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Predicting Sexual Offense Treatment Completion Through Specific Responsivity Factors

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Predicting Sexual Offense Treatment Completion Through Specific Responsivity Factors

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Predicting Sexual Offense Treatment Completion Through Specific Responsivity Factors

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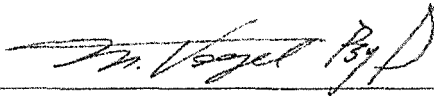
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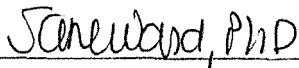Graduate School of Clinical Psychology

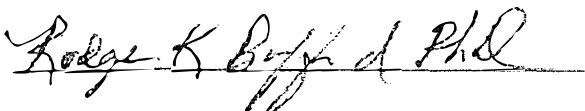George Fox University

as a Dissertation for the PsyD degree

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Abstract

Sexual offending is a serious, harmful, and costly behavior that impacts the safety of a community (Barros et al., 2020; Peterson et al., 2017; Severson & Pettus-Davis, 2013). To improve community safety and reduce further harm, several specialized treatments have been developed to rehabilitate individuals convicted of a sexual offense (ICSO). Recent meta-analytic studies have suggested that specialized cognitive-behavioral treatments for ICSO do in fact lead to a reduction in sexual recidivism (Gannon et al., 2019; Harrison et al., 2020; Kim et al., 2016). To increase engagement with and completion of treatment programs, and subsequently to reduce the risk of reoffense for ICSO, the Risk-Need-Responsivity (RNR) model provides guidelines for adjusting treatment given knowledge of client characteristics that may affect engagement (Bonta & Andrews, 2017). The present study examined responsivity factors in the domains of demographics, guardedness, personality, and criminality and found that ICSO who complete treatment differ than those who do not in each of these areas. A prediction model found that demographic characteristics, personality, and criminality were predictors of whether an individual completed treatment or did not complete treatment. Guardedness did not contribute to predictions after accounting for the other domains. Our findings extend those identified in the literature, highlight the importance of responsivity factors in predicting treatment completion, and raise two important implications for clinicians seeking to attend to responsivity considerations. First, prior research suggests that some clients may not be amenable to treatment. In fact, partially treating ICSO could actually increase their risk for reoffense (Carl & Lösel, 2021; Olver et al., 2011). Second, clinicians adhering to the RNR model should seek to adjust treatment programs as needed to account for certain client factors. Overall, the present study revealed that the consideration of responsivity factors is an invaluable component of robust

sexual offense treatment.

      *Keywords***:** sexual offense, treatment, attrition, responsivity

Acknowledgments

Scripture says, "Give thanks to the Lord, for he is good; his love endures forever" (1

Chron. 16:34). Lord, I thank You for Your goodness, without which this project and my progress

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Chapter 1

Individuals who commit sexual offenses have long posed a challenge to clinicians, legislators, justice officials, and communities. Sexual offenses vary in definition by jurisdiction but generally involve a criminal act with sexual intent or behavior. By nature, sexual offending is extremely harmful and has lasting effects on the victims and perpetrators. Economically, the Centers for Disease Control estimated that rape alone results in an average lifetime cost of $122,461 per victim (Peterson et al., 2017). Perpetrators and their families face the consequences of post-sentencing restrictions. Additionally, professionals (e.g., investigators, correctional officers, and treatment providers) often experience vicarious traumatization when working with individuals who have sexually offended (Barros et al., 2020; Severson & Pettus-Davis, 2013). Sexual offending is a serious, harmful, and costly behavior that impacts the safety of a community.

Treatment for Individuals Convicted of a Sexual Offense

To improve community safety and reduce further harm, several specialized treatments have been developed to rehabilitate individuals convicted of a sexual offense (ICSO).[1] Laws and Marshall (2003) provided an elegant overview of the history and development of such treatments. As early as the 1950s, behavioral interventions based on aversive stimuli (e.g., noxious odors or electric shocks) were used to modify socially unusual sexual behaviors. By the 1960s, dynamic and non-behavioral therapies were utilized with ICSO. While these treatments were largely ineffective, they provided a foundation on which behavioral treatments for this

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[1] Use of person-first language minimizes the negative bias of traditional labels (Harris & Socia, 2016; Lowe & Willis, 2020). Additionally, we refer only to men who have committed sexual offenses because our sample consists exclusively of men. A comprehensive view of the observed gender discrepancy in sexual offending is beyond the scope of this study (see Cortoni & Stefanov, 2020).

population could be created. In the late 1960s and early 1970s, behavioral interventions were applied directly to ICSO and persisted for about 20 years. These treatments were based on the hypothesis that sexual offending was the result of deviant sexual preference. The sexual preference hypothesis received little evidence in the following decades (see Baxter et al., 1986) and the behavioral interventions were very limited in effectiveness (see Bancroft, 1974).

As the cognitive revolution continued to develop (cf. Neisser, 1967), non-behavioral approaches to ICSO treatment began to resurface (Marshall & Laws, 2003). Self-control, social skills, sexual education, victim empathy, and cognitive restructuring began to rapidly supersede the behavioral approaches of the time. Thus, the early cognitive-behavioral therapies (CBT) for ICSO were birthed. And as CBT gained traction in the 1980s, it found further influence from relapse prevention models and social learning theory. As Marshall and Laws put it, this set the stage for an "explosion" of treatment programs in the 1990s that was also accompanied by further theorizing, policy development, and research interest (p. 104).

In the following decades, CBT has remained the predominant treatment for ICSO (Harrison et al., 2020). However, the field has shifted towards an approach informed by the Risk-Need-Responsivity (RNR) Model (Bonta & Andrews, 2017). Broadly, the RNR Model states that services: shall be respectful of the individual, valuing their autonomy, dignity, confidentiality, and right to equality; are to be grounded in empirically supported psychological theory; and may aspire to the broad goal of reducing crime victimization. More specifically, treatments informed by this model should assess risk, target needs, and do so in a responsive manner. The last principle, responsivity, echoes the importance of empirically supported treatment while also emphasizing appropriately customized approaches that account for an individual's strengths and weaknesses.

Due to the ongoing development of treatments for ICSO and the limited empirical base (Deming & Jennings, 2020), research findings should be interpreted with caution. However, recent meta-analytic studies have suggested that specialized CBT treatments for ICSO do in fact lead to a reduction in sexual recidivism (Gannon et al., 2019; Harrison et al., 2020; Kim et al., 2016). Amongst other findings, they also found that treatments that adhered to the RNR Model showed the most promise. That said, the evidence also indicated that relapse prevention models may still be beneficial. Given the promising results suggesting the reduction of sexual recidivism following the completion of an RNR-adherent, sexual offense-specific treatment program, ensuring meaningful treatment completion should be a high priority.

Responsivity Considerations

To increase engagement with and completion of treatment programs, the RNR responsivity principle provides two guidelines for best clinical practice (Bonta & Andrews, 2017). First, the general responsivity guideline states that treatment shall consist of cognitive-behavioral, social learning, and skills-based approaches. Second, the specific responsivity guideline states that providers shall adjust treatment as needed given individual client characteristics. Specific responsivity factors are particularly valuable as they can address case-by-case concerns regarding treatment amenability and prognosis. However, relative to the general responsivity principle, the specific responsivity principle has received relatively little attention in the empirical literature.

Looman et al. (2005) reviewed the literature and identified the following as responsivity factors: psychopathy, motivation, denial/minimization, intellectual functioning, hostility, personality profile, deviant arousal, and sexual offense type. More recently, Olver et al. (2011) provided the most comprehensive evidence for the importance of specific responsivity factors

when working with ICSO. Among other findings, they identified men with the following characteristics as statistically less likely to complete treatment successfully: younger, single, non-White, lower income, lower education, unemployed, more criminal history, and higher actuarial risk. That said, it is unclear whether individuals with these characteristics are inherently more resistant to treatment, or whether treatment programs are less effective in accommodating their specific needs.

Although both interpretations have some merit, the latter explanation provides grounds for clinicians to adjust treatment plans based on data gained at intake. Responsivity factors can inform optimal treatment dosage and timing, which ensures the appropriate allocation of often limited resources (Day et al., 2019). Lower-income individuals may receive government subsidies for treatment. For those with intellectual deficits, certain curricular options may be substituted in place of the traditional options (Hansen & Kahn, 2012). Higgs and Carter (2015) outlined a number of considerations for working with individuals diagnosed with autism spectrum disorder. Interventions from the Transtheoretical Model may address motivation and hostility (Tierney & McCabe, 2005). For individuals with psychopathic characteristics, more specialized treatment curricula may be more appropriate (Ward & Groener, 2018). Levenson (2014) proposed incorporating trauma-informed care that assesses adversity and integrates process-oriented interventions. While these options are undoubtedly helpful, further research is needed to evaluate how well treatment programs approach specific responsivity concerns.

