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FEMALE SEXUAL OFFENDING: THE EXPERIENCES IDENTIFIED BY TREATMENT PROVIDERS

By

Jalie L. Adams

A dissertation submitted to the faculty of

Bellarmine University

In partial fulfillment of the requirements for the degree

Doctor of Philosophy

In Education and Social Change

April 2024

FEMALE SEXUAL OFFENDING: THE EXPERIENCES IDENTIFIED BY TREATMENT PROVIDERS

By

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Dissertation Approved on

April 1st, 2024

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Acknowledgements and Dedication

My educational journey would not have been possible without the help and guidance of many great souls and some interesting life experiences along the way. To the largely ignored field of female sexual offending, I hope this dissertation shines a spotlight in the right direction. As a young and inexperienced provider leaving the ivory tower, embarking upon the therapeutic treatment of the incarcerated sexual offender population was the professional path that set this dissertation in motion. I am thankful for the experiences gained while working within sexual offender treatment programming and to the knowledgeable colleagues who took me under their strong wings. I was exactly where I needed to be. Their kindness and wisdom helped shape the compassionate and skilled provider that I am today. Many years have passed since I was that young provider entering the field of therapeutic sexual offender treatment, yet I hope to remain a constant light for all those willing to peer into the depths. We all deserve a little help sometimes.

To the therapeutic providers who took the time to share their war stories, battle wounds, and victories, I thank you. It is by sharing experiences that we learn and grow. To Elizabeth and Cindy, a simple thank you is not enough. You both took valuable time within your busy lives to read sections, if not the entirety, of this beast of written work. As first readers, you rule the school! As friends, your genuineness, encouragement, and dependability mean more than I could ever express. To my committee, your insightful feedback, assistive guidance, and thoughtful consideration are most appreciated. Thank you.

I am grateful to my loving and embracing family. I can't think of one person who didn't encourage and support my educational journey in both small and large ways. Regardless of which educational degree program I was attending, you have always been there when I needed you. You are my backbone and my strength. Your love, faith, and wisdom are awe-inspiring. To

my daddy who was there for all of my previous graduations, I will miss you at this one. I can only hope that you are proud of the woman I have become. Maybe one day I will pursue becoming that school teacher like you always suggested. To Alex, my kind and patient fiancé, I have the time to plan that wedding now. Thank you for putting up with and continuing to love a forever student. Lastly, to my Madre, you are the most selfless person I know. You have always put the needs of others above your own. Your strength, faith, and love guide me every day. I could not have accomplished anything in life without you. Thank you for always encouraging me through times of tears, frustration, and triumph. This Ph.D. is as much yours as it is mine.

In closing, to the fearless warriors and compassionate souls who aided and encouraged me on this journey, thank you. Finally, to God, my unwavering gratitude, for putting people in my life to help support me through it all. You knew what you were doing. From the bottom of my heart, thank you. This dissertation is dedicated to humanity. To those who look into the dark and explore the depths, may we emerge a little wiser and a little less broken. Let us all be the light to heal the world.

Abstract

Female sexual offending is a complex topic largely ignored within scholarly literature and among society. Therapeutic treatment providers with experience in the behavioral health care of the female sexual offender population provide the opportunity for additional awareness, insight, and understanding related to the phenomenon of female sexual offending through their distinct provider lens. This phenomenological research study used the lens of therapeutic provider experiences to build a succinct foundational overview of the topic of female sexual offending, expand knowledge related to the field, and develop insight into the providers who treat this complex population. This study was guided by the following research question: What are the experiences of treatment providers working with female sexual offenders? In-depth, semi-structured interviews were completed with 10 therapeutic behavioral health treatment providers with experience in providing direct mental health treatment services to females who have perpetrated sexual crimes. Through the unique provider lens, four core themes emerged which captured the essence of the experiences encountered by therapeutic treatment providers when delivering behavioral health care services to the female sexual offender population: (1) Experiences- Cyclical, (2) Experiences- Female Sexual Recidivists, (3) Experiences- Coping Skills, and (4) Experiences- Professional Need. Findings are addressed in relation to social exchange theory, reflective practice, the theoretical model of communal coping, and self-authorship. The study concludes with an examination of implications for future research and recommendations to inform and guide clinical practice.

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Female Sexual Offending: The Experiences Identified by Treatment Providers

Chapter One: Introduction

A Significant Need in the Field of Female Sexual Offending

Female sexual offense behavior is a complex topic with scarce previous research in the field (Cortoni et al., 2010; Willis & Levenson, 2016). McLeod (2015) identifies female sexual offenders as one of the most underrepresented groups of sexual offenders in the criminal justice system. Consistent data across studies indicate that females represent approximately one percent of the sexual offender population within the prison system (Elliott et al., 2010; McLeod, 2015; Pflugradt & Allen, 2010). More recently, Kajstura and Sawyer (2023) provide tangible figures on incarcerated women and estimate that as of 2023, there were approximately 3000 women imprisoned for rape, sexual assault, and other sexual assault crimes within the United States.

Although low percentages of incarcerated female sexual offenders may suggest that women rarely engage in sexually deviant behavior, it is possible that female perpetrated sexual crimes are underreported. Research from several studies attribute underreporting to societal biases and stereotypes in which professional and public opinions fail to acknowledge that women engage in sexually offensive behavior (Brayford, 2012; Muskens et al., 2011; Pflugradt & Allen, 2014; Shields & Cochran, 2020; Stemple et al., 2017). Longstanding views within society and the criminal justice system have assigned typical perpetrator roles to men, while promoting women within the context of victimization and oppression (Banton & West, 2020; Elliott et al., 2010). Furthermore, Pflugradt and Allen (2010) describe a prominent cultural belief which depicts women as nurturing caregivers. Considering this cultural context, women are viewed as responsible family providers who protect others and promote well-being. Brayford (2012) and Weinsheimer et al. (2017) suggest that within this societal perception, sexual abuse may be

disguised within everyday caretaking roles and may therefore be easily overlooked in the context of daily caretaking activities and not be detected as abuse. These long held misperceptions and errant cultural messages may result in a multitude of female perpetrated sexual crimes not being reported or detected within the criminal justice system. While society may find it unimaginable that women would engage in sexually harmful and abusive behaviors, some women willingly engage in sexually offensive behavior against both children and adults.

Should female perpetrated sexual crimes be reported, research suggests that sexually abusive behavior by women is often viewed by law enforcement personnel, mental health professionals, and community members as less serious than sexual offense behavior committed by male perpetrators (Banton & West, 2020; Brayford, 2012; Harrati et al., 2018; Shields & Cochran, 2020; Stemple et al., 2017; Weinsheimer et al., 2017). Shields and Cochran (2020) and Stemple et al. (2017) suggest that female sexual perpetrators receive more lenient treatment within the general public and indicate that when female perpetrated crimes are reported to the criminal justice system, law enforcement personnel believe criminal intervention to be less warranted. Research suggests that female offenders are less likely to be prosecuted, receive lighter penalties and shorter sentences, and are more likely to be diverted to mental health treatment and probation service options than their male counterparts (Banton & West, 2020; Shields & Cochran, 2020; Stemple et al., 2017; Weinsheimer et al., 2017).

Despite diversions and referrals to mental health treatment, therapeutic providers also fall victim to similar misperceptions regarding female sexual offense behavior. Mellor and Deering (2010) and Stemple et al. (2017) emphasize that the harmful effects of sexually deviant behavior committed by women is often minimized by providers in the mental health field. Mellor and Deering (2010) specifically examined the attitudes and potential bias of therapeutic providers

who work with the sexual offender population and indicate that female perpetrated sexual crimes were considered to be less harmful, less worthy of intervention, and less likely to result in criminal prosecution than sexual crimes perpetrated by male offenders. Such common perceptions that women are sexually harmless allow providers to build a culture of denial that fails to distinguish the severity of female perpetrated sexual abuse (Brayford, 2012; Stemple et al., 2017). A reliance on traditional gender stereotypes regarding female sexual offense behavior may diminish a treatment provider's ability to respond and treat female sexual offending appropriately, which may provide the opportunity for individuals to continue perpetrating sexual crimes (Mellor & Deering, 2010). The societal and professional under-recognition, minimization, and denial of female sexually deviant behavior has created numerous disclosure, reporting, and research obstacles in the field of female sexual offending.

Should deviant sexual behavior be reported and therapeutic services be sought, research indicates that most behavioral health providers are unwilling to provide therapeutic care to individuals who have perpetrated sexual crimes (Stiels-Glenn, 2010; Schmidt & Niehaus, 2022). Of those willing to provide services to sexual offenders, many indicated challenges to their core beliefs, intrusive thoughts, criticism and suspicion of others, and doubt of their professional confidence (Dean and Barnett, 2011). Despite the challenges in treating sexual offenders, providers also expressed a deep sense of satisfaction gained from building a trusting and empowering therapeutic relationship and a sense of pride and achievement related to developing clinical skills, improving professional knowledge, protecting the public, and contributing to offender change and growth (Dean and Barnett, 2011).

Like most studies involving female sexual offending, research pertaining to professional experiences, challenges, and resources when providing care specifically to female offenders has

been scarce. Few studies have examined the experiences of mental health care providers treating female sexual offenders. However, similar to public opinion, research indicates that therapeutic providers also demonstrate differential gender beliefs regarding sexual perpetrators. Hovey et al. (2013) directly examined therapists' beliefs regarding sexual offending and suggests that clinical providers found female perpetrated sexual crimes less believable than sexual crimes committed by male individuals. Such gender differences may have strong implications for therapeutic practice. Although treatment providers recognize that female perpetrated sexual offenses exist, their beliefs and practices indicate that they respond to concerns of female sexual offending in a less serious manner (Hovey et al., 2013), thus further contributing to the stereotypes and narrowed vison surrounding female sexual offense behavior that may inhibit female offenders from receiving the therapeutic care needed to reduce sexually deviant behavior.

The lack of data regarding female sexual offense behavior, as well as the minimal literature designated to the study of the treatment providers offering therapeutic services to the female offender population, have created widespread gaps in the field of female sexual offending. These extensive gaps have impaired understanding of female perpetrated sexual crimes and hindered advances to guide, support, and inform behavioral health clinical practice. Further study in the field of female sexual offending is essential. The providers who offer direct therapeutic care to the female sexual offender population hold unique insights and experiences related to the field. Advanced study through the specialized therapeutic provider lens, is one strategy to bridge the gap in the literature and expand knowledge in the field of female sexual offense behavior and the experiences of the providers who have delivered therapeutic care to this distinctive population. Future study, using the lens of therapeutic providers, is required to aid in establishing improved understanding of experiences when treating such a distinctive population

and offer a useful tool in advancing knowledge of sexually deviant behavior in the female population, increasing awareness of gender-specific distinctions, and enhancing insight to better support therapeutic providers who specialize in treating female offenders.

Study Overview and Purpose

Evidence suggests that sexual abuse perpetrated by women may be more prevalent than currently understood and likely exceeds current conviction rates (Brayford, 2012; Cortoni et al., 2017; Stemple et al., 2017). Longstanding perceptions regarding female sexual offense behavior need to be examined and challenged. An awareness of female perpetrated sexual crimes and the experiences of providers who have delivered care to this population will assist with establishing a comprehensive understanding of deviant sexual behavior in the female population and aid in understanding the unique characteristics specific to female sexual offenders and the providers who specialize in their direct care.

Therapeutic providers with experience treating the female sexual offender population offer unique insight related to the field. The low conviction rates of female sexual offenders have limited broad research related to female sexual offense behavior. However, the study of providers with experience in treating female sexual offenders provided the opportunity for additional insight and understanding related to the phenomenon of female sexual offending through the therapeutic provider lens. A phenomenological research approach captured the essence of the clinical experiences encountered by treatment providers when offering therapeutic care to female sexual offenders and explored how providers experience the world in order to establish an advanced understanding of the nature and meaning of life experiences when providing behavioral health care to female sexual offenders. This research study utilized the lens of therapeutic provider experiences and perspectives to build a succinct foundational overview of

the topic of female sexual offending, expand knowledge related to the field, and develop insight into the providers who specialize in treating this focused population. Specifically, the current study was guided by the following research question:

1. What are the experiences of treatment providers working with female sexual offenders?

To address this research question, a qualitative, phenomenological research design using a constructivist worldview explored the complex elements in the field of female sexual offending. A constructivist worldview aids individuals in understanding the world in which they live through the subjective meaning of life experiences (Creswell and Creswell, 2018). The goal of this worldview is to rely on the participants' views and understanding of the topic being studied in order to examine personal experiences, social interaction, and cultural norms within the participants' life. Participant experiences, social interactions, and cultural norms are a useful tool in shaping a detailed understanding of participant experiences and can aid in improving insight into a specific topic or field. Guided by constructivist theory and phenomenological research design, this study provided the necessary data to examine and interpret the perspective of individuals who have provided therapeutic behavioral health care to women who have engaged in sexual crimes, thus capturing the essence of the clinical experiences encountered by treatment providers when working with female sexual offenders. Such experiences provide a unique lens and opportunity to develop and enhance the limited knowledge and insight related to the topic of female sexual offending and the therapeutic providers who care for this distinct population.

Ontological, Epistemological, and Axiological Assumptions

Phenomenological research designs utilize the researcher as a primary data collection instrument (Vagle, 2018). As such, the researcher holds personal values and beliefs that may shape interpretations during the study. The present research study proceeds with underlying ontological, epistemological, and axiological assumptions of the researcher and should be considered when exploring the essence of the experiences of therapeutic treatment providers working with the female sexual offender population. Specifically, the study ensued with the ontological assumption that knowledge and reality are comprised of multiple truths which rely on individualized lived experiences. Therefore, this study relied on multiple behavioral health care provider perspectives to develop and identify key themes and knowledge related to the field of female sexual offending and the experiences of the clinical providers who have focused on the treatment needs of this distinctive population. Provider views, outlooks, and ideas aided in gaining an understanding of the essence of experiences endorsed by therapeutic clinical providers when treating female sexual offenders. Additionally, reality can be changed. This epistemological assumption is a key component in the therapeutic setting, and to this research study, as therapeutic providers assist individuals with personal growth, development, and healthy decision making. Therefore, this study assumed that provider experiences are generally geared towards healthy development and offense-free lifestyles for offenders. This research is intended to advance knowledge of the topic to better meet the needs of providers and offenders in a narrowly researched field. Finally, the axiological assumption of care and concern for all is emphasized throughout this study. All life is valuable. This research study evolved with the assumption that all individuals are able to adapt, learn, and provide meaningful value and insight

within the world. This assumption includes individuals who have committed sexual crimes and therapeutic treatment providers who often face fierce stigma from the general public.

Key Terms

In addition to ontological, epistemological, and axiological assumptions, the study will reference several important key terms throughout the research. These terms are defined in order to portray the lived experiences of therapeutic providers when treating and working with the female sexual offender population. The reader must understand these terms to establish meaning, impact, and interpretation of the results.

Treatment Provider: A therapeutic clinical provider who has worked directly with and focused on the behavioral health treatment of female sexual offenders (Jung et al., 2012). For this study, participants consisted of treatment providers who have an employment and educational background in behavioral health (social service clinicians, psychologists, licensed psychological associates, evaluation and referral coordinators, licensed professional clinical counselors, or licensed clinical social workers) and have experience providing direct patient care designed towards the therapeutic treatment of women who have engaged in sexual offense behavior.

Female Sexual Offender: A female individual who has engaged in sexually harmful and abusive behaviors and offenses towards others (Bensel et al., 2019).

Cognitive Distortions: Inaccurate thought patterns and changes to the ways in which individuals think about themselves, others, and their environment (Dean and Barnett, 2011).

Offense Supportive Attitudes: Attitudes and beliefs that support, justify, or excuse sexual offense behavior (Pflugradt and Allen, 2015).

Psychological Characteristics: The demographic and clinical characteristics of an individual that influence their thoughts or behavior (Muskens et al., 2011).

Co-Offender: An offender who committed a criminal offense with an accomplice (Muskens et al., 2011).

Recidivism: The reoccurrence of unlawful behavior which results in an additional criminal offense as indicated by an arrest, charge, conviction, or detention for the crime (Cortoni et al., 2010).

Sexual Recidivism: The reoccurrence of unlawful sexual behavior which results in an additional criminal offense arrest, charge, conviction, or reincarceration for a sexually deviant crime (Cortoni et al., 2010).

Coping Skills: Professional and personal resources and adaptive strategies to aid in the management of stressful experiences, promote self-care, and encourage ethical clinical practice (Willis et al., 2018).

Burnout: An emotional outcome typically related to occupational stressors that result in feelings of exhaustion, loss of idealism, and a diminished sense of professional accomplishment (Baum & Moyal, 2020).

Vicarious Trauma: Symptoms identical to those found in post-traumatic stress disorder that occur following exposure to the traumatic life stories and experiences of others, particularly within the behavioral health care profession (Baum & Moyal, 2020).

Chapter Two: A Review of the Literature

The following review of the literature examined and synthesized current research regarding the field of female sexual offending to identify emerging themes, conclusions, and research needs specific to the topic of female sexual offending and the providers who have experience treating this particular population. Furthermore, the review explored characteristics distinctive of female offenders, identified potential risk factors, examined prevalence and recidivism rates, and investigated provider experiences when treating the female sexual offender population. Given that research related to both female sexual offending and the providers who treat this specific population is significantly limited, lagging far behind research advances made in the study of male perpetrators, compiling a foundation of existing empirical research increased understanding and awareness of female perpetrated sexual crimes. Furthermore, existing empirical research provided a solid foundation on which additional insights related to the phenomenon of female sexual offending, through the therapeutic provider lens of the current research study, can develop.

