided by empirical evidence, they can be an important part of risk management processes to create more protective environments. Therefore, we believe that the definition of a protective factor should encompass social, interpersonal, and environmental factors as well as psychological and behavioral features.

In pursuit of an approach to risk reduction based on building protective resources, we could profitably further differentiate between static/unchangeable protective factors (e.g., secure attachment in childhood) and those that are behavioral or otherwise potentially changeable. In line with a recent theory of risk factors (Mann, Hanson, & Thornton, 2010), we also suggest that it is helpful to distinguish between the protective factor as an *underlying propensity* (psychological or personality characteristic) and observable *manifestations* of that propensity. For example, holding down a job may be a manifestation of several underlying propensities (e.g., work ethic, plus self-discipline, plus ability to manage social relationships), which together enable stable employment, along with external factors (e.g., economy, employment discrimination).

In another example, the underlying propensities of good social skills may be manifest in generally well-functioning intimate relationships.

Some researchers (e.g., Farrington, 2003) have divided the factors associated with positive desistance outcomes into two categories depending on whether the positive factor has a direct influence on desistance irrespective of risk level (termed *promotive factor*) or whether the positive factor moderates the impact of risk factors (i.e., has greater risk-reducing effects for those people deemed to be at high-risk of offending than for those deemed to be low-risk—the more precise use of the term *protective factor* or *resilience*). Ullrich and Coid (2011) did not find indications that protective factors have different effects at different levels of risk, whereas Lodewijks, de Ruiter, and Doreleijers (2010) found proof for a buffering or mitigating effect of protective factors on risk factors in adolescent samples. As we are equally concerned with both types of positive factors, and as the sexual offending protective factor literature is still in its infancy, these distinctions are probably too fine for the current state of knowledge, and so we use the term *protective factors* here as a general term to refer to both types.

To develop the definition further, we propose that protective factors must exist as definable propensities or manifestations thereof in their own right, rather than being no more than the absence of a risk factor. Accordingly, it should be possible to define individual protective factors without the use of negatives. To illustrate, "capacity for intimacy" would meet this condition, but "lack of hostility" would not. Put another way, some protective factors are likely to be the opposite of risk factors, a proposal that we explore in more detail below, but in this argument we draw a clear distinction between the *opposite* of a risk factor and the *absence* of a risk factor.

In addition, protective factors and risk factors can conceivably co-occur in the same domain. That is, even protective factors that are the opposite, or "healthy pole," of risk factors are not necessarily mutually exclusive entities from the risk factor. An example in which protective and risk factors can co-occur is in the domain of social influences. Negative social influences are generally considered a risk factor, at the same time positive social influences are considered a protective factor. However, it is quite possible for individuals to have both negative and positive social influences in their lives, that is, for strengths and risk factors to co-exist even though they seem like opposites. For example, a person could both belong to a drug-using social group and, separately, attend university classes with students learning engineering. A single measure of social influences "positive or negative?" would not capture this common complexity. A risk assessment tool that poses strengths as the opposites of vulnerabilities, yet measures both ends of risk domains simultaneously is the *Short-Term Assessment of Risk and Treatability* (START; Webster, Martin, Brink, Nicholls, & Middleton, 2004). However, despite good results for predicting non-violence with the strengths scale, no incremental predictive validity over vulnerabilities has yet been reported (e.g., Braithwaite, Charette, Crocker, & Reyes, 2010; Chu, Thomas, Ogloff, & Daffern, 2011; Viljoen, Nicholls, Greaves, de Ruiter, & Brink, 2011). Another risk assessment tool that incorporates protective strengths in addition to risk factors is the *Inventory of Offender Risk, Needs, and Strengths* (IORNS; Miller, 2006), which is a self-report measure to determine risks, needs, and protective factors for all types of offenders. In a sample of

American pre-release prisoners, the IORNS subscales Protective Strength Index and the Personal Resources Scale were able to differentiate between successful and unsuccessful reintegration (Miller, 2006). As far as we know, to date, no sexual offender predictive validity studies have been carried out with either of these tools.