Treatment Completion

Ideally, clients will successfully complete their treatment programs. The *Association for the Treatment of Sexual Abusers* (ATSA; 2014) stated that "'successful completion' of a sexual abuser-specific treatment program/regimen indicates that a client has demonstrated sufficient

progress in meeting the goals and objectives of an individualized treatment plan" (p. 40). In addition, ATSA stated that a client who completes treatment has:

Acknowledged treatment needs for which he was referred in sufficient detail for treatment staff to have developed a treatment plan that, if implemented properly, could be reasonably expected to reduce his risk to reoffend… Demonstrated an understanding of the thoughts, attitudes, emotions, behaviors, and sexual interests linked to his sexually abusive behavior and can identify these when they occur in his present functioning… and Demonstrated sufficiently sustained changes in managing these thoughts, attitudes, emotions, behaviors, and sexual interests and developed/ enhanced prosocial attitudes and skills such that it is reasonable to conclude that he has reduced his risk to reoffend. (p. 41)

Although successful completion is the goal, we know that a substantial number of individuals do not complete treatment for a variety of reasons (Olver et al., 2011). Commonly, clients will stop attending treatment once their supervision requirements have been met. Some clients, in violation of their mandated requirements, abscond from treatment and do not return. At times, clients will be referred to other providers if it is determined that they have significant mental health challenges or specific language needs.

In community-based treatment programs specifically, approximately 29% of clients are expected to leave treatment prior to completion (Olver et al., 2011). In other words, from the start, it is anticipated that approximately 29% of clients will not gain the full benefits of treatment. Additionally, Olver et al. provided evidence that such partially treated ICSO may be more likely to be reconvicted than individuals who were left untreated. While this finding may be confounded with evidence that higher-risk individuals are less likely to complete treatment,

Carl and Lösel (2021) found the same results after controlling for risk levels. Such findings further indicate the gravity of specific responsivity considerations so as not to increase a client's risk of recidivism.

Selected Specific Responsivity Factors

A number of specific responsivity factors may be easily assessed during a standard intake session conducted at the outset of sexual offense-specific treatment. Clinical interviews and standard psychological assessment instruments can provide valuable information about key demographic characteristics, general personality functioning, guarded attitudes toward treatment, and criminality. These are routine assessment areas that place no extra burden on clinicians as they consider responsivity factors with these clients.

As shown by Olver et al. (2011), demographic characteristics such as younger age, single marital status, and lower education are associated with higher levels of treatment attrition. These results are not surprising. Younger individuals may have less psychological maturity and frontal lobe development (Giedd, 2004). Clients invested in romantic relationships may have more motivation to complete treatment and move forward with their life. Educational attainment could serve as an indicator of a client's ability to engage with psychoeducational content. Further, lower education is associated with higher treatment attrition for even traditional psychotherapy (Bennemann et al., 2022). In addition to these factors, parental status (i.e.., parent or not parent) may be associated with treatment completion. Children, similar to a romantic partner, may provide greater motivation for treatment completion.

General personality functioning is also a predictor of treatment completion (Olver et al., 2011). Clients with substantial mental health concerns are less likely to have the capacity to engage with treatment. Such concerns could include severe personality pathology, mood

disorders, psychosis, or problematic substance use. These areas are easily assessed through

instruments often already used in forensic settings, such as the Personality Assessment Inventory

(PAI; Morey, 1991). Given that several PAI scales are associated with higher recidivism

(Boccaccini et al., 2010), it is likely that the PAI would be associated with treatment completion

as well. Additionally, indices on any instrument that measure inconsistent responding may

indicate some level of thought dysfunction.

Guarded attitudes also provide valuable prognostic information. For the purposes of the

present study, guardedness may consist of impression management, defensive reactions, or lack

of insight. Any psychotherapeutic endeavor, whether forensically situated or not, will be limited

by the extent to which the client is unwilling to admit their faults to themselves or others. The

literature indicates that guardedness is associated with increased treatment attrition both for

general clients (Busmann et al., 2019) and ICSO (Geer et al., 2001; Olver et al., 2011).

Guardedness may be assessed via the validity indicators included in common clinical

instruments, as well as the Paulhus Deception Scales (PDS; Paulhus, 1998).

Finally, criminality factors related to the type of offense and risk of reoffense may have

responsivity components. ICSO with offenses related to child sexual exploitation material

(CSEM) generally pose a lower risk for reoffense (Babchishin et al., 2018) and typically have

different treatment needs when compared to ICSO with contact offenses (Babchishin et al.,

2015). Such clients may actually be more receptive to cognitive-behavioral curricula than other

clients. Various indicators of static and dynamic risk may also present responsivity

considerations. Best practice already dictates that treatment dosage should be proportional to risk

level (Bonta et al., 2000; Smid et al., 2015). And finally, the length of incarceration could

indicate the extent to which individuals have been socialized with antisocial influences, a factor

known to be associated with increased recidivism (Bonta & Andrews, 2017).

Present Study

The present study evaluated various predictors (e.g., demographics, personality functioning, guardedness, and criminality) of treatment completion for adult male ICSO in an outpatient setting. The hypotheses for this study are as follows:

H1: Demographic characteristics (e.g., age, marital status, number of children, and level of education) will differ by ICSO who do and do not complete treatment.

H2: Personality functioning factors (e.g., psychopathology, substance use) will differ by ICSO who do and do not complete treatment.

H3: Guardedness (e.g., impression management and lack of insight) will differ by ICSO who do and do not complete treatment.

H4: Criminality (e.g., conviction type, static risk, dynamic risk, and length of incarceration) will differ by ICSO who do and do not complete treatment.

H5: Demographic, personality functioning, guardedness, and criminality factors will each contribute to the prediction of treatment completion when modeled together.

Chapter 2

Method

Participants

Data consisted of an archival sample of 361 men who were referred to treatment at an outpatient clinic in the Pacific Northwest for sexually problematic behaviors. The data were filtered to exclude clients who were: not administered all relevant assessment instruments, not recommended for treatment, terminated for causes outside of their control (e.g., death, serious illness), or transferred to another clinic for alternative treatment. The final sample consisted of

203 men ranging in age from 19 to 82 years ($M = 41.16$, $SD = 14.70$). Duration of treatment ranged from zero to five years ($M = 1.56$, $SD = 1.06$).

Demographics were split by termination status (see Table 1). The treatment completion ($n = 102$) and treatment non-completion ($n = 101$) groups were equivalent in size, with a 50.25% treatment completion rate. Reasons for non-completion included absconding, new arrests, and unwillingness to abide by treatment rules. Individuals who completed treatment ranged in age from 21–82 years ($M = 43.13$, $SD = 15.41$), were incarcerated for 0–240 months ($M = 47.81$, $SD = 62.82$), and spent 0.13–5.04 years in active treatment ($M = 1.91$, $SD = 0.85$). Individuals who did not complete treatment ranged in age from 19–79 years ($M = 39.18$, $SD = 13.74$), were incarcerated for 0–336 months ($M = 49.18$, $SD = 62.20$), and spent 0.00–5.00 years in active treatment ($M = 1.12$, $SD = 1.13$).

Table 1

Sample Demographics by Termination Status

Variable	Category	Termination Status Group	
		Completion	Non-Completion
Ethnicity	European American	72%	63%
	Hispanic/Latino	11%	18%
	Multiple Ethnicities	9%	5%
	Asian American	7%	2%
	Black/African American	1%	7%
	Iraqi	1%	0%
	American Indian/Alaska Native	0%	4%

		Termination Status Group	
Variable	Category	Completion	Non-Completion
	Native Hawaiian/Pacific Islander	0%	1%
Education	College graduate	21%	9%
	Some college	39%	30%
	High school diploma	23%	22%
	GED Certificate	14%	31%
	Less than diploma or GED	4%	9%
Marital Status	Married	19%	9%
	Engaged	3%	6%
	In a relationship	2%	8%
	Single	48%	66%
	Divorced	23%	11%
	Separated	5%	0%
Has Children	Yes	59%	56%
Veteran	Yes	20%	8%
Conviction(s)	Rape	16%	26%
	Sodomy	13%	15%
	Sexual Abuse	68%	53%
	CSEM	9%	6%
	Other Offense (Harassment, etc.)	33%	38%

Note. CSEM = child sexual exploitation material.