Literature Selection Criteria, Process, and Inclusion

Studies examining female sexual offense behavior and the providers who specialize in delivering direct care to the female sexual offender population were explored and considered for review. To review the most current research, as well as cover the last 15 years of literature in which to establish context in the field, a parameter was established for articles published between the years of 2008 to 2023. Studies were compiled from high quality, peer reviewed journals and represent empirically based research. For the purposes of this literature review, the focus was placed on the past 15 years of research in order to create a thorough grasp on where research in the field presently stands. Additionally, focus was placed on adult female sexual offenders and

therapeutic treatment providers with experience in the direct care of the adult female sexual offender population. Therefore, research related to juvenile offenders and research focused solely on male sexual perpetrators were excluded from review.

To date, research pertaining to the topic of female sexual offending and the therapeutic providers who treat this population is limited. As a result, an assortment of search terms was used to provide the most inclusive data related to the topic of female sexual offending. Specifically, search terms included combinations of the following: *female sexual offenders, etiology, theory, risk factors, assessment, prevalence, recidivism, treatment, therapeutic providers, therapist, professionals, attitudes, and experiences.* A systematic search process was completed using electronic databases, ancestral searches, and professional colleagues in the field to identify and locate literature regarding the field of female sexual offending. The electronic databases Psychinfo, PsychArticles, and the Psychology and Behavioral Sciences Collection yielded several relevant research articles. From these articles, ancestral searches were completed by reviewing article citations and reference lists. Lastly, professional colleagues in the sex offender treatment field were consulted and recommended various researchers and articles to consult for review. These search procedures generated the strong selection of applicable empirical research necessary to establish a sturdy foundation describing the field of female sexual offense behavior on which additional insights related to the phenomenon of female sexual offending, through the therapeutic provider lens of the current research study, can develop.

Each of the relevant research articles were examined and summaries were created for each article. The summaries outlined key aspects, research questions, methods, and results of each study. After each study was summarized, the findings were collectively examined and compared to identify significant themes related to female sexual offending and the providers who

specialize in the therapeutic care of this population. Upon comparison, specific themes related to offender characteristics, offense motivations, gender distinctions, prevalence and recidivism rates, assessment, risk and protective factors, treatment needs, and provider considerations emerged. Thus, this literature review synthesized research in the field of female sexual offending and provided a detailed depiction of the phenomenon of female sexual offense behavior and therapeutic treatment provider considerations in the field as a strong foundation on which new insights and development, through the therapeutic provider lens of the current study, may advance.

Female Sexual Offending: Characteristics, Considerations, and Topics in the Field

The Typical Profile: General Offender Characteristics

Female sexual offenders are an extremely diverse population and their individual characteristics, offense patterns, and treatment needs must be considered. While it is difficult to assign a typical profile for women who have engaged in sexual crimes, research consistently describes commonalities among female sexual offenders. As a majority, female sexual offenders tend to primarily be Caucasian, typically ranging between 20 and 30 years of age, have limited educational and employment qualifications, tend to offend against biological children or victims related by family, identify a significant physical, sexual, and emotional abuse and neglect history, and experience substantial mental health concerns (Bensel et al., 2019; Brayford, 2012; Comartin et al., 2018, 2021; Kaylor et al., 2021; Shields & Cochran, 2020; Williams & Bierie, 2015).

In-depth Psychological Profiles: Female Sexual Offenders

A closer examination of the psychological characteristics consistently reported across studies provides detailed information regarding female sexual offenders. Common psychological

elements collective of the female sexual offender population can be broadly summarized by unstable lifestyles, unhealthy coping mechanisms, and poor problem-solving abilities (Pflugradt & Allen, 2015). Data from multiple sources also describe high prevalence of unhealthy and abusive interpersonal relationships, low self-esteem, poor impulse control skills, low educational attainment, and employment instability (Brayford, 2012; Harrati et al., 2018; Pflugradt & Allen, 2010, 2014, 2015; Stemple et al., 2017; Wijkman et al., 2011; Willis & Levenson, 2016).

Furthermore, research also places significant importance on developmental factors and vulnerability traits common among female sexual offenders. Research completed by Elliott et al. (2010), Gannon et al. (2008), McLeod (2015), and Willis and Levenson (2016) describe collective experiences of early trauma, physical/sexual/emotional abuse, and neglect. Willis and Levenson (2016) further emphasize early traumatic experiences involving chaotic households with parents who are unable to provide safe and supportive environments for their children. These collective experiences of early trauma paired with an absence of protective factors are likely to be severely damaging to the individual and have lasting impacts across the lifespan. Such adverse traumatic experiences may build a foundation of unhealthy relational patterns and poor coping techniques, which may contribute to neglectful and abusive behaviors as an adult.

Harrati et al. (2018) specifically examined the link between early traumatic life experiences and sexually deviant behavior and indicate that female sexual offenders are likely to replicate the physical and sexual abuse they experienced in childhood by mimicking and identifying with abusive caregivers. Furthermore, women with severe trauma histories who sexually offend may engage in violence as a way of managing conflict, hold distorted and impaired sexual models, have troubled moral values, and be confused regarding sexuality, love,

and aggression. Lastly, Herrati et al. (2018) suggest that women who perpetrate sexual crimes often lack healthy interpersonal relational skills and have conflictual family relationships.

In a more recent study, McLeod and Dodd (2022) identify extensive childhood trauma histories and a lifetime of victimization and unhealthy relational patterns as crucial characteristics shared among the female sexual offender population. In describing shared characteristics among female sexual offenders, McLeod and Dodd (2022) emphasize a modern profile addressing psychological characteristics that embrace trauma-informed aspects of sexual offense behavior and identify distinct typologies among female offenders. McLeod and Dodd (2022) identify a relational offender typology as a female offender who does not recognize their behavior as morally wrong. These women intend no harm to the victim and believe they are demonstrating feelings of love and support in pursuit of emotional connection with the victim. McLeod and Dodd (2022) suggest that women among this typology have likely experienced trauma across the lifespan which manifests in the form of inappropriate boundary development. As a result, women of this typology lack the self-regulation skills associated with healthy interpersonal relationship formation and appropriate boundary setting.

Additionally, a female predatory offender typology may most resemble the psychological characteristics observed in the male sexual offender population (McLeod & Dodd, 2022). McLeod and Dodd (2022) suggest that women among the predatory typology often lack empathy, have little regard for others, and sexually offend due to a desire for power and control. Women among this category have likely experienced chronic traumatic life experiences of abuse, neglect, and isolation which inhibit their ability to emotionally connect with others in healthy and meaningful ways (McLeod & Dodd, 2022).

Lastly, McLeod and Dodd (2022) suggest that female sexual offenders may also fall among the chaotic offender typology in which women view themselves as powerless within their life circumstances and indicate high rates of life dissatisfaction and dysfunction. Women among this category are most likely to view themselves as a victim, are involved in abusive intimate partner relationships, and perpetrate their crimes with a co-offender. Furthermore, McLeod and Dodd (2022) indicate that women within chaotic offender typologies endorse significant cognitive distortions involving minimization and justification for their abusive actions and behaviors. Women within this category have likely experienced trauma related to dysfunctional households and significant intimate partner violence which may increase feelings of helplessness, reduce feelings of control within their life, weaken communication skills, and disrupt emotional regulation (McLeod and Dodd, 2022).

Profound histories of traumatic life experiences and victimization patterns are not the only shared characteristics among the female sexual offender population. Mental illness and offense supportive cognitive distortions have also been found to be a common characteristic among female sexual perpetrators (Wijkman et al., 2011). Specifically, Muskens et al. (2011) and Harrati et al. (2018) identify high rates of mood disorders as well as avoidant and dependent personality traits in the female population. Mental illness is often plagued by cognitive distortions and unhealthy thinking mechanisms. Specific to female sexual offenders are offense supportive attitudes and unhealthy core beliefs. Research conducted by Elliott et al. (2010), Pflugradt and Allen (2015), and Vess (2011) explore offense supportive cognitive distortions and have found that female sexual offenders are likely to view children as sexual objects, attribute the child with adult characteristics, relate to the child on an emotional level, and minimize the harm of sexually abusive behavior.

Co-offender Considerations

One area of interest related to female sexual offending is the possibility that females sexually offend with an accomplice. According to Muskens et al. (2011), as many as 96% of female sexual offenders commit crimes with a co-defendant. Bensel et al. (2019) and Muskens et al. (2011) examined the court records and psychological evaluations of a sample of female offenders and describe a typical co-offender situation as one in which females typically act with a male accomplice. Furthermore, female offenders were often romantically involved with or married to their accomplice. These relationships were frequently defined as abusive and often females reported they were encouraged or threatened to participate in sexually abusive behavior.

In addition, Bensel et al. (2019), Comartin et al. (2018), and Muskens et al. (2011) provided psychological profiles directly related to the differences between solo and co-offenders. Solo offenders were more likely to offend against an unrelated, male victim and they experienced high prevalence rates of mood disorders and mental illness. In contrast, co-offenders were more likely to offend against a female victim and reported high prevalence rates of avoidant and dependent personality disorders. Muskens et al. (2011) suggests that such results emphasize key differences in the motivations and psychological characteristics of offenders. Specifically, females who co-offend participate less in the initiation of the offense but co-offend out of possible fear of rejection or willingness to please their male co-offender. Elliot et al. (2010) found similar results regarding co-offending women and further emphasize the dependent and dysfunctional relationship experienced by co-offenders as based on power and control.

Research completed by Budd et al. (2017) used the National Incident-Based Reporting System (NIBRS) to specifically examine and provide in depth knowledge regarding co-offending among female sexual offenders. The NIBRS is the nation’s largest publicly available data set

tracking incident-level crimes reported to police. This data set allowed researchers to explore co-offending distinctions over a 21-year period to improve understanding of female sexual offense behaviors in terms of co-offending considerations. Data collected by Budd et al. (2017) indicate that females are significantly more likely to perpetrate sexual crimes with an accomplice in comparison to men. In addition, sexual crimes involving co-ed pairs are more likely to victimize females who are typically the dependent children or interfamilial family members of the female perpetrator. Such victim selection may indicate male perpetrator offending preferences. This research aligns with the work of Bensel et al. (2019), Elliot et al. (2010), and Muskens et al. (2011) suggesting that female sexual co-offenders may permit access to their children or relatives and sexually offend as a result of dysfunctional and dependent relationships with men.

As an additional consideration, Comartin et al. (2018) examined the childhood trauma histories and intimate partner relationships of female perpetrated sexual crimes involving an accomplice. Co-offending women were significantly more likely to experience significant disruptions in parental attachment. Specifically, co-offending women endorsed higher prevalence rates of life disturbances related to parental incarceration, divorce, parental substance abuse, and intimate partner violence. These additional distinctions related to the early attachment formation of women who engage in sexual co-offending stress the importance of assertiveness training, heathy interpersonal relationships, and self-esteem building for women who co-offend.

Additional Offense Motivations

Motives and explanations for sexually abusive behavior have been a primary focus in the field of sexual offending. Considering that previous research has identified high rates of trauma, abuse, and sexual victimization among female offenders, one possible explanation is the re-enactment of their own traumatic experiences. Vess (2011) describes the re-enactment of early

trauma as displaced feelings of anger, in which the individual identifies with their prior abuser as a means of coping and later becomes an offender when they act out their experiences on another person. Significant traumatic experiences may also severely damage an individual's ability to connect and form healthy relationships. Unhealthy relationships likely contribute to chaotic lifestyles, improper boundary setting, isolation, and warped attachments. Pflugradt and Allen (2010) and Cortoni et al. (2017) further relate a distorted desire for intimacy, sexual gratification, misguided social interaction, and perceived gains to following an abusive accomplice as additional offense motivations resulting from unhealthy relationship formations.

In a more recent study, Harrati et al. (2018) expand upon the motivations of female perpetrated sexual crimes and the strong link to early traumatic life experiences to identify four key motivations for offense behavior: a desire for power, sadism, extreme anger, and the quest for self-affirmation. Harrati et al. (2018) emphasize that women may commit sexual crimes as an underlying desire for power. Some women plan sexual abuse with the aim of controlling the victim. Often, women who sexually offend as a desire for power have experienced abandonment, family separation, and physical or sexual violence early in life (Harrati et al., 2018). Furthermore, Harrati et al. (2018) suggest that sadism has also been established as a motivation of sexual crimes perpetrated by women. For women in this category, sexual violence is the result of an established relational way of life in which confusion has occurred between incestuous practices and heathy, non-offensive sexual behavior. Harrati et al. (2018) indicate that women motivated by sadism were often raised in a family environment characterized by repeated incestuous relationships and violence. Extreme anger may also motivate sexually offensive behavior in women (Harrati et al., 2018). Some female perpetrators resort to excessive violence as a means to relieve feelings of resentment regarding past experiences. Harrati et al. (2018)

suggest that women motivated by extreme anger were often raised in psychologically neglectful and domestically violent homes. Lastly, Harrati et al. (2018) identified the quest for self-affirmation as a motivation for female perpetrated sexual behaviors. Women in this category often committed crimes in conjunction with other peers belonging to the same social network. In these situations, sexual aggression is viewed as a test of the sexual skills of the perpetrator. For these aggressors, the competitive and brutal nature of sexual behavior, paired with the use of torture and shame, are intended to display dominance. Individuals motivated by the quest for affirmation likely experienced family dysfunction marred by insecure and conflicting parental relationships. Regardless of the category of offense motivation, Harrati et al. (2018) suggest that early traumatic life experiences, such as domestic violence and neglect, have significant traumatic repercussions and impact behavior and relational formations into adulthood. As a result, cumulative traumatic events early in life may lead to the development of deviant sexual behavior as an adult.

Gender Specific Distinctions

Frequent debate among researchers involves specific gender distinctions between male and female offenders. Analysis of clinical files, court records, and psychometric assessments have produced several similarities and differences between genders. Research completed by Pflugradt and Allen (2015) identified several psychological characteristics shared by both male and female offenders. Both genders endorsed offense-supportive attitudes, conflict in interpersonal relationships, impulsivity, poor problem-solving skills, employment instability, and externalized coping mechanisms. Similar to Pflugradt and Allen (2015), Elliott et al. (2010) also emphasized gender commonalities in regard to poor self-management, dysfunctional relationships, and cognitive distortions.

While female sexual offenders may display similar psychological characteristics, deficits, and risk factors as men, it is important to consider ways in which females may be distinctly different from their male counterparts. Research by Burgess-Proctor et al. (2017), McLeod (2015), and Williams and Bierie (2015) examined sexual abuse cases within the United States. The findings detail distinctive differences within the female sexual offender population. First, data indicate that females are more likely to have a wider age range of victims and are less discriminate about victim gender. Second, female sexual offenders are more likely to offend against their own children or those within their care. Finally, female perpetrators have experienced significantly higher levels of trauma, abuse, and sexual victimization in their own life compared to the male offender population. Burgess-Proctor et al. (2017) indicate that the extensive trauma histories endorsed by women may contribute to the increased psychopathological concerns and mental health needs of the female sexual offender population.

In more recent research, Comartin et al. (2021) expand upon the gender differences identified by Burgess-Proctor et al. (2017) and McLeod (2015). Specifically, Comartin et al. (2021) indicate that women who sexually perpetrated against children were seven times more likely than men to report the presence of a co-offender and approximately four times more likely to be the parent or guardian of the victim. Such gender distinctions are suggestive of offense opportunities and motivations that may be unique to the female sexual offender population. These distinct differences may present unique risk factors, challenges, and treatment needs specific to female sexual offenders.

Prevalence and Recidivism Rates

Many developments have been made in understanding the prevalence and recidivism rates among male sexual offenders. However, similar knowledge related to female sexual

offending remains limited. Little is known about the recidivism rates of female sexual offenders. The main difficulty in gathering recidivism data has been due to the lower percentages of female perpetrated sexual crimes reported and prosecuted within the criminal justice system in comparison to the male population. Data has consistently suggested that females represent approximately 5% of all sexual offenders (Brayford, 2012; Cortoni et al., 2010; Willis & Levenson, 2016). Research by Williams and Bierie (2015) used the National Incident-Based Reporting System to compare female and male sexual offenders across 802,150 cases of sexual assault and abuse crimes reported to police among 37 states over a 10 year period from 1991 to 2011. This large scale study indicated that 43,018 or approximately 5% of sexual assault and abuse crimes reported to police were perpetrated by females, thus supporting previous prevalence percentages (Williams & Bierie, 2015). However, a more recent meta-analysis conducted by Cortoni et al. (2017) examined official government reports and data collected from among 12 countries between the years 2000-2013. When only examining officially reported crimes, Cortoni et al. (2017) indicate that women may represent an even smaller proportion of sexual offenders than originally reported. In contrast to previous research, Cortoni et al. (2017) indicate that the official rate of female sexual offenders is approximately 2%.

Officially reported crimes and prosecutions are not the only strategy to estimate the prevalence rates of female sexual offense behavior. Cortoni et al. (2017) have also examined prevalence rates using large-scale self-report victimization surveys completed by government and public agencies. In comparison to the official reported rate of female perpetrated sexual crimes, self-reported victim surveys indicate prevalence rates six times higher than official percentages. Therefore, when considering only victimization data, Cortoni et al. emphasize that female sexual offenders comprise approximately 12% of all sexual offenders (2017). Such

findings suggest that while women represent a small proportion of sexual offenders in police records and prosecution cases, there are a much larger proportion of female sexual offenders who are not reported to the police. Stemple et al. (2017) have also examined confidential surveys and detected greater prevalence rates of female perpetrated sexual crimes than official law enforcement reports suggest. Overall, female sexual offense behavior is under-reported to law officials and deviant sexual behavior perpetrated by women is likely more prevalent than indicated by current prosecution rates.

