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The Impact of Adverse Childhood Experiences on Attachment and Mentalization in Sex Offenders

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Abstract

Adverse childhood experiences have been linked to dysfunctional attachment, increased likelihood of criminal behavior, and mentalization deficits. Mentalization, also known as reflective functioning, is core aspect of social functioning that involved the capacity to "interpret both the self and others in terms of internal mental states such as feelings, wishes, goals, desires, and attitudes." This study looked at adverse childhood experiences, attachment, and mentalization in 93 registered sex offenders attending court-ordered outpatient treatment. This study revealed that sex offenders endorse significantly more adverse childhood experiences compared to the general population. It also showed that sex offenders exhibit lower attachment-related anxiety and attachment-related avoidance, indicating they perceive themselves as having less anxious and avoidant attachment. However, this finding may be due to their difficulty with perspective taking. The findings also revealed that sex offenders have significant deficits in mentalization and lower perspective taking abilities compared to the general population. This

study explores the advantages of providing trauma-informed care to sex offenders using mentalization-based treatment.

Keywords: sex offenders, mentalization, attachment, adverse childhood experiences, reflective functioning, perspective taking

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Chapter 1

Introduction

Sexual Offending

In 2012, there were 62,939 reported cases of child sexual abuse. Twenty six percent of the cases involved children who were between 12 and 14 years old and 34% were younger than 9 years (United States of American [USA, NSOPW], n.d.). That same year, there were 346,830 reported rapes or sexual assaults of individuals age 12 or greater. Of those cases, only 30% were reported to authorities (USA, NSOPW, n.d.). Definitions of what is considered sexual offending vary from state to state. In Oregon, the location in which this study was conducted, the term sex offender refers to a "person who has been convicted of a sex crime" (ORS, 2013). The term sex crime refers to, but is not limited to, rape, sodomy, sexual abuse, unlawful sexual penetration, incest, viewing/transferring child pornography, trafficking, public indecency, online sexual corruption of a child, and so forth (ORS, 2013). After a conviction, the person will need to register as a sex offender in that court's jurisdiction (ORS, 2013).

A significant area of concern for legislators and clinical practitioners is sexual offending recidivism, which is committing another crime, of whatever nature, with a history of prior conviction(s) (Mpofu, Athanasou, Rafe, & Belshaw, 2016). There is substantial research on recidivism rates among sexual offenders. Statistics show that the average sexual recidivism rate for those who sexually offended is 5% after 3 years, 13.7% after 5-6 years, and 24% after 15 years (Hanson & Morton-Bourgon, 2005). Risk factors that have been found to predict sexual recidivism include, but are not limited to, lack of empathy, prior criminality, sexual deviancy,

prior offence type and victim type, juvenile delinquency, age, motivation for treatment, criminal lifestyle, and personality disorders (Craig, Browne, & Stringer, 2003). Risk factors determine level of risk for recidivism and classify an offender into low, moderate, or high-risk level. Research has found that moderate to high-risk sexual offenders compromise in excess of 65% of incarcerated sexual offenders and their 10-year recidivism rate is between 56% and 70% (Hanson, Harris, Helmus, & Thornton, 2014; Mpofu et al., 2016).

The level of risk dictates the level of treatment sex offenders receive (Smid, Kamphuis, Wever, & Verbruggen, 2014). For instance, research suggests a recommended treatment plan for low-risk offenders is two sessions each week for a minimum duration of three months (Smid et al., 2014). High-risk offenders, on the other hand, would need to attend three sessions each week for a minimum duration of nine months, roughly four times higher dose of treatment than for low-risk offenders (Smid et al., 2014). This indicates that high-risk offenders require more intensive treatment. Treatment specifically for these offenders typically excludes an empathy component. The reasoning behind this is that offenders who commit heinous crimes completely lack empathy and are unable to care about the pain and suffering of other people (Hare, 1993; Mpofu et al., 2016). Therefore, there is a chance that participating in sex offender treatment with an empathy component would teach high-risk offenders how to use their knowledge to manipulate individuals and situations. Dr. Robert Hare, creator of the Hare Psychopathy Checklist, studied psychopaths and found that they often attend treatment to create a positive image of themselves, rather than actually wanting to rehabilitate themselves (Hare, 1993). They present a facade of looking as if they are interested in rehabilitation, but are actually attending treatment for their own advantage (Hare, 1993). Precisely for these reasons, high-risk offenders

with antisocial tendencies may require more intense treatment that specifically excludes an empathy component.

Research on sexual offending has showed that there is no simple answer to why sex offenders offend. It seems that there is an interplay among many different variables (e.g., psychological, biological, environmental, cultural) (United States of America [USA, DOJ], n.d.). One popular hypothesis is that sex offenders offend because they themselves have been sexually abused as children. Although this is a plausible explanation, statistics on sexual offending suggest that only 28-30% of sex offenders were sexually abused as children, 70% were not (Becker & Murphy, 1998; Proeve & Reilly, 2007). One particular research study found that 67% of sexual offenders reported experiencing sexual abuse when they were children, however, when they were given polygraphs, or lie detector tests, the number significantly dropped to 29% (Hindman & Peters, 2001). It is important to note that there are a few very important factors that may have prompted such high reporting of sexual abuse in this study. For instance, some offenders who initially did not report experiencing any early childhood abuse later reported such histories when they were under the influence of hypnosis or repressed memory therapy (Hindman & Peters, 2001). In their article on memory distortions and illusions, Lindsay & Read (1994) suggest that when memory recovery techniques are used without caution, they can lead adult clients who were not abused to now believe that they were. Therefore, this suggests that sex offenders may either intentionally or unintentionally exaggerate childhood abuse.

It is also important to consider that even 28-30% may be an inaccurate number due to underreporting of sexual abuse. Many offenders who have been abused as children often do not report abuse because a) they do not classify what happened to them as sexual abuse, b) they do

not remember the abuse, c) there is a stigma around reporting being abused by a member of the same sex, d) they were afraid to disclose the abuse for fear of retaliation by the offender, or e) they were afraid of the negative consequences (Leclerc & Wortley, 2015; Lemaigre, Taylor, & Gittoes, 2017). For these reasons, it is important to understand that when studying abuse in sex offenders, there may be over-reporting, as well as under reporting of abuse.

Sexual offending and adverse childhood experiences. A relationship between criminal behavior and adverse childhood experiences has long been established. Levenson and Socia (2016) found that higher numbers of adverse childhood experiences were associated with a variety of arrest outcomes, indicating that as the amount of childhood trauma increased the likelihood of versatility and persistence of criminal behavior also increased. A link between ACE scores and sexual offending has also been established. Research suggests that male sex offenders have significantly higher ACE scores than males in the general population (Levenson, 2014). Among male sex offenders, experiencing childhood trauma also increases the risk of perpetration of intimate partner violence 3.8-fold (Whitfield, Anda, Dube, & Felitti, 2003). Studies looking into the influence of childhood trauma on sexual violence found that for male sex offenders, childhood sexual abuse, emotional neglect, and parents who are not married were significant ($p < .05$) predictors of sexual deviance (Levenson & Grady, 2016). Furthermore, childhood physical abuse, substance abuse in the childhood home, and an incarcerated family member were significant predictors of sexual violence (Levenson & Grady, 2016). DeLisi and Beauregard (2018) found that adverse childhood experiences were associated with sexual homicide, particularly for offenders who had extensive abuse histories. Those who experienced two victimizations were 152% more likely and those with four victimizations were 249% more likely

to commit sexual homicide (DeLisi & Beauregard, 2018). All of these research studies suggest that in order to better understand the motives for criminal behavior, attention should be given to traumatic childhood experiences.

Adverse Childhood Experiences

The original Adverse Childhood Experiences (ACE) study, which consisted of more than 17,000 patients of the Kaiser Permanente health program, looked at the relationship between exposure of childhood abuse and household dysfunction during childhood and adulthood health risks and disease (Felitti et al., 1998). The study found that approximately two-thirds of adult males reported experiencing at least one adverse childhood experience, and 40% reported experiencing two or more adverse childhood experiences (Murphy et al., 2016; National Center for Injury Prevention and Control, 2016). Amongst males, significant prevalence rates are reported for *neglect* (physical = 10.7%, emotional = 12.4%), *abuse* (emotional = 7.6%, physical = 29.9%, sexual = 16%), and *household challenges* (mother treated violently = 11.5%, household substance use = 23.8%, household mental illness = 14.8%, parental divorce/separation = 21.8%, incarcerated household member = 4.1%). The ACE study sparked an interest amongst researchers to further explore the effects of childhood trauma. As a result, there is substantial research on adverse childhood experiences and mental health functioning. Research on ACE suggests that children who are abused and/or neglected may have developmental delays in cognitive, behavioral, and emotional processing and regulation (Irigaray et al., 2013; Swopes, Simonet, Jaffe, Tett, & Davis, 2013). Furthermore, high ACE scores have been known to increase mental health problems, behavior problems, and lead to aggression later in life (Swopes et al., 2013).

Attachment

Dysfunctional attachment is often the result of early childhood abuse, which impacts brain development and leads to problems with emotional and behavior regulation, including sexual violence (Grady, Levenson, & Bolder, 2016). One study disaggregated the different types of childhood maltreatment reported and found that abuse cases were most likely to increase the risk of forming insecure attachment (Grady et al., 2016). Lyn and Burton (2005) found that male sex offenders who have insecure attachment styles report a higher tolerance for violence and aggression show higher levels of aggression in sexual relationships, have unstable adult intimate relationships, and difficulties trusting romantic partners. Additionally, research has found that sex offenders' attachment styles have been linked to the types of sexual crimes they commit (Abbiati et al., 2014; Lyn & Burton, 2004). For instance, offenders who molest children more often have a preoccupied/anxious adult attachment style, whereas those who commit rapes are more likely to have a dismissive/ avoidant attachment style (Ward, Mccormack, & Hudson, 1997).