Recently, two promising SVR assessment tools have been developed that include protective factors for juvenile sexual offending. Print and colleagues (2009) developed a tool designed to guide the assessment of young people (aged 12-18) who are known to have sexually abused others: the AIM-2 (Print et al., 2009). The tool includes 24 protective factors (termed *strengths* or *resiliencies*) as well as 51 risk factors, grouped into four domains: developmental issues, family issues, current environment, and offence-specific issues. An initial validation study suggested that a high score on the strengths scale acted as a protective factor even for juvenile sexual offenders with a high score on the concerns scale (Griffin, Beech, Print, Bradshaw, & Quayle, 2008). Intending to contribute to a more comprehensive assessment for adolescent sexual recidivism, Worling (2013) developed a new tool specifically to assess protective factors for juvenile sexual offending: *Desistence for Adolescents Who Sexually Harm* (DASH-13). The tool consists of a checklist of 13 factors: 7 related specifically to future sexual health and 6 concerning more general, pro-social functioning. Investigation of the psychometric properties of the tool is currently in process.

Finally, protective factors can be the result of social development factors (families, peers, communities) as well as from biological and psychological maturation. As with risk factors (see Ward & Beech, 2006), there may well be neural mechanisms associated with protective factors, possibly originating from pre-natal or peri-natal conditions or early childhood experiences. Such mechanisms need to be uncovered and understood, to assist treatment providers' efforts to strengthen an individual's protective factors, or provide him or her with *prosthetics* to compensate for under-developed or "missing" protective factors. Although the medical analogy is far from ideal, we use the term *prosthetics* here to refer to "artificial" (or coached) protective factors that effectively compensate for the absence of "organically" occurring protective factors. Examples would be structured problem-solving skills or learned ways of expressing feelings assertively. Psychiatric medications (e.g., selective serotonine reuptake inhibitors (SSRIs) or anti-libidinal medications) could be considered to be prosthetic protective factors if they have the effect of reducing the intensity of sexual drive or enhancing sexual self-control.

Identifying Protective Factors for Sexual Offending

Mirroring the accepted definition of a risk factor for sexual offending, a protective factor should be empirically related to desistance from sexual offending. A stringent standard, equivalent to the standard set for a risk factor (see Mann et al., 2010), would require at least three separate studies, when meta-analytically integrated, to demonstrate that the presence of the protective factor was associated with lower reconviction rates. However, as the literature into protective factors for sexual offending is in its infancy with few empirical studies yet reported, there is a minimal evidence base to consider (see also Laws & Ward, 2011).

Moreover, there may be additional ways of identifying protective factors besides reconviction studies. After all, desistance research starts from a different point than treatment research by putting the individual (not the program) at the center of the change process. Rather than asking "what works" and comparing the reconviction rates of treatment and control groups, desistance studies ask how change works and seek to identify those factors that support the individual in his or her efforts to maintain desistance (for reviews, see Farrall & Calverley, 2005; Laub & Sampson, 2001). Therefore, in this article, we also draw on qualitative and quantitative desistance studies to identify *potential* protective factors in sexual offending. The hope is that future evaluation research might empirically test the protective factors proposed in this article and complement the understanding of desistance from sexual offending. In addition, it would be valuable if sexual offending research were to differentiate between protective factors associated with desistance from general or violent offending and protective factors associated specifically with desistance from sexual offending, as these may not necessarily be the same factors.

We will consider a variety of sources of ideas about what psychological propensities or sociological circumstances might aid desistance from sexual offending. Our exploration of potential protective factors concentrates on three areas: (a) the sex offending risk factor literature, to consider when the opposing/healthy end of a risk domain could be considered protective; (b) the desistance literature in criminology specifically on sexual violence; and (c) the content of an existing measure of protective factors intended to be applicable for violent as well as sexual offending assessment. The aim is to integrate the findings from these diverse sources to create a list of potential protective factors for sexual offending.

Protective Factors as the Opposite of Risk Factors for Sexual Offending

As already discussed, it seems likely that often protective factors and risk factors would be two sides of the same coin. That is, the unhealthy pole of a continuum represents a risk factor (e.g., offence-supportive beliefs), whereas the healthy pole represents a protective factor (e.g., in this example, beliefs supportive of respectful and age-appropriate sexual relationships). As proposed earlier, protective factors must exist as definable propensities rather than being no more than the absence of a risk factor. However, in some cases, risk factors are actually formulated as the absence of a healthy propensity or skill (e.g., "poor problem-solving skills"), so the presence of the healthy propensity (in this example, "good problem-solving skills") could be considered a protective factor.