Materials

Data on demographics, personality functioning, guardedness, and criminality factors were obtained from a variety of sources. See Table 2 for an overview of variables grouped by theoretical responsivity domain.

Table 2

Variables Organized by Source and Responsivity Domain

Source	Responsivity Domain			
	Demographic	Personality Functioning	Guardedness	Criminality
Intake Interview and Collateral	Age, ethnicity, education, marital status, veteran status, number of children	-	-	Conviction, length of incarceration
PAI	-	ICN, INF, clinical, treatment, interpersonal, and supplementary indices	NIM and PIM indices	-
PDS	-	-	IM, SDE, and total score indices	-
IORNS	-	IRS index	FIM index	Risk/need indices
STABLE-2007	-	-	-	Items, total score

Note. PAI = Personality Assessment Inventory; PDS = Paulhus Deception Scales; IORNS = Inventory of Offender Risks, Needs, and Strengths; ICN = Inconsistency; INF = Infrequency; NIM = Negative Impression Management; PIM = Positive Impression Management; IRS = Inconsistent Response Scale; IM = Impression Management; SDE = Self-Deceptive Enhancement; FIM = Favorable Impression Management

Intake Interview and Review of Collateral Information

Demographic information was collected during the intake process at the beginning of treatment. Clients completed a demographic questionnaire and answered questions during a clinical interview. Clients reported their age, ethnicity, gender, educational level, marital status, veteran status, number of children, and length of incarceration. Collateral information, often consisting of police reports and sentencing documentation, were reviewed for information about convictions and criminal history. However, it is important to acknowledge that convictions and sentences are confounded by contextual factors (see Thompson et al., 2020). At termination, it was documented whether the client successfully completed treatment, obtained the maximum benefit possible, or left for other reasons (e.g., returned to prison, legal supervision expired).

Personality Assessment Inventory (PAI)

The PAI is a 344-item measure of personality and clinical psychopathology written at a fourth-grade reading level (Morey, 1991). Participants rate their level of agreement with each item on a 4-point scale ranging from "Not at all true" to "Very true." Twenty-two non-overlapping indices and several supplementary indices provide diagnostic and treatment-related information using a census-matched standardization sample. The mean internal consistency was good across the indices ($\alpha = .81$); the test-retest reliability ranged from .85 to .94. Extensive information about empirical validation of the PAI is provided in the manual.

Paulhus Deception Scales (PDS)

The PDS is a 40-item measure of two types of socially desirable responding: impression management and self-deceptive enhancement (Paulhus, 1998). Two indices may be extracted from the PDS. The first index, *Impression Management*, measures the degree to which the respondent typically seeks to deny common faults or shortcomings to meet social demands. The second index, *Self-Deceptive Enhancement*, measures the degree to which the respondent lacks

insight regarding their overly-positive self-presentation. Across general population and prison

entrant samples, internal consistency was generally good (α = .70–.84). Structural, convergent,

and discriminant validity are also reported in the manual.

Inventory of Offender Risk, Needs, and Strengths (IORNS)

The IORNS is a 130-item, self-report measure of risks and strengths for forensic

populations (Miller, 2006). Several indices may be extracted from IORNS that address protocol

validity, risk, and protective factors: the Static Risk Index (SRI), Dynamic Risk Index (DNI),

Protective Strength Index (PSI), Overall Risk Index (ORI), and several more. Across the male

forensic sample, internal consistency was generally adequate to good (α = .59–.90). Test-retest

reliability ranged from poor to good (r = .42–.89). The primary indices demonstrated moderate to

large correlations with established measures of criminogenic needs, psychopathy, criminal

history, and psychopathology. Additionally, limited evidence shows that the primary indices

were predictive of general, violent, and sexual recidivism (Miller, 2015). Further evidence for

content and construct validity were reported in the manual.

STABLE-2007

The STABLE-2007 is a clinician-rated measure of dynamic, or changeable, risk factors

such as relational patterns and attitudes (Fernandez et al., 2014). Clinicians use data gained from

an intake interview and collateral information to rate the client on each of 13 items using a

structured scoring system. Scores on each item range from 0–2, and the total score ranges from

0–26. Items assess the following areas: significant social influences, capacity for relationship

stability, emotional identification with children, hostility towards women, general social

rejection, lack of concern for others, impulsivity, poor problem solving, sex drive/preoccupation,

sex as coping, deviant sexual interest, negative emotionality, and cooperation with supervision.

Intraclass correlation coefficients for each item ranged from 0.56–0.91. Internal consistency was adequate ($\alpha = .80$; Hanson et al., 2007). STABLE-2007 scores were predictive of general, violent, and sexual recidivism. Additionally, recent meta-analytic evidence indicated that the STABLE-2007 has incremental predictive validity beyond static measures of risk (Brankley et al., 2021).

Sexual Offense Treatment Program and Termination Status

The present data come from a community-based sexual offense treatment program situated in Pacific Northwest. The program provides psychological evaluation, group therapy, and individual therapy. Therapeutic services are grounded in RNR principles (Bonta & Andrews, 2017) and consist primarily of a group-based CBT curriculum. The curriculum addressed thought regulation, emotional regulation, offense-related factors, and arousal reconditioning where appropriate. The alternative *LATTICES* curriculum was typically used for high-risk clients (Ward & Groener, 2018). Consistent with best practices identified by Gannon et al. (2019), the program is directed and supervised by a qualified clinical psychologist.

For the purposes of the present study, termination status was collapsed into two groups: "completion" and "non-completion." Completion consisted of successful treatment completion and maximum benefit while non-completion consisted of all other reasons for termination (e.g., absconding from supervision, return to prison, etc.). Maximum benefit was considered to be treatment completion because such individuals reduced their risk to some extent through engagement in treatment.

Procedure

Data were generated through intake sessions and discharge summaries during a six-year period. All clients were referred to treatment to address problematic sexual behaviors and

undergo cognitive-behavioral treatment. Intake sessions consisted of a one-hour clinical

interview and a standard forensic/personality assessment battery. Discharge summaries consisted

of an evaluation of treatment progress and identification of termination status. Physical data were

stored in HIPAA-compliant, locked cabinets. Physical data were entered into a secure, non-

identifiable spreadsheet. Data were stored on password-protected computers and no identifying

information was collected that could be used to recognize specific clients. Following Institutional

Review Board approval (HSRC-2212052), the data set was analyzed in R (R Core Team, 2022)

using Fife's (2020) analytic framework.

Fife's (2020) data analytic steps were followed:

1. Our hypotheses were pre-registered on the Open Science Framework following the guidelines for registering secondary data analyses (Weston et al., 2019).

2. Psychometric properties were assessed.

3. Univariate distributions were inspected.

4. The hypotheses were evaluated graphically.

5. Models were estimated and residuals were inspected.

6. Model estimates and effect sizes were interpreted.

7. Bayes Factors were calculated to quantify evidence and provide a basis for decisions.

Step 8, replication of results, was omitted due to resource limitations. However, future

replication efforts are highly encouraged.

To identify potential coding errors, data were inspected for consistency. One method

employed was to verify known relationships between variables. For example, summated index

scores on the STABLE-2007 were compared to the calculated sum of the constituent items. A

similar process was performed using the PAI supplementary scales, which are direct transformations of other PAI scales. Cases identified as having coding inconsistencies were reviewed and corrected using the physical file.

To determine the maximum number of appropriate predictor variables for the primary model, we utilized a formula empirically derived to determine the necessary sample size for accurately generalizing sample estimates to population parameters: $n = 100 + \text{EPV}i$ (Bujang et al., 2018). The EPV coefficient represents the events per variable. Bujang and colleagues recommended an EPV of 50 for optimal generalizability. However, they noted that an EPV as small as 10 may be used in some instances (e.g., when the effect size is expected to be large or variable selection procedures are used). Given the fixed value of n in the present investigation, we used the formula to solve for i, the number of predictor variables to be included in the final model. With 203 participants and an EPV ranging from 10 to 50, the appropriate number of predictor variables would range from two to 10. That said, it is important to note the risk of overfitting increases with the addition of more predictor variables (Agresti, 2013).

