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The Influence of Personality and Trauma on the Outcomes of Sex Offender Treatment in an Outpatient Setting

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The Influence of Personality and Trauma on the Outcomes of Sex Offender Treatment in an Outpatient Setting

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by

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has been approved

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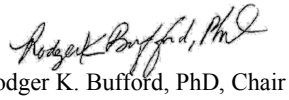

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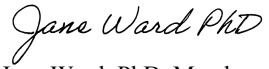

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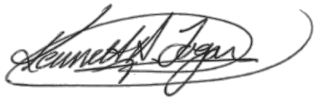

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Abstract

Sex offenders in the United States invoke a negative reaction in a majority of people. Often, there is a stigma about the character and personality of an individual who would commit such acts. These perceptions have largely kept the development of treatment modalities limited when compared to other psychological problems. One area that continues to need research is in the factors that contribute to the outcomes of treatment for sex offenders. The present study investigated the relationships between perceived historical trauma, personality, and treatment completion in an outpatient group of sexual offenders. We hypothesized that (1) sexual offenders who completed treatment would have reported fewer historical traumatic experiences, as measured by the Adverse Childhood Experiences (ACEs) questionnaire; (2) individuals who completed treatment would exhibit different personality characteristics, as measured by the Personality Assessment Inventory (PAI) Aggression, Antisocial, Borderline and Dominance scales; and (3) ACEs and PAI scores would predict treatment completion in a combined model. A preliminary analysis consisting of several independent samples *t*-tests was conducted to identify variables for the final prediction model. Statistically significant differences between individuals who completed and did not complete treatment were observed on the ACEs, PAI Aggression, PAI Borderline, and PAI Antisocial indices. When modeled together, both ACEs and PAI scales were predictive of treatment completion, $\chi^2 = 19.02$, $p < .001$, *Nagelkerke* $R^2 = .30$. The PAI Antisocial index was the only statistically significant PAI scale that contributed to predicting treatment outcomes. Overall, our results facilitate distinguishing among individuals who will benefit and individuals who are unlikely to be amenable for treatment. Further research is necessary to establish generalizability to other populations and modalities. Given the present results, treating clinicians should ponder the use of the ACEs and the PAI as instruments

administered to all patients during intake. These tools will assist in the identification for patients amenable to treatment.

Keywords: sex abuse, sex offense, ACEs, adverse childhood experiences, PAI, Personality Assessment Inventory, treatment outcomes, CBT group therapy

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The Influence of Personality and Trauma on the Outcomes of Sex Offender Treatment in an Outpatient Setting

Chapter 1

Sexual crimes are an ongoing public safety concern. In 2018, over 100,000 rapes were reported in the United States according to the Federal Bureau of Investigations (Federal Bureau of Investigation, 2019). As evidenced by the "#MeToo" movement and increases in media coverage, public awareness of sexual offenses has dramatically increased. Much of the empirical literature consists of research based on institutional populations. Sexual offenders account for 10% of the 1.6 million people incarcerated in the United States (Guerino et al., 2011). The implication is that approximately 160,000 individuals will require sexual offense treatment upon their release into the community. There is sex offender treatment available. As of 2010, there were 1,307 treatment programs in the United States treating roughly 53,811 individuals (McGrath et al., 2010).

On average, 15% of sexual offenders will recidivate, or be arrested and charged with committing new sexual offenses, within the first 5 years of release, though actual recidivism may be notably higher (Hanson & Morton-Bougon, 2005). This number increases the longer they remain out of prison. Lösel and Schumucker (2005) supported these recidivism findings in a meta-analysis, but also found that treated sexual offenders have an 11.1% chance of reoffending, while among those who were untreated 17.5% reoffended over a five-year period. Using a 10-year follow up, Olver et al. (2008) found that individuals left untreated had a documented 32.3% likelihood of recidivism, while their treated counterparts had a 21.8% chance of recidivism. These data are clear that if left untreated, sexual offenders will reoffend at significantly higher

rates. This translates to tens of thousands of new individuals becoming victimized. Further, it stresses the need for additional research regarding risk, recidivism, and treatment approaches.

Promising research is available. For instance, Levenson, et al. (2016) found an association between adverse childhood experiences (ACEs) and sexually related crimes. Hanson and Morton-Bougon (2005) found in their meta-analysis a correlation between childhood homelife and sexual offending. By analyzing multiple studies, they concluded that family environments may have an impact on risk for sexual offending. If an individual is in a family system or environment where they are a victim themselves, they may develop poor attachment styles. They may also see offending as normal or something that occurs within family systems. Maltreatment and victimization in childhood increases antisocial behavior, leading to an increased likelihood in offending as an adult (Herrenkohl et al., 2016). Additionally, they found that there are two key factors in determining whether an individual might offend. The first is deviant sexual interests, or problematic sexual arousal. The second is comprised of two components which include an antisocial personality orientation and lifestyle instability.

Adverse Childhood Experiences and Sex Offenses

Traumatic events result in pathogenic development in several life areas (Anda et al., 2006; Buss et al, 2017; Cicchetti & Toth, 1995; DeBellis & Zisk, 2014). With complications occurring in development, individuals may develop distorted boundaries that eventually result in their sexual offending behaviors. One way to measure early traumatic events is to use the ACEs questionnaire, a significant public health crisis instrument (Felitti et al., 1998). The ACEs questionnaire is a widely used questionnaire to measures possible traumatic experiences an individual has experienced prior to the age of 18. It consists of ten items looking at a variety of different encounters with adversity. As the score increases on the ACEs, there is an increased

likelihood of a child's sense of safety, stability, and bonding becoming compromised. ACEs can correlate highly with vulnerabilities related to psychopathology, disease, and many underlying psychological disturbances (Sheridan & McLaughlin, 2019). According to the Bureau of Justice, 42.4% of child sexual abuse victims 11 years old and under were sexually assaulted by a family member (Snyder, 2000). Sexual abuse as a child may increase their likelihood of becoming offenders themselves.