Mentalization

The ability to "interpret both the self and others in terms of internal mental states such as feelings, wishes, goals, desires, and attitudes" is a developmental psychology concept known as mentalization, or reflective functioning (Fonagy et al., 2016, p. 1). It refers to one's ability to perceive and interpret human behavior in terms of mental states. Mentalization is sometimes interchangeably used with the terms theory of mind, mindfulness, and social cognition (Bateman & Fonagy, 2012; Brune et al., 2016). It consists of affective mentalization, or the attribution of emotional states, and cognitive mentalization, the inference of thoughts, intentions, and desires

(Brune et al., 2016). Interestingly, some individuals can be affective-oriented, while others cognitively oriented (Bateman & Fonagy, 2012). Some individuals can show cognitive understanding of mental states without activating emotion, such as with narcissistic personality disorder. Others, however, are so overwhelmed by automatic affect arousal that they are unable to successfully integrate mental states, or cognitive knowledge, with affective experiences. This can be seen in individuals with borderline personality disorder, who display more affect-driven mentalization (Bateman & Fonagy, 2012).

Mentalization and empathy, although often used interchangeably, are rather different constructs. Allen and Fonagy (2006), describe a helpful framework for comparing and contrasting between mentalization and empathy, where empathy is defined as "an affective response more appropriate to someone else's situation than to one's own" (p. 110). Where mentalization includes taking in the mental and emotional state of another person, empathy refers to being able to interpret that information and produce an emotional response (Allen & Fonagy, 2006). Although these constructs may often occur jointly, some individuals may be lacking more in one construct. For instance, an individual may exhibit empathy, or be affectively-oriented, but their inaccurate representation of another person's mental and emotional state may lead to an empathic failure or emotional overactivation (Bateman & Fonagy, 2012). The opposite is also possible; an individual can appear to have mentalization skills, or be cognitively-oriented, but have difficulty producing an appropriate empathic response (Bateman & Fonagy, 2012). For this reason, this study focuses on mentalization rather than empathy because improving mentalization skills may lead to different, more appropriate, emotional reactions.

Mentalization involves a self-reflective component as well an interpersonal component. Both parts provide the individual with a capacity to differentiate between inner and outer reality, pretend from "real" modes of functioning, and intrapersonal mental and emotional processes from interpersonal communications. The ability to mentalize determines one's ability for affect regulation, impulse control, and self-monitoring (Fonagy, Gergely, Jurist, & Target, 2004). For these reasons, it is a core aspect of human social functioning and is crucial for individuals to be able to navigate the social world. Not only does it shape our perception of ourselves and others, it shapes our ability to connect and communicate with other people. Deficits in mentalization lead to a tendency to misinterpret or misread the minds of other people, as well as their own minds (Bateman & Fonagy, 2012). This may cause significant problems in the social context. When mentalization is impaired, individuals often lack social problem-solving skills and end up upsetting people whom they wish to befriend (Bateman & Fonagy, 2012).

Mentalization is a developmental achievement that allows children to respond not only to other people's behaviors, but also to their own perception of other people's feelings, beliefs, attitudes, hopes, desires, etc. (Fonagy et al., 2004). Therefore, a child's early experiences with other people, particularly their caregivers, enables them to understand the meaning behind others' actions. Once they understand this, the child is then able to identify and understand their own psychological experiences as well as understand how to respond to particular interpersonal transactions (Fonagy et al., 2004).

Research has shown that a parents' own capacity for mentalization predicts their child's ability to then mentalize (Rosso, Viterbori, & Scopesi, 2015). Therefore, if a child's caregiver lacks awareness into their own mental state and that of others, they are then unable to respond

appropriately to the child's mental and emotional state, undermining a child's ability to develop a healthy sense of self. Donald Winnicott, an influential psychodynamic theorist, supported this idea, believing that a healthy development of the self develops through the perception of oneself in another person's mind as being able to think and feel (Fonagy et al., 2004).

Mentalization is also often referred to as perspective taking, or the "tendency to spontaneously adopt the psychological point of view of others" (Davis, 1983, p. 113-115). Early works by Piaget and Mead stressed the importance of a perspective taking capability for "non-egocentric behavior— that is, behavior that subordinates the self (or the self's perspective) to the larger society made up of other people" (Davis, 1983, p. 113-115). Being able to take on the perspective of someone else allows an individual to anticipate the behavior and reactions of others. This facilitates smoother and more rewarding interpersonal relationships. For this reason, perspective taking is associated with better social functioning (Davis, 1983).

Mentalization and sexual offending. Deficits in mentalization have been linked to sexual offending in that sex offenders and violent offenders lack empathy and are unable to accurately identify the emotions in people (USA, DOJ, n.d.). Since they are incapable of understanding or feeling what another person is feeling, they struggle with recognizing certain emotions in adults and children (Fernandez, Marshall, Lightbody, & O'Sullivan, 1999). This is particularly true for sex offenders who are child molesters (Fernandez et al., 1999).

Research on violence in adolescents showed that mentalization actually serves as a protective factor in the relationship between early maltreatment and potential for violence in adolescents (Taubner, Zimmermann, Ramberg, & Schröder, 2016). Therefore, mentalization capabilities may help protect against early childhood abuse as well as lower an individual's

potential for violence. If deficits in mentalization exist in sex offenders, intervening and teaching mentalization skills may aid in lowering an individual's potential for violence.

Mentalization and adverse childhood experiences. Deficits in mentalization can also result from abuse (Fonagy et al., 2004; Frodi & Smetana, 1984). When children are abused or maltreated, they often have deficits in mentalization (Bateman & Fonagy, 2012). The types of maltreatment that show to have the greatest effect on mentalization include physical, sexual, and psychological abuse (Bateman & Fonagy, 2012).

Abused children often do not feel safe trying to understand the perspective of others because of the intentional hostility of their abuser. The abuser's hostile and malicious mental state actually terrifies the child, leaving them feeling scared and helpless (Bateman & Fonagy, 2012). For this reason, many traumatized children are not willing to explore and understand the feelings of others, including their abuser, so they give up thinking about internal mental states, especially once a relationship becomes too emotionally intense (Brune et al., 2016; Fonagy et al., 2004). This inhibition of mentalizing, a psychological defense, is an adaptation to the dysfunctional and traumatic attachment they have with their abusers (Allen & Fonagy, 2006). Furthermore, research shows that maltreated children even show difficulties learning emotional lexicon (Beeghly & Cicchetti, 1994). Since these children never acquire the appropriate representations of self-other relations, this often leads to unhealthy relationship patterns later in life (Fonagy et al., 2004). More seriously, the failure of mentalizing plays a crucial role in the development of psychiatric disorders, including borderline personality disorder, antisocial personality disorder, and eating disorders (Bateman & Fonagy, 2012).

Mentalization and attachment. A vast majority of researchers studying mentalization and attachment have suggested that one's capacity to mentalize depends on the quality of attachment relationships, particularly early attachments (Allen & Fonagy, 2006; Bateman & Fonagy, 2012; Fonagy et al., 2004). According to research, what is most important for the development of mentalizing is secure attachment (Allen & Fonagy, 2006; Fonagy et al., 2004). Researchers have concurred that an individual's ability to mentalize develops as a result of secure attachments to caregivers and feeling understood by someone else. "Secure attachment enhances the development of the self, inner security, feelings of self-worth, self-reliance, and personal power of the emerging self as well as the development of autonomy" (Fonagy et al., 2004, p. 55). When a child is securely attached to their primary caregiver, it allows them to find or understand themselves, including their beliefs, feelings, and intentions, in the mind of their caregivers (Fonagy et al., 2004).

In contrast, impairments in mentalizing have been associated with disruptions in early attachment with early caregivers (Bateman & Fonagy, 2012; Fonagy et al., 2016). One study found that parental rejection, punishment, and lack of emotional warmth was correlated highest with an individual's affective mentalizing score (Brune et al., 2016). They also discovered that enduring harsh and rejecting parenting practices or being in the presence of abusive caregivers often biases the perception of others as untrustworthy and hostile. This leads to a child to lose his or her level of certainty in their appraisal of other people's thoughts and feelings (Brune et al., 2016) This loss in confidence may actually "shut down the mentalizing system as a dysfunctional means of self-protection, because exposure to the mind of an abusive caregiver can be a source of overwhelming emotional pain" (Brune et al., 2016). Surprisingly, another negative outcome of

insecure attachment was found to be manipulation of others' behaviors (Fonagy et al., 2004). According to Fonagy and colleagues (2004), children with disorganized attachment, unlike securely-attached children, are "scanning not the representation of his own mental states in the mind of the other, but the mental states of that other that threaten to undermine his own self" (Fonagy et al., 2004, p. 55). Furthermore, research suggests that children and adults with this particular attachment style are actually skillful in coercing, or manipulating, other people into behaving in certain ways. Their motivation behind this is to provoke behavior which is consistent with their own internal representation (Fonagy et al., 2004). With adults, research shows that insecure attachment, specifically disorganized attachment, negatively impacts mentalizing abilities later in life (Allen & Fonagy, 2006).

Mentalization-based treatment. Mentalization-based treatment (MBT) was originally intended for patients with borderline personality disorder. However, there is increasing evidence to support its effectiveness for a variety of psychological disorders (Allen, Fonagy, & Bateman, 2008; Bateman & Fonagy, 2012). MBT aims to improve mentalizing by teaching patients to explore their feelings, challenge non-mentalizing, focus on the affect shared between patient and therapist, and learn to mentalize the relationship, or focus their attention on the therapist's mind (Bateman & Fonagy, 2012). MBT has also been adapted to work in group settings. Mentalization-based group therapy is intended to train individuals how to mentalize (Bateman & Fonagy, 2012). During therapy, patients are encouraged to actively explore their own minds as well as the minds of others, to challenge stereotypes they may have, to be comfortable with sharing their personal experiences, and to be reflect on experiences in different ways, or explore alternative perspectives (Bateman & Fonagy, 2012).