Chapter 3

Results

To evaluate our hypotheses, we utilized generalized linear modeling with Bayesian estimation and uninformative priors. For the first four hypotheses, linear regression models were estimated to evaluate continuous predictors and Bayesian contingency tables were estimated to evaluate categorical predictors. Cohen's d values were estimated for the former and Cramer's V values were estimated for the latter. For the fifth hypothesis, a hierarchical binomial logistic regression analysis was conducted to evaluate the predictive strength of each of the responsivity factors on treatment completion. The final prediction model was built through a systematic

process of purposeful variable selection and evaluation of assumptions while bearing in mind the

limitations of sample size (Hosmer et al., 2013). A comprehensive collection of descriptive,

graphical, and quantitative results is available in the online supplementary materials

(https://osf.io/fbd63/). As a result of the filter criteria, there were no missing data in the variables

of interest.

Hypothesis 1: Demographic Variables and Treatment Completion

Age, ethnicity, number of children, occupation, and veteran status displayed minimal to

no differences between the individuals who completed and did not complete treatment (BF_{10}s <

10.00; see Table 3). Even after dichotomizing number of children (i.e., has children or does not

have children) and occupation (i.e., employed or unemployed), no substantial differences were

identified. Graphical and statistical analyses suggested that individuals who complete treatment

are more likely to have been married before, Cramer's V = 0.28, 95% CI = [0.15, 0.41], BF_{10} =

1,670.92. Consequently, to make analysis and interpretation more straightforward, the marital

status variable was dichotomized into those who have been married and those who have not been

previously married.

A graphical analysis suggested that the two groups may differ in their educational

attainment. Individuals who did not complete treatment reported receiving less education.

Individuals who did complete treatment were more likely to have received their high school

diploma, attended some college, or graduated college. Consequently, the education variable was

dichotomized to reflect those who had achieved a high school diploma or higher, and those who

had achieved a GED certificate or lower. After recoding, results indicated that individuals who

complete treatment are more likely to have received their high school diploma or attended higher

education, Cramer's V = 0.24, 95% CI = [0.10, 0.36], BF_{10} = 128.14.

Table 3

Responsivity Domains by Termination Status

Variable	Completion		Non-completion		d	95% CI	BF_{10}
	M	SD	M	SD		LL, UL	
Demographics							
Age	43.13	15.41	39.18	13.74	0.22	−0.03, 0.49	1.28
Children Count	1.35	1.63	1.32	1.56	0.02	−0.23, 0.27	0.29
Personality							
PAI ICN	48.17	7.76	52.59	9.19	−0.46	−0.72, −0.19	85.11
PAI INF	51.84	9.38	56.46	11.00	−0.39	−0.66, −0.13	25.00
PAI ANT	51.88	7.82	58.48	10.09	−0.65	−0.91, −0.38	3,098.83
PAI DRG	48.86	8.81	58.50	14.20	−0.72	−0.98, −0.45	9,159.57
PAI AGG	41.61	6.20	47.82	9.58	−0.68	−0.94, −0.42	8,982.19
PAI STR	54.38	9.91	59.08	12.34	−0.36	−0.63, −0.09	12.76
PAI PAR-P	49.73	9.05	53.99	10.31	−0.38	−0.65, −0.11	15.83
PAI PAR-R	47.47	9.69	51.67	9.57	−0.38	−0.65, −0.12	20.85
PAI BOR-S	46.88	8.76	52.15	12.25	−0.31	−0.70, −0.11	54.23
PAI ANT-A	57.55	9.35	65.90	10.92	−0.72	−0.99, −0.46	>1,000,000
PAI AGG-A	41.70	7.38	46.69	10.97	−0.47	−0.74, −0.20	63.15
PAI AGG-V	41.89	7.35	46.49	8.41	−0.51	−0.78, −0.24	974.53
PAI AGG-P	45.89	6.11	52.27	9.69	−0.69	−.95, −0.43	9,840.38
PAI VPI Index	50.23	8.04	55.60	14.30	−0.40	−0.67, −0.14	30.66
PAI TPI Index	51.35	8.48	57.26	13.99	−0.45	−0.72, −0.18	53.23
PAI ALC Est	54.24	4.25	58.48	6.71	−0.67	−0.94, −0.40	6,311.46
PAI DRG Est	52.05	5.16	57.22	8.38	−0.66	−0.92, −0.39	2,722.48

| Variable | Completion | | Non-completion | | d | 95% CI | BF_{10} |
	M	SD	M	SD		LL, UL	
PAI MCE Index	50.11	6.40	53.62	8.01	−0.41	−0.68, −0.15	42.53
Guardedness							
PDS IM	66.63	10.71	60.92	11.53	0.45	0.18, 0.73	108.76
Criminality							
STABLE-2007	6.03	3.57	8.70	3.78	−0.64	−0.91, −0.37	2,486.91
IORNS SRI	42.84	8.06	50.73	10.88	−0.72	−0.99, −0.46	17,338.20
IORNS DNI	41.98	6.07	46.19	9.71	−0.45	−0.73, −0.18	71.46
IORNS ORI	42.60	6.02	49.06	10.52	−0.67	−0.93, −0.40	5,836.38
IORNS PPY	42.64	5.17	45.83	9.31	−0.3I 7	−0.64, −0.10	12.13
IORNS AGG	42.34	6.82	47.19	9.05	−0.53	−0.80, −0.26	335.84
IORNS IMP	1.10	1.47	1.87	1.85	−0.40	−0.67, −0.13	29.64
IORNS ABX	1.15	1.39	2.33	1.76	−0.66	−0.93, −0.40	5,819.87
IORNS NFR	0.18	0.41	0.56	0.96	−0.46	−0.73, −0.18	106.75
IORNS NFA	1.10	1.10	1.70	1.15	−0.47	−0.74, −0.20	117.09

Note. For sake of space, non-demographic variables without substantial mean differences (BF_{10} < 10) were omitted from the table. See supplementary materials for all results. PAI = Personality Assessment Inventory; ICN = Inconsistency; INF = Infrequency; NIM = Negative Impression Management; PIM = Positive Impression Management; ANT = Antisocial; DRG = Drug Problems; AGG = Aggression; STR = Stress; PAR-P = Persecution; PAR-R = Resentment; BOR-S = Self-Harm; ANT-A = Antisocial Behaviors; AGG-A = Aggressive Attitude; AGG-V = Verbal Aggression; AGG-P = Physical Aggression; VPI = Violence Potential Index; TPI = Treatment Potential Index; ALC Est = Alcohol Estimate Score; DRG Est = Drug Estimated Score; MCE = Mean Clinical Elevation; PDS IM = Paulhus Deception Scales Impression

Management; IORNS = IORNS = Inventory of Offender Risks, Needs, and Strengths; SRI =

Static Risk Index; DNI = Dynamic Risk Index; ORI = Overall Risk Index; PPY = Psychopathy;

AGG = Aggression; IMP = Impulsivity; ABX = Aggressive Behaviors; NFR = Negative Friends;

Negative Family.

Hypothesis 2: Personality Functioning Variables and Treatment Completion

About 29% of the PAI scales displayed substantial differences between the two groups

(BF_{10}s > 10.00). Most notably, individuals who did not complete treatment displayed higher

levels of certain markers of psychopathology, substance use, and antisocial characteristics (see

Figure 1). The PAI Antisocial Attitudes subscale showed the most meaningful differences

between individuals who completed and did not complete treatment. The IORNS inconsistency

scale displayed no differences, $d = -0.28$, 95% CI = [-0.55, -0.02], $BF_{10} = 2.85$, although this

result is limited by severe range restriction.