Confused and compromised sexual boundaries are commonplace in individuals who commit sexual offenses. The importance of sexual boundaries cannot be stressed enough. Sexual boundaries relate to different types of sexual intimacy such as oral, anal, vaginal, and digital sexual acts. Sexual offenders by nature transgress someone else's sexual boundary or boundaries. The United States has passed numerous laws prohibiting the violation of another's sexual boundaries. The importance of developing healthy sexual boundaries is imperative for the rehabilitation of sex offenders.

Levenson et al. (2016) found that male offenders are three times more likely to have experienced sexual assault than men who have not committed sexual assault. This suggests a link between people who commit sexual offenses and having experienced a sexual assault themselves. Among other experiences, the ACEs items ask about experiencing physical, emotional, or sexual abuse. Additionally, men who commit sexual offenses are nearly twice as likely to report they experienced physical abuse, have a thirteen times greater chance of reporting verbal abuse, and are four times as likely to report they come from a broken home and experienced neglect (Levenson et al., 2016). These findings indicate that sexual offenders experience notably higher levels of adverse childhood experiences than the general population.

Sexual offenders tend to have higher ACEs scores than the general population. Levenson et al. (2016) found that fewer than 16% of male sex offenders reported an ACEs score of 0; nearly half of all male sexual offenders reported a score of 4 or more. ACEs are also predictive of general recidivism. In one study focused on predicting recidivism for all people who have been incarcerated, one-unit score increase on the ACEs was associated with an 18% higher chance of recidivism (Heirigs et al., 2020). Higher scores were associated with higher recidivism rates. It is clear there is an association between general recidivism and ACEs scores, but currently no data are available on how the ACEs may influence sex offender treatment outcomes.

The Personality Assessment Inventory and Sex Offenses

The Personality Assessment Inventory (PAI) is used to provide relevant information for clinical diagnosis, treatment, and screening for psychopathology. It is utilized in conjunction with a clinical evaluation. It covers a wide array of personality domains, including anxiety, depression, substance use, and psychopathology (Morey, 2007). There are data supporting certain personality profiles for sexual offenders among subscales in the PAI (Boccaccini et al., 2013). However, more research is required to extend and elaborate upon these findings.

One of the main distinguishable personality traits that correlates heavily with sexual offending is antisocial personality orientation. Antisocial characteristics include impulsivity, substance use, unemployment, rule-violating, reckless behavior, and fighting (Hanson & Morton-Bougon, 2005). In their meta-analysis, Hanson et al. determined this was one of two main components to identifying sex offenders. Higher scores in two other major personality domains are also indicative of an increased chance of an individual committing a sexual offense: the Borderline Features scale and the Negative Relationships scale (Boccaccini et al., 2013). The Borderline Features and Negative Relationships scale measure personality characteristics such as

emotional lability, impulsivity, interpersonal difficulties, identity disturbance, and cognitive impairment (Morey, 2007).

Four more PAI scales also show a connection with sex offenders committing crimes after their release, including the Antisocial scale, Aggression scale, Dominance Scale, and the Violence Potential Index. Elevations on these subscales predicted a three-times higher likelihood of an individual sex offender reoffending (Boccaccini et al., 2010). The evidence is strong that specific PAI personality profiles correlate with sexual offending behavior patterns and reoffending outcomes.

PTSD and Sex Offending

PTSD is a major theme present in the lives of sexual offenders. McMackin et al. (2002) found that 95% of juvenile male sex offenders met at least one criterion for Post-Traumatic Stress Disorder (PTSD) criterion. Among these, 65% were diagnosed with PTSD. The additional connections made are 38% of sex offenders experienced regular fear, 55% experienced regular moments of hopelessness, and 20% of these young men experienced horror (McMackin et al., 2002). McMackin's findings were gathered from 40 youths who had committed a sex offense and had been assigned to sex offender treatment. The results from this study are self-reported and have the potential to be impacted by self-report bias.

From the above research, it appears that a majority of men who commit sexual offenses have encountered some type of trauma and have a significantly higher rate of PTSD than the general population. These individuals are more likely to have encountered sexual assault, neglect, verbal abuse, a broken home, and physical abuse. They are also more likely to suffer from depression and PTSD.

There is a strong stigma towards individuals who commit sexual crimes. This stigma largely hinders someone's ability to desire, seek out, or receive treatment. Due to the societal stigma, there are minimal community resources being offered to treatment programs or the development of new treatment modalities. This leaves an at-risk population underserved. These individuals need treatment to prevent reoffence and the creation of additional victims. If there is an association between the ACEs and the PAI on treatment outcomes, then it is imperative for the research to be completed. The potential gains are treating an underserved population and potential prevention of tens of thousands of new sex abuse victims.

Treatment Modalities

The most predominant treatment model currently in use is a cognitive behavioral therapeutic (CBT), skills-based approach, focusing on reducing risk and eliminating risk factors (Yates, 2013). However, a shortcoming of the CBT approach is that it is missing a strong emphasis on mending damaged relationships. An integrated approach has started to become standard for the field. It is being employed largely in group therapeutic settings. Using an integrated approach that is CBT-dominated, the emphasis for treatment has transitioned to expanding empirical awareness of events occurring in group, streamlining interventions with non-verbal signals, and targeted reinforcement of social interaction and bonding. This is accomplished by enhancing self-disclosure, social awareness, self-esteem, empathy, and management of deviant thoughts (Jennings & Deming, 2013). As the new integrated approach with CBT group therapy emerged, relationships and social interactions have become a component of treatment.

Relapse Prevention (RP) was developed to assist with sex offenders who are involved in active treatment (Launay, 2001). The modality originated in the 1960s for individuals suffering

from alcoholism who were having difficulties maintaining abstinence and sobriety (e.g., Ellis, 1962). However, it became evident over time that individuals who participated in this treatment had an alcohol relapse rate of roughly 80% (Hunt et. al., 1971). In the treatment community, it has largely become synonymous with the cognitive behavioral model (Yates, 2013). The model's key strategy focuses on identifying high-risk situations that are unique to the individuals' offense cycle. Although not as popular as it once was, the RP model has several important components including internal dialogue (self-talk), self-reinforcement, reframing, self-instructional training, various forms of modelling, reframing, and cognitive restructuring (Boer, 2017).