Purpose of This Study

This study aims to examine the effects of adverse childhood experiences and dysfunctional attachment on mentalization abilities in sex offenders. If deficits in mentalization are found among offenders, which is one of the hypotheses of this study, future interventions can focus on building mentalization skills in sex offenders. The hypotheses for this study include:

H1: Sex offenders will have higher ACE scores compared to the general male population.

H2: Sex offenders will score higher on the Anxiety and Avoidance subscales of the Experiences in Close Relationships - Relationship Structures Questionnaire compared to the general population.

H3: Sex offenders will score lower in mentalization and perspective taking compared to the general population as measured on the Reflective Functioning Questionnaire and the Perspective Taking subscale of the Interpersonal Reactivity Index (IRI).

H4: ACE will be negatively correlated with mentalization as measured on the Reflective Functioning Questionnaire and the Perspective Taking subscale of the IRI.

H5: Anxiety and Avoidance will be negatively correlated with mentalization as measured on the Reflective Functioning Questionnaire and the Perspective Taking subscale of the IRI.

Chapter 2

Methods

Participants

The sample consisted of 93 registered sex offenders undergoing outpatient treatment in two sex offender treatment programs in Oregon. For the purposes of this study, offenders that were in high-risk groups (as identified by the center directors) were excluded from the sample. Participant compensation for the current study consisted of receiving 1 credit hour toward required community service by the treatment programs. For participants with reading or language difficulties, the surveys were administered verbally by the group facilitator to the entire group, as to protect their identity.

Participants were all males, with ages ranging from 20 to 80, with a mean age of 41.77 (*SD* = 15.46). Ethnically, 71% were Caucasian, 7.5% Hispanic or Latino, 1.1% Black or African American, 3.2% Asian or Pacific Islander, 11.88% multi-ethnic, and 2.2% other. In terms of education, 8.6% did not graduate high school, 31.2% graduated high school, 37.6% had some college, but no degree, 15.1% were college graduates, 4.3% had a graduate degree, and 1.1% had a professional degree. In terms of marital status, 55.9% were single, 17.2% married, 6.5% living with a partner, 16.1% divorced, and 1.1% separated. In terms of employment, 74.2% were employed, 9.7% unemployed, 8.6% retired, and 5.4% on disability. In terms of annual income, 26.7% earned $0-$16,000, 25.6% earned $16,000-$29,999, 25.6% earned $30,000-$45,999, 10% earned $46,000-$55,999, and 12.1111% earned over $56,000. The average annual income was between $16,000 and $45,999, respectfully (see Table 1).

Table 1

Demographic Characteristics of the Sample

Variable	*n*	%	*M*(*SD*)
Age	87		41.77(15.46)
Ethnicity	90		
White	66	71%	
Hispanic or Latino	7	7.5%	
Black or African American	1	1.1%	
Native American or American Indian	0	0%	
Asian/Pacific Islander	3	3.2%	
Multi-ethnic	11	11.8%	
Other	2	2.2%	
Education level completed	91		
Not high school graduate	8	8.6%	
High school graduate	29	31.2%	
Some college, no diploma	35	37.6%	
College graduate	14	15.1%	
Graduate degree	4	4.3%	
Professional degree	1	1.1%	
Annual income	90		
$0-$15,999	24	25.8%	
$16,000-$29,999	23	24.7%	
$30,000-$45,999	23	24.7%	
$46,000-$55,999	9	9.7%	
Greater than $56,000	11	11.8%	
Marital status	90		
Single	52	55.9%	
Married	16	17.2%	
Living with partner	6	6.5%	
Widowed	0	0%	
Divorced	15	16.1%	
Separated	1	1.1%	
Employment status	91		
Employed	69	74.2%	
Unemployed	9	9.7%	
Retired	8	8.6%	
On disability	5	5.4%	

Materials

Demographics. A survey was developed to gather demographic data. This included age, ethnicity, education level, annual income, marital status, and employment status.

Adverse Childhood Experiences Questionnaire (ACE) (Centers for Disease Control and Prevention, 2016). The ACE is a 10-item yes/no questionnaire that is categorized into three groups: abuse, neglect, and household challenges. Each category is further divided into multiple subcategories. Abuse includes emotional abuse, physical abuse, and sexual abuse. Neglect includes emotional neglect and physical neglect. Household challenges include household substance use, household mental illness, parental separation or divorce, mother being treated violently, and having an incarcerated household member. The yes/no format yields a total score ranging from 0 to 10. "Yes" answers receive 1 point and "No" answers receive 0 points. Prior research supports the ACE's psychometric properties, including satisfactory internal consistency of .77 (Bufford, Sisemore, & Blackburn, 2017; Dube, Williamson, Thompson, Felitti, & Anda, 2004). The questionnaire was initially designed to be used as a checklist, but for the purposes of this study it was used as a scale. Cronbach's alpha for this sample was .78.

Experiences in Close Relationships - Relationship Structures Questionnaire (ECR-RS) (Fraley, Hudson, Heffernan, & Segal, 2015). The ECR-RS is a 9-item self-report measure that is scored on a 7-point Likert scale ranging from *Strongly Disagree* to *Strongly Agree*. The ECR-RS assesses two variables: attachment-related anxiety and attachment-related avoidance. Attachment-related anxiety measures the extent to which a person is worried that the target may reject him or her (e.g., "I'm afraid that this person may abandon me"). Three of the nine items are used to assess anxiety (items 7-9). Attachment-related avoidance measures the strategies

people use to regulate their attachment behavior in a specific relational context (e.g., "I don't feel comfortable opening up to this person"). High scores suggest the individual is "uncomfortable with closeness and dependency, whereas people with low scores are comfortable using others as a secure base and safe haven" (Fraley et al., 2015, p. 358). Six of the nine items are used to assess avoidance (items 1-6, with the first four items reverse scored). The ECR-RS is designed to assess individual differences separately in each five relational domains: relationships with mother, father, romantic partner, (non-romantic) best friend, and general (global) attachment styles. For all five relationship domains, reliabilities for the anxious and avoidant subscales were high, ranging from .81 (global avoidance) to .92 (avoidance with mother). For the purposes of this study, participants were asked to rate only the general domain (global attachment) with respect to how they "generally think and feel in close relationships." Their responses were used to assess the global attachment subscale. Cronbach's alpha for this sample was .87 for the attachment-related anxiety subscale and .77 for the attachment-related avoidance subscale.

Reflective Functioning Questionnaire (RFQ) (University College London, 2018). The RFQ is an 8-item measure that is scored on a 7-point Likert scale ranging from *Strongly Disagree* to *Strongly Agree*. The RFQ is a self-report screener that is designed to measure an individual's capacity to interpret both the self and others in terms of internal mental states such as feelings, wishes, goals, desires, and attitudes. The RFQ has two factors assessing Certainty and Uncertainty about the mental states of self and others. Certainty loads on items 1, 2, 3, 4, 5, 6 and Uncertainty loads on items 2, 4, 5, 6, 7, and 8. The RFQ shows satisfactory internal consistency and excellent reliability, test–retest reliability, and validity (.84 and .75) (Fonagy et al., 2016). Estimates of internal consistency for RFQ Certainty and RFQ Uncertainty were 0.67

and 0.63. This questionnaire was recommended for use by Peter Fonagy as a measure for mentalization (Bateman & Fonagy, 2012). Reliability for this sample was .78 for RFQ Certainty and .68 for RFQ Uncertainty.

Perspective Taking Subscale of the Interpersonal Reactivity Index (IRI) (Davis, 1983). The IRI is a 28-item self-report measure that is scored on a Likert scale labeled A through E, ranging from *Does not describe me well* to *Describes me very well*. The IRI looks at four different dimensions of dispositional empathy: Empathic Concern, Perspective Taking, Personal Distress, and Fantasy. The IRI measures trait-based empathy, which means it assess people's characteristic tendencies to empathize. For the purposes of this study, only the Perspective Taking (PT) subscale will be used. The 7-item PT subscale measures the tendency to adopt the point of view of other people in everyday life (Davis, 1983). Participants will rate the items using a 5-point Likert scale ranging from *Does not describe me well* to *Describes me very well*. Higher scores on the IRI are indicative of greater perspective taking. The IRI has good psychometric properties, including satisfactory internal reliability of .71 - .77 and test-retest reliability of .62 and .71 (Davis, 1983). The IRI was recommended for use by Peter Fonagy as a measure for mentalization (Bateman & Fonagy, 2012). Cronbach's alpha for the PT subscale was .76 (see Table 2).

Table 2

Variable Reliability for Sex Offender Sample

Variable	Cronbach's alpha	Skewness	Kurtosis
ACE	.78	.59	-.80
Anxious Attachment	.87	.37	-.83
RFQ Certainty	.78	.26	-.67
RFQ Uncertainty	.68	1.80	3.63
Perspective Taking	.76	.07	-.55

Procedure

Following IRB approval, participants were given an informed consent form prior to the survey asking their permission to participate in the study. They were asked demographic questions and were given a number of questionnaires, including Adverse Childhood Experiences Questionnaire, Experiences in Close Relationships- Relationship Structures Questionnaire, Reflective Functioning Questionnaire, and the Perspective Taking subscale of the Interpersonal Reactivity Index. The surveys were given to participants in print form following a weekly group session. They were given the option of completing their survey in the therapy room or in the office lounge. In the treatment centers, the groups are differentiated by the risk category of each offender. For this study, the high-risk groups were not asked to participate. For compensation, the directors of the programs gave each participant one credit hour toward their required community service. All materials were de-identified and locked away for safekeeping.