Figure 1

PAI Indices by Completion Status
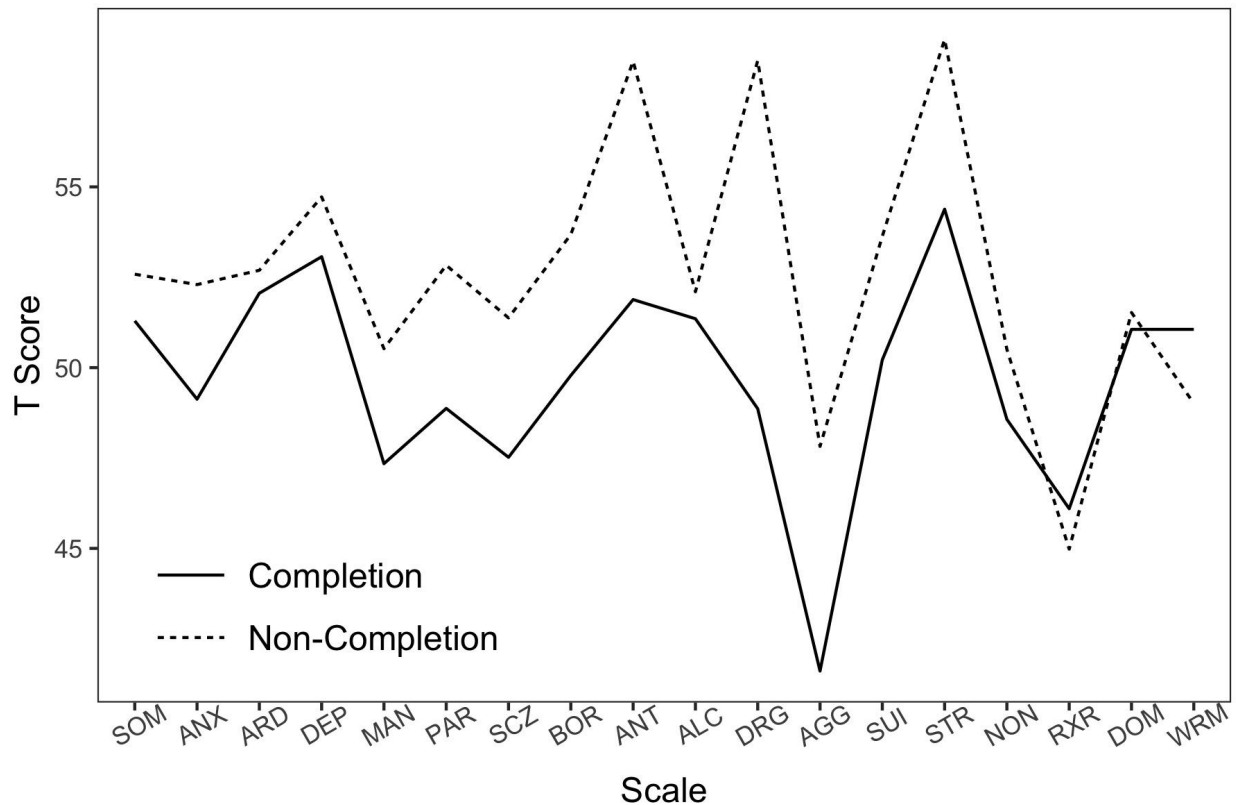
Note. PAI = Personality Assessment Inventory. SOM = Somatic Concerns; ANX = Anxiety; ARD = Anxiety Related Disorders; DEP = Depression; MAN = Mania; PAR = Paranoia; SCZ = Schizophrenia; BOR = Borderline; ANT = Antisocial; ALC = Alcohol Problems; DRG = Drug Problems; AGG = Aggression; SUI = Suicidal Ideation; STR = Stress; NON = Nonsupport; RXR = Treatment Rejection; DOM = Dominance; WRM = Warmth.

Hypothesis 3: Guardedness Variables and Treatment Completion

Indicators of guardedness showed mixed differences between the two groups. While no substantial differences were observed for the PAI NIM, PAI PIM, IORNS FIM, PDS SDE, or PDS Total (BF_{10}s < 10.00), the PDS IM scale was significantly higher for individuals who completed treatment. That is, individuals who completed treatment displayed higher levels of impression management at intake.

Hypothesis 4: Criminality Variables and Treatment Completion

ICSO who did not complete treatment demonstrated higher levels of risk and criminogenic needs, as measured by the STABLE-2007 and the IORNS. They also scored higher on the following STABLE-2007 items: Item 1, Significant Social Influences, Cramer's $V = 0.33$, 95% CI = [0.21, 0.45], $BF_{10} = 10{,}718.98$; Item 2, Capacity for Relationship Stability, Cramer's $V = 0.26$, [0.13, 0.38], $BF_{10} = 135.66$; Item 6, Lack of Concern for Others, Cramer's $V = 0.32$, [0.19, 0.43], $BF_{10} = 2{,}358.48$; Item 7, Impulsivity, Cramer's $V = 0.23$, [0.10, 0.36], $BF_{10} = 27.54$; Item 8, Poor Problem-Solving Skills, Cramer's $V = 0.37$, [0.24, 0.49], $BF_{10} = 138{,}254.54$; and Item 13, Cooperation with Supervision, Cramer's $V = 0.42$, [0.30, 0.53], $BF_{10} > 1{,}000{,}000$. Length of incarceration and type of conviction did not differ between the two groups.

Hypothesis 5: Predicting Treatment Completion

To construct the final prediction model, the top candidate variables from the four responsivity domains identified were carefully examined given several empirical and theoretical considerations. To avoid multicollinearity, candidate variables were inspected for their associations with other candidate variables. Given the restriction of two to 10 predictors, only one to three variables from each domain were included. After consideration, the following variables were entered into the hierarchical regression analysis: education, marital status, STABLE-2007 Item 13, IORNS SRI, PAI DRG, and PDS IM. Several fit indices demonstrated that the prediction model became incrementally stronger until the PDS IM index was added (see Table 4). Consequently, Model 5 was selected, estimated, and interpreted.

Diagnostic inspections revealed no problems associated with outliers, interactions, normality of residuals, posterior predictive checks, binned residuals, multicollinearity, or autocorrelation. Overall, the model performed quite well and correctly categorized about 80% of

individuals, AUC = 0.82 (see Table 5). Individuals with a high school diploma or higher had

42% greater odds of completing treatment than individuals with a GED or lower. Individuals

who had never been married had 60% lower odds of completing treatment than individuals who

were or had been previously married. Individuals with a with a score of 1 on Item 13 of the

STABLE-2007 had 60% lower odds of completing treatment than individuals with a score of 0.

Individuals with a with a score of 2 on Item 13 of the STABLE-2007 had 69% lower odds of

completing treatment than individuals with a score of 0. One-unit increases in IORNS SRI or

PAI DRG scores each resulted in 5% lower odds of completing treatment.

Table 4

Hierarchical Logistic Regression Fit Indices

Model + Added Variable	ELPD	LOOIC	WAIC	R^2	AUC	BF_{10}
1. Education	−136.74	273.48	273.48	0.04	.57	38.95
2. Adding Marital Status	−129.68	259.36	259.35	0.11	.67	270.80
3. Adding STABLE-2007 Item 13	−118.60	237.21	237.18	0.21	.78	5,578.08
4. Adding IORNS SRI	−113.87	227.74	227.70	0.26	.81	89.42
5. Adding PAI DRG	−109.67	219.33	219.28	0.31	.83	10.05
6. Adding PDS IM	−110.19	220.39	220.33	0.32	.83	0.07

Note. Model 1 is compared to the null, intercept-only model. ELPD = expected log pointwise

predictive density. LOOIC = leave-one-out cross-validation information criterion; WAIC =

Watanabe–Akaike information criterion; AUC = area under the curve; IORNS = Inventory of

Offender Risks, Needs, and Strengths; SRI = Static Risk Index; PAI = Personality Assessment

Inventory; DRG = Drug Problems; PDS = Paulhus Deception Scales; IM = Impression

Management. The pseudo-R^2 value reported is a Bayesian estimate (Gelman et al., 2019).

Table 5

Logistic Regression Results

Variable	b	95% CI for b		OR	BF_{10}
		LL	UL		
Intercept	5.71	3.50	8.13	301.76	11,087.25
Education–Diploma/Above	0.35	−0.19	1.13	1.42	1.21
Marital–Never married	−0.90	−1.72	−0.15	0.40	13.74
STABLE-2007 #13–1	−0.92	−1.93	−0.05	0.40	6.93
STABLE-2007 #13–2	−1.19	−2.54	−0.07	0.31	7.76
IORNS SRI	−0.05	−0.09	−0.01	0.95	0.67
PAI DRG	− 0.05	−0.09	−0.02	0.95	8.66

Note. CI = credible interval; *LL* = lower limit; *UL* = upper limit; *OR* = odds ratio; IORNS =

Inventory of Offender Risks, Needs, and Strengths; SRI = Static Risk Index; PAI = Personality

Assessment Inventory; DRG = Drug Problems.