The Self-Regulation Model (SRM) is an expansion of the RP model (Yates, 2013). The SRM is one of two popular modalities emerging in the past decade. The SRM explicitly takes into account the individuality of the offense. Additionally, the model's primary concerns are focusing on an individual's ability to organize, monitor, and control internal processes including emotions, cognitions, and their behavior with a view of achieving desired goals (Boer, 2017). It is an attempt to treat each offender as a unique individual and not overgeneralize people. The model proposes that one's inability to self-regulate appropriately creates need deficits and thus increases the likelihood of sexual offending. This model suggests that part of sexual offending is an individual's poor goal selection along with other personal factors. Poor goal selection leads to poor behaviors, including problematic behaviors such as sexual offending (Kingston et al., 2012).

Another popular model is the Good Lives Model (GLM; Ward, 2002). The GLM approach focuses on a multitude of goals. It assumes that, like other people, sexual offenders are goal-oriented and desire to meet their basic human needs and acquire goods. The model posits that every individual will get their needs met by either culturally positive or culturally negative

ways. However, the mechanism driving each individual is unmet needs (Boer, 2017). The framework created by this model suggests that sexual offending is a maladaptive behavioral schema that developed as a result of an individual attempting to get their needs and wishes met in socially inappropriate ways. The goal of GLM is to assist individuals in understanding and comprehending the importance of pro-social engagement in obtaining one's desires (Yates, 2013). The intention behind GLM is for augmenting more popular models of treatment, such as the Risk-Need-Responsivity (RNR) model.

The premise of the RNR model is effective correctional treatment (Andrews & Bonta, 2010; Boer, 2017). The model incorporates risk (assessing likelihood of reoffense and matching services to a client's individual needs), need (examining specific factors involved in the individual's offense and life), and responsivity (responding with a tailored cognitive behavioral treatment to the unique features of the client to encourage the highest level of engagement). The RNR model has been largely integrated into popularized styles of treatment. In one meta-analysis, CBT-based treatment adhering to RNR principles led to a 19.2–43.4% decrease in sexual recidivism (Hansen et al., 2009). Out of all the models, the RNR integrated model appears to yield the most substantial results for reducing recidivism.

There are a variety of treatment options available to individuals who commit a sexual offense. Similarly, sexual offenses have a wide diversity of different manifestations. Therefore, applying one rigid approach to all sexual offenders is limiting. By simply applying one modality to all clients, it does not account for the complexities of humans, human behavior, and the variety of circumstances that present themselves in a clinician's office. None of the models listed utilizes an integrative approach and so they run the assumption that their models will work in all or a majority of circumstances (Yates, 2013). Treatment may need to be tailored to the offender

(Boer, 2017). There is still a need to research how individuals with specific offense presentations differentially develop throughout treatment. By examining trauma and personality at the outset of treatment, clinicians may gain more insight that can assist with placing sexual offenders into the best possible treatment.

Hypotheses

The purpose of the present study is to explore the ability to predict outpatient treatment outcomes in group treatment using a CBT approach and following RNR principles from a sexual offender's trauma history and personality. We hypothesize that:

1. Sexual offenders who complete treatment will report fewer ACEs than those who did not complete treatment.
2. Sexual offenders who complete treatment will score lower on the PAI Aggression, PAI Borderline, PAI Antisocial, and PAI Dominance indices than those who did not complete treatment.
3. In aggregate, scores on the ACEs, PAI Aggression, PAI Borderline, and PAI Antisocial indices will predict treatment completion.

Chapter 2

Methods

Participants

Archival data were gathered from a clinical sample of men who received group treatment with a CBT approach the included RNR principles at an outpatient sex offender clinic and were no longer engaged in active treatment ($N = 74$). The majority of men were mandated by court order to attend treatment. They ranged in age from 20 to 82 years old ($M = 36.66$, $SD = 14.73$).

They were incarcerated for 0 to 192 months (M = 30.68, SD = 47.33). Demographics are presented in Table 1.

Table 1

Sample Demographics

Variable	Category	Completion	Non-completion
Ethnicity	European American	64.9%	54.1%
	Hispanic/Latino	10.8%	16.2%
	Multiple ethnicities	8.1%	8.1%
	Black/African American	2.7%	10.8%
	American Indian/Alaska Native	0%	5.4%
	Asian	10.8%	2.7%
Marital	Married	16.2%	10.8%
Status	Single, never married	59.5%	70.3%
	Divorced	8.1%	2.7%
	Unmarried, cohabiting with partner	8.1%	13.5%
	Separated	10.8%	2.7%

Note. N = 74.

Materials

Adverse Childhood Experiences

Adverse Childhood Experiences (ACEs; Felitti, 1998), The ACEs is a dichotomous 10-item scale. For each item, respondents answer “Yes” or “No” to traumatic experiences they have encountered before the age of 18 years. Domains of potential endorsement include abuse, household dysfunction, mental illness, substance abuse, divorce, and neglect. The ACEs has

adequate internal consistency ($\alpha = .72$) and test-retest reliability ($\tau = .79$; Karatekin & Hill, 2019). It is considered a reliable and valid instrument in retrospective assessment.

Personality Assessment Inventory

The Personality Assessment Inventory (PAI; Morey, 1991, 2007). The PAI is a 344-item self-report inventory that assesses different areas of an individual's personality and psychopathology on 22 subscales, which include somatic concerns, anxiety, anxiety related disorders, depression, mania, paranoia, schizophrenia, borderline features, antisocial features, alcohol problems, drugs problems, aggression, nonsupport, stress, treatment resistance, dominance, and warmth. It is used exclusively with adults and is designed for assisting and informing clinicians in developing treatment plans and diagnoses. Reliability studies indicate a high median α and test-retest correlations that exceed .80 on all 22 scales. In addition, there is convergent and discriminant validity with more than 50 other instruments.