Chapter 3

Results

Hypothesis 1

It was hypothesized that sex offenders would have higher ACE scores compared to the general population. It is important to note that prior to running the analysis, 7.53% of ACE items were missing from the total sample (7 out of 93). All of these missing scores came from items 6-10. Missing values were replaced with the mean for each particular item.

In this sample of 93 participants, 16% of offenders reported no adverse childhood experiences, 25.8% reported one adverse childhood experience, 8.6% reported two, 11.8% reported three, 6.5% reported four, and 31.3% reported five or more adverse experiences.

Offenders endorsed childhood emotional abuse (44.1%), physical abuse (39.8%), sexual abuse (31.2%), emotional neglect (26.9%), parental separation or divorce during their childhood (49.5%), their mother being treated violently during their childhood (17.2%), household substance abuse during their childhood (37.6%), household mental illness during their childhood (26.9%), having an incarcerated household member during their childhood (16.1%), and physical neglect during childhood (11.8%) (see Table 3).

Table 3

Percentages of Endorsed ACE Items from the Sex Offender Sample and the Kaiser ACE Study, and Group Differences (z-ratio)

ACE Item	*n*	% of Sex Offender	% Kaiser ACE Study[a]	*z*-ratio
1. Emotional abuse	41	44.1%	7.6%	12.89**
2. Physical abuse	37	39.8%	29.9%	2.07*
3. Sexual abuse	29	31.2%	16%	3.95**
4. Emotional neglect	25	26.9%	12.4%	4.19**
5. Physical neglect	11	11.8%	10.7%	0.35
6. Parental separation or divorce	47	49.5%	21.8%	6.48**
7. Mother treated violently	18	17.2%	11.5%	1.80*
8. Household substance abuse	36	37.6%	23.8%	3.19**
9. Household mental illness	27	26.9%	14.8%	3.37**
10. Incarcerated household member	16	16.1%	4.1%	5.77**

Note. [a] Compared to males only. * Indicates significance level of $p < .05$. ** Indicates significance level of $p < .0001$.

Z-ratios were calculated to identify the significance of the difference between ACE percentages in this sex offender sample and the Kaiser ACE study sample (National Center for

Injury Prevention and Control, 2016). With the exception of physical neglect, offenders scored significantly higher on each item of the ACE compared to the Kaiser sample (see Table 3).

An independent t-test was run to compare the average ACE score from the sex offender population ($M = 3.03$, $SD = 2.58$) to the general population. Ideally, the norm population would have been the sample from the Kaiser ACE study. However, because means and standard deviations were not available, a norm sample of college students was taken from Bufford et al.'s study (2017) ($M = 1.41$, $SD = 1.97$) for comparison. The large difference between the two samples, $t = 6.04$, $p < .0001$, $d = .71$, suggests the sex offender population reported significantly more adverse childhood experiences compared to a college student sample. Another independent t-test was run to determine the relationship between the average ACE score from the sex offender population with the average ACE score of Forster, Grigsby, Rogers, & Benjamin (2018) ($M = 1.77$, $SD = 0.96$). Testing yielded similar results. There was a large difference between the two samples, $t = 4.69$, $p < .0001$, $d = 0.65$, suggesting the sex offender population reported significantly more adverse childhood experiences compared with the second norm sample. Overall, participants in this sample reported a higher number of adverse childhood events when compared to college students (see Table 4).

Table 4

ACE Scores from the Sex Offender Sample and Two Norm Samples

Sample	*n*	M (*SD*)	*t*-score	Cohen's *d*
Sex Offenders	93	3.03 (2.58)		
Bufford et al., 2017[a]	519	1.41 (1.97)	6.04	.71
Forster et al., 2018[b]	2,953	1.77 (.96)	4.69	.65

Note. ACE = adverse childhood experiences. [a] Bufford et al., (2017). [b] Forster et al., (2018)

Hypothesis 2

It was hypothesized that sex offenders will score higher on attachment-related anxiety and avoidance scales compared to the general population. An independent sample t-test was run to compare the anxious attachment and avoidant attachment subscales of the ECR-RS in the sex offender population to a comparison sample taken from Fraley et al.'s study (2015), which surveyed males and females in the general population using an online survey posted on the Fraley's website. The results of the t-test did not support the hypothesis as sex offenders did not have higher scores on the anxious attachment subscale. In fact, the opposite was found. In sex offenders, anxious attachment ($M = 3.26$, $SD = 1.74$) was significantly lower compared to the norm population ($M = 4.17$, $SD = 1.67$), $t = -5.05$, $p < .0001$, $d = 0.53$. Avoidant attachment in sex offenders ($M = 3.37$, $SD = 1.18$) was lower than the norm population ($M = 3.51$, $SD = 1.23$), though was not statistically significant, $t = -1.17$, $p = 0.12$, $d = .17$.

Hypothesis 3

It was hypothesized that sex offenders will score lower in mentalization and perspective taking compared to the general population as measured on the Reflective Functioning

Questionnaire and the Perspective Taking subscale of the Interpersonal Reactivity Index (IRI). It is important to note that on the RFQ, 8.60% of responses (8 out of 93) were missing from the total sample. Missing values were replaced with the mean for each particular item.

An independent t-test was run to compare reflective functioning in sex offenders to a norm sample (Fonagy et al., 2016). The norm sample consisted of a general sample (n = 295). When compared to the norm sample (M = 3.16, SD = 2.70), RFQ Certainty in sex offenders (M = 1.31, SD = .79), was significantly different, t = -22.46, p < .0001, d = .93. Surprisingly, RFQ Uncertainty in sex offenders (M = .45, SD = .52), when compared to the norm sample (M = 0.47, SD = 0.97), was not found to be statistically significant, t = -0.39, p = 0.35, d = .92.

An independent t-test was run to compare perspective taking in sex offenders to the male norm sample (n = 63,871) from Chopik, O'Brien, & Konrath's study (2016). The norm sample comparison between sex offenders (M = 2.71, SD = .68) and the norm sample (M = 3.55, SD = 0.77) yielded statistically highly significant results, t = -11.85, p < .0001, d = 1.16.

Hypothesis 4

It was hypothesized that ACE will be negatively correlated with mentalization as measured on the Reflective Functioning Scale and the Perspective Taking subscale on the Interpersonal Reactivity Index. Pearson correlations were analyzed to examine the relationships between ACE, reflective functioning, and perspective taking.

A Pearson correlation was calculated to explore the relationship between RFQ Uncertainty and RFQ Certainty and the overall ACE average in the sex offender sample. Results found no statistically significant relationship between RFQ Certainty and ACE (r = -.03, p = .79) and no statistically significant relationship between RFQ Uncertainty and overall ACE mean (r =

.15, p = .15). A small correlation was found between RFQ Uncertainty and emotional neglect on the ACE (r = .21, p = .043). With the exception of emotional neglect, no other ACE item correlated with reflective functioning, either RFQ Certainty or RFQ Uncertainty.

A Pearson correlation was calculated to explore the relationship between the overall ACE mean (M = 3.03, SD = 2.58) and perspective taking in the sex offender sample (M = 2.71, SD = .68). Results showed no statistically significant relationship between ACE and perspective taking in sex offenders (r = -.07, p = .50).

Hypothesis 5

It was hypothesized that anxious and avoidant attachment will be negatively correlated with mentalization as measured on the Reflective Functioning Questionnaire (RFQ) and the Perspective Taking (PT) subscale of the Interpersonal Reactivity Index (IRI). Pearson correlations were run to evaluate the relationship between avoidant and anxious attachment subscales, the ECR-RS, the Reflective Functioning Questionnaire (RFQ), and the Perspective Taking subscale of the IRI. There was a significant negative correlation between avoidant attachment and RFQ Certainty (r = -.22, p = .03), and a significant correlation between avoidant attachment and RFQ Uncertainty (r = .22, p < .05). There was a significant negative correlation between anxious attachment and RFQ Certainty (r = -.44, p < 0.01) and there was a significant correlation between anxious attachment and RFQ Uncertainty (r = .46, p < 0.01). There was a significant negative correlation between avoidant attachment and perspective taking (r = -.36, p < .01). The correlation between anxious attachment and perspective taking approached but did not meet statistically significant values (r = -.20, p = 0.06).

Additional Correlations

Anxious attachment had a small correlation with ACE's emotional neglect in the sex offender sample (r = .22, p = 0.36). Avoidant attachment, however, was not correlated with emotional neglect (r =.02, p =.87) nor any other ACE items.

A Pearson correlation was used to explore a relationship between perspective taking and reflective functioning. The correlation between perspective taking and RFQ Certainty approached but did not meet statistically significant values, (r = .19, p = .06). The correlation between perspective taking and RFQ Uncertainty showed no statistically significant relationship (r = -.14, p =.19) (see Tables 5 and 6).

Table 5

Means and Standard Deviations for Variables in the Sex Offender Sample and Norm Populations

Variable	Sex Offenders (n = 93)	Frayley (n = 2,300)	Fonagy (n = 295)	Chopik (n = 63,871)	*t*-score	Cohen's *d*
Anxious Attachment	3.26 (1.74)	4.17 (1.67)			-5.05*	.53
Avoidant Attachment	3.37 (1.18)	3.51 (1.23)			-1.17	.17
RFQ Certainty	1.31 (.79)		1.98 (2.16)		-22.46*	.93
Perspective Taking	2.71 (.68)			3.55 (0.77)	-11.85*	1.16

Note. Significance level of $p < .0001$

Table 6

Correlations Between Variables in the Sex Offender Sample

Variable	ACE	Anxious Attachment	Avoidant Attachment	RFQ Certainty	RFQ Uncertainty	Perspective Taking
ACE	1					
Anxious Attachment	.161	1				
Avoidant Attachment	-.053	.314**	1			
RFQ Certainty	-.028	-.435**	-.221*	1		
RFQ Uncertainty	.149	.459**	.219*	-.636**	1	
Perspective Taking	.070	-.200	-.359**	.196	-.137	1

Note. * Correlation is significant at the 0.05 level. ** Correlation is significant at the 0.01 level.