Furthermore, Cortoni et al. (2010) has completed the largest scale research related to the recidivism rates of female sexual offenders. Cortoni et al. (2010) conducted a meta-analysis of 10 previous studies that examined the recidivism rates of 2,490 female sexual offenders over an average of 6.5 years follow-up. The study examined the recidivism rates of both sexual recidivism (a new charge, conviction, or re-incarceration for a sexual offense) and general recidivism (arrested, charged, convicted, or incarcerated for any new offense). Results indicated that female sexual offenders present lower recidivism rates for all types of crime than the comparable rates for male sexual offenders. Specifically, Cortoni et al. (2010) reported female sexual recidivism rates of less than 3% and general recidivism rates of 23.5%. Such results suggest that once female sexual offenders have been detected by the criminal justice system, they are not likely to reengage in sexually offensive behavior. In addition, Cortoni et al. (2010) suggested that most female sexual offenders are not convicted of new criminal charges, and of those who are, they are 10 times more likely to be charged with a nonsexual crime than a new sexual offense.

Assessment Tools

Risk assessment tools are helpful instruments in predicting potential risk factors related to re-offending and sexual recidivism. One challenge that researchers have consistently encountered regarding female sexual offenders is the lack of assessment measures. To date, no risk assessment instruments exist for female sexual offenders (Brayford, 2012; Comartin et al., 2021; Cortoni et al., 2010; Pflugradt & Allen, 2014; Vess, 2011). All currently available risk assessment tools have been developed for and validated on samples of male offenders and cannot accurately predict recidivism risk for female sexual offenders. Vess (2011) and Comartin et al. (2021) attribute the lack of female assessment tools to insufficient numbers of reported female perpetrated sexual crimes and poor available sample sizes within research. As previously reported, females represent a small proportion of known sexual offenders and an even smaller proportion of known sexual recidivists (Vess, 2011). Cortoni et al. (2010) provides a recidivism rate of less than 3% for female sexual offenders. Such low numbers of identified female sexual recidivists have prevented the development of empirically validated assessment instruments in which to accurately predict recidivism risk specific to the female population. Furthermore, Cortoni et al. (2010) reports that risk assessment tools designed for male sexual offenders are likely to overestimate the recidivism risk of female sexual offenders and therefore should not be used in applied decision making.

Potential Risk Factors

While no current sexual offense risk assessment instruments exist for female sexual offenders, researchers have been able to evaluate potential risk factors for female offenders by examining factors related to general offending, as well as examining the specific factors which may have contributed to an individual's past sexual offense. Across studies, researchers have

endorsed vulnerabilities specific to the female sexual offender population. For women, it is likely that sexual offense behavior is related to experiences of severe trauma and disturbed attachment, social and psychological alienation, and cognitive distortions (Cortoni et al., 2010; Elliott et al., 2010; Vess, 2011). Additional factors possibly related to recidivism risk include dysfunctional relationships, poor emotion regulation, mental illness, poor self-esteem and low confidence, criminal thinking, thought distortions, inappropriate attitudes related to children, substance use, less formal education, and multiple incarcerations (Elliott et al., 2010; Pflugradt & Allen, 2014; Vess, 2011; Wijkman et al., 2011).

One unique aspect to consider regarding female sexual offenders is the presence of a co-offender. Research by Muskens et al. (2011) and Pflugradt and Allen (2014) examined the risk of re-offending for single and co-offenders. Specifically, Muskens et al. (2011) suggest that solo offenders have an increased risk of recidivism compared to co-offenders. Thus, results indicate that the presence of a co-offender lowers the risk of re-offending for females (Pflugradt & Allen, 2014).

Protective Factors

Only two studies examined protective factors for female sexual offenders. Elliott et al. (2010) suggests that motivation to change, engagement, and a willingness to partake in open discussions related to the sexual crime are indicators of positive intervention experiences. In addition, women who display positive attitudes, awareness of offense patterns, and acknowledgement of offense consequences present with increased protective factors and decreased risk of recidivism (Elliott et al., 2010). Completing sex offender treatment programs also provides a protective factor for female offenders. Pflugradt and Allen (2014) suggest that individuals who are willing to participate in, actively engage with, and complete sex offender

treatment programs are more likely to experience positive outcomes and are less likely to engage in future deviant behavior.

Treatment Needs

Females who commit sexual crimes present with unique treatment needs to address likely histories of neglect and victimization that may be contributing factors to deviant sexual behavior. Researchers have examined several areas in which female sexual offenders experience particular treatment needs. Burgess-Proctor et al. (2017), Comartin et al. (2021), Harrati et al. (2018), and Willis and Levenson (2016) emphasize the need to explore and process the role of traumatic life events, unhealthy relational patterns, and maladaptive schemas that influence the adoption of high-risk criminal sexual behavior. Elliott et al. (2010), Pflugradt and Allen (2015), and Wijkman et al. (2011) further elaborate on the importance of addressing treatment needs related to decreasing the susceptibility to unhealthy relationships, reducing dependency on men, and establishing healthy boundaries. Specifically, Elliott et al. (2010) suggests that improving problem solving abilities is one specific treatment need that may assist with reducing dependency in relationships. Furthermore, Pflugradt and Allen (2015) suggest focusing on empowerment, gaining a sense of control, and improving self-esteem as important treatment needs related to reducing dysfunctional relationships and building positive and healthy support networks. In general, Burgess-Proctor et al. (2017) and Wijkman et al. (2011) indicate the overall need for this population to participate in psychiatric and psychological treatment to address widespread mental health concerns and assist with healthy relationship development as well as individual needs that may differ from male sexual offense behaviors.

Therapeutic Provider Considerations

Challenges and Rewards in the Field

While research by Stiels-Glenn (2010) and Schmidt & Niehaus (2022) indicate that most behavioral health providers are unwilling to provide therapeutic care to individuals who have perpetrated sexual crimes, the therapeutic providers who treat this specific population represent a vital vocation and note unique experiences related to the field. Dean and Barnett (2011) examined the personal impact upon providers who delivered one-on-one therapeutic care to high-risk sexual offenders and emphasized the significantly challenging yet rewarding nature of such clinical work. Research suggests that clinical providers who offer therapeutic care to sexual offenders may experience both negative and positive personal impacts as a result of the care they provide. Specifically, Dean and Barnett (2011) indicate that therapeutic providers may experience a change in how they view themselves, others, and the therapeutic relationship. Furthermore, providers may experience intrusive thoughts and images related to their clients or therapeutic process and feel overly responsible for the treatment outcome.

Throughout their work, Dean and Barnett (2011) suggest that therapeutic providers in the field of sexual offending often engage in self-questioning. Providers are likely to question their views of themselves and others. As a result, therapeutic providers may begin to challenge their core beliefs, doubt their professional competence, and suffer from reduced self-confidence. In addition, providers have noted viewing others more critically, losing faith in humanity, and becoming guarded and suspicious of others. If left unchecked, Dean and Barnett (2011) indicate that these changes in the perception of self and others can impact the emotions and behaviors of therapeutic providers, leading to short-tempered, resentful, and withdrawn individuals.

Baum and Moyal (2020) identify behavioral health care with the sexual offender population as one of the most demanding responsibilities in the mental health field. Specifically, Baum and Moyal (2020) indicate that therapeutic providers working with sexual offenders are required to engage empathetically with offenders and listen to the graphic and often violent abuse histories common in this population. Guided by ethical behavioral health practice, therapeutic providers seek to help their clients work through inappropriate cognitive distortions, increase awareness of unhealthy and manipulative offense behaviors, and instill a sense of remorse among their clients. As a result of such demanding responsibilities, Baum and Moyal (2020) suggest that therapeutic providers experience a multitude of adverse effects.

Similar to previous research in the field, Baum and Moyal (2020) suggest that the high levels of distress experienced by therapeutic providers who treat the sexual offender population may result in provider experiences of irritability, anger, cynicism, isolation, suspiciousness of others, intrusive thoughts, and unsafe world views. In more detailed consideration, Baum and Moyal (2020) examined gender differences among therapeutic providers in relation to adverse effects and distress when providing care to the sexual offender population. According to Baum and Moyal (2020), male therapeutic providers are somewhat more susceptible to adverse effects when treating the sexual offender population than their female counterparts. Male therapeutic providers experienced higher levels of distress in the form of burnout, emotional distress, reduced self-esteem, and vicarious trauma (Baum & Moyal, 2020). Several explanations for these identified gender differences may be attributed to personal factors, stigma when providing care to sexual offenders, and a lack of support within the field of sexual offense behavior (Baum & Moyal, 2020).

While providing therapeutic care to sexual offenders may negatively impact and affect treatment providers, Dean and Barnett (2011) also indicate positive provider impacts related to professional development and personal accomplishment. Treatment providers have identified a deep sense of satisfaction gained from building a trusting and empowering therapeutic relationship. Dean and Barnett (2011) also suggest a sense of pride and achievement related to developing clinical skills, improving professional knowledge, protecting the public, and contributing to offender change and growth.

Stigma and Bias

Sexual offenders are a highly stigmatized group. Previous research highlights societal biases and stereotypes in which therapeutic provider and public opinions fail to acknowledge that women engage in sexually offensive behavior (Brayford, 2012; Muskens et al., 2011; Pflugradt & Allen, 2014; Shields & Cochran, 2020; Stemple et al., 2017). Despite this errant societal stigma, research by Damiris et al. (2021), Jahnke (2018), and Levenson et al. (2017) suggest that if female perpetrated crimes are reported and prosecuted with the legal system, female sexual offenders are typically perceived as dangerous individuals who hold evil and amoral intentions. Furthermore, individuals who have committed sexual crimes are also likely to encounter hostile and punitive attitudes as well as social rejection from the public. Treatment providers are not immune to the common stereotypes, public stigma, and social bias that plague the sexual offender population.

Jung et al. (2012) and Levenson et al. (2017) report that therapeutic providers are also subject to experiencing social biases, negative emotion, high risk assumptions, and skepticism regarding the treatment amenability for sexual offenders. A study of 86 German psychotherapists indicate that less than 5% of mental health care providers are willing to deliver care and treat

individuals who have engaged in sexual offense behaviors (Stiels-Glenn, 2010). Stiels-Glenn (2010) further suggests that mental health care providers' unwillingness to treat sexual offenders is largely due to negative feelings regarding sexual offender clients and a belief that they do not have the professional competence and skill to treat this population. In a more recent study, Schmidt & Niehaus (2022) examined the attitudes of 427 Swiss therapists who had provided therapeutic outpatient care to individuals within the community setting. Specifically, Schmidt & Niehaus (2022) evaluated the willingness of therapeutic providers to treat individuals with sexually deviant behaviors and found that approximately 63% of therapists were unwilling to treat this population. Furthermore, Schmidt & Niehaus (2022) report that 87.5% of therapists indicated they did not have the professional clinical skill set to treat individuals with sexually deviant thoughts and behaviors.

The stigmatization and ostracizing of the sexual offender population is unlikely to reduce recidivism rates or improve community safety. Jahnke (2018) argues that the isolation resulting from social rejection and hostile attitudes is likely to contribute to further deficits in social and emotional functioning, lower self-confidence, and amplify mental health concerns in this population. These impacts may therefore increase the risk of future sexually deviant behavior. Mental health care providers are also likely to morally reject and decline to provide therapeutic care to individuals with sexual crimes. Christensen (2021) suggests that the dismissive behaviors of therapeutic providers and the societal invisibility regarding the topic of female sexual offense behavior is likely to prevent victims from disclosing female perpetrated sexual crimes, invalidate victim experiences, further psychologically and emotionally damage victims, and provide opportunities for female offenders to continue perpetrating sexual crimes.

To effectively meet the needs of this population and build a trusting, non-judgmental, treatment focused therapeutic relationship, providers must consider and explore their own personal attitudes and beliefs regarding work with this specific population. Mental health care providers must be able to provide empathetic and non-judgmental assistance geared towards rehabilitation to best meet the needs of individuals who have engaged in sexual crimes. Jahnke (2018), Jung et al. (2012), and Levenson et al. (2017) also stress the importance of continuing education, training opportunities, and quality supervision to assist providers with neutrality and objectivity when providing care to such a highly stigmatized group.

In a more recent study, therapeutic providers also identified the need for professional development, training access, and dissemination of research regarding the topic of female sexual offense behavior as strategies to reduce professional minimization and improve consistency of therapeutic care among providers (Christensen, 2021). Christensen (2021) suggests that if therapeutic providers are more informed regarding the topic of female sexual offending, they will feel more confident in their professional decision making, more open to the recognition and discussion of female sexual offense behavior, and more likely to overcome gender stereotypes.

Like most studies involving female sexual offending, research pertaining to therapeutic provider experiences, challenges, and resources when delivering care specifically to female offenders are scant. Few studies have examined the experiences of mental health care providers treating female sexual offenders. In a study of 427 Swiss mental health care providers, only 6.3% of therapists identified having experience treating the female sexual offender population (Schmidt & Niehaus, 2022). However, similar to public opinion, research indicates that providers also demonstrate differential gender beliefs regarding sexual perpetrators. Hovey et al. (2013) directly examined therapists' beliefs regarding sexual offending and suggest that clinical

providers found female perpetrated sexual crimes less believable than sexual crimes committed by male individuals. Such gender differences may have strong implications for therapeutic practice. Although treatment providers recognize that female perpetrated sexual offenses exist, their beliefs and practices indicate that they respond to concerns of female sexual offending in a less serious manner (Hovey et al., 2013). Thus, further contributing to the stereotypes and narrowed vison surrounding female sexual offense behavior that may inhibit female offenders from receiving the therapeutic care needed to reduce sexually deviant behavior.

Mitigating Factors

Therapeutic providers who offer services to the female sexual offender population would likely benefit from additional training programs and curricula designed to address the specific needs of female offenders (Christensen, 2021; Hovey et al., 2013). In addition, Dean and Barnett (2011) and Willis et al. (2018) emphasize the need for workplace support for clinicians when treating the sexual offender population. Providing care and therapeutic services to the sexual offender population has been linked to negative emotional responses such as stress, anxiety, burnout, and vicarious trauma within providers (Baum & Moyal, 2020; Willis et al., 2018). An inability to identify, monitor, and manage the personal impact of providing therapeutic care to the sexual offender population could dampen objectivity, damage the therapeutic relationship, and reduce the effectiveness of therapeutic services. Dean and Barnett (2011) and Willis et al. (2018) suggest that supportive workplace environments may provide a buffer to the challenges faced by therapeutic treatment providers, improve longevity, and prevent adverse treatment outcomes. Specifically, Dean and Barnett (2011) identify supervisory support and the opportunity for debriefing after sessions as crucial for aiding providers in managing and resolving emotional experiences throughout their work. In addition, Willis et al. (2018) indicate

that genuineness, emotional validation, affirmation, opportunities for growth, and task assistance from supervisors and colleagues make the difference between provider burnout, poor treatment outcomes, and long-term success.

The utilization of personal coping skills is also necessary to mitigate the challenges of working with the sexual offender population. Dean and Barnett (2011) stress the importance of physical and psychological strategies to prevent and manage the occurrence of intrusive cognitions and negative emotional responses that are likely to manifest while providing care to sexual offenders. Furthermore, therapeutic treatment providers have disclosed the need for emotional detachment, separation between their work and personal life, and appropriate boundary setting to keep them safe, resilient, and fulfilled in the valuable and crucial work they provide (Dean and Barnett, 2011).

Additional Theoretical Frameworks for Discussion

While a constructivist worldview was used to highlight the perspective of therapeutic treatment providers in the field of female sexual offending in which to capture the essence of their unique experiences, a blend of four additional theoretical frameworks was used to further discussion and develop meaningful interpretation among the essence of therapeutic provider experiences identified within the study. Social exchange theory, reflective practice, the theoretical model of communal coping, and the theory of self-authorship provided a framework in which to evaluate, understand, and describe therapeutic behavioral health care provider experiences in the field of female sexual offending. Furthermore, a discussion of these theoretical frameworks, in relation to the therapeutic treatment provider experiences identified in the study, offered a useful tool to guide aspects of clinical practice, encourage critical thinking and connection among providers, aid clinical decision making and problem-solving abilities for

treatment providers, and generally improve and strengthen positive provider experiences when delivering behavioral health care services to the female sexual offender population. Within this research study, social exchange theory, reflective practice, communal coping, and self-authorship provided relevant theories in which to view therapeutic treatment provider experiences in the field of female sexual offending and to improve understanding and interpretation of the essence of core lived experiences within the phenomenon.

Social Exchange Theory

Scholars suggest that individuals engage in a multitude of daily activity exchanges or behaviors within various social groups and organizational structures (Cook et al., 2013). The daily exchange of behaviors can be best described through social exchange theory. Within social exchange theory, behavior is determined based on individual perspectives in which activity is deemed as either costly or rewarding. More specifically, social exchange theory is defined as an exchange of activity between two parties (Cook et al., 2013). Cook et al. (2013) indicates that social exchange theory operates under principles of reinforcement and punishment in which behavior perceived as rewarding is continued and behavior viewed as costly is terminated. In the field of female sexual offending, providers experience a host of costly activity exchanges when delivering therapeutic care to females who have perpetrated sexual crimes. Despite the costs of delivering therapeutic care to female sexual offenders, treatment providers make the daily decision to stay in and engage with a challenging profession. Social exchange theory suggests that treatment providers remain in the field because the rewards of providing therapeutic behavioral health care services to female sexual offenders outweigh any costs within the profession.