Treatment Program

The data assigned to this study comes from a community-based outpatient sexual offense treatment program located in the Pacific Northwest. The treatment programming consists of psychological evaluations, group therapy, and individual therapy. The theoretical framework was developed within the RNR principles (Bonta & Andrews, 2017). Largely, the main modality for treatment is group-based CBT interventions. The focus areas of the curriculum are thought regulation, emotional regulation, offense-related factors, and individual needs based on type of offense. An alternative curriculum exists specifically for high-risk offenders. This curriculum is developed at an outpatient clinic in the Pacific Northwest and is titled LATTICES (Ward & Groener, 2018). The overall framework is conceptualized and administered using best practices within the known literature and supervised by a qualified licensed clinical psychologist.

Data Collection

All participant information comes from a single clinic located in the Pacific Northwest. All participants had already completed their treatment. Their ACEs, PAI scores, and demographic data were collected at intake. All identifying information was removed before data were made available for research to protect the confidentiality of clients. All data points collected are listed in the materials and variables sections. Federal guidelines for human subject protections were followed throughout the study and IRB approval was obtained (#GFU2212021).

Design

The independent, predictor variables in the study are the ACEs total score, the PAI Aggression index, the PAI Antisocial index, the PAI Borderline index, the PAI Dominance index, and age. The dependent variable in the study is dichotomous and based on completion of treatment. Group One included clients who accomplished successful treatment completion or achieved maximum benefit. Group Two included clients who did not complete treatment successfully for a variety of reason. Excluded from the outcome analysis are those whose probation expired, who transferred to another treatment placement, or left treatment due to external circumstances beyond their own control (e.g., death, serious medical conditions).

To complete treatment successfully, an individual completes the curriculum, engages in group, has applied treatment concepts to their life, admits to their offense, and takes accountability for their offense. To achieve maximum benefit from treatment, an individual must complete enough aspects of treatment for partially reducing risk. Unsuccessful treatment termination can result for several reasons, but it generally refers to an individual's removal from treatment prior to completion. An individual may refuse to participate in a given curriculum,

display behavioral problems, violate treatment/probation guidelines, or leave once their probation expires.

Analysis

All analyses were conducted in JASP (JASP Team, 2022). Prior to analysis, descriptive statistics were calculated for all variables of interest and distributional information was inspected. Next, independent samples *t*-tests were conducted to test the first two hypotheses. Significant *t*-tests guided the final analysis. Lastly, a logistic regression was conducted to test the third hypothesis while taking into account statistical assumptions.

Chapter 3

Results

Descriptive analyses were conducted to examine the distribution of data in the independent and dependent variables. Distributional information is reported in Table 2. A preliminary analysis consisting of several independent samples *t*-tests was conducted to identify variables for the final prediction model (see Table 2). Statistically significant differences between individuals who completed and did not complete treatment were observed on the ACEs, PAI Aggression, PAI Borderline, and PAI Antisocial indices. In particular on the ACEs, no individual with scores of above six successfully completed treatment. Similarly, few individuals with *T* scores above 60 on the PAI Antisocial index successfully completed treatment. See Figures 1 and 2. Specifically, individuals who completed treatment scored lower on each of these indices. No statistically significant differences were observed for age or the PAI Dominance index. The four indices showing statistically significant differences and age were chosen as

variables for logistic regression. Cohen's *d* effect sizes for these four indices ranged from 0.54 to 0.97.

Table 2

Distributional Information and Group Differences

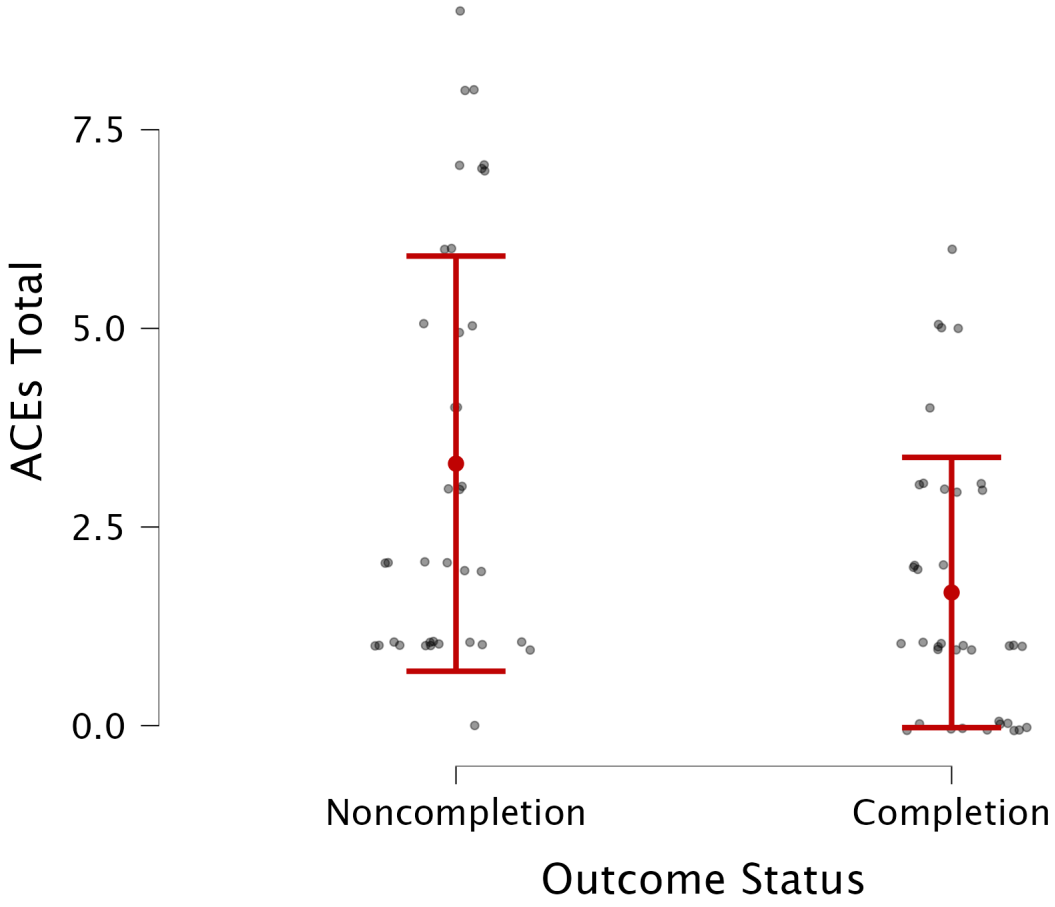
Variable	Total				Completers		Noncompleters		*t*	*Cohen's d*
	M (*SD*)	Skewness	Kurtosis	Range	*M*	*SD*	*M*	*SD*		
Age	36.66 (14.73)	1.18	0.84	20–82	39.16	16.53	34.16	12.40	−1.47	−0.34 [−0.80, 0.12]
ACEs	2.49 (2.34)	1.05	0.17	0–9	1.68	1.70	3.30	2.61	3.16**	0.74 [0.26, 1.20]
PAI Aggression	44.91 (8.29)	0.59	−0.23	32–67	42.35	6.67	47.46	9.02	2.77**	0.64 [0.17, 1.11]
PAI Dominance	51.10 (9.00)	0.13	0.11	29–74	50.35	9.71	51.84	8.30	0.71	0.17 [−0.29, 0.62]
PAI Borderline	51.80 (10.67)	0.59	0.35	33–85	49.00	8.58	54.60	11.89	2.32*	0.54 [0.07, 1.00]
PAI Antisocial	55.43 (10.23)	0.76	0.18	41–86	50.95	7.43	59.92	10.75	4.18***	0.97 [0.49, 1.45]