Robustness Checks

　　　To examine the robustness of our findings, we critically evaluated several of our analytic

choices. Prior to the analysis, we chose to identify individuals who obtained maximum benefit (n = 14) as having completed treatment. First, we examined the average PAI profiles of individuals who completed, did not complete, and obtained maximum benefit. Results were mixed, with the individuals who obtained maximum benefit showing similarities to each group. Next, we recoded individuals who obtained maximum benefit as "non-completion" and estimated Model 5 again. The model performed somewhat worse, ELPD = −117.89, LOOIC, 235.79, WAIC = 235.73, AUC = .78. The present data suggest that individuals who obtain maximum benefit are somewhat more similar to those who successfully complete treatment, although they are not wholly alike. Individuals who obtained maximum benefit displayed higher levels of stress, health concerns, and feelings of nonsupport.

Chapter 4

Discussion

The present study provides valuable and practical information regarding client characteristics that predict completion of sexual offense treatment in an outpatient setting. Our findings are largely consistent with our hypotheses and correspond to the most recent meta-analysis on responsivity factors and treatment outcomes (Olver et al., 2011). ICSO who do not successfully complete treatment differ in demographics, personality functioning, guardedness, and criminality. However, a closer inspection of each is required to identify which specific characteristics are predictive of treatment completion.

Demographic Considerations

Our results indicate that individuals who completed treatment were more likely to have obtained a high school diploma or higher. While GED certificates are practically equivalent to high school diplomas, they were considered to be lower than a diploma due to the observation

that individuals with GED certificates earn substantially less money, regardless of age, sex, or

ethnicity (Ewert, 2012). Educational attainment can be a marker of intelligence, ambition,

consciousness, and familial socio-economic status (Haider & von Stumm, 2022). Each of these

could serve as psychological or instrumental resources that assist clients in successfully

completing treatment.

Individuals who completed treatment were also more likely to be currently married or to

have been previously married. Marital status may serve as an indicator of capacity for intimacy

and relational stability, similar to the second item on the STABLE-2007. However, the present

findings demonstrated that the former is more predictive of treatment completion than the latter.

Given that marriage is more formal than dating or cohabitating, marital status may also indicate

willingness to commit to long-term engagements. With treatment duration averaging about two

years for those who successfully completed in the present study, the ability to commit and follow

through may be a vital capacity for clients.

Personality Functioning Considerations

Consistent with Olver et al. (2011), individuals who completed treatment demonstrated

less serious psychopathology, substance use, and antisocial characteristics than those who did not

complete treatment. This finding is unsurprising given that these factors serve as substantial

barriers to successful sexual offense-specific treatment. And per RNR guidelines, treatment

aimed at reducing risk of recidivism only addresses these concerns insofar as they are

demonstrable crimongenic needs. In some cases, sexual offense-specific treatment should be

deferred while individuals with these concerns may seek alternative treatment services

elsewhere. In other cases, simply incorporating concurrent mental health therapy or support

group meetings may be enough to meet their needs. As previously mentioned, the *LATTICES*

curriculum may be utilized for those with a high level of antisocial characteristics (Ward &

Groener, 2018).

Guardedness Considerations

Our findings were mixed in regard to guardedness. Most indices of guardedness showed

no differences between groups, but the PDS measure of impression management was somewhat

higher in those who completed treatment. These findings contrast with Olver et al.'s (2011)

results and our hypothesized expectations that guardedness would pose a barrier to treatment.

However, it is possible that the ability to recognize and report socially favorable traits is an

indicator of social awareness. Additionally, only 13 of the 41 studies included in Olver et al.'s

meta-analysis described community treatment programs. Perhaps impression management

differentially contributes to treatment completion depending on the setting. Keep in mind,

however, that the majority of guardedness indices that we examined did not show meaningful

differences between the two groups.

Criminality Considerations

Individuals who completed treatment had lower levels of self-reported and clinician-rated

risk/need factors. Individuals who did not complete treatment were markedly higher on self-

reported static risk, self-reported aggressive behaviors, clinician-rated rejection of supervision,

and clinician-rated social deficits (e.g., poor relational history, indifference towards others). Most

notably, the IORNS SRI index displayed a substantial difference between groups. Research has

demonstrated that the IORNS SRI scale is particularly correlated with Factor Two on the

Psychopathy Checklist-Revised (PCL-R), which describes the behavioral characteristics of

psychopathy such as impulsivity, criminal versatility, and poor behavioral regulation (Miller,

2006). Clients with these characteristics are likely to lack the behavioral regulation necessary to

follow laws, attend treatment regularly each week, or abide by treatment expectations.

Variables Not Associated with Completion/Non-Completion

For those factors which are not associated with treatment completion, clinicians should

be cautious about making interpretations about responsivity given those factors. For instance,

Stück et al. (2021) did not find evidence to support either self-efficacy or attachment style to be

relevant to treatment completion. Responsivity considerations should be limited to those

characteristics that are empirically verified.

In the present study, individuals who completed and individuals who did not complete

treatment did not differ substantially on the following variables: demographics such as age,

ethnicity, number of children, employment status, or veteran status; personality functioning

variables such as depression, anxiety, or interpersonal patters of warmth and dominance;

defensiveness variables such self-deceptive enhancement, impression management on the PAI,

and impression management on the IORNS; and criminality variables such as length of

incarceration, self-reported protective strengths, several items on the STABLE-2007, and type of

conviction.

Implications

The present research highlights the importance of responsivity factors in predicting

treatment completion and raises two important implications for clinicians. First, some clients

may not be amenable and should not engage in treatment. Resources are often limited and should

be used to treat ICSO who will gain the most benefit. Further, the literature indicates a possible

iatrogenic effect in which partial treatment may actually increase recidivism rates (Olver et al.,

2011), even when accounting for risk (Carl & Lösel, 2021). Individuals who drop out of

treatment prematurely may leave with more negative attitudes toward authority or lower self-

esteem. It is a sobering reminder that providing treatment may not unilaterally increase community safety in all cases.

Second, clinicians should seek to adjust treatment programs as needed to account for certain client factors. While the client is certainly responsible for putting in the work, clinicians are still responsible for meeting individualized client needs as best they can (Beyko & Wong, 2005). Responsivity factors cannot provide unequivocal guidelines for whether or not a client is amenable to treatment or whether treatment should be adjusted. However, responsivity can play a vital role in making informed treatment decisions.

As an example, imagine a prospective client has just completed an intake assessment. He has a GED, has never been married, has been oppositional towards their PPO, self-reports many markers of static risk, and has a history of substance abuse. Such a client is empirically less likely to complete treatment and clients with these characteristics can be given particular attention. Clinicians may choose to spend more time considering potential barriers to treatment completion, they may seek consultation from other providers, or they may consider referring the client elsewhere. If the client is experiencing serious psychopathology, such as psychosis or mania, then sexual offense-specific treatment may not be right for them at this time.

Limitations

The present study is not without limitations. The statistical assumption of independence is weakened, as clients were assigned to different therapists, therapy groups, and probation/parole officers (PPOs). However, accounting for possible statistical dependence using mixed modeling was not practical because a number of clients transferred therapists, groups, and PPOs during their time in treatment. Another statistical limitation is that information was lost when categories were collapsed into dichotomous variables. Future research should seek to

understand the nuanced differences in between those who do and do not complete treatment in terms of education, marital status, and ethnicity.

Additionally, use caution when incorporating these findings into clinical practice. Our results are somewhat dependent on variable coding, sources of error (e.g., self-report or clinician bias), sample limitations, and information gained prior to the start of treatment. While self-reported unemployment at intake was not associated with treatment non-completion, ongoing unemployment could create an obstacle to financing treatment services. Keep in mind the dynamic nature of many of the variables considered here. Finally, the present findings may not be generalized without caution, as our sample did not represent female ICSO, clients in residential or institutional treatment programs, individuals living beyond the Pacific Northwest of the United States, or programs not adhering to RNR principles.

Conclusions

Our findings regarding the importance of responsivity considerations contribute to the empirical literature, inform thoughtful clinical practice, and hopefully encourage others to conduct more research in this often neglected field. Cooperation with supervision, marital status, and educational attainment stand out as key responsivity areas that can be easily assessed by clinicians prior to treatment. Ongoing research is required to assess the extent to which treatment programs are adequately incorporating the most recent empirical findings into their practice. The differences observed between our study and Olver et al.'s (2011) meta-analysis may be due, in part, to the successful adaptation of treatment programs in the last decade. Further research can also provide further guidance into identifying when responsivity factors indicate non-amenability or a need for treatment flexibility.