Chapter 4

Discussion

Sample Characteristics

The majority of the sample identified as Caucasian, which is not surprising given the location of the outpatient treatment centers in the Pacific Northwest. The majority had a high school degree or some college education. Seventy-four percent of the sample reported being employed and over 70% had an income level under $50,000, with about 50% having an income under $30,000. This may be due to this population having difficulty finding employers who will hire them despite their criminal record. They also may have limited job opportunities due to limits in education and experience, or to specific legal or probationary restrictions (e.g., not permitted to work near schools, around children, etc.).

Interesting demographic findings for this sex offender population were also related to marital status. More than 55% of the sample reported being single. This may shed light on relationship commitment issues, trust issues, intimacy deficits, limited ways to find romantic partners (e.g., restrictions on internet use), and concerns related to disclosing to partners about their offense (Ward et al., 1997). There is a lot of sensitivity around self-disclosing about their sexual offense for fear of rejection (Ward et al., 1997). Interestingly, for those offenders who are in romantic relationships, research suggests that the relationship itself actually serves as a prominent predictor of desistance (Bersani, Laub, & Nieuwbeerta, 2009; Lytle, Bailey, & Bensel, 2017). Furthermore, if the relationship is supportive, it can provide a source of acceptance for offenders, which is much needed considering the “ostracizing stigma” they face (Bensel &

Sample, 2016; Lytle et al., 2017). The high percentage of single offenders may also be attributed to offenders who have committed offenses against children and who have pedophilic interests. This may be one explanation for why such a high number of offenders reported being single.

Adverse Childhood Experiences

Overall, the results of this study supported the hypothesis that sex offenders endorsed significantly more adverse childhood experiences compared to the comparison samples. Emotional abuse and parental separation or divorce stood out as strongly in this sample (d = 12.89 and 6.48 respectively; both very large). Compared to males in the Kaiser ACE study, sex offenders were much more likely to have reported all forms of adverse childhood experiences except for physical neglect, which was similar to the comparison sample. It is unknown why specifically physical neglect was similar between sex offenders and the general population. Possible hypotheses may include socioeconomic stressors (i.e. low income), parental substance use, and parental mental health concerns (Fluke, Shusterman, Hollinshead, & Yuan, 2008).

Thirty-one percent of sex offenders in this sample endorsed sexual abuse during their childhood. This number is actually consistent with previous literature, showing that 28-30% of sex offenders were sexually abused as children (Becker & Murphy, 1998; Hindman & Peters, 2001; Proeve & Reilly, 2007). Although in Hindman and Peter's (2001) study, 67% of sex offenders reported experiencing sexual abuse, but when given polygraphs, the number significantly dropped to 29%. It appeared that Hindman and Peter's sex offender sample was over-reporting abuse, possibly trying to either rationalize their behaviors or gain sympathy from people. In this study, however, findings suggest that sex offenders may have been answering more honestly, as their percentages matched those of other studies.

Surprisingly, 16% of sex offenders reported they did not experience any adverse childhood events. There are a few possible explanations for this: some sex offenders may not have experienced any adverse childhood events, some sex offenders may under-report abuse, and some may not view their experiences as abuse. Research on disclosing abuse suggests that there are many barriers that inhibit or prevent individuals from disclosing abuse. A few of these barriers include the associated shame and guilt of admitting one was abused, cognitive or developmental delays that impede one's ability to comprehend that they were abused, memory lapses, lack of information, denial that the abuse occurred, fear of retaliation by the offender, or fear of the negative consequences (Fieldman & Crespi, 2002; Leclerc & Wortley, 2015; Lemaigre, Taylor, & Gittoes, 2017). Defenses such as denial and minimization may serve to protect the offender's conscience from having to admit to the abuse and confront it. However, their denial may also shield them from having to acknowledge to themselves that their own abusive behaviors towards others are wrong; to acknowledge that they experienced adverse childhood events may mean having to acknowledge that they have somehow caused those same events in their victims' lives (Ware, Marshall, & Marshall, 2015).

The findings of this study, specifically that sex offenders endorsed more adverse childhood experiences than comparison samples, are consistent with previous research (Levenson et al., 2014). Seeing as though a significant number of offenders reported adverse childhood experiences and there is already an existing link between ACE and criminal behavior/sexual offending (DeLisi & Beauregard, 2018; Levenson & Grady, 2016; Whitfield, Anda, Dube, & Felitti, 2003), sex offenders who endorse childhood trauma may be at a

significantly higher risk for other criminal behavior, including sexual deviance, violent sexual offending, intimate partner violence, and sexual homicide.

Attachment

This study looked at two different types of attachment: attachment-related anxiety and attachment-related avoidance. Attachment-related anxiety is the "extent to which a person is worried that the target may reject him/her" and attachment-related avoidance refers to the "strategies that people use to regulate their attachment behavior in a specific relational contexts" (Fraley et al., 2015, p. 358).

In this sample, sex offenders exhibited lower attachment-related avoidance and significantly lower attachment-related anxiety when compared with adults in the general population. This suggests that offenders perceive themselves as having less anxious and avoidant-type attachment. These findings were inconsistent with previous research, which suggests dysfunctional attachment is often the result of childhood abuse (Grady et al., 2016; Lyn & Burton, 2004). With this in mind, it was hypothesized that sex offenders who tend to endorse more childhood trauma would also endorse more attachment-related anxiety and attachment-related avoidance. However, this was not what was found, although we did find that in our sample of sex offenders there were higher rates of ACEs. One possible explanation for this discrepancy may be a lack of awareness into one's own attachment style.

A small relationship was found between anxious attachment and emotional neglect from ACE. Avoidant attachment, however, was not correlated with emotional neglect. These findings suggest that sex offenders who were emotionally neglected may display slightly more anxiety in their interpersonal relationships. This is consistent with previous research that shows that

children whose emotional and psychological needs were not met may have delays in emotional processing and regulation (Irigaray et al., 2013; Swopes et al., 2013). Due to their needs not only not being met, but neglected, adult offenders may experience increased anxiety and may struggle with effectively managing and regulating the feeling.

Mentalization

In support of the hypothesis, offenders exhibited mentalization deficits compared to the norm sample. This suggests that sex offenders are less certain about others' emotional and mental states when compared to other adults. The ability to mentalize, as previously mentioned, is a core aspect of human social functioning. Being able to mentalize shapes our perception of ourselves and other people and it influences how we connect and communicate with other people (Bateman & Fonagy, 2012). When deficits in mentalization exist, such as in sex offenders, this may lead them to misinterpret or misread the minds of other people, as well as their own understanding of themselves (Bateman & Fonagy, 2012). Not surprisingly, this may lead to a lack of problem-solving skills and also create significant problems in the social context (Bateman & Fonagy, 2012).

Surprisingly, uncertainty in these sex offenders, when compared to the comparison sample, was not found to be statistically significant. These results were surprising because if offenders have lower mentalization abilities, it would be expected that they would also admit to being more uncertain about others' mental and emotional states. However, the results of this study suggest this is not the case. Although their mentalization abilities are lower than the comparison sample, they deny any uncertainty regarding mental and emotional states and do not believe that they have deficits in this area. These results provide extremely important information

into sex offenders' own insight into their functioning. As previously mentioned, their mentalization deficits may impact how they perceive themselves (Bateman & Fonagy, 2012). One hypothesis is that mentalization deficits may lead these sex offenders to be certain about other' internal states when in reality they are wrong. A second possible hypothesis as to why they are not reporting more uncertainty, though there is no literature addressing it, may stem from reluctance to admit to others, and most importantly themselves, that they struggle with understanding other people. This concept may be too threatening to their self-esteem and ego; therefore, they consciously deny any uncertainty.

Perspective Taking

In support of the hypothesis, the results of this study also found that sex offenders have significantly lower perspective taking abilities than the comparison sample. No relationship was found between perspective taking and reflective functioning, either RFQ Certainty or RFQ Uncertainty. In their early works, Piaget and Mead stressed the importance of perspective taking for "non-egocentric behavior," or behavior that "subordinates the self (or the self's perspective) to the larger society" (Davis, 1983, p. 115). Being able to take in another person's perspective allows an individual to "anticipate the behavior and reactions of others, therefore facilitating smoother and more rewarding interpersonal relationships" (Davis, 1983, p. 115). As a result, individuals who have perspective-taking abilities tend to have better social functioning.

Mentalization, perspective taking, and ACE. Although there were no statistically significant relationships between overall mentalization and ACE, there was a small-to-moderate relationship between RFQ Uncertainty and emotional neglect from the ACE. This finding suggests that the more emotional neglect an offender experienced during childhood, the more

uncertain they were later in life about others' mental and emotional states. This is consistent with previous research findings. For instance, when a child's emotional and psychological needs are not being met, they begin to question why their primary caregiver, the person that is supposed to care for them, provide for them, and make them feel safe in this world, does not do so. They begin to question not only themselves and their worth, but also struggle to understand the internal world of their caregiver. As they mature, it is increasingly difficult for them to comprehend the thoughts, feelings, and intentions of other people (Bateman & Fonagy, 2012). Their early experiences have tainted their perception and understanding of other people. Children who endure harsh and rejecting parenting practices or being in the presence of abusive caregivers often biases the perception of others as untrustworthy and hostile. This leads to a child to lose their certainty about their ability to understand other's thoughts and feelings (Brune et al., 2016). This loss in confidence may actually "shut down the mentalizing system as a dysfunctional means of self-protection, because exposure to the mind of an abusive caregiver can be a source of overwhelming emotional pain" (Brune et al., 2016, p. 29).