Note. $N = 74$. ACEs = adverse childhood experiences; PAI = Personality Assessment Inventory.

*$p < .05$, **$p < .01$, ***$p < .001$

Figure 1

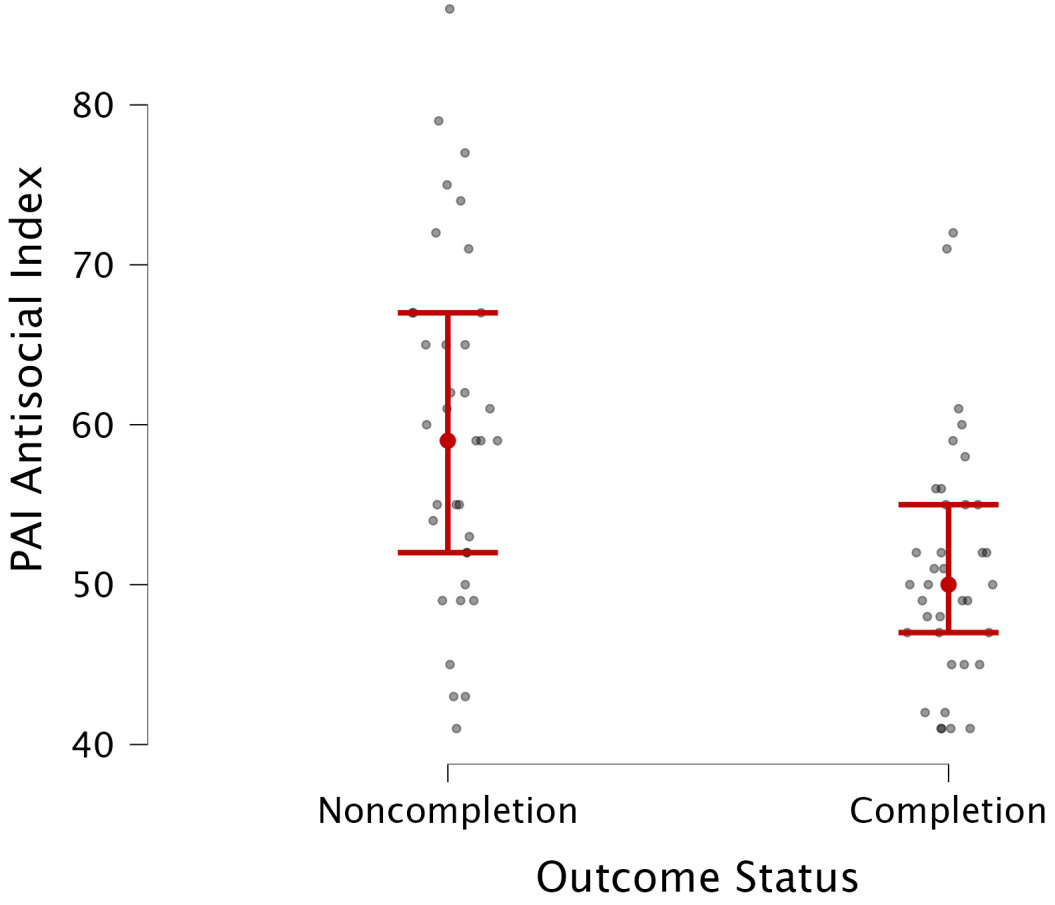
ACEs by Completion Status



Note. ACEs = adverse childhood experiences.

Figure 2

PAI Antisocial by Completion Status



Note. PAI = Personality Assessment Inventory.

Primary Analysis

A logistic regression model was used to predict treatment outcomes using simultaneous entry of age and the variables identified in the preliminary analysis, including (ACEs total, PAI Aggression, PAI Borderline, and PAI Antisocial (Agresti, 2013). Logistic regression, unlike traditional linear regression, yields a pseudo R^2. Intercorrelations indicated that there is no multicollinearity within the predictor variables (see Table 3). Further, age was not significantly related to the other variables and thus was not included in the final model. The overall model was

statistically significant, $\chi^2 = 19.02$, $p < .001$, *Nagelkerke* $R^2 = .30$ (see Table 4). The PAI Antisocial index was the only statistically significant predictor of treatment outcomes. This indicates that the other predictor variables did not add incremental predictive information to the model.

Table 3

Intercorrelations Among Age and Predictor Variables

Variable	1	2	3	4	5
1. Age	-				
2. ACEs	–0.16	-			
3. Aggression	0.06	0.31**	-		
4. Borderline	–0.12	0.34**	0.60***	-	
5. Antisocial	–0.15	0.56***	0.51***	0.69***	-
6. Dominance	–0.03	–0.08	–0.22	–0.18	0.08

Note. $N = 74$. ACEs = adverse childhood experiences.