Sexual offending has an enormous economic and emotional toll that stretches beyond just

the individual who offended and the victim of the offense. Treatment is a key component to promoting community safety and helping to rebuild damaged lives. Not only is treatment empirically supported to reduce risk of reoffending, but it may be an integral step along the way of healing, reunification, and community wellness. Therefore, clinicians have an obligation to ensure optimal treatment completion by considering specific responsivity factors in their clients. Responsivity also promotes the much-needed humanization of those who have sexually offended. As Birgden and Cucolo (2011) emphasized, ICSO "need to be treated as human beings who are legitimately part of the moral and political community and should be acknowledged as both rights holders and rights violators" (p. 308).

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offenders. *Sexual Abuse, 27*(1), 34–50. https://doi.org/10.1177/1079063214564389

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Clinical Psychology, 79*(1), 6–21. https://doi.org/10.1037/a0022200

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treatment. *Sexual Abuse, 0*(0), 1–32. https://doi.org/10.1177/10790632211054048

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sentencing of individuals convicted of sexual crimes. *Sexual Abuse, 32*(7), 778–805.

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Behavior Change in the treatment of sex offenders. *Sexual Abuse: Journal of Research

and Treatment, 17*(2), 153–170. https://doi.org/10.1177/107906320501700206

Ward, J., & Groener, D. (2018). *LATTICES- Clinician's guide: An integrated treatment

approach for high-risk forensic clients*. Safer Society Press.

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increasing the transparency of analysis of preexisting data sets. *Advances in Methods and*

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Appendix

Blain "Cameron" Stumpf

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SUMMARY

An intentional and enthusiastic PsyD student, passionate about coming alongside individuals and empowering them to thrive. I seek to cultivate the unique potential in those I work with by utilizing relationally engaged and evidence-based practices. Additionally, I value contributing to the empirical literature with an emphasis on open research practices.

EDUCATION

Doctorate of Clinical Psychology   Anticipated MAY 2025
  George Fox University

Master of Arts, Clinical Psychology   MAY 2022
  George Fox University, GPA 3.9

Bachelor of Science, Psychology   MAY 2020
  George Fox University, *summa cum laude,* GPA 3.9

Associate of Arts, Psychology   MAY 2018
  Folsom Lake College, GPA 3.9

SUPERVISED CLINICAL EXPERIENCE

Practicum I Student Therapist   APR 2021 − PRESENT
Dr. Jane Ward, Oregon Center for Change, Beaverton, OR
     Providing individual and group therapeutic services to adult men convicted of sexual offenses.
     Assessing clients using clinical interview, collateral information, and empirical instruments.
     Emphasizing Risk-Need-Responsivity, cognitive-behavioral, and trauma-informed intervention.
     Participating in weekly group supervision to enhance collaborative and effective treatment.

Pre-Practicum Student Therapist   AUG 2020 − APR 2021
Dr. Aundrea Paxton, George Fox University, Newberg, OR
     Learned to provide therapy through a person-centered modality both virtually and in-person.
     Attended weekly group supervision with a student supervisor and other trainees.
     Provided simulated therapeutic services to two undergraduate students weekly.
     Maintained ethically-sound records of simulated treatment in TherapyNotes.

ADDITIONAL EXPERIENCE

Graduate Assistant   MAY 2021 − PRESENT

George Fox University, Newberg, OR

Academic Tutor   FEB 2020 – DEC 2021
George Fox University, Newberg, OR

Youth Leader   OCT 2018 – APR 2021
Newberg Christian Church, Newberg, OR

Behavioral Health Constant Observer   OCT 2018 – MAY 2020
Providence Newberg Medical Center, Newberg, OR

Peer Coach   FEB 2019 – MAY 2020
George Fox University, Newberg, OR

Lay Counseling Group Leader   MAY 2019 – AUG 2019
Lakeside Church, Folsom, CA

TEACHING/INSTRUCTION

Adjunct Professor: Statistical Procedures   JAN 2022 – MAY 2022
SWRK 340, George Fox University

Regular Guest Lecturer: Psychological Testing   JAN 2022 – MAY 2022
PSYC 400, Jordan Fastenau, George Fox University

Guest Lecture: Ethics in Abnormal Psychology   FEB 2022
PSYC 420, Dr. Kristina Kays, George Fox University

Guest Lecture: Paraphilic Disorders   NOV 2021
PSYC 420, Jordan Fastenau, George Fox University

Guest Lecture: Treating Sex Offenders   APR 2021
PSYC 460, Dr. Kristina Kays, George Fox University

Guest Lecture: Social Cognition   APR 2021
PSYC 320, Dr. Kristina Kays, George Fox University

Guest Lecture: Statistical Analysis in JASP   APR 2021
PSYC 391, Dr. Susan L. O'Donnell, George Fox University

Guest Lecture: Estes' Statistical Theory of Learning OCT 2019
PSYC 360, Dr. Susan L. O'Donnell, George Fox University

RESEARCH

Stumpf, B. C., & Koch, C. (2022, May 26–29). *A Bayesian look at field independence and crossmodal/supramodal correspondences* [Poster presentation]. Association for Psychological Science 34th Annual Convention, Chicago, IL, United States.

Rogers, N. R., Stumpf, B. C., Ward, J., & Vogel, M. J. (2022, April 27–May 1). *CSEM-related offenses do not seem to be associated with higher scores on the PAI ASD discriminant function* [Poster presentation]. Western Psychological Association 102nd Annual Convention, Portland, OR, United States. https://doi.org/10.13140/RG.2.2.12355.27687

Chang, K. B.T., & Stumpf, B. C. (2022, April 27–May 1). *Coping strategy differences between high*

school and college students in Nicaragua [Poster presentation]. Western Psychological Association 102nd Annual Convention, Portland, OR, United States. https://doi.org/10.13140/RG.2.2.34165.65763

Stumpf, B. C., & Koch, C. (2022, April 27–May 1). *Exploring the correspondence phenomenon through a mixed-methods investigation* [Poster presentation]. Western Psychological Association 102nd Annual Convention, Portland, OR, United States. https://doi.org/10.13140/RG.2.2.27454.77127

Stumpf, B. C., Vogel, M. J., Bond, S. K., George, M. P., & Riedel, A. (2022, March 18–19). *The dark night of grad school: Assessing the spiritual and religious experiences of doctoral students in a clinical psychology training program* [Poster presentation]. Empowered: Christian Association for Psychological Studies Virtual Conference. https://doi.org/10.13140/RG.2.2.25777.04969

Kays, K., Ram, M. S., & **Stumpf, B. C.** (2022, March 18–19). *Empowering beyond imposter phenomenon* [Conference session]. Empowered: Christian Association for Psychological Studies Virtual Conference. https://tinyurl.com/5n7cm727

Chang, K. B.T., **Stumpf, B. C.**, Lehman, S. M., & Lopez, S. F. (2022, February 16–19). *Emotional health and coping strategies: A psychometric evaluation of the BRIEF Cope in Spanish for Nicaraguan youth* [Poster presentation]. Society for Personality and Social Psychology 23rd Annual Convention, San Francisco, CA, United States. https://doi.org/10.13140/RG.2.2.32487.93604

Stumpf, B. C., & O'Donnell, S. L. (2022, January 30). *A psychometric investigation of the Thurston Cradock Test of Shame* [Presentation]. Virtual Richter Scholars Symposium. https://www.georgefox.edu/academics/richter/index.html

Stumpf, B. C., & Koch, C. (2021, August 12–14). *Exploring individual differences in correspondence demonstration* [Poster presentation]. American Psychological Association 129th Annual Convention. https://doi.org/10.13140/RG.2.2.30071.55203

Stumpf, B. C., & Chang, K. B.T. (2021). Resilience in Nicaragua: Preliminary factor analysis and validation of the CYRM-28. *International Journal of Child and Adolescent Resilience, 8*(1), 135–145. https://doi.org/10.7202/1077722ar

Bullock, A. R.L., **Stumpf, B. C.**, & Chang, K. B.T. (2021). Virtues, resilience, and well-being of indigenous youth in Peru. *International Journal of Child and Adolescent Resilience, 8*(1), 98–109. https://doi.org/10.7202/1077720ar

Bullock, A. R.L., **Stumpf, B. C.,** & Chang, K. B.T. (2020, June 10–September 30). *Virtues, resilience, and well-being of indigenous youth in Peru* [Paper presentation]. 2020 Virtual Juried Proceedings of the Western Social Science Association. https://tinyurl.com/y8u3tyvb

Shannon, B. L., Campbell, D., **Stumpf, B. C.,** & Chang, K. B.T. (2020, June 10–September 30). *Adolescent resilience and self-esteem in Nicaragua* [Paper presentation]. 2020 Virtual Juried Proceedings of the Western Social Science Association. https://tinyurl.com/murdx6pf

Stumpf, B. C., & Chang, K. B.T. (2020, June 10–September 30). *Resilience in Nicaragua: Preliminary Validation and factor analysis of the CYRM-28* [Paper presentation]. 2020 Virtual Juried Proceedings of the Western Social Science Association. https://tinyurl.com/3hkpuydf

Stumpf, B. C., & O'Donnell, S. L. (2020, June 1–September 1). *Predicting partner and friend avoidance from parent avoidance and postformal thought* [Poster presentation]. 2020 Association for

Psychological Science Poster Showcase. https://doi.org/10.13140/RG.2.2.16572.46726

Stumpf, B. C., & O'Donnell, S. L. (2020, May 21–24). *Predicting partner and friend avoidance from parent avoidance and postformal thought* [Accepted for poster presentation]. Association for Psychological Science 32nd Annual Conference, Chicago, IL, United States. (Conference canceled).