Reflective Practice

Reflective practice as a theoretical framework has been largely researched within the healthcare setting (Schön, 2017). Scholars suggest that the complexity of healthcare systems require reflective practice among professionals in order to provide effective healthcare services (Kinsella, 2010). The complexity of healthcare systems spans to the behavioral health care of the female sexual offender population. Within the theory of reflective practice, practitioners are identified as instrumental problem solvers who are most capable of applying professional skill and knowledge to any challenging situation within their field (Kinsella, 2010). Schön (2017) suggests that through experience, competent professionals know more than they can express with words. With the capacity for reflection, Schön (2017) indicates that professionals can use their experiences and intuitive knowledge to manage the often challenging and uncertain situations involved in delivering clinical practice within the healthcare setting and begin to put their experience and knowledge into verbal and written expression. Furthermore, reflective practice scholars suggest that knowledge is created in the midst of clinical experience and through reflection of this experience practitioners can shape and construct rational action to best serve the individuals in their care (Kinsella, 2010). The therapeutic providers who have experience treating the female sexual offender population are experts in their field and their experiences hold the solutions to the complexities of delivering behavioral health care services to this specific population. Under the framework of reflective practice, therapeutic providers with experience in delivering behavioral health care services to female sexual offenders are the individuals most capable of solving problems and meeting the female specific treatment needs of female sexual offenders. Through the reflection of their experiences, therapeutic providers can construct treatment plans and behavioral health service options to best meet the needs of the female sexual

offender population. Their experiences can guide and inform future practice, promote wisdom, and support colleagues in the field.

The Theoretical Model of Communal Coping

Scholars have identified supervisory support and task assistance from colleagues as crucial strategies to aid providers in managing and resolving negative emotional experiences throughout their work (Dean & Barnett, 2011; Willis et al., 2018). Colleagues as a supportive coping resource supports the theoretical model of communal coping and is directly related to therapeutic provider experiences when delivering behavioral health care services to the female sexual offender population. Communal coping suggests that a team of individuals work together to appraise and proactively engage with a stressor (Afifi et al., 2020). Research suggests that communal coping improves health and strengthens communities who may frequently experience stressful conditions (Afifi et al., 2020). Previous literature indicates that when delivering behavioral health care services to the female sexual offender population, therapeutic treatment providers often experience high levels of stress (Baum & Moyal, 2020). As a community, treatment providers in the field of female sexual offending experience stressful conditions. The theoretical model of communal coping has the ability to move individuals towards improved psychological well-being and positive adaptation through social connection, shared resources, and alternative perspectives (Afifi et al., 2020). Communal coping, or turning to colleagues in the field for support, may allow providers to feel connected to their peers and remind providers that they are not alone in their experiences while treating female sexual offenders. Additionally, by seeking support from colleagues, providers may be able to share resources and receive guidance and support within the field. Under stressful situations, providers who turn to their

colleagues for support are likely to experience improved well-being and strengthened connections to colleagues in the field.

Self-Authorship

The theory of self-authorship suggests that individuals experience adaptive challenges in which the solution is not always clearly defined (Magolda, 2014). Furthermore, Magolda (2014) suggests that adaptive challenges are solved among the process of working through challenges and changing the ways in which individuals make sense of knowledge, identities, and relationships. Female sexual offending is a field in which the solutions to therapeutic provider experiences of treating a challenging and complex population are not clearly defined. Self-authorship offers a smooth blend with the constructivist worldview guiding this study. Both frameworks recognize the importance of constructing meaning which is shaped through individual perspective and interactions, cultural context, and environmental systems. Throughout their experiences, therapeutic providers in the field of female sexual offending are on a journey of self-authorship. Self-authorship promotes critical thinking strategies, problem solving abilities, supportive relationships, and leadership abilities in order to navigate life's challenges (Magolda, 2014). Self-authorship is one strategy to encourage therapeutic providers in the field of female sexual offending to think critically, evaluate personal experiences, and make effective decisions regarding both their own professional needs and the needs of their clients.

In Summary

The synthesis of current literature in the field of female sexual offending provided an overview of emergent themes, conclusions, and research needs specific to the female sexual offender population and the providers who offer direct therapeutic care to these individuals. Female sexual offenders present with distinctive psychological characteristics, offense

motivations, and risk factors in comparison to their male counterparts (Burgess-Proctor et al., 2017; McLeod, 2015; Williams & Bierie 2015). Though data related to the field of female sexual offending and the providers who specialize in the direct care of the female offender population has been limited by low conviction rates and societal stigmatization, researchers are beginning to examine and gain an understanding of female perpetrated sexual crimes. The therapeutic provider lens of the current research study provided the opportunity to advance knowledge in the field of female sexual offending through specialized provider perspectives. The current study captured the essence of the experiences encountered by treatment providers offering mental health care and treatment services to female sexual offenders to further build insight into the field of female sexual offending and the therapeutic providers who specialize in treating this focused population.

The strongest findings of previous research point to complex trauma histories, unstable relationships, and unhealthy coping mechanisms as significant contributing factors to neglectful and abusive behaviors within the female sexual offender population (Brayford, 2012; Harrati et al., 2018; Pflugradt & Allen, 2010, 2014, 2015; Stemple et al., 2017; Wijkman et al., 2011; Willis & Levenson, 2016). Studies have consistently found that women who commit sexual crimes are likely to experience mental health concerns, poor self-esteem, unhealthy attachment, and offense supportive cognitive distortions (Elliott et al.,2010; Pflugradt & Allen, 2015; Vess, 2011). Specifically, women who perpetrate sexual crimes likely experience mood disorders and avoidant or dependent personality characteristics (Muskens et al., 2011). Research suggests that for women, sexual crimes are committed not as a product of sexual motive, but as a distorted desire for intimacy, improper boundary setting, misguided social interaction, and warped attachments (Burgess-Proctor et al., 2017; Comartin et al., 2021; Elliott et al., 2010; Harrati et

al., 2018; Pflugradt and Allen, 2015; Wijkman et al., 2011; Willis and Levenson, 2016). Furthermore, research from Vess (2011) and Harrati et al. (2018) expand upon the motives driving female sexual offense behavior and attribute displaced feelings of anger and a desire for power and control as additional motivating factors to sexual offense behavior within the female population. Therefore, a unique approach must be considered when evaluating, treating, and researching the unique field of female sexual offending.

Due to the limited knowledge related to female sexual offenders and their criminal careers, researchers and therapeutic treatment providers run the risk of generalizing characteristics from the male sexual offender population and using risk assessment tools designed for men to evaluate and determine potential risk factors for female offenders. In doing so, they are likely to overestimate the recidivism risk of female sexual offenders and neglect offense patterns, risk factors, and treatment needs specific to the female population (Cortoni et al., 2010). Risk evaluation and treatment interventions should be completed on an individual basis for female offenders. Creating individualized treatment plans will likely aid women in addressing early trauma histories, reducing vulnerability to unhealthy relationships, establishing strong boundaries, and gaining the positive coping strategies to empower their lives.

While individualized treatment plans and the specific treatment needs of female sexual offenders must be addressed throughout therapeutic care, such specific and emotionally heavy interventions are likely to impact providers in the form of burnout, stress, negative emotional responses, and vicarious trauma (Baum and Moyal, 2020; Jung et al., 2012; Levenson et al., 2017). Continued training and access to supportive supervisors and colleagues may assist with identifying, monitoring, and managing the personal impacts of providing therapeutic care to the female sexual offender population. Additional training opportunities and supportive peer

interaction are also likely to improve objectivity, prevent adverse treatment outcomes, expand therapist longevity, and promote effectiveness of therapeutic services (Christensen, 2021; Hovey et al., 2013; Willis et al.,2018).

Not only does the literature indicate wide gaps in the study of female sexual offenders, but large gaps also remain in the study of the therapeutic treatment providers offering services to this specific population. Treatment providers with experience in the therapeutic care of the female sexual offender population represent an essential vocation and offer unique insights and experiences related to the field. Further study, through the therapeutic provider lens, is one strategy to bridge the gap among the literature and expand knowledge in the field of female sexual offense behavior and the experiences of the providers who deliver therapeutic care to this distinctive population.

Limited research in the field of female sexual offending has impaired understanding of female perpetrated sexual crimes and hindered advances to guide, support, and inform clinical practice. Advanced study, through the therapeutic provider lens, will aid in promoting improved understanding of experiences when treating such a distinctive population. Building an understanding of provider experiences when treating female sexual offenders provides a useful tool in advancing knowledge of sexually deviant behavior in the female population, increasing awareness of gender-specific distinctions, and enhancing insights to better support therapeutic providers who specialize in treating female offenders.

This qualitative study used phenomenological research methods and a constructivist worldview to explore the complex elements in the field of female sexual offending through the therapeutic provider lens. Phenomenological research approaches focus on the commonality of lived experiences within a group of individuals and produce an in-depth description of the

essence of a phenomenon (Vagle, 2018). Furthermore, a constructivist worldview relies on the participants' interpretations and perception of a situation, with the goal of understanding the social interaction and cultural norms of the world in which they live, through subjective meaning of their life experiences (Creswell and Creswell, 2018). Paired with a constructivist worldview, this phenomenological research design assisted with interpreting and examining the perspective of individuals with experience providing therapeutic care to women who have engaged in sexual crimes. Additionally, while a constructivist worldview was used to highlight the perspective of therapeutic treatment providers in the field of female sexual offending, a blend of four additional theoretical frameworks were used to further discussion and develop meaningful interpretation among the essence of therapeutic provider experiences when delivering behavioral health care services to the female sexual offender population. Social exchange theory, reflective practice, the theoretical model of communal coping, and the theory of self-authorship provided a framework in which to evaluate, understand, and describe therapeutic behavioral health care provider experiences in the field of female sexual offending. Guided by the following research question, this study captured the essence of the clinical experiences encountered by treatment providers when working with female sexual offenders and provided a unique lens and an opportunity to develop and enhance the scarce knowledge and insight related to the topic of female sexual offending and the providers who care for this distinctive population:

1. What are the experiences of treatment providers working with female sexual offenders?

Chapter Three: Methodology

Research Framework

A Constructivist Worldview

Creswell and Creswell (2018) describe a constructivist worldview as one in which individuals seek to understand the world in which they live through subjective meaning of their life experiences. The goal of this worldview is to rely on the participants' views and understanding of the situation being studied and to examine social interaction, historical events, and cultural norms within the individuals' life. The researcher will then assist with interpreting the meanings that participants have about the world to develop patterns related to the explored topic. A constructivist worldview can be applied to the study of behavioral health care providers with experience in treating female sexual offenders. This study incorporated a constructivist worldview to highlight the perspective, meaning, and understanding of individuals who hold experience in delivering therapeutic services to women who have engaged in sexual offense behavior, thus capturing the essence of the clinical experiences encountered by treatment providers when working with female sexual offenders.

Research Design

A Qualitative Design

This study combined a qualitative research design with a constructivist worldview to examine and explore the complex elements in the field of female sexual offending. Scholars suggest that qualitative research methods are useful when studying a population that cannot be easily constructed (Creswell & Poth, 2018). In addition, qualitative research designs provide a detailed understanding and rich description of an issue that can only be established by conversing with people and allowing them to share their personal experiences (Creswell & Poth, 2018).

These methods address the lived human experience and are helpful in understanding and describing human phenomena, interaction, and debate. The field of female sexual offending is a broad and complex phenomenon that is difficult to capture using the concise measures of quantitative approaches. Therefore, a qualitative research design allowed this study to explore multiple variables across a broad range of data to identify common themes and build understanding related to clinical experiences when providing therapeutic behavioral health care to female sexual offenders and the complexity of treating this population through the lens of therapeutic treatment providers.

A Phenomenological Approach

Creswell and Poth (2018) address the importance of studying the human experiences of individuals to gain insight into their lived experiences and feelings, as well as commonalities and shared experiences within a population. Phenomenological research design originated under the guidance and development of Edmund Husserl, a German philosopher who recognized lived experiences as the fundamental source of knowledge (Dowling, 2007). For Husserl, the goal of phenomenology is the thorough study of things as they appear (Dowling, 2007). Husserl stressed that the study of things as they appear establishes a fundamental understanding and description of a topic and the lived human experience that must be acquired before interpretation can occur (Dowling, 2007). Since the founding phenomenological goals established by Husserl, phenomenology has continued to transform into modern research methodology. Mark Vagle, a 21st century phenomenological research methodologist, continues to build upon the framework of Husserl and identifies phenomenology as the best approach to study the lived human experiences within a population in order to describe how people are meaningfully connected with and experience the world (Vagle, 2018). Vagle (2018) suggests that phenomenological research

approaches assist with establishing a deep understanding of the nature and meaning of everyday life experiences to build insight and engage in more direct contact with the world. Thus, phenomenological studies reveal how things are experienced in order to explore the essence and core lived experiences of a phenomenon (Vagle, 2018). These common experiences are useful in developing awareness and building insight to better understand human behavior and meet the needs of a specific population, concept, or phenomenon.

Without the ability to understand the human lived experiences of individuals, researchers cannot gain insight into the daily interactions and behaviors that shape human life. A phenomenological research approach focuses on the commonality of lived experiences within a group of individuals and produces in-depth descriptions of the essence of a phenomenon (Vagle, 2018). Female sexual offense behavior is a complex topic with scarce previous research in the field (Cortoni et al., 2010; Pflugradt & Allen, 2010, 2015; Shields & Cochran, 2020; Williams & Bierie, 2015; Willis & Levenson, 2016). The complexity of female perpetrated sexual crimes, the human and provider lived experience, and the lack of previous research indicate the necessity of a qualitative research design and the construction of a phenomenological research approach in which to shape understanding of the phenomenon of female sexual offense behavior through the lens of therapeutic providers. In addition, the provider lens offers the unique opportunity to develop insights related to their specific experiences while treating this complex population. A phenomenological research approach directly addressed the research question of this study and captured the essence of the experiences encountered by treatment providers when offering mental health care and treatment services to female sexual offenders.

Role of the Researcher

Phenomenological study designs utilize the researcher as a primary data collection instrument (Vagle, 2018). As such, Vagle (2018) stresses the importance of the researcher's sustained engagement with the participants and the phenomenon. In this study, the researcher incorporated observations and semi-structured dialogue to directly engage with therapeutic providers with experience in offering mental health services to females who have committed sexual offense crimes and connect with providers in sustained conversation about their unique experiences. The researcher then analyzed and interpreted the data to identify key themes which captured the essence of provider experiences when treating this population.

Reflexivity Statement

As a primary data collection instrument, the researcher holds personal values, experiences, and biases that may shape their interpretations during the study. I am a licensed psychological associate within the criminal justice system. Throughout my work in the mental health field, I have developed ontological, epistemological, and axiological assumptions that may impact the present study. Specifically, I hold the ontological belief that knowledge and reality are comprised of multiple truths which rely on individualized lived experiences. Therefore, this study relied on multiple provider perspectives to develop and identify key themes and knowledge related to the field of female sexual offending. I worked to ensure that provider views, outlooks, and ideas emerged to gain a deeper understanding of the experiences endorsed by clinical therapeutic providers with experience treating female sexual offenders. Personally, I believe that reality can be changed through reflection, improved understanding, and decision making. This epistemological assumption is a key component in the therapeutic setting, and to this research study, as providers assist individuals with personal growth, development, and healthy decision

making within their lives. Finally, I present the axiological assumption of care and concern for all. I value all life and stress the belief that all individuals are able to adapt, learn, and grow. This belief includes individuals who have committed sexual crimes and often face fierce stigma from the general public, as well as the providers who specialize in the direct care of this population.

I have worked as a mental health care provider within the correctional setting for ten years. Five of those years were spent working directly in a sexual offender treatment milieu addressing the behavioral health care and therapeutic needs of both male and female sexual perpetrators. Therefore, my perceptions may be shaped by my experiences working with this population. As a therapeutic provider in a sexual offender treatment program, I have worked directly with offenders and fellow clinical treatment providers to build understanding of sexual offense cycles, relapse prevention measures, and individualized treatment modalities. My experiences and values were useful for this research study, rather than detrimental. My knowledge of the topic of sexual offending, as well as clinical experience in the mental health field, enhanced awareness, understanding, and sensitivity to the challenges encountered when examining sexual offense behavior and exploring the experiences of providers when treating this population. My personal experiences, values, and beliefs assisted in forming the open, deep, and respectful relationships and connections within the research environment necessary to collect and interpret the authentic lived experiences of participants in order to capture the essence of the clinical experiences encountered by treatment providers working with female sexual offenders.

As a mental health care provider, my work has been directly impacted by the lack of research dedicated to the field of female sexual offending, limited insight regarding the providers who specialize in treating this population, and the significant existing gaps related to therapeutic care for this population. I have witnessed firsthand the societal and professional minimization,

denial, and fear which have challenged advancement in the field of female sexual offending. I have also encountered caring providers who are emotionally driven to offer the best behavioral health care possible to this population. As reported by Diaz-Strong et al. (2014), policies and procedures are built on affect and the production of emotions to regulate change, promote public education, and establish new policy. This concept directly applies to the field of female sexual offending. Female sexual offending is a field often minimized by errant societal stereotypes and strong feelings of fear, shame, and secrecy. While it may be emotionally and politically easier to ignore female sexual offending, females commit sexual crimes, and their gender specific characteristics must be addressed. As Diaz-Strong et al. (2014) suggest, our feelings shape our investments as researchers. As a researcher, I am not afraid to discuss emotionally and politically challenging subjects. I am invested in making visible the existing gaps in the literature and using research in the field of female sexual offending to support change and build awareness of female perpetrated sexual crimes and the experiences of therapeutic treatment providers in order to promote knowledge and research advancement in the field.

I have experienced a multitude of challenges when providing therapeutic care to female sexual offenders. To date, no standardized risk assessment tools, treatment manuals, or provider supports have been created specifically for the evaluation and therapeutic care of female sexual offenders and the clinical providers who care for this distinctive population (Cortoni et al., 2010; Pflugradt & Allen, 2014; Vess, 2011). As a result, I have spent significant time and effort attempting to alter resources designed for male offenders to meet the needs of the female population. This is not a standardized procedure and leaves much to be desired in the form of accurate risk prediction and effective treatment modalities for women who have committed sexual crimes. I have faced additional barriers and lack of resources when providing therapeutic

care to women who have engaged in multiple sexual crimes. There is little data or guidance available to providers when delivering care to sexual recidivists. I have encountered several women seeking care who have engaged in multiple sexual crimes. I strongly feel that the lack of data, resources, and support available has negatively impacted and reduced the effectiveness of the care I was able to provide these women. There is a clear need for further research to assist with most effectively meeting the specific needs of female offenders and the providers who specialize in the direct care of this population. By capturing the essence of the clinical experiences encountered by treatment providers when working with female sexual offenders, the present study used provider perspectives and experiences to further research and build insight into the field, thus developing awareness related to the field of female sexual offense behavior and the providers who specialize in treating this population.