Table 4

Logistic Regression Predicting Treatment Completion

Predictor	*Estimate*	95% CI	Odds ratios	Wald statistic
Intercept	5.98	[2.09, 9.87]	395.07	9.07**
ACEs	–0.17	[–0.18, –0.01]	0.91	4.68
Aggression	–0.05	[–0.04, 0.11]	1.03	0.67
Borderline	0.03	[–0.13, 0.03]	0.95	1.34
Antisocial	–0.09	[–0.45, 0.11]	0.85	1.35**

Note. $N = 74$. ACEs = adverse childhood experiences

Chapter 4

Discussion

Comparisons of clients who completed sex offender treatment with those who did not showed that completers tended to be older and to have overall lowers scores in the ACEs and PAI domains examined. Conversely, the individuals who did not complete their treatment tended to have higher scores on the PAI scales measured and tended to report having experienced higher incidence of childhood trauma. Regarding the regression analysis, we observed that individuals who have higher antisocial personality characteristics were less likely to complete treatment. That is to say that the more presence of antisocial characteristics the less likely that an individual is to complete treatment.

What this study does show is a number of conclusions. First, the study found that noncompleters had higher ACEs score. Additionally, it was observed that if an individual has an ACEs score at six or above, it is significantly unlikely that they will complete treatment from a CBT group-based treatment modality. This is not to say that an individual with a high ACEs score will not benefit from treatment altogether. It is important to understand all the implications in this finding.

Since it is unlikely for an individual to complete treatment with an ACEs score six or above, a treating clinician should consider if it is ethical to begin treatment at all for the individual. Historically, the field of psychology has employed modalities thought to benefit clients to later be revealed it was harmful. One more recent example of this is conversion therapy utilized on the homosexual population in an attempt to treat individuals identifying as homosexual and assist in “rehabilitating” them to heterosexuality (Richmond, 2019; Turban et al., 2020). Many participants are persuaded into voluntarily participating. Additionally, this style

of therapy operates with the assumption that homosexuality is a mental illness. This is not to say this example are an exact comparison but to demonstrate the field of clinical psychology treating patients with ineffective treatment modalities that do not work, or even worse, harm clients.

It is important to consider ethically if the treatment has not demonstrated effectiveness, then the inverse may be possible. The inverse being instead of rehabilitation, harm is happening. This harm could affect patients or other group members. Ways in which the individual could experience harm are by exposure to traumatic offending stories, the depletion of resources, and emotional distress. Regarding the other patients in groups, if an individual is not amenable to treatment it is possible the individual may become disruptive to group cohesion and homeostasis. Group cohesion and homeostasis are important aspects of group therapy (Burlingame et al., 2011).

An additional correlation was observed throughout data analysis. Current and other findings (Caperton et al., 2004; Clounch, 2008) provide strong evidence to suggest the PAI antisocial scale scores are inversely correlated with outcomes. The implication of the finding is essential as further understanding in the mechanisms will assist in getting patients into the correct treatment. Additionally, it is not difficult to conclude that the antisocial scale could be treated as a screener instrument. It shows that individuals with PAI Antisocial scores above a certain level are unlikely to complete treatment.

With these results being statistically significant, another conversation arises. If there is such a connection between the PAI and the ACEs and the results of sex offender treatment, a treating clinician should contemplate the utilization of these instruments before treatment begins. The ethical question suggests the necessity of administration of the instruments during the intake process. A clinician may be able to identify individuals unlikely to be amendable to treatment.

By doing this, it saves time and resources for all parties. If the clinic has an established waitlist, it becomes all the more imperative to think about maximum yield of resources the clinic and clinician can offer the community.

An important part of the discussion of these findings is its application to specifically adult male offenders. The literature is clear that adolescent offending occurs for vastly different reasons (Davis & Leitenberg, 1987). Female offenders, similarly, offend for notably different reasons (Colson et al, 2013). These findings should only be applied to adult males involved in the criminal justice system. Further research will be needed to determine if there are similar outcomes regarding adolescents and female offenders.

This present study provides reliable and accurate information. This study allows for the conversation to begin around treating adult male sexual offenders ethically and with research to assist in the understanding of what contributes to successful treatment. The current stigma and culture around sexual offending forms one of the largest barriers from engagement in meaningful research. This study aims to show that there is a vast amount of research needed and it can yield promising results.

Limitations

Several limitations became evident through the present study. First, this study appears to be the first of its kind, which indicates a strong need for replication in different countries and geographies. This study is completed solely at an outpatient clinic in the Pacific Northwest. Utilizing a different sample from a different region will assist in validation of these findings. Replicating this study in another country will assist in comprehension of utility on a more universal level. Something to consider is the relatively small sample size of 74. Though this is

not an egregiously small sample, increases in the number of participants will assist in establishing a more complete conceptualization within the global population.

Another limiting factor is the sample was completed on people using a group-based CBT treatment modality. It is unknown if these findings are applicable across sexual offending treatments or specific to this model. Further research would assist in deepening the understanding of the application of these results. In line with a limitation is that a unique curriculum was used, and those participants are included in the data. It is possible the data is skewed somewhat due to inclusion of a CBT curriculum and the LATTICES curriculum.

An additional consideration for future understanding is application cross-culturally. Unfortunately, the sample, though it had some diversity, was largely white. Replicating this study on a more diverse sample will likely add validity and comprehension to the results in the present study. Other demographics that were not explored include the gender, sexuality, age of victim, and length of incarceration. Though not a complete list, these are possible factors that may influence the outcomes unknown currently.

To conclude, there is evidence that ACEs total score and PAI Antisocial scores are predictive of treatment outcomes of group-based CBT sex-offender treatment program that incorporated RNR principles (Ward & Groener, 2018) among adult male sexual offenders. In other words, our results facilitate distinguishing among individuals who may benefit and individuals who are less likely to be amenable for treatment. Further research is necessary to establish generalizability to other populations and modalities. Given the present results, treating clinicians should ponder the use of the ACEs and the PAI as instruments administered to all patients during intake. These tools will assist in the identification for patients amenable to treatment or not.