Stumpf, B. C. (2020, April 1–4). Resilience in Nicaragua: Validation and factor analysis of the CYRM-28. In K. B.T. Chang (Chair), *An exploration of resilience in Latin American contexts: Self-esteem, well-being, religion, virtues, and factor structure of the Child and Youth Resilience Measure* [Panel canceled]. Western Social Science Association 62nd Annual Conference, Portland, OR, United States.

Mendenhall, W. R., **Stumpf, B. C.,** Knakkergaard, B. A., & Koch, C. (2020, February 29). *Characteristics of gritty people* [Poster presentation]. Oregon Academy of Science 79th Annual Proceedings, Portland, OR, United States. https://doi.org/10.13140/RG.2.2.17976.49922

Chang, K. B.T., **Stumpf, B. C**., & Campbell, D. (2020, January 25). *Coping styles and resilience in Nicaraguan youth*. In S. N. Doan (Chair), *Resilience* [Symposium]. Western Positive Psychology Association 5th Annual Conference, Claremont, CA, United States. https://doi.org/10.13140/RG.2.2.23072.33286

Chang, K. B.T., Johnson, R. S., **Stumpf, B. C**., & Hancock, M. N. (2019, February 7–9). *Different forms of happiness and resilience for high school and university students in Nicaragua* [Poster presentation]. Society for Personality and Social Psychology 20th Annual Convention, Portland, OR, United States. https://doi.org/10.13140/RG.2.2.18683.87843

PROFESSIONAL TRAININGS

Wilson, E. E. (2022, March 9). *Sex, religion, and spirituality in the therapy room: Clinical interventions.* Grand Rounds, Graduate School of Clinical Psychology, George Fox University, Newberg, OR.

Bourg, W. (2022, January 2). *Intractable conflict in families and society: What do we know about healing the rifts*. Colloquium, Graduate School of Clinical Psychology, George Fox University, Newberg, OR.

Liebscher, B., & Vaiz, L. (2021, November 3). *May it be well with your soul: Anti-racism, spiritual freedom, and wellness.* Colloquium, Graduate School of Clinical Psychology, George Fox University, Newberg, OR.

Wilson, E. E. (2021, October 13). *Erotic transcendence: Integrating faith with what's new in sex research.* Grand Rounds, Graduate School of Clinical Psychology, George Fox University, Newberg, OR.

Ben-Porath, Y. (2021, August 16). *Introducing the MMPI-3*. On-Demand Conference Workshop, American Psychological Association 128th Annual Convention.

Fife, D. (2021, August 12). *Best practices in open science data analysis: Ethics, visualization, and estimation*. Conference Workshop, American Psychological Association 129th Annual Convention.

Ben-Porath, Y. (2021, July 30). *Introduction to MMPI-3 for forensic psychologists*. Training, American Academy of Forensic Psychology, Palo Alto University.

Katherine C. Gomez, MA, & Katherine Gotch, MA. (2021, June 11). *The intersection of sex trafficking & sexual offending: Practical applications for sexual abuse specific professionals*. Training and Workshop, Oregon Association for the Treatment of Sexual Abusers.

Chloe Ackerman, PsyD. (2021, March 10). *Gender diverse clients: Therapy and intervention readiness assessments*. Grand Rounds, Graduate School of Clinical Psychology, George Fox University, Newberg, OR.

Janelle Kwee, PhD. (2021, February 3). *Saying 'yes' to your embodied life: An invitation for psychotherapists.* Colloquium, Graduate School of Clinical Psychology, George Fox University, Newberg, OR.

Jason Steward, PhD. (2020, November 4). *Complex PTSD: Advanced case conceptualization, assessment, and treatment approaches in trauma populations.* Colloquium, Graduate School of Clinical Psychology, George Fox University, Newberg, OR.

Justin Lee, PhD. (2020, October 14). *Examining the role of neuropsychology within the pediatric cancer setting*. Grand Rounds, Graduate School of Clinical Psychology, George Fox University, Newberg, OR.

CERTIFICATIONS

Rorschach Performance Assessment System (R-PAS)	MAR 2022
Montreal Cognitive Assessment (MoCA)	OCT 2021
Data Analysis with R Programming	MAY 2021
Basic Life Support CPR	FEB 2021
Crisis Intervention	MAY 2020
First Aid	MAR 2020
Prevention and Management of Assaultive Behavior (PMAB)	DEC 2018

GRANTS

Stumpf, B. C. (Principal Investigator). (2021). *A psychometric investigation Thurston-Cradock Test of Shame* [Grant, $2,923]. Paul K. and Evelyn E. C. Richter Memorial Fund.

HONORS

PsiChiR Monthly Contest Winner	OCT 2020 – DEC 2020
For correctly writing R code for Psi Chi's monthly contest.	
Karen Smith Award	MAY 2020
For outstanding student achievement and potential in assessment and clinical work.	
Certificate of Distinction	MAY 2020

For superior knowledge, application, and service in pursuit of a BS in Psychology.

Dean's List   AUG 2018 – MAY 2020

For consistently achieving a GPA greater than 3.5 each semester.

STUDENT LEADERSHIP ROLES

Advisor   MAR 2021 – PRESENT

Mendeley, George Fox University, Newberg, OR

Ambassador   JUL 2020 – PRESENT

Center for Open Science, George Fox University, Newberg, OR

Campus Representative   SEP 2018 – PRESENT

APA & APS, George Fox University, Newberg, OR

Vice-President   MAR 2019 – MAY 2020

Psychology Club, George Fox University, Newberg, OR

VOLUNTEER

Technical and Leadership Team   MAR 2020 – OCT 2021

New Horizons Fellowship, Canby, OR

Student Wellness Committee   OCT 2020 – MAY 2021

Graduate School of Clinical Psychology, George Fox University

Peer Reviewer   APR 2020

Researching Injustice and Social Equality (RISE) Awards, APS

Peer Reviewer   DEC 2020

Manuscript submitted to *Motivation and Emotion*, supervised by Dr. Susan L. O'Donnell

Peer Reviewer   APR 2020

Student Research Awards, APS

Student Evaluator   FEB 2019, FEB 2020

Scholarship Competition, George Fox University

Technical Expert and Youth Leader   JUN 2016, JUL 2018, JUN 2019

Lakeside Church High School Camp, Pollock Pines, CA

MyZone Youth Leader   SEP 2018 – OCT 2018

Newberg Christian Church, Newberg, OR

MEMBERSHIPS

Christian Association for Psychological Studies   JAN 2022 – PRESENT

Association for Contextual Behavioral Science   OCT 2021 – PRESENT

Psychological Science Accelerator   DEC 2020 – PRESENT

APA Div. 5: Quantitative and Qualitative Methods   MAR 2020 – PRESENT

American Psychological Association   MAR 2020 – PRESENT

Western Psychological Association	JAN 2020 – PRESENT
Western Positive Psychology Association	JAN 2020 – PRESENT
Psi Chi	APR 2019 – PRESENT
The National Society of Leadership and Success	AUG 2018 – PRESENT
Psi Beta	MAR 2018 – PRESENT
Association for Psychological Science	JAN 2018 – PRESENT
Phi Theta Kappa	JAN 2017 – PRESENT
Oregon Academy of Science	FEB 2020 – FEB 2021
APA Div. 8: Society for Personality and Social Psychology	NOV 2018 – DEC 2019

PROGRAM COMPETENCIES

TherapyNotes | R Code | JASP | Google Suite | Microsoft Office | Adobe Suite CC