From the human perspective, I have also experienced the stress, frustration, burnout, and emotional responses that can occur when addressing and treating the trauma histories and offense characteristics specific to the female sexual offender population. These common experiences and shared understanding served as a foundation of human connection and compassion to enhance collaboration with participants in the study. As suggested by Kinloch and San Pedro (2014), researchers are able to meaningfully and openly collaborate with participants to learn about and understand the complexities of human life and the unique experiences of participants. Throughout this research study, I had the opportunity and honor to speak openly, listen actively, and engage meaningfully with participants who represent fellow providers in the mental health field. Such meaningful connections and co-collaborations assisted in building trust with participants, aided in gaining insights of the lived experiences of providers, and contributed to

crafting deeper understanding in the field of female sexual offense behavior and the distinctive experiences of the providers who have cared for the female sexual offender population.

Additionally, I recognize that sharing the human experience and discussing life events and emotional responses are a vulnerable undertaking for participants in human subject study. As a researcher, I worked to honor these vulnerabilities by allowing space for silence, reflection, genuineness, humility, and care throughout the research process. Furthermore, I value meaningful conversation and connections among individuals. As a researcher, I made every effort to establish relationships centered on dignity, trust, and respect. This process included interpreting and reporting participant voices as clearly and authentically as possible. Such authenticity promoted and supported humanization throughout the research process. Blackburn (2014) identifies humanization in the research process as allowing participant individuality, creativity, and personhood to be displayed and validated across the study. This study, as well as my personal views as a mental health provider and researcher, relied on individualized and unique life experiences to highlight the perspective, meaning, and understanding of individuals. I took care to honor and represent these life experiences as accurately and truthfully as possible.

My personal experiences within the mental health field have contributed to the belief that a knowledgeable, compassionate, and supportive therapeutic provider can make a difference in the lives of their clients. I believe that providers can help individuals to learn, grow, and emotionally develop. I hold these same beliefs when treating the female sexual offender population. I believe that is it possible for females who have perpetrated sexual crimes to live an offense free and healthy life. Participation in mental health care is one aspect to assist female sexual offenders with the growth and development required to live an offense free life and reduce the potential for recidivism. Furthermore, I believe that a provider who is experiencing

significant and frequent negative emotional responses and burnout cannot provide the best care to their clients and effectively meet the specific treatment needs of the female sexual offender population. Therefore, I value and appreciate each participant's willingness to share their personal experiences working with female sexual offenders. I acknowledge the importance of self-awareness, self-care, and incorporating supportive resources as a provider to assist with providing the most effective therapeutic services to female offenders. With these beliefs in mind, I follow in the footsteps of Blackburn (2014) and strive to be a worthy witness for the participants in my research study. As Blackburn (2014) suggests, I am challenged to action and intend to use the dialogue acquired in this research study to gain insights and build awareness in the field of female sexual offense behavior. As a personal goal, I strive to use the knowledge acquired in this research study to act in ways that promote social change, increase knowledge related to the field of female sexual offending, and support the therapeutic providers who specialize in treating this population.

My previous experiences and established beliefs while working with incarcerated sexual offenders have contributed to the formation of personal assumptions and biases which may shape my research. Specifically, I embrace the perspective that sexual offending is a complex and complicated topic, which typically occurs in an atmosphere of secrecy and shame. Additionally, like previous research by Burgess-Proctor et al. (2017), Comartin et al. (2021), Harrati et al. (2018), and Willis and Levenson (2016) has suggested, I hold the assumption that much of the female sexual offender population have experienced significant traumatic life events, unhealthy relational patterns, and maladaptive schemas that may impact the adoption of high-risk criminal sexual behavior. Furthermore, I promote the assumption that these emotionally heavy, female specific, treatment needs and life experiences may present as a personal and professional

challenge for therapeutic providers that may impact their experiences. As a result, sexual offense behavior is often a difficult topic of discussion for both the individuals who have perpetrated sexual crimes and the providers with experience delivering therapeutic care to this population.

From my knowledge and experience in the field, I argue against stereotypical societal biases which depict women as nurturing, family providers and fail to acknowledge that women willingly engage in sexually deviant behavior (Brayford; 2012; Muskens et al., 2011; Pflugradt & Allen, 2010, 2014; Shields & Cochran, 2020; Stemple et al., 2017). Women commit sexually deviant crimes. With this in mind, I hold the biased belief that female sexual offenders require distinctive care and consideration that has yet to be fully identified and researched. I promote the assumption that female sexual offenders face a more challenging therapeutic and treatment centered road than their male counterparts with whom previous research indicates the majority of almost all study and resources have been focused (Cortoni et al., 2010; Pflugradt & Allen, 2010, 2015; Shields & Cochran, 2020; Williams & Bierie, 2015). Additionally, I support the belief that therapeutic providers will also face significantly challenging experiences when providing care to the female sexual offender population as a direct result of societal bias, limited resources, and poor research advancement in the field. Consequently, I hold biased views in favor and support of offense-free lifestyles for the female sexual offender population and encouragement for the therapeutic providers who acknowledge that female perpetrated sexual crimes exist, are willing to provide care for this population, and are prepared to consider the topic of female sexual offense behavior within the realm of research, mental health services, professional experiences, and society.

Despite the difficulty of the subject matter, sexual deviance and offense behavior, as well as therapeutic provider experiences are an important and necessary topic to address within both

therapeutic and research milieus. My experiences as a mental health provider have demonstrated that behavioral health providers play a crucial role in the long-term success and effective treatment of female sexual offenders. Therefore, provider perspectives offer unique insight into the field of female sexual offending. Taking these assumptions and biases into consideration, I have made every effort to ensure objectivity and compassion throughout the research study. To assist with objectivity and not allow past knowledge to impact data collection and analysis, I incorporated bracketing, triangulation of the data, and member checking techniques by discussing personal experiences, bracketing them to the side, considering multiple data sources, and focusing on and re-checking the experiences of the participants. This has allowed the reader to learn about the researchers' experiences and determine for themselves whether sufficient focus was placed on interpreting the participant experience and reporting results accurately. Ultimately, I hope that the data collected from this study will improve awareness of and build knowledge in the multifaceted field of female sexual offending.

Participant Selection and Sampling Approach

Purposeful selection was used throughout this study to deliberately select therapeutic treatment providers who can offer descriptive information relevant to the field of female sexual offending. Maxwell (2013) describes purposeful selection as a strategy in which specific individuals or settings are deliberately selected to provide information directly related to the research questions or goals. Individuals with experience providing therapeutic behavioral health care to female sexual offenders were purposefully selected and recruited from private practices and community resources within the Southeastern region of the United States. Through the attendance of continuing education trainings, professional conferences, and experience within the mental health field, the researcher has obtained the professional contact information of

behavioral health providers who have specialized in the field of female sexual offending. These resources were used as a first line recruitment strategy for the purposeful selection of therapeutic behavioral health care providers with clinical experience in the field of female sexual offending. With this professional knowledge, the researcher compiled an initial recruitment list of 19 behavioral health care providers with past or present experience treating the female sexual offender population from contact information obtained through professional associations.

Each individual participant was initially contacted through in-person communication or by phone or email contact regarding study recruitment. See Appendix A for the initial recruitment script provided to each participant. Of the 19 therapeutic providers initially contacted by the researcher, seven individuals did not respond to phone or email recruitment strategies and five individuals declined to participate in the research study. Seven therapeutic behavioral health care providers agreed to participate in the study. Furthermore, snowball sampling was also used to identify additional behavioral health providers with experience in the treatment of female sexual offenders. Snowball sampling techniques use current research participants to identify and recruit future participants from among their colleagues (Maxwell, 2013). Each of the initial seven participants were asked to identify additional therapeutic treatment providers or colleagues in the field of female sexual offending who may be willing to participate in research. The researcher informed each participant that they were able to decline to respond to this question and were not required to provide the names or contact information for the recruitment of future potential participants. Snowball sampling provided information for three additional providers, all of whom agreed to participate in the study. Purposeful selection and snowball sampling yielded a total of 10 therapeutic treatment providers who agreed to participate in the research study.

Each participant was provided with an informed consent prior to participation in the study (see Appendix B). Each participant was of consenting age and capable of considering the options and choices beneficial for their personal goals and life development. All participants were informed that they had the right to withdraw at any time, without incurring any penalty. Additionally, no form of financial or external compensation was provided for participation in this study. Within this study, participant demographics consisted of only one male participant. This demographic information provided identifying information that could have made the male participant easily identifiable. To protect the anonymity of all participants as much as possible, gender identification was removed. As an additional step to remove gender identification, gender neutral pseudonyms using numerical values were provided which labeled participants by number. As such, participant gender is unidentifiable, and the researcher was able to protect the anonymity of each participant. Common practice in qualitative research is to provide pseudonyms (either names or numbers) to participants to protect their anonymity. For this study, numbers were assigned at random by the researcher and in no way reflect the order that interviews or analysis was completed. Any names or identifying participant genders provided through participant experience or report was changed to protect the anonymity of providers and their clients.

Phenomenological research methodology emphasize that the phenomenon or topic of interest determines how it is to be studied (Vagle, 2018). As such, phenomenological research designs incorporate a sense of openness when considering adequate sample sizes. Some scholars suggest that phenomenological designs require sample sizes varying between three to fifteen participants in order to explore a specific phenomenon (Creswell & Poth, 2018). While sample sizes may vary depending on the topic of study, phenomenological research approaches rely on

the participant voice to provide rich descriptions of the lived human experience (Vagle, 2018). Rich descriptions provide detailed data in which to capture and deliver a full and informative picture of the phenomenon (Maxwell, 2013). To gather rich and descriptive data, Vagle (2018) suggests that researchers may spend a significant amount of time interviewing participants in order to establish a deep understanding of core lived experiences. The time spent with participants and the establishment of rich description contribute to the small sample sizes common in phenomenology (Vagle, 2018). The establishment of rich description will aid the study in reaching saturation in which no new information, properties, or dimensions emerge from the data (Saldana, 2021). Saldana (2021) suggests that achieving data saturation is a primary goal of qualitative research data collection and interpretation methods. Data saturation can be accomplished with fewer participants when care is taken to select an appropriate sample and gather the rich descriptive data necessary to capture the essence of a phenomenon.

Care was taken throughout this study to recruit and select participants who could provide the rich and descriptive data necessary to capture and deliver a full and informative essence of the phenomenon and reach data saturation. Data saturation was a goal of the researcher and was accomplished through prolonged engagement, participant selection, and focused attention throughout data collection. Ten therapeutic behavioral health treatment providers with experience in providing direct mental health treatment services to females who have perpetrated sexual crimes participated in the study. Eligible participants had an employment and educational background in behavioral health (social service clinicians, psychologists, licensed psychological associates, evaluation and referral coordinators, licensed professional clinical counselors, or licensed clinical social workers) and currently or previously provided direct patient care designed towards the therapeutic treatment of women who have engaged in sexual offense behavior.

Participants recruited and selected with past experience providing direct therapeutic care to women who have engaged in sexual offense behavior were not more than five years removed from the specialized profession. Within this five-year timeframe, their experiences in the field provided data helpful in capturing the essence of the clinical experiences encountered by therapeutic treatment providers when delivering behavioral health care to the female sexual offender population. This timeframe provided a balance among provider experience, memory formation, and currency in the field. Within this five-year time frame provider experiences are established in the form of declarative long-term memory and can be recalled when necessary (Huizen, 2021). Additionally, some scholars suggests that experiences or data in a topic that is greater than five years old becomes outdated for the field (Gottlieb, 2003). In order to capture core experiences that can be recalled when necessary by therapeutic providers, as well as capture current experiences in the field of female sexual offending, treatment providers were no more than five years removed from the profession.

Once agreeing to participate in the study, one-on-one, semi-structured interviews were completed with each participant. During the first step of the interview process, participant demographics were collected and participants were assessed to ensure they directly met the eligibility requirements of the study. The demographic section was incorporated into the semi-structured interview protocol and collected the demographic data of the participant and specifically assessed the participant employment and educational background, as well as the participants experience providing patient care to the female sexual offender population, prior to continuing with the interview. This method also provided a warmup to the semi-structured interview and allowed participants to get comfortable within the interview process. Eligibility requirements consisted of an employment and educational background in behavioral health and

experience with patient care designed towards the therapeutic treatment of women who have engaged in sexual offense behavior. Additionally, participants must have provided behavioral health services to this population within the last five years. If eligibility requirements were not met, the interview was discontinued. All participants met eligibility requirements.

Prolonged engagement with each participant during the data collection process allowed the researcher adequate time to collect rich, thick, and descriptive data from the participant voice. Prolonged engagement was achieved through direct contact with participants during the one-on-one interview process. The researcher spent approximately eight hours in the field completing one-time virtual or in-person interviews with participants. Throughout the data collection process, the researcher remained focused on data saturation and determined to capture the complete essence of therapeutic provider experiences. The researcher engaged with participants throughout the interview process until all questions of the semi-structured interview protocol were addressed and no new information from the participant voice emerged. Individual participant interviews ranged from approximately 31 to 80 minutes and averaged approximately 45 minutes in length. The time spent with the participants recruited for this study provided the detailed and rich description required to reach data saturation and capture the essence of the clinical experiences encountered by treatment providers when working with female sexual offenders. Data Saturation was achieved when the researcher recognized that no new information was developing from the individual participant voice. Additionally, the researcher identified commonalities and collective experiences identified among participants. The commonalities and collective experiences of all 10 therapeutic behavioral health providers delivered a full and informative picture of the phenomenon and captured the essence of their experiences when delivering care to the female sexual offender population. Within their collective provider

experiences, no new information developed. Data saturation was achieved. Consulting the inclusive participant voice and understanding of the field of female sexual offending, the researcher used a constructivist worldview to examine the participants identified experiences and construct meaningful interpretation of their views and perspectives. No further participants were required to answer the research question of this study.

Participants ranged in age between the years of 30 to 75 years old and have averaged approximately 23 years of experience within the mental health field. In addition, participants have averaged approximately 12 years specializing in the direct care of the sexual offender population. Demographically, participants consisted of ethnicities identified as 70% White and 30% African American. Additionally, 90% of participants identified as female while 10% identified as male. Research suggests that greater than 75% of all therapeutic behavioral health care providers within the United States are female (Diena, 2023). Therefore, the majority of the behavioral health providers within the U.S. consist of primarily female individuals. This demographic was representative of the participant sample in the current study. Furthermore, participants reported past and present experiences within a variety of mental health care settings including community based individual therapy and private practice venues, residential treatment programs, sexual offender treatment specific programming within the community and incarcerated milieu, and psychological assessment and evaluation procedures. Table 1 provides a detailed overview of participant demographics. The diversity of the sample, variety of experiences, and rich descriptions provided by the participant voice created a thorough depiction of the essence of the clinical experiences encountered by therapeutic treatment providers when working with the female sexual offender population.

Table 1

Participant Demographics

Pseudonym	Age Range	Ethnicity	Job Title	Years' Experience
Participant One	45-50	White	Licensed Psychologist	10
Participant Two	65-70	White	Licensed Psychologist	12
Participant Three	30-35	African American	Licensed Psychological Associate	1
Participant Four	30-35	African American	Licensed Psychological Associate	2
Participant Five	55-60	White	Evaluation And Referral Coordinator	12
Participant Six	45-50	African American	Licensed Professional Clinical Counselor	8
Participant Seven	50-55	White	Licensed Professional Clinical Counselor	25
Participant Eight	45-50	White	Licensed Clinical Social Worker	8
Participant Nine	50-55	White	Licensed Professional Clinical Counselor	13
Participant Ten	70-75	White	Licensed Psychological Practitioner	28

Note. Each participant was given a pseudonym to protect their identity. Years' experience refers to the total number of years' experience specifically working with the sexual offender population.

Participant Profiles

Participant One

Participant One is a 45-50-year-old, licensed psychologist who has been working in the mental health field for 18 years. Currently, Participant One works as a licensed psychologist with a focus on criminal justice reform. In this role, they provide a variety of community mental health services to justice involved youth and their families. Within the past three years, Participant One has also focused on the mental health treatment of incarcerated adults. While in this position, they spent 10 years providing individual therapy to both male and female adult offenders incarcerated for sexual crimes. Participant One expressed their appreciation and encouragement for providers specializing in the mental health care of female sexual offenders stating, "I want to encourage them to keep at it. The care they provide these women is making a difference in the lives of others. A positive difference."

Participant Two

Participant Two, a 65-70-year-old licensed psychologist, brings forth 37 years of experience in the mental health field. Throughout their career, Participant Two has had a multitude of experiences in both treatment focused milieus and private practice venues. Currently, Participant Two provides individual psychological services and evaluations to a small caseload of individuals within the private practice setting. Participant Two indicated that these individual services include providing mental health care to individuals with a history of sexual offense charges and those who are returning to the community following incarceration for sexual offense behavior. Participant Two has also worked as a mental health care provider in a sexual offender treatment program for those incarcerated for sexual offense crimes. As a mental health care provider in the sexual offender treatment program, Participant Two provided specific

therapeutic services designed towards the prevention of sexual offense behavior for those incarcerated for sexual offenses. Within both the private practice and sexual offender treatment program milieu, Participant Two has acquired 17 years of experience providing direct psychological services to the sexual offender population. Participant Two expressed his gratitude that the topic of female sexual offending is finally being researched.