Table 1 shows the risk factors for sexual offending that have the strongest empirical support (see Mann et al., 2010, for an account of the evidence base for these factors). For each of these factors, a description is given of the suggested corresponding positive pole, that is, the healthy propensities of these risk factors (see Table 1). The healthy poles of the 14 factors identified as most valid for sexual offending are proposed to be *Moderate intensity sexual drive, Sexual preference for consenting adults, Attitudes supportive of respectful and age-appropriate sexual relationships, Preference for*

Table 1. Established and Promising Risk Factors for Sexual Offending and Their Corresponding Healthy Poles.

Risk factor	Corresponding healthy pole
Sexual preoccupation	Moderate intensity sexual drive A preference for having sex with someone you are emotionally attached to and who is attached to you. Romantic or emotionally intimate connection is seen as being as desirable as sexual gratification.
Deviant sexual interest	Sexual preference for consenting adults A preference for sex with consenting sexual partners of adult age. Desire for potentially reciprocal sexual activities in which the adult partner is more likely than not to also be interested in the activity.
Offence-supportive attitudes	Attitudes supportive of respectful and age-appropriate sexual relationships Weighs the rights of others equally with own wants and desires. Recognizes the right to refuse sexual activity and opposes sexual abuse. Recognizes the nature of childhood and the implications of emotional & physical immaturity for likely harm that would be caused by early sexual activity.
Emotional congruence with children	Preference for emotional intimacy with adults Recognizes the nature of childhood developmental stages and the more limited capacity of children in relation to adult-oriented constructs such as reciprocal emotional intimacy.
Lack of emotionally intimate relationships with adults	Capacity for lasting emotionally intimate relationships with adults Has one or more emotional confidantes; has lasting intimate relationships including sexual relationships; can maintain a stable relationship for longer period of time; relationships are characterized by mutual disclosure of vulnerability and acceptance of each other's faults. Sustained emotionally intimate marital type relationships; emotionally intimate friendships; cooperative and discriminating approach to casual social/work contacts.
Lifestyle impulsiveness (poor self-regulation, impulsive and reckless, unstable work patterns)	Self-control Able to set and achieve medium and long-term goals through effortful goal-directed actions. Considers consequences before taking decisions, and weighs consequences to others at least as highly as consequences to self. Values pro-social solutions and seeks to achieve peaceful resolutions of difference rather than aggressive resolutions. Regulating immediate impulses, stress reactions, and general lifestyle.
Poor cognitive problem solving	Effective problem-solving skills Able to articulate different solutions to a problem, including pro-social solutions, and choose between solutions by considering the consequences, to self and others, of each option. Weights long-term gain over short-term gain.
Resistance to rules and supervision	Acceptance of rules and supervision Capacity to connect with people in authority. Meaningful relationships with supervising or treating professionals. Able to accept rules and regulations and keep to agreements with treatment staff, employers, probation officers and other professionals. Manages to obey imposed legal conditions.
Grievance/hostility	Trustful and forgiving orientation An orientation to others that is typically trustful and peaceful, seeing the others' point of view/perspective, preferring peaceful solutions to interpersonal conflict and generally able to offer forgiveness after being wronged.
Negative social influences	Law-abiding social network Social network primarily or entirely composed of stable, law-abiding individuals who promote pro-social activity and who offer support and strengthen self-control.

(continued)

Table 1. (continued)

Risk factor	Corresponding healthy pole
Hostility toward women	Positive attitudes toward women Generally pro-social, trusting and respectful attitudes toward women. Views women as equal to men. Believes women have good intentions.
Machiavellianism	Honest and respectful attitudes Views others as equal. Recognizes others' abilities and strengths. Values honesty and does not take advantage of others.
Lack of concern for others/ callousness	Care and concern for others Shows interest in others. Cares about other people's feelings and well-being. Attempts to help others when in need. Does not act on own needs before considering those of others.
Dysfunctional coping	Functional coping Dealing with negative emotions (like anger, anxiety, or rejection) through appropriate, socially acceptable strategies. Managing stress in a calm, non-sexual, and effective manner.

emotional intimacy with adults, Capacity for lasting emotionally intimate relationships with adults, Self-control, Effective problem solving skills, Acceptance of rules and supervision, Trustful and forgiving orientation, Law-abiding social network, Positive attitudes toward women, Honest and respectful attitudes, Care and concern for others, and *Functional coping*. Given the strong empirical base for the risk poles of these sexual offending factors, it is hypothesized that their healthy poles are equally strong related to reductions in sexually violent recidivism.