Mentalization, perspective taking, and attachment. Findings suggest that although these sex offenders endorsed less anxious and avoidant attachment styles, there was still a relationship between their attachment style and reflective functioning. For example, the significant negative correlation between avoidant attachment and RFQ Certainty suggests that in these sex offenders, the more certain they are of other's emotional and mental states, the less avoidant-type behaviors they display, or vice versa. Unsurprisingly, there was a small relationship between avoidant attachment and RFQ Uncertainty, suggesting as uncertainty increases, so do avoidant-type behaviors.

There was a significant negative correlation between anxious attachment and RFQ Certainty and there was a significant correlation between anxious attachment and RFQ Uncertainty. This suggests that similar to avoidance, the more certain they are of other's emotional and mental states, the less anxious behaviors they display, or vice versa. In other words, the more uncertain they are about one's mental and emotional states, the more anxious they feel in those situations.

There was a significant negative relationship between avoidant attachment and perspective taking in sex offenders. This suggests that sex offenders' ability to take the perspective of other people increases, or their perception of being able to do so increases, while their avoidant attachment decreases. Their confidence in the appraisal of others' mental and emotional states leads them to be less avoidant of situations, or vice versa. This was not found to be true of anxiety. The correlation between anxious attachment and perspective taking approached but did not meet statistically significant values. These findings are most likely related to the difference between avoidant and anxious attachment. With avoidant attachment, individuals have a mistrust in others, but are able to maintain self-confidence in themselves and their levels of certainty. Therefore, as their perspective taking abilities increase, mistrust in others decreases, resulting in less avoidant attachment behaviors. With anxious attachment, however, there is a deep-rooted mistrust in self and ability to take the perspective of others. This suggests that even if perspective taking abilities increase, their low self-confidence and self-mistrust results in no changes in attachment behaviors.

Limitations

There are four noted limitations in this study. The first, when looking at adverse childhood experiences, sex offender means were compared to ACE means in college students. This is a limitation of this study because there is a possibility that college students may experience less adverse childhood experiences than the general population, which in turn drastically lowers their ACE means, creating a larger difference between ACE means in sex offenders and college students. Second, in this study, all sex offenders were male. Research on a female sample, instead, may yield different results. Third, the reliability for the RFQ Uncertainty was low in this sample, suggesting the measure may not have been very reliable. Additionally, the data from RFQ Uncertainty was highly skewed right and the leptokurtic distribution suggests that the measure may be insensitive, making the measure less powerful. Fourth, replacing missing data on the ACE and RFQ measures may have distorted the results.

Implications

The findings of this study provide very important information into the functioning of sex offenders. While these data do not allow firm causal conclusions, findings suggest that a significant history of childhood trauma, coupled with deficits in mentalization and dysfunctional attachment styles are related to how participants understand themselves, others, and the world around them and are consistent with proposed causal links. Traumatic abuse during their childhood, a critical time for exploration and creativity, may have impacted their ability to form secure attachments (Grady et al., 2016) and correctly identify thoughts and feelings in other people (Bateman & Fonagy, 2012; Fonagy et al., 2004; Frodi & Smetana, 1984). Sadly, according to theory, their early experiences, dysfunctional attachment, and their deficits in

mentalization suggest a serious lack of insight. A lack of insight in turn makes it extremely difficult for them to understand their impulses to offend and how their offenses impact their victims. Although this is not an excuse or justification for offending, it hopefully will inform treatment goals for clinicians working with this population.

Future Directions

This study has shown that sex offenders have significant deficits in mentalization. Future studies may look at (a) how deficits in mentalization impact sex offenders' interpersonal functioning, (b) implementing mentalization-based therapy with sex offenders to look at efficacy of the treatment on improving mentalization skills in sex offenders, and (c) look at the other three dimensions of empathy from the Interpersonal Reactivity Index (Empathic Concern, Personal Distress, and Fantasy). Regarding attachment, future studies can a) use an interview-based attachment measure rather than the self-report that was used in this study, b) look at the relationship between attachment style and other variables (i.e., type of offense, personality characteristics), and c) use the Experiences in Close Relationships - Relationship Structures Questionnaire to identify offenders' attachment specifically to their mothers, fathers, romantic partners, and friends. Other studies can look into additional barriers, or defenses/resistance, that prevent sex offenders from disclosing personal experiences of childhood abuse.

Treatment Considerations and Conclusions

The findings of this study suggest that sex offenders have mentalization deficits. Thus, treatment such as Mentalization-Based Therapy (MBT) may improve mentalizing. Since MBT has a self-reflective component as well as an interpersonal component, offenders may be trained how to explore their own minds, thoughts, and feelings as well as those of others, including their

victims (Bateman & Fonagy, 2012). Luckily, MBT has also been adapted to work in group settings, which is the most common type of treatment for sex offenders. Mentalization-based group therapy encourages participants to actively explore their own minds as well as the minds of others, to challenge stereotypes they may have, to be comfortable with sharing their personal experiences, and to reflect on experiences in different ways, or explore alternative perspectives (Bateman & Fonagy, 2012).

The current study found that sex offenders experienced significantly higher rates of childhood abuse compared to the general population. This finding supports the need to provide trauma-informed care to offenders. Sex offender treatment models, such as RNR or Good Lives, primarily focus on relapse prevention via cognitive and behavioral change such as identifying triggers, risk factors, and improving affective and behavioral self-regulation (Levenson, 2014). However, an offender's own developmental history, including early adverse childhood experiences, is often missed. We know from research that early childhood trauma is associated with poor attachment, interpersonal problems, neurocognitive delays, and more importantly, persistent criminal behavior (Bateman & Fonagy, 2012; Fonagy et al., 2016; Grady et al., 2016; Levenson & Socia, 2016). For these reasons, it is crucial to provide trauma-informed care in sex offender treatment. The Trauma-Informed Care model (TIC) helps to create a trauma-informed therapy environment in which clinicians have a "holistic understanding of the individual in the context of his/her collective experiences", including childhood trauma (Levenson, 2014, p. 15). They are encouraged to "recognize the impact of violence and victimization on psychosocial development and coping skills" in sex offenders" (Levenson, 2014, p. 15). Incorporating trauma-

informed care into existing models of sex offender treatment can “assist in mitigating future potential to reoffend” (Levenson, 2014, p. 17-18).

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Appendix A

Informed Consent for Participation

I_____ understand that my participation in this research project is voluntary and that I can stop at any time without penalty. I understand all data will be kept confidential with only the researcher and a faculty advisor having access to my survey results.

Study Purpose: The goal of this study is to understand the relationship between early childhood experiences, attachment, and mental functioning.

Study Procedures: Participation in this study will take approximately 20 minutes. If you choose to participate, you will be asked to fill out a questionnaire packet. Your responses will not be identified with you personally, as your name or other identifying information (e.g., social security number, date of birth) will not be collected and used with the survey data. Please do not put your name anywhere on the survey.

Compensation: Your participation is voluntary. If you choose to participate, you may receive a one-hour credit towards required community service.

Risks: Due to the personal nature of the questions, you may feel slight discomfort answering the questions.

Confidentiality: Great care will be taken to provide as much confidentiality as possible. Responses to the questionnaires will be seen and entered by Oksana Sklyarov. Raw data from the questionnaire will be kept in a locked file. If you have any questions or concerns about your participation in this research, you may contact this researcher, Oksana Sklyarov, MA, via osklyarov15@georgefox.edu. This study was approved by the George Fox University Institutional Review Board.

Consent:
I have read the description of this research project and have voluntarily chosen to participate. I understand that the questionnaires will be received and maintained in confidence and used for research purposes only. I also understand that if I wish to discontinue participation at any time prior to the completion of the packet, I may do so without penalty. By signing, I agree to participate in the research project, under the terms noted above.

_____ _____
Signature of Participant Date

Appendix B

Demographic Information

Age _____ (in years)

Ethnicity:

- White
- Hispanic or Latino
- Black or African American
- Native American of American Indian
- Asian/Pacific Islander
- Multi-ethnic
- Other _____

Education Level:

- Not high school graduate
- High school graduate
- Some college, no diploma
- College graduate
- Graduate degree
- Professional degree

Income (yearly):

- $0-$15,999
- $16,000-$29,999
- $30,000-$45,999
- $46,000-$55,999
- $56,000+

Marital status:

- Single
- Married
- Living with partner
- Widowed
- Divorced
- Separated

Employment:

- Employed
- Unemployed
- Retired
- On disability

Appendix C

Adverse Childhood Experience Questionnaire

While you were growing up, during your first 18 years of life:

1. Did a parent or other adult in the household often ...
Swear at you, insult you, put you down, or humiliate you?
or
Act in a way that made you afraid that you might be physically hurt?
Yes No

2. Did a parent or other adult in the household often ... Push, grab, slap, or throw something at you?
or
Ever hit you so hard that you had marks or were injured?
Yes No

3. Did an adult or person at least 5 years older than you ever...
Touch or fondle you or have you touch their body in a sexual way?
or
Try to or actually have oral, anal, or vaginal sex with you?
Yes No

4. Did you often feel that ...
No one in your family loved you or thought you were important or special?
or
Your family didn't look out for each other, feel close to each other, or support each other?
Yes No

5. Did you often feel that ...
You didn't have enough to eat, had to wear dirty clothes, and had no one to protect you?
or
Your parents were too drunk or high to take care of you or take you to the doctor if you needed it?
Yes No

6. Were your parents ever separated or divorced?
Yes No

7. Was your mother or stepmother:
Often pushed, grabbed, slapped, or had something thrown at her?

or
Sometimes or often kicked, bitten, hit with a fist, or hit with something hard?
or
Ever repeatedly hit over at least a few minutes or threatened with a gun or knife?
Yes No

8. Did you live with anyone who was a problem drinker or alcoholic or who used street drugs?
Yes No

9. Was a household member depressed or mentally ill or did a household member attempt suicide?
Yes No

10. Did a household member go to prison?
Yes No

Appendix D

Experiences in Close Relationships - Relationship Structures Questionnaire

Please read each of the following statements and rate the extent to which you believe each statement best describes your feelings about close relationships in general.