Participant Three

Participant Three is a 30-35-year-old licensed psychological associate and applied behavioral analyst who has been providing therapeutic care within the mental health field for the past 12 years. In their current role, Participant Three creates behavior support plans for children and young adults with developmental disabilities. However, within the past five years, Participant Three held direct therapeutic experience providing behavioral health care services within a treatment program milieu for sexual offenders. Participant Three indicated that the treatment of sexual offenders was not the job for them, but they spent one year gaining fundamental experience providing mental health care to a challenging population in the form of group therapy geared towards strengthening relapse prevention strategies for individuals who have perpetrated sexual crimes. Participant Three recognized the importance of exploring the field of female sexual offending and encouraged providers in the field to "Take care of yourself and try to find joy in the work you do."

Participant Four

In addition to holding a licensure as a licensed psychological associate, 30-35-year-old Participant Four is also certified as a licensed mental health counselor. Participant Four has 10 years' experience within the mental health field but has spent the last two years providing individual and group therapy to sexual offenders who are likely to recidivate in the community.

While Participant Four never thought they would be working with the sexual offender population, they have observed positive therapeutic gains with their clients and find the work to be both beneficial and valuable. Participant Four would like to remind other providers in the field that they "can make a difference and to dive right into the process with a forgiving mind."

Participant Five

55-60-year-old evaluation and referral coordinator, Participant Five, has acquired 20 years' experience in the mental health field. Currently, Participant Five works within the community setting to offer psychological level of care evaluations for a variety of vulnerable populations. In this role, Participant Five uses their educational background in psychology to assess, evaluate, and diagnose the mental health disorders of the individuals in their care. Over the past 12 years, Participant Five has completed psychosocial assessments, level of care evaluations, and diagnostic procedures for the sexual offender population. Participant Five indicated that they use these level of care assessments to address any current mental health needs and connect individuals with appropriate community mental health resources. Participant Five recognized 20 years in the mental health field as a major accomplishment. For other providers seeking to make a career in the mental health field, Participant Five encouraged clinicians to "find healthy coping outlets and take care of yourself first and foremost."

Participant Six

Participant Six, 45-50-year-old licensed professional clinical counselor brings 26 years of experience within the mental health field to the research study. Currently, Participant Six works within a private practice in which they provide individual therapy to approximately 20 individuals. Within this role, they have provided psychological services, level of care assessments, and community referrals to individuals with histories of sexual offense charges.

Additionally, Participant Six has previously worked in mental health facilities designed for the therapeutic treatment of individuals with histories of sexually abusive and deviant behaviors. Throughout their 26 years of experience within the mental health field, Participant Six indicated they have spent 8 years focusing on the mental health care of the sexual offender population. Among their experiences, Participant Six emphasized the importance of networking and urged providers to "make connections with other providers in the field and utilize the limited resources available to the best of your ability."

Participant Seven

Licensed professional clinical counselor, 50-55-year-old Participant Seven applies their professional concentration to the assessment and evaluation of the sexual offender population. Participant Seven's professional experiences within the mental health field span across a 30 year period. Specifically, Participant Seven indicated they have spent 25 years of their career in a position which has allowed them to focus on providing psychological assessments and therapy services to a broad spectrum of populations, including those who have perpetrated sexual crimes. Participant Seven reported that they are glad the topic of female sexual offending and provider experiences with this population are being explored as "A lot of this type stuff is kept secret and not talked about." Furthermore, Participant Seven expressed, "Most people don't consider females as being sexual offenders, but it does happen. Women engage in sexually deviant behavior. I hope this research study sheds light on this topic and helps providers to effectively treat these women."

Participant Eight

Participant Eight, a 45-50-year-old licensed clinical social worker bestows 25 years' worth of experience to the mental health field. Within their current role, Participant Eight is part

of an interdisciplinary team created to provide behavioral health services to high-risk patients within the geriatric population. Specifically, Participant Eight focuses on providing care management services designed to prevent geriatric clientele from entering the hospital setting. Less than one year ago, Participant Eight focused on providing behavioral health care to the sexual offender population, spending eight years working within a residential treatment facility for individuals with a history of sexual perpetration and behavioral health needs. Participant Eight has also provided behavioral health crisis and risk assessments to the sexual offender population. As such, Participant Eight has experience providing individual based therapy, family therapy components, and crisis risk assessments to both male and female individuals who have perpetrated sexual crimes. Participant Eight stressed the importance of a strong work life balance and encouraged providers to learn and use boundaries. Additionally, Participant Eight urged providers to remember "You don't have to be perfect or have all the answers. Clients are not always looking for us to fix them, but to provide the tools to help. Work to empower, not enable. That's a fine line, but achievable."

Participant Nine

50-55-year-old licensed professional clinical counselor, Participant Nine, holds 23 years' experience within the mental health field. Currently, Participant Nine is employed as a behavioral health therapist for adults with traumatic brain injuries. However, approximately three years ago, Participant Nine was actively engaged in a career specializing in the direct care of the sexual offender population. Participant Nine spent 13 years dedicated to the mental health care of both male and female sexual offenders. Throughout their work with the sexual offender population, Participant Nine provided cognitive behavioral therapy, individual and group counseling sessions, and crisis intervention strategies to assist offenders is uncovering the

reasons for their choices to perpetrate sexual crimes. Participant Nine reported, “I focused on uncovering all the deep dark secrets.” Participant Nine emphasized that uncovering all of the hidden secrets an individual is carrying is an important strategy to help an individual heal. Furthermore, Participant Nine expressed the importance of “helping people understand where their trauma comes from, what it is, and how to deal with it so they can lead a more productive and offense-free lifestyle. These are the secrets we are uncovering throughout the therapeutic process.” Moving forward, Participant Nine would like to remind providers in the field to “Watch out for manipulation and turn to your coworkers for support. They are a great resource.”

Participant Ten

Licensed psychological practitioner, 70-75- year-old Participant Ten has made a career devoted to protecting the public and providing therapeutic care to the sexual offender population. Participant Ten has achieved 30 years of experience within the mental health field. Of those 30 years, 28 have been dedicated to the specific mental health care and therapeutic treatment programming of sexual offenders. In addition to their certification as a licensed psychological practitioner, Participant Ten is an approved provider to evaluate and treat individuals with sexual offenses on their criminal record. In their current role, Participant Ten primarily specializes in the therapeutic care of adult individuals with a sexual offense on record. In this therapeutic capacity, Participant Ten typically focuses on providing individual therapy and risk evaluations to individuals who have perpetrated sexual crimes. Considering their therapeutic work, Participant Ten expressed “I tell my clients that we are here to break the chain. My way of treatment is to look at everything. The offense is only one small piece of the whole gambit.” To address the whole gambit, Participant Ten identified interweaving an individual’s autobiography among the whole treatment process. Participant Ten conveyed, “this provides the client the

opportunity to share their entire life story and to be heard." Participant Ten encouraged providers to listen to the client's life story and remember that "Nothing is inadmissible."

Ethical Precautions

Qualitative research provides an innovative opportunity for deep investigation, profound exploration, and enhanced knowledge throughout a variety of fields and disciplines. In particular, human subjects research, with a constructivist worldview, offers the potential for meaningful insights and advances that may contribute to increased understanding of a topic and resources to better support individuals, populations, or society as a whole. While there are considerable benefits to human subject research, care must be taken to ensure the well-being of all research participants.

The National Commission for the Protection of Human Subjects of Biomedical and Behavioral Research (1978) established and developed three comprehensive principles relevant to protecting and ensuring the well-being of human subjects involved in research. Respect for persons, beneficence, and justice make up the basic ethical principles required to aid and guide researchers in human subject study. These ethical guidelines, as well as each researcher's personal ethical conduct and positionality, promote enhanced awareness, understanding, and sensitivity to the unique needs and challenges encountered when completing human subject research. Along each step of the research process, the positionality of the researcher, as well as the ethical principles of respect of persons, beneficence, and justice were incorporated into the human subject research design.

Respect for Persons

The National Commission for the Protection of Human Subjects of Biomedical and Behavioral Research (1978) describes respect for persons as both the treatment of individuals as

autonomous agents and the protection of individuals with diminished autonomy. Respect for persons is addressed through this research study by the use of informed consent. Prior to agreeing to voluntarily participate in the research study, each participant received a thorough informed consent. This document provided key information related to the purpose of the study, detailed information describing the potential risks and benefits of participation, and information on how data will be utilized upon study completion. Informed consent was discussed verbally, as well as in written documentation, to aid in participant understanding and to provide the participant time to ask any clarifying questions pertaining to the research study. With this knowledge, participants may act as autonomous agents regarding their voluntary participation in the research study. Within this research study, each participant was of consenting age and capable of considering the options and choices beneficial for their personal goals and life development. Each participant voluntarily agreed to participate in the study with the right to withdraw at any time, without incurring any penalty.

Beneficence

Beneficence refers to participant well-being and is described as actions that do not harm, minimize potential harms, and maximize potential benefits (National Commission for the Protection of Human Subjects of Biomedical and Behavioral Research, 1978). Considerable thought related to reducing risk and maximizing benefits was applied throughout the study. The current study presented minimal risk of harm with the potential for significant benefits related to improved understanding in the field of female sexual offending through the therapeutic provider lens of the clinical professionals with experience in the direct care of this population.

While the risk of harm cannot be completely eliminated from the study, steps were taken to minimize any potential risk. Throughout the study, the researcher worked diligently to

maintain the confidentiality of each research participant. Though absolute confidentiality cannot be guaranteed, the protection, safety, and well-being of the participant were of primary concern for this researcher. The researcher worked to uphold and maintain the privacy of the participant throughout the duration of the study and avoided providing any identifying information in reports or documentation. No identifying names, locations, or organizations were provided. For each participant, gender neutral pseudonyms using numerical values were incorporated and the gender identification of providers were removed to protect the anonymity of all participants as much as possible. Any names or identifying information provided through participant experience or report were changed to protect the anonymity of providers and their clients. Furthermore, raw data was maintained and protected in accordance with university procedure. In addition, when analyzing and reporting data, results were reported in an honest, straightforward, and clear manner. Lastly, the researcher did not falsify data.

Though minimal, there were potential risks or discomforts that the participant may have experienced in this study. Throughout this research study, participants discussed and interpreted potentially sensitive and personal experiences. Therefore, there was a risk of emotional discomfort. Participants were provided access to psychological resources and services upon request. Furthermore, during any portion of the research process, participants were able to decline to participate or answer any question posed by the researcher, without incurring any penalty.

Justice

The final principal identified by the National Commission for the Protection of Human Subjects of Biomedical and Behavioral Research (1978), justice, refers to fairness within research. The National Commission for the Protection of Human Subjects of Biomedical and

Behavioral Research (1978) suggests that an injustice occurs when an individual is denied a benefit without good reason or when a burden is imposed undeservedly. Therefore, throughout this research study, the researcher worked diligently to establish justice and fairness among participants. This researcher worked to treat every participant fairly and to ensure that every participant received the same treatment throughout the research study. A comprehensive informed consent was covered with each participant. In addition, a semi-structured interview protocol was used to assist with consistency throughout the study. Furthermore, each participant was treated with professionalism, respect, and compassion throughout each aspect of the research study design. Additionally, no form of financial or external compensation was provided for participation in this study. Participation in the study was voluntary and participants were able to choose to discontinue participation in the study at any time, without incurring any penalty. Finally, psychological services were made available for all participants upon their request. Thus, these practices established fairness in distribution and justice across the research study.

Data Collection

Interviews and Setting

In-depth, open-ended, semi-structured interviews were completed to gather information and engage behavioral health providers in conversation about their unique experiences providing therapeutic care to female sexual offenders. See Appendix C for the semi-structured interview protocol used throughout the study. Interviews were completed at a time and place convenient to the participant and occurred through virtual Teams or Zoom meeting spaces as well as in-person, face-to-face interaction. For the study, two interviews were completed virtually, and eight interviews were completed in-person. In-person interviews took place either at the participants' professional office location or their home, based on the participant's choice. All interviews were

audio recorded using virtual Microsoft Teams or Zoom programming or an electronic hand-held voice recording device for later transcription by the researcher. Participants were able to decline audio recording of the interview upon request. Four participants declined to have their interview audio recorded and hand written interview notes were documented by the researcher. For the interviews that were audio recorded, transcriptions were completed by the researcher within 48 hours of interview completion. The researcher was responsible for transcribing the conversation and removing all identifiable information. Field notes were also incorporated during the interview process to highlight specific observations related to the interview setting, participant expressions, body language, and general researcher impressions. All audio recordings, transcriptions, field notes, and raw data were secured and maintained by the researcher on a password protected computer in a password protected cloud location, in accordance with Institutional Review Board policy and procedure. Audio recordings were destroyed by the researcher upon completion of the interview transcription. If participants decided to withdraw consent prior to interview completion, any audio recording or transcription data would have been destroyed immediately by the researcher. No participants withdrew from the study.

Observations

In addition to interviews, observations were completed to assist with triangulation of the data and establish a comprehensive understanding of the phenomenon of female sexual offending and provider experiences when treating this distinctive population. Observations included the interview environment, communication, body language, and researcher impressions regarding the setting, interview process, and participant interaction. Observations were documented by the researcher and listed within the researcher's field notes. During the interview process, the researcher documented by hand any pertinent observations that occurred. For the two interviews

completed virtually, direct observation of the setting and interview environment was not assessed. Immediately following interview completion, the researcher reflected and described in detail any further observations or thoughts within their field notes. This process was completed immediately following interview completion in order to capture all relevant data while it was fresh upon the researcher's memory. An example of observations from a participant interview within the researcher's field notes is provided in Appendix D. The researcher created a field note standardized form in which to list notes regarding the interview structure, interview observations, and general researcher thoughts and ideas. This standardized form created an organizational structure for viewing to aid the researcher in data analysis.

Data Analysis

Interpretive data analysis was used throughout the study to examine interviews and observations collected by the researcher. Data analysis for this study followed Colaizzi's descriptive phenomenological 7-step approach to data examination. Colaizzi's 7-step approach to data analysis relies on participant voice to establish rich descriptions of the lived human experience in which to produce an inclusive depiction of the phenomenon under study (Morrow et al., 2015). Figure 1 provides a summary of Colaizzi's 7-step approach in direct relation to the data analysis of the clinical experiences when providing therapeutic behavioral health care to female sexual offenders. The figure presents a step-by-step guide depicting the goals, process, and actions among each of Colaizzi's 7-steps to data examination as directly applied to the study and interpretation of the lived experiences of behavioral health treatment providers with experience working with the female sexual offender population.

Figure 1

Colaizzi's 7-Step Approach to the Data Analysis of the Experiences of Treatment Providers When Working with Female Sexual Offenders

Research Question		
What are the experiences of treatment providers working with female sexual offenders?		
Colaizzi's 7-Step Approach to Data Analysis		
Step	**Goal**	**Process/Action**
Step 1	Data review and familiarization	Complete multiple readings of all data
Step 2	Identify significant data	Use a blend of first cycle descriptive and in vivo coding strategies to identify significant information in direct relevance to the research question
Step 3	Distinguish categories	Use focused coding as a second cycle coding method to formulate categories relevant to the research question
Step 4	Group data into themes	Utilize pattern coding as a third cycle coding method to group significant data into themes
Step 5	Develop a complete depiction of the phenomenon	Incorporate themes into meaningful interpretation
Step 6	Create the fundamental structure of the phenomenon	Condense the depiction of the phenomenon into concise but thorough statements to capture key aspects vital to the fundamental structure of the phenomenon
Step 7	Verify the fundamental structure of the phenomenon	Complete member checking with all participants, modify any misinterpretations in the data, and conclude interpretive data analysis

Colaizzi's 7-step approach to data examination offers an immersive and thorough data analysis technique designed to yield a complete description of a phenomenon (Morrow et al., 2015). Throughout this process, the researcher submerged themself within the data, becoming familiar with all participant interviews, field notes, and observations. This immersive data review aided the researcher in identifying significant statements from the participants that were in direct relevance to the phenomenon of female sexual offending and the resulting experiences of the behavioral health providers with experience treating this specific population. Additionally, an immersive review of field notes and observations helped to submerge the researcher back into the interview experience with participants and improve aspects of memory and content. Field notes consisted of data regarding the interview structure, interview observations, and initial researcher thoughts and ideas emerging from participant interviews. This data was also coded to evaluate emerging themes and to compare and triangulate among the coding of participant interview data.

Multiple coding cycles were used throughout Colaizzi's 7-step approach to data examination to identify significant data, distinguish significant categories, and group data into themes. Throughout each coding cycle, bracketing techniques were incorporated to separate and reflect on researcher beliefs, judgements, and experiences of the topics being studied (Vagle, 2018). A blend of first cycle descriptive and in vivo coding strategies assisted the researcher in becoming familiar with the data and identifying significant statements essential to the research question. Saldana (2021) describes descriptive coding as a one word or short phrase summary depicting the basic topics of qualitative data. In addition, in vivo coding processes utilize the participants' own language to create short coding phrases found within qualitative data (Saldana, 2021). Thus, with first cycle descriptive and in vivo coding techniques, organization at a basic

level emerged, while continuing to honor and prioritize the participant's voice in capturing the essence of the clinical experiences encountered by behavioral health treatment providers when working with female sexual offenders.

Focused coding techniques used as a second cycle coding method allowed the researcher to distinguish and formulate significant categories relevant to the clinical experiences encountered by behavioral health treatment providers working with female sexual offenders. Focused coding identifies the most frequent and significant codes in order to develop the most prominent categories and themes from the data (Saldana, 2021). By completing second cycle focused coding for each participant interview, the researcher compared codes across interview transcripts which supported comparability, frequency, and insight among the data. Additionally, focused coding techniques were incorporated to code the field notes and observations of the researcher. Focused coding allowed the researcher to identify categories and emerging themes from initial interview impressions documented in the field notes. These initial categories and possible emerging themes were compared and triangulated with the focused coding of participant interviews to evaluate aspects of credibility and confirmability.