Protective Factors in the Desistance Literature

"Desistance from crime" has become a dominant area of research activity within criminology over the last 20 years (see Farrall & Calverley, 2005). The concept of desistance relates to the process of abstaining from crime after repeated or habitual engagement in criminal activities (Maruna, 2001). Desistance processes often involve key turning points or disorienting life episodes (Laub & Sampson, 2001), but desistance is not a single moment or event in a person's life. Instead, desistance is widely understood as a long-term maintenance process involving a slow recognition of the need to change, motivational fluctuation, and possible false starts followed by lapses or relapses. By changing the focus of inquiry from investigating why some ex-prisoners "fail" (or re-offend) and instead trying to understand how and why some individuals succeed or "go straight," desistance research has opened up new understandings in criminology with distinct implications for assessment and treatment practice.

General desistance factors. The factors identified by the criminological literature for desistance from general criminal offending may also be relevant to sexual offending (Laws & Ward, 2011). For example, aging, stable employment, marriage, sobriety, lack of stress, and good mental health have all been found to have a protective effect

on criminal behavior (Laub & Sampson, 2001). Moreover, research with ex-prisoners suggests that long-term, persistent offenders tend to lack a sense of hope or feelings of agency (Maruna, 2001; Zamble & Quinsey, 1997). However, reformed ex-prisoners are characterized by hope and optimism: They seem to maintain an overly optimistic sense of control over their future and strong internal beliefs about their own self-worth and personal destinies (Burnett & Maruna, 2006; LeBel et al., 2008; Maruna, 2001). Desisters also seem to embrace change-enhancing cognitive patterns: consistent patterns of cognition that encompass the ability to evaluate one's behavior and learn from one's mistakes (Maruna, 2001). Arguably, one potential indicator of this willingness to change is the individual's persistence with a course of intervention to change risk-relevant behavior. In addition, desisters seem to possess a sense of achievement and accomplishment (see Maruna & LeBel, 2003). Making meaningful contributions to one's community or family can lead to grounded increments in self-esteem, feelings of meaningful purposiveness, and a cognitive restructuring toward responsibility for young people in trouble with the law (Toch, 2000). Such successful achievements can predict successful desistance (LeBel et al., 2008) or abstinence from crime (Uggen & Janikula, 1999). Last, the desistance literature has established the importance of moving away from groups of delinquent peers (Warr, 1998) and establishing meaningful intimate relationships (Laub & Sampson, 2001). The latter also being the opposite pole of "lack of emotional intimacy with others," which is a strongly evidenced risk factor for sexual offending (Mann et al., 2010).

Sex offending desistance factors. To date studies of desistance from sexual crimes are few (see Laws & Ward, 2011). Farmer, Beech, and Ward (2012) studied the self-narratives of individuals convicted of child molestation who had apparently desisted from offending, comparing them with individuals who were thought to be still actively seeking opportunities to offend. Several factors differentiated the desistance group from the active group. The desisters appeared to have an *enhanced sense of personal agency*, had a *stronger internal locus of control*, were consistently more able to *find positive outcomes from negative events*, identified *treatment as* having provided them with a *turning point*, and, most strikingly, seemed to have found a *place within a social group or network*. They described belonging to three particular types of social groups or communities: family, friends, and church. In contrast, the "active" or at-risk group all described themselves as socially alienated or isolated from others (Farmer et al., 2012).