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Curriculum Vitae

Nicholas Ryan Rogers, B.S., M.A., QMHP

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EDUCATION

In Progress	**PsyD Clinical Psychology** *(APA Accredited)* George Fox University, Newberg, OR Academic Advisor: TBD *Anticipated Graduation May 2024* **Dissertation:** *The Influence of Personality and Trauma on the Outcomes of Sex Offender Treatment in an Outpatient Setting,* **Defended:** *Sept 22*
2021	**MA Clinical Psychology** *Magna Cum Laude GPA: 3.8* George Fox University, Newberg, OR Academic Advisor: Glena Andrews PhD, ABPP
2017	**BS Criminal Justice**, *Summa Cum Laude GPA:3.9* Husson University, Bangor, ME Academic Advisor: Russ Strout
2016	**AS Criminal Justice**, *Cum Laude* Southern Maine Community College, South Portland, ME

SUPERVISED CLINICAL EXPERIENCE

Aug 2022— Present

Pre-Internship
Health & Counseling Center: University Counseling
George Fox University
Newberg, OR
Supervisor: Dr. Bill Buhrow PsyD
Description

- Provide evidence-based treatment to undergraduate and graduate students at an on-campus clinic
- Conduct intakes for therapeutic and assessment services
- Utilize multiple therapeutic skills and orientations
    - CBT, Humanistic, Narrative Therapy

- Administer Assessment
  - Learning Disabilities, ADHD

Aug 2021— August 2022 *Practicum II*
Behavioral Health Clinic: Assessment
Newberg, OR
Supervisor: Dr. Julie Oyemaja PsyD
Description
- Administering psychological assessment across the lifespan
  - Neurological, Cognitive, Personality
- Conduct intakes for therapeutic and assessment services
- Administrative development for the clinic
- Program development for a community-based clinic
- Develop a new practice and systems for a community based clinic
- Develop client specific test batteries for administration
- Interpretation of expansive neuropsychological evaluations

Jan 2021—Present *Behavioral Health Crisis Consultation Team*
Providence Newberg Medical Center & Willamette Valley Medical Center
Newberg & McMinnville, OR
Supervisor: Dr. Luann Foster PsyD
Description
- Provide crisis consultation and high acuity risk assessment for Yamhill county in Oregon (multiple emergency departments)
- Evaluate individuals in emergency departments for suicide risk and give recommendations for treatment options
- Determine need of legal hold and movement of patients in crisis
- Secure transportation and relocation for patients in crisis
- Only on-call psych provider in the county
- Meet weekly with an interdisciplinary team
- Diagnose individuals in crisis

July 2020—July 2021 *Practicum I: Practicum Intern*
Oregon Center for Change
Beaverton, OR
Supervisor: Dr. Jane Ward PhD

Description
- Provide evidence-based treatment to individuals convicted of sexual offenses.
- Work within a forensic population
- Navigate the criminal justice system (courts, lawyers, probation officers)
- Operate in a Cognitive Behavioral Therapy framework
- Facilitate group therapy
- Conduct personality & forensic assessment
- Individual client therapy for 30+ weeks of treatment
- Write legal documentation for Washington County in Oregon.
    - These documents included quarterly reports, intakes, assessment interpretation, and weekly notes

Oct 2020—Oct 2022 *Doctoral Student Intake Screener*
Friendsview Retirement Community
Newberg, OR
Supervisor: Dr. Glena Andrews PhD, ABPP (2020-2021)
Supervisor: Dr. Kenneth Logan PsyD (2021- present)
Description:
- Conduct weekly intakes in a retirement community
- Intakes include interviews, assessments, screeners, and neurological assessments
- Make diagnostic recommendation regarding memory impairment and onset of chronic illness
- Write a report for each client and submit it to the admissions committee with recommendations

Sep 2019—Sep 2020 *Forensic Team Member*
Private Practice
Newberg, OR
Supervisor: Patricia Warford, PsyD
Description:
- Forensic assessment administration and interpretation
- Work within correctional systems
- Navigate criminal justice system
- Development of understanding of laws and regulation of psychological assessment in a clinical population
- Report organization & extensive file review

- Diagnosing in the forensic setting

Sep 2019—April 2020 *Pre-Practicum: Student Therapist*
Graduate School of Clinical Psychology
George Fox University, Newberg, OR
Supervisors: Glena Andrews, PhD, ABPP; Alisha Wegner, MA
Description:

- Provide outpatient, individual, client-centered psychotherapy services to two volunteer undergraduate students
- Conduct intake interviews, write treatment plans, make diagnoses, write professional reports, and make case presentations
- Consult with supervisors and members of clinical team
- All sessions video-taped, reviewed extensively, and discussed in individual and group supervision

RELATED PROFESSIONAL EXPERIENCE

August 2018 – 2019 *Community Action*, Hillsboro, OR
Supervisor: Melissa Baca
Description: Case Manager
Proficient in navigating community resources to assist individuals suffering from chronic homelessness achieve housing stability

- Knowledge of available resources for individuals with low SES and ability to utilize resources
- Expertise in immediate rapport building
- Certified in Motivational Interviewing
- Employ ethical standards as well as adhere to all HIPPA regulations and standards
- Monitor homeless veterans with a caseload of up to 25 clients
- Work in dynamic integrated teams with numerous organizations within the community

December 2009—2018 *Spring Harbor Hospital*, Westbrook, ME
Supervisor: Danielle Cline BSN,
Description: Psychiatric Technician III & Admissions Coordinator
Proficient in immediate care and basic group therapy of individuals with acute mental illness.