Lastly, pattern coding was used as a third cycle coding method to group significant statements and topics from data analysis into themes. Saldana (2021) suggests that pattern coding is a useful strategy in grouping first and second cycle coding segments into condensed themes and categories to create meaningful analysis and explanation. Pattern coding continued to weave together data and statements that described and explained the significant themes capturing the essence of the clinical experiences encountered by treatment providers working with female sexual offenders. These multiple coding cycles assisted with establishing the meaningful interpretation necessary to develop a full, inclusive, and exhaustive depiction of the fundamental

structure of the phenomenon of female sexual offending through the lens of behavioral health treatment providers and captured the essence of provider experiences while treating this population.

Member checking was used to verify and create the fundamental structure of the phenomenon. Member checking allowed participants to provide feedback related to the researchers' conclusions and assisted with ruling out the possibility of misinterpreted meanings and perceptions of the data (Maxwell, 2013). Member checking was completed with each participant in the study and allowed the researcher to collaborate and verify with participants that the fundamental structure of the interview captured their specific experiences. Once completed and transcribed by the researcher, interview transcripts were emailed to participants for verification. This process allowed participants to review their interview transcripts, ensure that their voice was captured and depicted accurately and authentically, and provide any feedback related to possible misinterpretations. All participants confirmed via email correspondence that they received and reviewed their interview transcript. Following member checking, the researcher used participant feedback to modify any misinterpretations in the data. Only one participant requested modifications and clarity made to an interview response. This modification was completed and sent back to the participant, via email correspondence, for a final review. Upon completion of member checking, all participants indicated they were satisfied that their experiences were accurately portrayed, and the researcher completed interpretive data analysis.

Trustworthiness

Trustworthiness in qualitative research directly addresses concerns of validity and reliability throughout research designs. Guba (1981) suggests that qualitative studies must include aspects of credibility, transferability, dependability, and confirmability in order to meet

the criteria of a trustworthy study. Credibility for this study was achieved through prolonged engagement, triangulation, and member checking. Throughout the study, the researcher spent approximately eight hours in the field completing one-on-one interviews to build relationships, gather relevant data to meet saturation, and collect multiple participant perspectives. Triangulation was also incorporated by using interviews, field notes, and observations to cross-check data and interpretations. The researcher spent approximately 52 hours analyzing and interpreting data to capture a deep understanding of the core lived experiences identified by therapeutic providers when delivering behavioral health care services to the female sexual offender population. Additionally, triangulation was used to build confirmability throughout the study by comparing participant views and perspectives across interview transcripts in which to identify their collective voice to shape and construct themes regarding their experiences. The collective participant voice was compared and triangulated with researcher field notes and observations to cross-check interpretations and ensure study findings were shaped by the participant perspective and not the perspective of the researcher. Finally, member checking allowed the participants to review and verify for accuracy their individual interview transcript. Member checking was completed by emailing interview transcripts to each participant for review and verification to evaluate the truthfulness of the account.

In addition, transferability was addressed through the collection and development of thick description. Thick description allowed the researcher to describe in detail each part of the study including the participants, settings, procedures, interviews, dialogue, observations, results, and researcher interpretations (Guba, 1981). Thick description and detailed depiction also assisted with establishing dependability. Guba (1981) suggests that thick description provides the ability for future researchers to produce a step-by-step replication of the study.

Finally, confirmability was established using bracketing and researcher reflexivity. Bracketing and reflexivity allowed the researcher to examine perspectives and bias that they may bring to the study and explore how these perspectives may shape data interpretations (Guba, 1981). Throughout this process, the researcher used self-examination to separate personal beliefs and experiences from the topic being studied. The researcher also continually questioned whether the data and interpretations were aligned with the research question and purpose of the study. Field notes, reflexive statements, and analytic memos were incorporated as material was processed to assist with reflexivity and the establishment of an audit trail. An example of an analytic memo is provided in Appendix E. An audit trail and review of material promoted transparency, tracking, and accountability of the research study.

Chapter Four: Findings

This qualitative, phenomenological research study aimed to capture the essence of the clinical experiences encountered by treatment providers with experience in delivering therapeutic care to female sexual offenders and explored how providers experience the world in order to establish an advanced understanding of the nature and meaning of everyday life experiences in the field of providing behavioral health care to female sexual offenders. This study utilized the lens of therapeutic provider experiences and perspectives to build a succinct foundational overview of the topic of female sexual offending, expand knowledge related to the field, and develop insight into the providers who have treated this focused population. Specifically, this study was guided by the following research question:

1. What are the experiences of treatment providers working with female sexual offenders?

Through the analysis and interpretation of data collected from in-depth therapeutic provider interviews, field notes, observations, and data analysis, themes emerged which directly addressed the research question and captured the essence of the clinical experiences encountered by treatment providers with experience working with female sexual offenders. Such experiences provide a unique lens and opportunity to develop and enhance the limited knowledge and insight related to the topic of female sexual offending and the providers who have cared for the female sexual offender population.

Findings were established using multiple coding cycles used throughout Colaizzi's 7-step approach to data examination. A blend of first cycle descriptive and in vivo coding procedures prioritized the participant voice while identifying short phrases from the participant's own words that captured the essence of their experiences when delivering care to the female sexual offender

population. These short phrases using the participant voice created a base level organization in which the researcher immersed themselves in data interpretation. Additionally, in vivo coding procedures directly aligned with the constructivist framework of this study and allowed the participant views and life experiences to develop and construct meaningful interpretation related to the topic. First cycle descriptive and in vivo coding methods produced an initial 109 codes relevant to the research question.

Following first cycle coding methods, focused coding procedures were used as a second cycle coding technique in which to condense the initial 109 codes into the most frequent and significant codes. With this strategy, the researcher compared codes across interview transcripts and developed prominent categories from the data. At this step, the initial 109 codes were condensed into 56 of the most frequent codes and grouped into six broad categories. Focused coding was also used to categorize the field notes and observations of the researcher. Focused coding allowed the researcher to identify categories and emerging themes from initial interview impressions documented in the field notes. The initial categories and possible emerging themes from field notes and observations were compared and triangulated with the focused coding of participant interviews to evaluate aspects of credibility and confirmability among the data. The focused coding of field notes and observations provided 20 of the most frequent codes grouped within four main categories. An example of codes established from researcher field notes and observations is provided in Appendix F. Codes established from field notes and observations supported the emerging and developing codes among participant interviews. Lastly, pattern coding was used as a third cycle coding method. Pattern coding was used by the researcher to group first and second cycle coding findings into condensed themes and complete meaningful interpretation. Upon the completion of multiple coding cycles, data was condensed, and four core

themes and sub-themes emerged which captured the essence of the clinical experiences encounter by behavioral health treatment providers with experience delivering therapeutic care to the female sexual offender population. Appendix G provides an example of the coding cycles used by the researcher and provides a visual representation of the condensed codes as they emerged among each cycle.

Through the exploration of therapeutic provider perspectives and understanding of their lived experiences when delivering behavioral health care to female sexual offenders, the researcher used a constructivist framework to prioritize the participant voice throughout coding cycles and capture the essence of therapeutic provider experiences in the field. The constructivist framework emphasized the perspective, meaning, and understanding of therapeutic providers when offering behavioral health care to the female sexual offender population and constructed themes in which to meaningful interpret findings and directly answer the research question of the study. Four core themes and several sub-themes emerged which captured the essence of the experiences encountered by therapeutic treatment providers with experience delivering behavioral health care services to the female sexual offender population:

1. Experiences- Cyclical
    A. Challenging client life experiences
    B. Treatment barriers
    C. Negative emotional responses
    D. Rewarding and worthwhile experiences
2. Experiences- Female Sexual Recidivists
    A. Additional Treatment Complexities
    B. Failure and Reduced Professional Competence

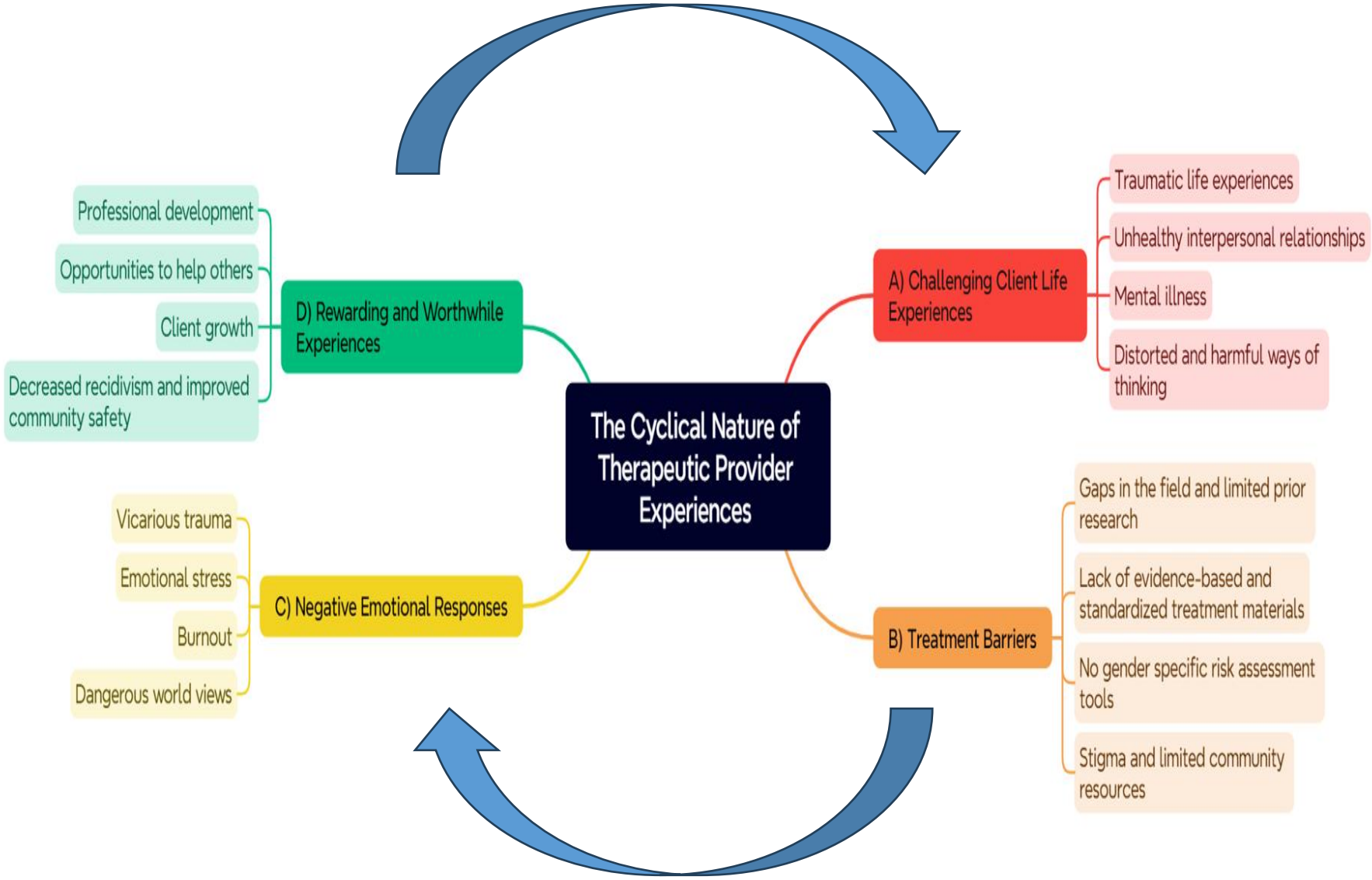
3. Experiences- Coping Skills
    A. Self-care
    B. Boundaries
    C. Persistence
    D. Supportive colleagues
4. Experiences- Professional Need
    A. Training and education
    B. Easier access to mental health services
    C. Female specific treatment materials
    D. Trauma based therapy

Theme One: Experiences- Cyclical

In the field of female sexual offending, therapeutic treatment providers are encountering experiences that are cyclical in nature. Figure 2 provides a visual outline of four core sub-themes regarding the cycle of experiences which treatment providers endorsed throughout their work in the behavioral health care of the female sexual offender population.

Figure 2

The Cyclical Nature of Therapeutic Provider Experiences



Challenging Client Life Experiences

In the field of female sexual offending, therapeutic behavioral health care providers are treating challenging client life experiences of trauma, unhealthy interpersonal relationships, mental illness, and distorted and harmful ways of thinking. This primary finding establishes the foundation upon which provider experiences when treating female sexual offenders are formed. All participants commented and focused on the types of life experiences, gender characteristics, and treatment needs endorsed by their female clients who have engaged in sexual offense behavior. Through their lens, therapeutic providers are recognizing distinct characteristics and treatment needs among the female sexual offender population.

Therapeutic treatment providers with experience in the field of female sexual offending consistently identify female sexual offenders as a complex and challenging population to serve. Part of the complexity when providing behavioral health care to this population involve the significant traumatic life experiences encountered by women who have perpetrated sexual crimes. All providers identified traumatic life experiences as a foundational aspect contributing to female sexual offense behavior. Furthermore, treatment providers indicated that significant experiences of lifetime trauma also contribute to the development of unhealthy interpersonal relationships and distorted and harmful ways of thinking among this population. According to Participant One, “It’s a giant, interconnected, stewpot.” Traumatic life experiences are the foundational connection among relationship formation and thought process in women who engage in sexually offensive behaviors.

Participant Four also commented on the foundational aspect of traumatic life experiences, “Traumatic life experiences are a common theme with all the women I have worked with. It seems to be a foundational aspect to female sexual offense behavior.” According to Participant

Six, traumatic life experiences are one of the most consistent features that they attribute to women who have engaged in sexual offense behavior. Participant Six indicated:

> The foundation is trauma. Trauma, especially in childhood, affects brain development. It's almost like women in this population are stunted mentally and have not developed into healthy functioning adults. They haven't developed the ability to have healthy functioning relationships and connections with others.

Like Participant Six, Participant One and Participant Two also identified the connection among traumatic life experiences, unhealthy interpersonal relationship development, and cognitive distortions. According to Participant One, "Women have had such extensive trauma histories that they have developed unhealthy attachments and distorted and harmful ways of thinking." Furthermore, Participant Two expressed:

> Females are carrying with them a significant amount of trauma. The women I have worked with have endorsed histories of physical abuse, emotional neglect, and sexual trauma throughout their life. Usually by family and the men in their lives. As a result of some of their past life experiences, many of these women are surrounded by abusive relationships, feelings of dependency, poor self-worth, and have not established the healthy boundaries within their life required to form positive and supportive relationships.

The foundational aspects of traumatic life experiences are so deeply set within the female sexual offender population that Participant One stated, "I can't think of one female with whom I have provided psychological care that did not endorse a history of significant lifetime trauma." For female sexual offenders, the foundational aspects of traumatic life experiences span across their lifetime but typically begin in early childhood.

Participant Ten specifically addressed the link between trauma in early childhood and sexual offense behavior as an adult for female offenders. Participant Ten expressed:

> I evaluate and assess [traumatic] adverse childhood experiences with every single person. There is nobody that does not score in the significant range. Before age 18, almost all women were hit, talked down to, physically, emotionally, sexually abused, had parents who abused substances, or family members who went to prison. So many traumatic things. They come from fractured households. No one has a healthy concept of interpersonal relationships.

Traumatic life experiences beginning in early childhood can span the lifetime and impact an individual's perceptions and interpersonal connections throughout their life. For almost all female offenders, providers indicated that misguided perceptions resulting from early traumatic life experiences contributed to deviant sexual behavior as an adult. Distorted and harmful ways of thinking established from childhood and adult traumatic life experiences were identified by all therapeutic providers.

Therapeutic treatment providers indicated that cognitive distortions held by female sexual offenders often involved misplaced feelings of love, emotional identification with children, minimization of harm, and a lack of accountability for their behaviors. Participant Two provided a detailed description that captured the general experiences of many therapeutic providers in the study:

> [Female sexual offenders] typically hold distorted views and ways of thinking. Specifically, regarding views of love and relationships. Their views of what love is has been misguided throughout their life and become distorted. They have virtually no sense of personal or emotional boundaries and have not developed the skills to display feelings

> of love and connection in healthy ways. There is an emotional immaturity and a sense of dependency present. This allows them to emotionally identify with children or to feel dependent in relationships. Either way leads to harmful ways of thinking. As a whole, there is a lack of accountability for their behavior, a minimization of the harm caused by sexual perpetration, and a likelihood to blame others for their actions. Such distorted views set the stage for sexually deviant behavior.

These distorted and harmful ways of thinking presented as challenging life experiences that are navigated within the therapeutic process.

In addition to traumatic life experiences, unhealthy interpersonal relationships, and distorted and harmful ways of thinking, mental illness presents as a challenging client life experience for therapeutic providers delivering behavioral health care to women who have perpetrated sexual crimes. Participant Nine emphasized the mental health concerns prevalent within the female sexual offender population:

> The co-occurring mental health issues that females experience, it can be brutal. The level of damage that people come with, that's the hardest part. There are significant rates of self-injurious behavior, mood disorders, substance abuse, dependency. You name it, it's there.

Participant Ten further identified co-occurring elements related to borderline personality disorder that may impact an individual's decision to act in sexually deviant ways. Specifically, Participant Ten indicated elements of borderline personality disorder that "set [female offenders] up to act out sexually." Participant Ten expressed that elements related to borderline personality disorder such as unstable moods, chaotic relationships, impulsive behavior, and high risk activities are a

challenging aspect to the behavioral health care of female sexual offenders but should be a primary concentration of therapeutic care for this population.