Measure of Protective Factors

In this section, we review a structured assessment tool developed specifically for the assessment of protective factors for adult violent as well as sexual offending: the *Structured Assessment of Protective Factors for violence risk* (SAPROF; de Vogel, de Ruiter, Bouman, & de Vries Robbé, 2009, 2012). The SAPROF was designed to assess general protective factors for recidivism in adults convicted of any violent crime (including sexual). The tool aims to form a positive supplement to risk focused

structured professional judgment (SPJ) tools like the *Historical Clinical Risk Management-20* (HCR-20 Version 2; Webster, Douglas, Eaves, & Hart, 1997), its revision the HCR-20 Version 3 (HCR-20^{V3}; Douglas, Hart, Webster, & Belfrage, 2013), or related SPJ risk tools. However, it can also be used in addition to actuarial risk tools such as the STABLE-2007. The SAPROF contains 17 protective factors, which are mostly dynamic in nature and divided into three scales: internal factors, motivational factors, and external factors (similarly to psychological, behavioral, and environmental features). Each factor is provided with a rationale describing its empirical background, which largely relies on general violent crime research and to a lesser extent incorporates research on sexual offending. After completing the scale, the assessor has the option to mark factors as critical for the overall protection or for treatment planning ("keys" and "goals") and makes a "final protection judgment." The results from the assessment are intended to be integrated with results from a risk tool to come to an overall final judgment on the level of risk, which incorporates both the present risk—and protective factors.

Previous results with forensic psychiatric patients convicted of violent offending showed good predictive validities for the SAPROF for violent incidents toward others and self-harm during treatment (Abidin et al., 2013) as well as for violent recidivism after discharge from treatment (de Vries Robbé, de Vogel, & de Spa, 2011). Moreover, incremental predictive value of assessing the SAPROF protective factors in addition to the HCR-20 risk factors was demonstrated (de Vries Robbé et al., 2013). The first empirical SAPROF study that concentrated solely on patients convicted of sexual offending was recently carried out (de Vries Robbé, de Vogel, Koster, & Bogaerts, 2015). In this study, the predictive validity of the protective factors in the SAPROF for non-recidivism among 83 discharged treated sexual offenders was analyzed. The total score of the 17 protective factors was significantly predictive of no new convictions for any (including sexual) violence for short-term as well as long-term (15-year) follow-up as was the final protection judgment. When only sexually violent recidivism was used as outcome measure, the SAPROF total score was also a significant predictor at different follow-up times. The protective factors remained significantly predictive of general violent re-offending and sexually violent re-offending when controlling for ratings on the HCR-20 and SVR-20 risk factors. Prospective clinical studies into the predictive validity of the protective factors in the SAPROF for no violent incidents toward others during treatment of forensic psychiatric patients (follow-up 12 months) also showed good results for those patients convicted of sexual offending (de Vries Robbé, de Vogel, Wever, Douglas, & Nijman, 2014). Although these results are promising, the research samples are still small and replication of these findings is essential. Additional studies into the predictive validity of the SAPROF for different categories of sexual crime types will also need to be conducted in the near future.

Proposed Protective Factors for Sexual Offending

We propose that the various literatures discussed in the preceding review can be summarized into eight "protective domains" that could be hypothesized to assist desistance

from sexual offending. Table 2 provides an overview of the protective factors derived from the preceding review and their relationship to the proposed protective domains. The factors are categorized by source: (a) the healthy poles of SVR domains, (b) desistance factors for sexual offending, and (c) protective factors from the general risk assessment tool for violent and sexual offending (general protective factors).

Healthy Sexual Interests

This domain refers to a propensity to prefer sexual relationships with consenting adults co-existing with a moderate intensity sexual drive. Individuals with protective factors in this domain are likely to show a balance between a desire for sexual fulfillment and a desire for other types of fulfillment. They will have adequate sexual knowledge and beliefs that support age-appropriate and consenting relationships. This domain is construed as the healthy poles of two, well-established sexual offending risk factors: *Sexual preference for consenting adults* and *Moderate intensity sexual drive*. Additional evidence for healthy sexual interests may be found in the presence of *Attitudes supportive of respectful and age-appropriate sexual relationships* (the healthy pole of the risk factor Offence-supportive attitudes). The protective factor *Medication* could have a protective effect on sexual drive.

Capacity for Emotional Intimacy

This domain refers to a propensity to form and maintain emotionally close and satisfying relationships with other adults. Individuals with protective factors in this domain will most likely have a *Trustful and forgiving orientation to others* (healthy pole for the risk factor Grievance/hostile attitude to others), a *Preference for emotional intimacy with adults* rather than children (healthy pole for the risk factor Emotional congruence with children), and the ability to communicate effectively. The most obvious manifestation of this propensity is that the individual has, or has had, long-lasting and emotionally stable intimate relationships with adult partners (e.g., the risk factor healthy pole *Capacity for lasting emotionally intimate relationships with adults*). The healthy poles *Positive attitudes toward women, Honest and respectful attitudes*, and *Care and concern for others* all reflect underlying personality traits which enhance capacity for emotional intimacy. This domain is also reflected in different general protective factors: *Intimate relationship, Secure attachment in childhood*, and *Empathy*.