- Employed expert level knowledge of crisis intervention with a

focus in de-escalation
- Shift Supervisor of other Psychiatric Technicians
- Employed clear and detailed knowledge regarding HIPPA and ethical standards needed to maintain patient privacy and confidentiality
- Worked closely with patients for extended periods of time evaluating behavioral, psychological, and neurocognitive issues
- Wrote behavioral observation reports for each patient
- Trained other employees
- Facilitated group therapy with a focus in CBT
- Facilitated and organized the admission of patients from three different hospitals
- Executed initial intake interviews and assessments
- Part of an integrated medical team to ensure best quality of care and treatment
    - Team included: Psychiatrists, Physician Assistants, Nurses, Managers, Medical Director, Psychiatric Technicians, Social Workers, and appropriate Community Resources

PROFFESSIONAL TRAINING

Aug 2022—Present

Clinical Team IV
George Fox University Graduate School of Clinical Psychology
Newberg, OR
Licensed Psychologist Supervisor: Nancy Thurstan PsyD, ABPP/CL
- Consultation group that meets weekly to present and discuss cases from various clinical perspectives and theoretical orientations
- Give personal experience presentations and seek consultation

Aug 2021—May 2022

Clinical Team III
George Fox University Graduate School of Clinical Psychology
Newberg, OR
Licensed Psychologist Supervisor: Leann Foster, PsyD
- Consultation group that meets weekly to present and discuss cases from various clinical perspectives and theoretical orientations

- Give personal experience presentations and seek consultation

Sep 2020— Feb 2021 *Admissions Committee member*
Graduate School of Clinical Psychology
George Fox University, Newberg, OR
Description:

- Weekly committee meetings to sort through applications of incoming candidates for the doctoral program in clinical psychology at George Fox University
- Assess and score applicants
- Discuss and present arguments for and against interview
- Organizing admissions interview day
- Select and extend offers to potential candidates

Sep 2020—May 2021 Clinical Team II
George Fox University Graduate School of Clinical Psychology
Newberg, OR
Licensed Psychologist Supervisor: Winston Seegobin, PsyD

- Consultation group that meets weekly to present and discuss cases from various clinical perspectives and theoretical orientations
- Give personal experience presentations and seek consultation

Sep 2019—April 2020 *Clinical Team*
George Fox University Graduate School of Clinical Psychology
Newberg, OR
Licensed Psychologist Supervisor: Christina Weiss, PsyD

- Consultation group that meets weekly to present and discuss cases from various clinical perspectives and theoretical orientations

Brandy Liebscher PsyD. Anti-Racism, Spiritual Freedom, and Wellness, Graduate School of clinical Psychology, Newberg, OR. November 3rd, 2021

Elisabeth Wilson, PhD, LMFT. *Erotic Transcendence: Integrating faith with what's new in sex*

research, Graduate School of Clinical Psychology, Newberg, OR. October 13th, 2021.

Patricia Robinson PhD. *New Roles for Primary Care: primary behavioral healthcare essentials*, Interprofessional Primary Care Institute, Newberg, OR. August 18th – August 20th

Chloe Ackerman, PsyD. *Gender Diverse Clients: Therapy & Intervention Readiness Assessments*, Graduate School of Clinical Psychology, George Fox University, Newberg, OR. March 10th, 2021

Janelle Kwee, PsyD. *Saying 'Yes' to Your Embodied Life: An Invitation for Psychotherapists*, Graduate School of Clinical Psychology, George Fox University, Newberg, OR. February 3rd, 2021

Jason Steward, PhD. *Treatment for Military personal who have experienced sexual trauma in the military as well as treatment for people with Complex PTSD*, Graduate School of Clinical Psychology, George Fox University, Newberg, OR. November 4, 2020

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

Daniel Gatzembidi, PsyD. Effective Therapy with Underserved and Marginalized People, Graduate School of Clinical Psychology, George Fox University, Newberg, OR. March 18th, 2020

Amy Stoeber PhD. *Mitigating the Effects of ACES & Transforming Primary Care through Resilience Building & Compassionate Connection*, Graduate School of Clinical Psychology, George Fox University, Newberg, OR. February 21, 2020

Cheryl Forster, PsyD. *Intercultural prerequisites for effective diversity work.* Colloquium, Graduate School of Clinical Psychology, George Fox University, Newberg, OR. October 15, 2019.

Everett L. Worthington, Jr., PhD. *Promoting forgiveness.* Colloquium, Graduate School of Clinical Psychology, George Fox University, Newberg, OR. September 25, 2019.

RESEARCH & TEACHING EXPERIENCE

2022 *Supervisor*:
Population: Graduate psychology students

Purpose: Assist with professional development, navigation of ethical issues, and clinical skill maturation for graduate students
Graduate School of Clinical Psychology
George Fox University, Newberg, OR

Professor: Semester Long
Class: Psychological Assessment
Undergraduate School of Clinical Psychology
George Fox University, Newberg, OR

Rogers, N. R., **Stumpf**, B. C., Ward, J., & Vogel, M. J. (2022, April 30). *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://westernpsych.org/

Guest Lecturer
Undergraduate School of Clinical Psychology
George Fox University, Newberg, OR
Presentation: Narcotics, Addiction, & Trauma

2021

Expert Lecturer
Undergraduate School of Clinical Psychology
George Fox University, Newberg, OR
Presentation: Neuropsychological assessment application to Abnormal Psychology

Guest Lecturer
Undergraduate School of Clinical Psychology
George Fox University, Newberg, OR
Presentation: *Neuropsychological Assessment*

2020—Present

Research Vertical Team Member (Levels I, II, III, IV)
Graduate School of Clinical Psychology
George Fox University, Newberg, OR
Chair: Dr. Rodger Bufford PhD
Research: meet bi-weekly to discuss and evaluate progress, methodology, and design of group and individual research projects, including dissertation
Areas of team focus: Neuropsychology

Specific personal interests: Neuropsychology, Forensic Psychology, & Crisis Intervention

2019 Mushlitz, A., Andrews, G., & Rogers, N. (2019). *Memory and Behavior: A Pilot Study with People on Probation* [A Poster Presentation]. American Psychological Association (APA) 128th annual conference Washington D.C., United States.

PROFESSIONAL AFFILIATIONS

2019—Present American Psychological Association
(Graduate Student Affiliate)

RELEVANT MEMBERSHIPS & PARTICIPATION

2019—2022 *Neuropsychology Student Interest Group (Member)*
Graduate School of Clinical Psychology
George Fox University, Newberg, OR

Forensic Student Interest Group (Member)
Graduate School of Clinical Psychology
George Fox University, Newberg, OR

REFERENCES

References available upon request. Please e-mail me at nrogers19@georgefox.edu *to request professional, academic, or personal references.*