Use the following scale from 1 to 7.

Strongly disagree	1	2	3	4	5	6	7	Strongly agree

1. _____ It helps to turn to people in times of need.

2. _____ I usually discuss my problems and concerns with others.

3. _____ I talk things over with people.

4. _____ I find it easy to depend on others.

5. _____ I don't feel comfortable opening up to others.

6. _____ I prefer not to show others how I feel deep down.

7. _____ I often worry that other people do not really care for me.

8. _____ I'm afraid that other people may abandon me.

9. _____ I worry that others won't care about me as much as I care about them.

Appendix E

Reflective Functioning Questionnaire

Please work through the next 8 statements. For each statement, choose a number between 1 and 7 to say how much you disagree or agree with the statement, and write it beside the statement. Do not think too much about it – your initial responses are usually the best. Thank you.

Use the following scale from 1 to 7.

Strongly disagree	1	2	3	4	5	6	7	Strongly agree

1. ___ People's thoughts are a mystery to me

2. ___ I don't always know why I do what I do

3. ___ When I get angry I say things without really knowing why I am saying them

4. ___ When I get angry I say things that I later regret

5. ___ If I feel insecure I can behave in ways that put others' backs up

6. ___ Sometimes I do things without really knowing why

7. ___ I always know what I feel

8. ___ Strong feelings often cloud my thinking

Appendix F

Interpersonal Reactivity Index: Perspective Taking Subscale

The following statements inquire about your thoughts and feelings in a variety of situations. For each item, indicate how well it describes you by choosing the appropriate letter on the scale at the top of the page: A, B, C, D, or E. When you have decided on your answer, fill in the letter next to the item number. Read each item carefully before responding. Answer as honestly as you can.

Use the following scale from A to E.

A	B	C	D	E
Does not describe me well				Describes me very well

1. ____ I sometimes find it difficult to see things from the "other guy's" point of view.

2. ____ I try to look at everybody's side of a disagreement before I make a decision.

3. ____ I sometimes try to understand my friends better by imagining how things look from their perspective.

4. ____ If I'm sure I'm right about something, I don't waste much time listening to other people's arguments.

5. ____ I believe that there are two sides to every question and try to look at them both.

6. ____ When I'm upset at someone, I usually try to "put myself in his shoes" for a while.

7. ____ Before criticizing somebody, I try to imagine how I would feel if I were in their place.

Appendix G

Curriculum Vitae

Oksana Sklyarov

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Scottsbluff, NE 69361
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(208) 230-2612

Education

PsyD **Doctor of Psychology, Clinical Psychology**
George Fox University, *Newberg, OR*
Graduate School of Clinical Psychology (GSCP): APA Accredited
Expected Completion: May 2020

MA **Master of Arts, Clinical Psychology**
George Fox University, *Newberg, OR*
Graduate School of Clinical Psychology: APA Accredited
May 2017

BA **Bachelor of Arts, Psychology**
The College of Idaho, *Caldwell, ID*
Minors: Criminal Justice Studies, Human Services, and Health Education
May 2014

Languages

English – fluent, read, and write
Russian – fluent, read, and write
Ukrainian – fluent, read and write

Active Memberships

American Psychological Association
Christian Association for Psychological Studies
Oregon Psychological Association
American Psychology-Law Society
Society for Relational Theory and Theology

Awards, Honors, and Scholarships

2018 – Richter Scholarship Award

2015 – 2017 – GSCP Multicultural Diversity Scholarship
2010 – 2014 – The College of Idaho Alumni Merit Award
2013 – The College of Idaho Honors Fall 2013 Dean's List
2013 – The College of Idaho Honors Spring 2013 Dean's List
2010 – 2012 – The College of Idaho Robert R. Lee Promise Scholarship

Supervised Clinical Experiences

August 2018 – May 2019
Pre-Internship at the Health and Counseling Center at George Fox University
Supervisor: William Buhrow, Psy.D.
Provided brief individual therapy to undergraduate students using Cognitive-Behavioral Therapy, Solution-Focused Therapy, and Brief Psychodynamic Therapy. Common diagnoses included major depressive disorder, anxiety disorder, adjustment disorder, and trauma-related disorders. Also, I conducted assessments for ADHD in students, as well as learning disability assessments.

September 2017 – April 2018
Supplemental Practicum at the Behavioral Health Center at George Fox University
Supervisor: Joel Gregor, Psy.D.
Conducted risk assessments for individuals who have been seen in the Providence Newberg Medical Center Emergency Department for suicidal ideation or other significant mental health issues. Conducted intake assessment, developed a safety plan with each individual, and connected them to a psychotherapist for outpatient mental health treatment.

July 2017 – August 2018
Practicum II at NW Family Psychology (Private Practice, Forensic)
Supervisor: Jeffrey Lee, Ph.D.
Conducted forensic evaluations by administering psychological and neuropsychological assessments, including psychosexual evaluations, domestic violence evaluations, violence risk evaluations, child custody evaluations, and parenting capacity evaluations. Conducted clinical and diagnostic interviews with individuals of various ages, ethnic and religious backgrounds, sexual orientations, and disabilities (physical and intellectual). Majority of diagnoses included PTSD, substance-use disorders, major depressive disorder, anxiety disorder, and adjustment disorder. Generated integrative reports and summarized findings to patients and/or hiring agencies.

October 2016 – March 2018
Supplemental Practicum at Oregon Center for Change (Sex-Offender Treatment)
Supervisor: Jane Ward, Ph.D.

Co-facilitated group therapy with registered sex offenders using Cognitive Behavioral Therapy. Conducted intake interviews, performed risk-assessments, administered psychological and psychosexual assessments, and reviewed up-to-date research on best evidence-based treatment practices for sex offenders.

May 2016 – August 2018
Supplemental Practicum at Building Healthy Relationships (Private Practice)
Supervisor: Patricia Warford, Psy.D.
Collaborated with a leading forensic psychologist on high-profile criminal cases, conducted aid and assist evaluations, administered and interpreted psychological assessments, interviewed inmates in jails and prisons, reviewed collateral documentation, collected research about criminal behavior and the legal system, identified predictors of criminal behavior, and consulted with attorneys.

September 2016 – May 2017
Practicum I at Archer Glen Elementary
Supervisor: Hannah Stere, Psy.D.
Provided individual therapy to children ages 5-11 using Cognitive Behavioral Therapy and Play Therapy. Researched evidence-based interventions, collaborated with school personnel, attended trainings, met and discussed student goals/objectives with parents, navigated the school setting, and conducted classroom observations to study child development.

January 2016 – April 2016
Pre-Practicum – Student Therapist Trainee at George Fox University
Supervisor: Glena Andrews, PhD
Provided individual therapy to undergraduate students using Person-Centered Therapy.

February 2013 – May 2013
Internship at Southwest Idaho Juvenile Detention Center
Supervisor: Steve Jett
Collaborated with staff to supervise justice-involved juveniles, worked with a counselor to conduct intake assessments and develop treatment plan for juveniles with mental health issues.

September 2013 – December 2013
Internship at Nampa Police Department
Supervisor: Craig Kingsbury, Chief of Police
Collaborated with police and detectives on criminal cases, studied criminal behavior, generated reports by transcribing video footage of interviews, filed police reports, and participated in ride-alongs with police officers.

Related Work Experiences

January 2018 – July 2018

Cedar Hills Psychiatric Hospital – Assessment and Referral Counselor
Supervisor: Lori Hoffman, M.A.

Conducted intake assessments with adults to determine appropriate level of care, provided mental health diagnoses, formulated treatment and discharge plans, obtained pre-authorizations for admissions, completed all necessary documentation, admitted patients to proper units, worked with local emergency departments to arrange transfer of patients to inpatient programs, and collaborated with multi-disciplinary team regarding patient care. Majority of diagnoses included schizophrenia, drug-induced psychosis, substance use, PTSD, depression, bipolar, and chronic pain. Also, conducted intake assessments in the military program with soldiers, veterans, retirees, and their families.

July 2014 – April 2015

Idaho Innocence Project at Boise State University - Business Manager
Supervisor: Greg Hampikian, Ph.D.

Collaborated with the founder and director of Idaho Innocence Project, who is a leading DNA expert. Worked on high-profile criminal cases, studied criminal behavior, and reviewed research on psychopathology and criminality. Also, was responsible for bookkeeping, including billing attorneys, organizing documentation, and handling and preparing tax documents.

October 2014 – April 2015

Idaho Behavioral Health – Community-Based Rehabilitation Specialist
Supervisor: Tami Jones, LCSW

Provided individual, group, and family therapy to a diverse population utilizing Cognitive-Behavioral Therapy, Play Therapy, and Solution-Focused Brief Therapy. Collaborated with other providers, teachers, parents, family members to ensure patient needs are being met. Mental health services included symptom management, building coping skills, communication skills, problem-solving skills, social skills, community living skills, and providing crisis support.

Continuing Education and Professional Trainings

Oregon Chapter, National Association of Social Workers (2019): NASW Continuing Education Program: Theraplay: Moments of Meeting in Play Therapy. A Continuing Education Training in Wilsonville, Oregon.

American Psychology – Law Society (2019, March). Professional conference in Portland, Oregon.