Constructive Social and Professional Support Network

This protective domain refers to the capability of forming constructive relationships with other adults, both socially and with persons in professional support and authority roles. Individuals with protective factors in this domain will have a law-abiding social network. This is represented in the sexual offending desistance factor *Place within a social group or network* and in the risk factor healthy pole *Law-abiding social network*.

Table 2. Proposed Protective Domains and Evidence.

Proposed protective domains	Evidence		
	Healthy poles of risk factors	Desistance factors	General protective factors
1. Healthy sexual interests	Moderate intensity sexual drive		Medication
	Sexual preference for consenting adults		
	Attitudes supportive of respectful and age-appropriate sexual relationships		
2. Capacity for emotional intimacy	Preference for emotional intimacy with adults		Empathy
	Capacity for lasting emotionally intimate relationships with adults		Secure attachment in childhood
	Trustful and forgiving orientation		Intimate relationship
	Positive attitudes toward women		
	Honest and respectful attitudes		
	Care and concern for others		
3. Constructive social and professional support network	Acceptance of rules and supervision	Treatment as turning point	Motivation for treatment
	Law-abiding social network	Place within a social group or network	Attitudes toward authority
	Honest and respectful attitudes		Professional care
	Empathy		Living circumstances
			Network
4. Goal-directed living	Self-control	Enhanced sense of personal agency	Self-control
		Stronger internal locus of control	Financial management
			Life goals
5. Good problem solving	Effective problem-solving skills		Intelligence
	Functional coping		Coping
6. Engaged in employment or constructive leisure activities		Place within a social group or network	Work
			Leisure activities
7. Sobriety	Self-control		Self-control
			Professional care
			External control
8. Hopeful, optimistic and motivated attitude to desistance		Find positive outcomes from negative events	Motivation for treatment
		Treatment as turning point	Medication

Additional support is provided by the general protective factor *Network*. Individuals with protective factors in this domain may also have meaningful relationships with professionals, reflected by sexual offending desistance factor *Treatment as turning point* and demonstrated in general protective factors *Motivation for treatment, Professional care*, and *Living circumstances*. Furthermore, they may have a positive attitude to authority, risk factor healthy pole *Acceptance of rules and supervision* and general protective factor *Attitudes toward authority*. The risk factors healthy poles *Honest and respectful attitudes* and *Care and concern for others* provide underlying traits which facilitate the development of a constructive social and professional support network.

Goal-Directed Living

This protective domain refers to the capacity to set goals and direct daily activities so that progress can be made toward those goals (general protective factor *Life goals*). Individuals with protective factors in this domain will show effortful, positive, goal-directed behaviors (the risk factor healthy pole *Self-control*), will have *Enhanced sense of personal agency* and *Stronger internal locus of control* (both desistance factors), and will show good self-discipline (reflected in general protective factors *Self-control* and *Financial management*).

Good Problem Solving

This protective domain refers to the capacity to manage life's daily problems without becoming overwhelmed or resorting to anti-social or avoidance techniques to regain control. Such a propensity is reflected by the risk factor healthy poles *Functional coping* and *Effective problem-solving skills* and general protective factor *Coping.* Protective factor *Intelligence* may reflect underlying abilities for good problem solving.

Engaged in Employment or Constructive Leisure Activities

This protective domain refers to the propensity to live a life that involves constructive and rewarding activity and ideally also a sense of intrinsic satisfaction and accomplishment. Employment is the most obvious protective factor, reflected by general protective factor *Work*. Equal results could be obtained from engaging in personally meaningful leisure or social activities such as sports, social hobbies, or caring for others (reflected in general protective factor *Leisure activities* and sexual offending desistance factor *Place within a social group or network*).

Sobriety

This protective domain refers to the abstention from drug or alcohol misuse. It is an established protective factor in the literature with *Self-control* as a risk factor healthy

pole (and general protective factor), indicating the likelihood of sobriety intentions to succeed. External motivation through general protective factors *Professional care* and *External control* may provide assistance with sobriety.

Hopeful, Optimistic and Motivated Attitude to Desistance

This protective domain refers to optimistic change-enhancing cognitive patterns. Individuals with protective factors in this domain are likely to *Find positive outcomes from negative events* and see *Treatment as a turning point* (both sexual offending desistance factors). As a result they are often motivated to work with treatment providers or other helping agencies (reflected in general protective factors *Motivation for treatment* and *Medication*).

In summary, eight protective domains are proposed based on being healthy poles of well-established sexual offending risk domains or being desistance factors for sexual offending. Additional support for the proposed domains is found in general protective factors from the SAPROF, which preliminarily proved predictive of sexual and violent re-offending by sexual offenders. We propose that each domain represents an underlying propensity, which may be pre-existing, may have developed as the individual reflects on his life and the consequences of his offending, or may have developed as a prosthetic through a rehabilitative intervention. The presence of each propensity may be observed in a range of possible behavioral indicators, or manifestations of the propensity.

Limitations

The biggest limitation of this exploration study of protective factors for future offending for those who have sexually offended in the past is that very few studies on this topic are available. For the general protective factors assessment tool discussed few studies have been found on sexual offender samples. Similarly, only one specific empirical desistance study was found for sexual offending. The results from these studies need to be replicated in other sexual offender samples to be able to generalize the findings. Given the limited resources, the current study design aimed to include direct as well as indirect evidence for the proposed domains. Nevertheless, the domains are not supported by a large body of empirical evidence and should be viewed as a preliminary proposal. This article presents a first step toward more in-depth studies into protective factors for sexual offending and their potential value for risk assessment and treatment of sexually violent offenders. Hopefully, this will spark enthusiasm among researchers and clinicians to incorporate protective factors in their studies of sexual offending, which will result in a broader evidence base for more comprehensive sexual offender assessment.

Conclusion and Implications for Research

De Ruiter and Nicholls (2011) describe the study of protective factors as a new frontier in forensic mental health which needs to be explored to increase our knowledge on

what works in risk prevention. We know very little about what those who have offended sexually value, what makes them happy, and what skills and strengths are related to their desistance from offending. The desistance literature is very sparse in relation to sexual offending. We therefore urgently need desistance studies that focus on sexual offending. We also need to further investigate whether and to what extent assessments of protective factors increase the accuracy of SVR assessment. We may need to create additional structured schemes for identifying protective factors specifically for sexual reoffending, and use these routinely, so that we can collect and compare data from samples of individuals convicted of different types of sexual crimes and relate these to risk focused tools, treatment efforts, and recidivism outcome.

The above described domain of *Healthy sexual interests* is the only proposed protective domain which is identified as exclusively relevant for *sexual* offending. It would be valuable to develop tools for adult sexual offenders that specifically assess protective factors in this domain, in a similar fashion as has been done for juvenile offenders in the DASH-13 (Worling, 2013). The other seven domains can be considered general protective domains and are represented in many of the factors in the SAPROF, which is not surprising given that this tool provided input for the domains. These factors can primarily be described as "dynamic improving," meaning that potentially they could change for the better, serve as positive goals for treatment efforts and be used for evaluating treatment progress. Large-scale prospective follow-up research is needed to be able to validate their assumed potential for desistance from sexual offending.

In this article, we have argued for a greater focus on protective factors in assessment, research and practice. In recent years, those who work in sexual offender treatment have shown an extensive interest in the *Good Lives Model* of offender rehabilitation (Ward & Gannon, 2006). As a strengths-based approach to understanding and treating sexual offending this has played an important role in enabling treatment practice to move away from the more confrontational approaches that were typical in the 1980s. However, the field of sexual offending risk assessment still uses a predominantly deficit-focused approach. It takes some years to collect and analyze the data necessary to validate new risk prediction and prevention items or scales. We therefore believe that it is necessary for those engaged in sexual offender assessment to incorporate the notion of protective factors into their research and practice as a matter of urgency. A sea change in our approach to risk assessment could yield multiple benefits, both to treatment clients and to society.

Authors' Note

Michiel de Vries Robbé is co-author of one of the tools described in the manuscript (SAPROF).

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