Safi, D., & Millkey, A., (2019, February). *Opportunities in forensic psychology.* Colloquium presentation at George Fox University, Newberg, OR.

Pengally, S. (2018, October). *Old pain in new brains.* Grand Rounds presentation at George Fox University, Newberg, OR.

McMinn, L., & McMinn, M. (2018, September). *Spiritual formation and the life of a psychologist: Looking closer at soul-care.* Colloquium presentation at George Fox University, Newberg, OR.

Christian Association for Psychological Studies (2018). Professional conference in Norfolk, Virginia.

Vogel, M. (2018, March). *Integration and ekklesia.* Colloquium presentation at George Fox University, Newberg, OR.

Taloyo, C. (2018, February). *The history and application of interpersonal psychotherapy*. Grand Rounds presentation at George Fox University, Newberg, OR.

Sordahl, J. (2017, November). *Telehealth*. Colloquium presentation at George Fox University, Newberg, OR.

Gil-Kashiwabara, E. (2017, October). *Using community based participatory research (CBPR) to promote mental health in American Indian/Alaska Native (AI/AN) children, youth and families.* Grand Rounds presentation at George Fox University, Newberg, OR.

Oregon Association for the Treatment of Sexual Abusers (2017, March). Professional conference in Lincoln City, Oregon.

Seegobin, W., Peterson, M., McMinn, M., & Andrews, G. (2017, March). *Difficult dialogues*. Diversity Grand Rounds presentation at George Fox University, Newberg, OR.

Warford, P., & Baltzell, T. (2017, March). *Domestic violence: A coordinated community response*. Grand Rounds presentation at George Fox University, Newberg, OR.

Brown, S. (2017, February). *Native self-actualization: Its assessment and application in therapy*. Colloquium presentation at George Fox University, Newberg, OR.

Bourg, W. (2016, November). *Divorce: An attachment trauma*. Grand Rounds presentation at George Fox University, Newberg, OR.

Kuhnhausen, B. (2016, October). *Sacredness, naming, and healing: Lanterns along the way*. Colloquium presentation at George Fox University, Newberg, OR.

SBIRT (Screening, Brief Intervention, and Reference to Treatment) Training at George Fox University, Newberg, OR. 16 March 2016.

CAMS (Collaborative Assessment and Management of Suicidality) Training at George Fox University, Newberg, OR. 11 March 2016.

Jenkins, S. (2016, March). *Managing with diverse clients*. Diversity Grand Rounds presentation at George Fox University, Newberg, OR.

Hall, T., & Janzen, D. (2016, February). *Neuropsychology: What do we know 15 years after the decade of the brain? and Okay, enough small talk. Let's get down to business!* Colloquium presentation at George Fox University, Newberg, OR.

Mauldin, J. (2015, October). *Let's talk about sex: Sex and sexuality with clinical applications*. Grand Rounds presentation at George Fox University, Newberg, OR.

Hoffman, M. (2015, September). *Relational psychoanalysis and Christian faith: A heuristic faith*. Colloquium presentation at George Fox University, Newberg, OR.

McRay, B. (2015, February). *Spiritual formation and psychotherapy.* Colloquium presentation at George Fox University, Newberg, OR.

Sammons, M. (2015, February). *Credentialing, banking, the internship Crisis, and other challenges for graduate students in psychology*. Grand Rounds presentation at George Fox University, Newberg, OR.

Teaching Experiences

August 2018 – May 2019

Teaching Assistant for Consultation, Education, and Program Evaluation course at George Fox University

Supervisor: Marie-Christine Goodworth, Ph.D.

Assisted professor with instructional responsibilities by reinforcing lessons presented by the professor, reviewing materials with students one-on-one or in small groups, providing guidance and supervision to students who are working on consultation projects, preparing weekly quizzes based on required readings, and helping with calculating grades.

January 2014 – May 2014

Teaching Assistant for Criminal Justice course at The College of Idaho

Supervisor: Diane Raptosh, Ph.D.

Assisted professor with instructional responsibilities by organizing and teaching lesson plans, grading student quizzes and homework assignments, facilitating classroom discussions among students, organizing trips to prisons and driving students to prisons, and coordinating with guest speakers.

Research/Presentation Experiences

Dissertation: The impact of adverse childhood experiences on attachment and mentalization in sex offenders. Defended in November 2018.

Sklyarov, O. (2019). The impact of adverse childhood experiences on attachment and mentalization in sex offenders. Presentation at the Richter Student Grant Symposium at George Fox University in Newberg, Oregon.

Sklyarov, O., Fringer, L., Gallup, S., & Grace, E. (2018). Effectiveness of outpatient sex offender treatment: An outcome study. Presentation at the American Psychological Association in San Francisco, California.

Rudneva, L., **Sklyarov, O**., Ditty, M., & Buhrow, W. (2018). Intimate partner violence, perception of safety, and faith among female college students attending faith-based institutions. Presentation at Christian Association for Psychological Studies in Norfolk, Virginia.

Sklyarov, O., Gallup, S., & Muchlitz, A. (2017). Religion and spirituality: Daoism and psychotherapy. Presentation at George Fox University in Newberg, Oregon.

Sklyarov, O., Gallup, S., & Fringer, L. (2016). The neurology, emotions, and memory of psychopathy. Presentation at George Fox University in Newberg, Oregon.

Sklyarov, O. (2016). Childhood trauma in bipolar disorder. Presentation at George Fox University in Newberg, Oregon.

Sklyarov, O. (2014). Psychological defense mechanisms. Independent Study at The College of Idaho in Caldwell, Idaho.

Sklyarov, O., Wiggins, C., Henrie, J., & Starkand, K. (2013). Narcissism and sadomasochism: Examining personality differences and sexual behaviors. Presentation at The College of Idaho Student Research Conference in Caldwell, Idaho.

Sklyarov, O., Wiggins, C. (2012). Narcissism and sociosexuality: A correlational design used to find a link between narcissistic individuals and sociosexual orientation. Presentation at The College of Idaho Student Research Conference in Caldwell, Idaho.

Sklyarov, O., Packer, A., Bolin, D., Epa N., Gerard, K., Somerville, A. (2012). Dropout rates among Hispanic immigrants: Examined external and internal factors that lead to high school drop-out rates among Hispanics. Fieldwork project in Cultural Anthropology at The College of Idaho in Caldwell, Idaho.

Sklyarov, O. (2012). A short ethnography on dating behaviors in the 1940s and 1950s. Fieldwork project in Cultural Anthropology at The College of Idaho in Caldwell, Idaho.

Academic Service and Leadership Experiences

August 2018 – May 2019

Member, Military Psychology Student Interest Group in GSCP

Organized meetings between graduate students and military medical recruiters, participated in meetings and discussions regarding military careers, military psychology, and working with soldiers and veterans. Discussed current research and clinical application.

August 2018 – May 2019

Member, Professional Development Student Interest Group in GSCP

Bi-annual group for developing professional skills.

July 2016 – September 2016

Translated the Family Adaptability and Cohesion Scale IV from English to Russian

Created a translation team including graduate students and Russian-speaking individuals, reviewed each item for cultural relevance, translated each item and then back-translated into English to ensure accuracy. Submitted translated version to the scale developers for validation. Received permission to use the translation for research purposes and clinical settings. Also received life time access to the FACES IV administration manual, scoring materials, and research articles.

October 2016 – May 2019

Founder, Forensic Psychology Student Interest Group in GSCP

Created a group for graduate students interested in forensic psychology. Led meetings, invited and collaborated with guest speakers, connected students to resources, research, and training opportunities.

August 2015 – May 2019

Member, Health Psychology Student Interest Group in GSCP

Bi-annual group for discussing issues related to health psychology and integrated care. Discussed current research and clinical application.

August 2015 – May 2019

Member, Multicultural Committee in GSCP

Bi-annual group for developing competencies in diversity issues, attend trainings, and address multicultural and diversity issues in psychology.

August 2015 – May 2019

Member, Clinical Team in GSCP

Weekly consultation group that meets to present clinical cases, conceptualize patients from various modalities, recommend treatment interventions, and provide feedback to other members about their cases.

August 2015 – May 2019

Member, Research Vertical Team at George Fox University

Bi-monthly group for developing research competencies. Work on dissertation development, participate in collaborative supplemental research projects, and help develop fellow students' areas of research interest.

Supervision of Other Students

August 2018 – May 2019

4th Year Student Supervisor at George Fox University

Provided weekly clinical supervision to a 2nd year graduate student. Oversaw clinical work, provided mentorship, and guided professional development and movement towards professional competencies.

July 2017 – August 2018

Student Editor at NW Family Psychology

Per request of the supervisor, I edited forensic psychological reports by other graduate students, provided constructive feedback on test administration, interpretation, and report-writing skills. Also, was asked to collaborate with supervisor on child custody evaluations and provide edits and feedback on supervisor's evaluations.

August 2016 – May 2017

2nd Year Student Mentor at George Fox University

Provided mentorship for incoming graduate students.

Volunteer Experiences

September 2015 – May 2019

Juliette's House: Child Abuse Intervention Center, *McMinnville, OR* – Student Volunteer

Along with students and employees from George Fox University, I assist in organizing annual banquet invitations and prepping them to be mailed, painting, cleaning, weeding, etc.

September 2016 – December 2016

Revival Baptist Church, *Vancouver, WA* - Sunday School Teacher

Organized and taught Sunday school class for children ages 7-10 by preparing Bible lessons, planning activities and games, communicating with parents in regard to their children's progress and development, and collaborated with other teachers to plan trips, events, and school plays. Studied child development, ways to communication with children, and navigate family systems.

June 2009 – September 2013

House of Prayer, *Boise, ID* - Choir Director and Sunday School Teacher

Established and managed a children's choir for children ages 6-10 by finding worship songs, teaching lyrics and melody, and organizing church performances.