With these distinct and challenging client life experiences as a focus in the therapeutic milieu, providers are designing treatment plans and implementing clinical practice to meet female specific treatment needs. Participant Ten revealed, “I tell my clients that we are here to break the chain. No one needs to live controlled by traumatic re-enactments.” Participant Nine further emphasized incorporating therapeutic strategies to “assist clients with uncovering the reasons for their choices to commit sexual offenses.” Participant Nine stressed the importance of “uncovering all the deep dark secrets” throughout the therapeutic process. According to Participant Nine, this emotionally heavy work is the most effective strategy for “Helping people understand where their trauma comes from, what it is, and how to deal with it so they can lead a more productive and offense-free lifestyle.” The occurrence of challenging client life experiences involving trauma, unhealthy interpersonal relationships, mental illness, and distorted and harmful ways of thinking establish the foundation upon which provider experiences when treating female sexual offenders are formed and guide clinical practice throughout the therapeutic process.

Treatment Barriers

In addition to the treatment of challenging client life experiences, therapeutic providers endorsed experiencing significant barriers to the therapeutic process when providing care to female sexual offenders. All participants stressed the significant gaps in the field of female sexual offending and the limited research available for their review. In particular, a lack of evidenced-based and standardized treatment materials have presented as a significant barrier to providers who specialize in the field. Participant One provided an inclusive account that encompasses the therapeutic barriers expressed by the majority of participants:

> A lack of resources and limited research in the field have been a major barrier. Most of the therapeutic resources for sexual offenders that I have found have been geared towards the treatment of male offenders. Finding resources and materials specifically for female offenders is difficult. They are basically nonexistent. So, I have had to adapt the resources designed for men in order apply to the female population. This has taken a lot of personal time and energy and is in no way a standardized procedure. Sometimes, I think the lack of resources have limited the care I have been able to provide to female offenders.

Participant Seven voiced a similar experience, stating "Most things are [designed for] … men and females just get lumped in." Similarly, Participant Two expressed:

> There are not a lot of treatment tools or resources available. Almost everything available has been designed for use with male offenders. Most of the resources or tools I do have, are things I have adapted from tools or materials designed for men. You have to be creative in this field. Use what's available and make what you need if it's not already out there. You do the best you can with what you have access to.

The lack of gender specific treatment materials and minimal research designated to the field of female sexual offending have created numerous barriers for the providers specializing in the therapeutic care of this population.

One significant barrier is the lack of gender specific risk assessment measures. No therapeutic provider was able to identify any female specific risk assessment tools. Participant Two indicated, "When I am working with the male population, there is guidance. Treatment tools are available, therapeutic resources, testing instruments, risk assessment tools. I have found very little of that available for the female population." All providers echoed similar experiences.

Participant Ten attributed the lack of female specific risk assessment tools to the low number of identified and reported occurrences of female perpetrated sexual crimes. Participant Ten expressed, "Women are considered caregivers and nurturers. If an offense does occur, it does not come to light. It's disguised within caretaking roles. This has impacted the development of female specific tools and resources." The lack of female specific risk assessment tools has presented as a barrier to therapeutic providers and impacted their ability to accurately predict risk among the female sexual offender population.

Therapeutic providers also noted barriers related to stigma and limited community resources. Both Participant Six and Participant Five, endorsed the perspective that female sexually deviant behavior is not a topic taken seriously within society. Furthermore, therapeutic providers within the behavioral health field indicated that female sexual offenders are generally ignored or ostracized within the community. Participant Three articulated:

> I don't think that people in general like to think about sexual offending. Especially when it comes to women. Women are the caregivers in society, ... are our babysitters, our parents, our teachers, our friends. We don't want to think of women breaking the law and harming others, especially in any type of sexual nature. So, I think they are generally just ignored.

If detected, Participant Two expressed:

> There are not a lot of mental health providers out there who want to work with sexual offenders. … no sexual perpetrator is portrayed … in a positive light. Usually, sexual perpetrators are portrayed … as the worst of the worst. No matter the gender, male or female. These negative perceptions impact not only the general public, but mental health care providers as well. The stigma makes them less willing to treat this population."

The stigma surrounding the field of female sexual offending have also impacted access to community behavioral health resources for this population.

Participant Seven reported, “It’s hard to find referral sources and treatment resources for this population.” Participant Six noted a similar experience, “The main barrier is when I’m trying to make mental health referrals within the community. Providers, facilities, treatment programs, they don’t want to work with this population.” The same concept was echoed by Participant Five:

> It’s hard finding placement for these individuals. Hospitals view them as a safety risk. So, if someone needs admission because they are suicidal or depressed, it’s very hard to find a facility willing to take them. Same with making referrals to community providers. Not every therapist wants to work with this population.

Additionally, therapeutic providers expressed that most of the support and resources available to individuals who have perpetrated sexual crimes are related to supervision and detention within the criminal justice system. Participant Six summarized the general opinion of most providers, “There are not really that many supports in the community. If you’re not involved in the legal system, treatment is not easily accessible.” Female individuals engage in sexually deviant behavior and perpetrate sexual crimes. The stigma regarding female sexually offensive behavior and limited community resources pose a significant barrier to the therapeutic treatment of female offenders and increase the likelihood that female perpetrated sexual crimes go unreported and untreated within society.

Negative Emotional Responses

The therapeutic treatment of such challenging client life experiences, in combination with frequent barriers to providing therapeutic services, contribute to negative emotional responses

among behavioral health care providers with experience in the treatment of female sexual offenders. Therapeutic providers who have treated this population identified experiences of vicarious trauma, emotional stress, burnout, and dangerous world views. Most therapeutic providers identified negative emotional responses resulting from exposure to the traumatic life stories and experiences of their clients. Participant Two expressed:

> It's deep work in terms of the emotional aspects. A lot of time is spent helping clients to work through their specific trauma histories. This takes an emotional toll on the provider as well … an emotional weight. It's traumatizing. That has been a difficulty at times, … [it's] hard … to face the crime and address the topics head on. It's a sad and painful topic. But necessary. This comes with heavy emotions for the client and provider.

Participant Nine further identified aspects of vicarious trauma:

> I'm a visual person. When describing aspects of the offense, I visualize it. I visualize my rendering of the scene. I can see it. … there is an emotional entanglement. … this is secondary stress and trauma. It's traumatizing, diving into the depths.

Participant Three also expressed an emotional entanglement regarding the therapeutic care of female sexual offenders:

> I struggled at times. I was stressed in the job. This impacted my sleep and everything else, I guess. I had nightmares. In this particular field, it's heavy. It's a lot of emotional work. The topic, you have to listen to, read, and discuss very difficult things. And those topics, the trauma, the pain, it has a tendency to seep. The emotions don't always stay contained to the office space. … you carry emotions with you. I didn't sleep well. I worried. Worried about my clients and others. I was irritable from stress. I'm not sure if others noticed, but it felt that way to me.

Similarly, Participant Eight stated:

> In this field you hear some of the worst cases. These stories stay with me. … I have been told I'm an empath. So, I have to control my emotions. Working with this population, you are made privy to what they have done. I have a lot of empathy for the victim. My emotions are heavy. I sometimes have a sense of anger. It's hard to have compassion at times for the perpetrator.

Encounters with the significantly traumatic life histories of female sexual offenders resulted in common experiences of vicarious trauma among therapeutic treatment providers.

Additionally, therapeutic treatment providers identified negative emotional responses involving emotional stress. Participant Three reported:

> I felt a lot of stress when I was providing care to sexual offenders. I felt a lot of responsibility to provide the best care in order to help keep others safe. But I think so much stress … did not help improve my therapeutic skills … [I was] not as good a provider.

Participant One further depicted aspects of emotional stress:

> I've had intrusive thoughts at times. Just things that pop into your head. Therapy doesn't really end when you leave the office. Sometimes you carry things with you. … I had difficulty shutting my brain off. I would think about my clients, their life, wanting to help them. Wanting to provide the best care I could, help with healing and safety. So, I guess internally and externally this can be draining at times. Carrying such heavy topics with you. You feel it. Exhaustion, worry, stress, doubt.

The emotionally heavy and demanding aspects required when providing behavioral health care to the female sexual offender population negatively impacted therapeutic treatment providers in the form of emotional stress.

The emotionally heavy and draining aspects of therapeutic care within the female sexual offender population also contributed to high rates of burnout among providers. Participant Six indicated, “If I’m not careful, I get burned out quickly. It’s a complex population. Very draining. It takes a lot out of you internally when you work with this population.” Participant One similarly identified challenges related to burnout, “Burnout is prevalent. It’s hard work. Emotionally heavy work. It can be a lot and that’s difficult at times.” Encounters with challenging client life experiences and barriers to the therapeutic care of female offenders have resulted in frequent provider experiences involving burnout.

Lastly, therapeutic treatment providers identified negative emotional responses involving dangerous world views. Participant One provided a detailed description of the dangerous world views established as a result of providing behavioral health care to female sexual offenders. Participant One stated, “there [is] … a fear there. It makes you wonder if your … ever really safe. I had difficulty trusting others. I guess it made me more guarded.” Participant Nine also identified dangerous world views related to fear. Participant Nine expressed, “There is some fear. I don’t watch the news … because I’m always afraid I’m going to turn on the news and see one of my clients.” The behavioral health treatment of challenging client life experiences, in combination with frequent barriers to providing therapeutic services, contributed to the formation of dangerous world views among providers. Therapeutic provider experiences of vicarious trauma, emotional stress, burnout, and dangerous worldviews captured the negative emotional responses of treatment providers with experience in the field of female sexual offending.

Rewarding and Worthwhile Experiences

Despite the therapeutic challenges and negative emotional responses encountered when providing care to female sexual offenders, providers emphasized rewarding and worthwhile experiences that motivate them to remain in the field. A sense of pride and dignity was felt throughout this research study. Therapeutic treatment providers were proud of the work they have accomplished throughout their career and the care they have been able to provide to a challenging population. This sense of pride and dignity was displayed in their energy throughout the interview process, their willingness to discuss an emotionally heavy topic, and their drive to share knowledge with others. Therapeutic treatment providers displayed care for their profession and concern for the population they serve. The sense of professional pride and achievement, as well as care and concern for the individuals within their care, presented as an underlying guiding influence for therapeutic treatment providers in the field of female sexual offending. More specifically, all participants endorsed aspects of professional development, opportunities to help others, client growth, decreased recidivism, and improved community safety as rewarding interactions while treating this population.

Characteristics of professional development were identified by the majority of participants throughout the research study. Participant Four provided an inclusive account that captured the essence of provider experiences throughout the study in regards to professional development:

> This is not an easy field. Actually, it's quite challenging at times. Working with this population, it's not for everyone. But if you jump in and you stick it out, even when it's hard, it's worthwhile. I have learned so much about myself as a professional and about the individuals in my care. Working with this population, in this field, I have become a

> better provider. A stronger, more knowledgeable, [and] more compassionate provider. Not to boast, but I'm good at it. I can do this job well. The job has pushed me to stay on my feet. To be firm in my boundaries. To be creative and insightful. To look for resources. To stay passionate and willing to learn new things. To consider all angles and perspectives. To look for new ways of teaching, guiding, and reaching others. I think I am a skilled and kind provider because of my experiences working with this population.

Additionally, Participant Ten offered an authentically expressed depiction of professional development that begins to tie in a humanitarian aspect to their lived experiences providing therapeutic care to this population:

> Working with this population has taught me so many things. It has helped me to understand the pathology behind someone's decision to commit a sexual offense. It has helped me to understand that no two offenders are identical. … I'm constantly thinking of creative ways to present something. … There have been beautiful moments. People willing to consider other perspectives and ways of thinking. People willing to participate in therapy. To learn and grow. Beautiful people.

Within their depiction, Participant Ten acknowledged aspects of humanity and connected beautiful moments of learning and development throughout the therapeutic process. Not only are beautiful moments linked with qualities of professional development for the provider, but there are also beautiful moments connected to beautiful people willing to learn and grow throughout the therapeutic process. Participant Ten recognized personal value in these beautiful moments of professional and client development. Their words humanized an often painful and difficult subject and offered a reminder to providers and society that with therapeutic help individuals

who have engaged in sexually offensive behavior can be beautiful people capable of making healthy and safe life decisions.

In addition to rewarding and worthwhile experiences of professional development, Participant Ten valued moments centered upon helping others. The opportunity to help others was also identified as a rewarding experience among most providers in the study. Stated simply by Participant Three, Participant Eight, Participant One, Participant Seven, and Participant Six, "I like to help people." Participant Eight emphasized:

> Clients are motivated and kind. Often times, they don't have anyone and they really appreciate the support. Just getting those affirmations that you helped someone. When you've made a difference. When they share their wins and losses. Knowing that clients feel I'm a safe person and they know I can help. That's a rewarding experience.

Participant Seven expressed similar experiences, "That sense when you feel like you have made an impact, that you have helped someone, that's great. That's the reward." Participant Six further emphasized, "When you help people, that's an accomplishment. To see them grow and make changes within their life. To see them smile. That's an accomplishment." The opportunity to help others presented as a strong rewarding factor in motivating providers throughout the therapeutic process within the field of female sexual offending.

The opportunity to help others appeared to be closely connected to rewarding experiences involving client growth. Participant One and Participant Ten described meaningful experiences regarding client growth. Participant One expressed, "The work is meaningful. You have the opportunity to make a positive difference in the lives of others. That's the greatest accomplishment in the profession. To help others learn, grow, and live positive and meaningful lives." Additionally, Participant Ten stated, "I deeply care that everyone has the opportunity to

create a meaningful life for themselves." Furthermore, Participant Four provided a descriptive picture of their motivating and rewarding experiences regarding client growth:

> I really do see a difference with my clients. I feel like this work is beneficial. I … see positive gains. I do believe there are good clinicians, you know, people who are passionate that can impact these … women. And they can induce change or if not complete changes, at least better management. Because a lot of offenders, they may still have some of these unhealthy and harmful thoughts. And society, … they feel like these people are never going to be well. But I have a motivating idea that people can get better. I like teaching. I love to be in a group and see the light bulbs going off. I like seeing the way participants interact with one another. When they … understand a concept … and make connections regarding offense patterns or triggers that led them to offend. When they really understand how their offending is linked to cognitive distortions and poor life choices. Really seeing them make connections. That's what I like. I enjoy seeing that. It's why I do this work. People can do better. They can make healthy decisions. They can live a safe and meaningful life that does not involve sexually deviant behavior.

As a whole, providers identified characteristics of client growth involving personal insight, positive life choices, and offense free lifestyles as meaningful experiences when providing therapeutic care to females who have perpetrated sexual crimes. These meaningful experiences surrounding client growth were valued by therapeutic treatment providers and motivated them to remain dedicated to serving a challenging population.

A characteristic of client growth supported by therapeutic treatment providers is the goal of living a meaningful and offense-free life moving forward. Providers within the study stressed rewarding and worthwhile experiences related to decreased recidivism and improved community

safety. Participant Ten stated, “My job is to make sure society is protected.” Similarly, Participant Nine identified protecting the community as their motivation for work in the field of female sexual offending. Participant Two provided a comprehensive response which summarized and depicts rewarding and motivational experiences related to professional development, opportunities to help others, client growth, decreased recidivism, and improved community safety. Their statement captured the essence of all provider experiences regarding rewarding and worthwhile therapeutic care throughout the study:

> I aim to be the best provider possible. I want to be strong in my clinical skills and knowledgeable in my profession. I want to use my skills and resources to make a difference in the lives of others. To help individuals learn, grow, and live a healthy life. To prevent recidivism and improve individual and community safety. To help others and make the world a better place. … I have had many rewarding experiences over the years. These rewarding experiences are some of my motivation and what keep me going. They keep me energized. At the base level, all of these rewarding experiences involve clients who are motivated and use the therapeutic process to aid them in self-discovery, insight, and personal development. Exactly what it is meant for. The reward is client growth, healing, and seeing individuals reach and obtain their personal life goals. The reward is helping others and creating a safe community.

Therapeutic treatment providers in the field of female sexual offending indicated they value the meaningful care they provide their clients. They take their job seriously and strive to help their clients live an offense free life. Providers expressed they work to decrease the risk of recidivism among the individuals in their care and act daily to improve individual and community safety. Rewarding experiences involving decreased recidivism and improved community safety have

motivated providers to remain in the field and provide therapeutic care to women who have engaged in sexually deviant behaviors.

Despite the therapeutic challenges and negative emotional responses encountered when providing care to female sexual offenders, providers emphasized rewarding and worthwhile experiences related to professional development, opportunities to help others, client growth, decreased recidivism, and improved community safety. These experiences inspire therapeutic providers throughout their work with the female sexual offender population and motivate them to remain in a challenging profession, overcome barriers to treatment, and continue their efforts towards growth, development, and making the world a safer place. Thus, capturing the cyclical nature of therapeutic provider experiences in the field of female sexual offending which cycles among the four core sub-themes involving experiences of challenging client life experiences, treatment barriers, negative emotional responses, and rewarding and worthwhile experiences for providers.

Theme One: Experiences- Cyclical in Summary

Theme one captured a comprehensive essence of therapeutic provider experiences that are cyclical in nature. Findings established a cycle of four core sub-themes regarding therapeutic provider experiences when delivering behavioral health care services to the female sexual offender population. First, in the field of female sexual offending, therapeutic behavioral health care providers are treating challenging client life experiences. This primary finding established the foundation upon which provider experiences when treating female sexual offenders are formed. Through their lens, therapeutic providers recognized challenging client life experiences of trauma, unhealthy interpersonal relationships, mental illness, and distorted and harmful ways

of thinking as distinct characteristics and treatment needs that must be addressed among the behavioral health care of the female sexual offender population.

However, when therapeutic providers are attempting to treat the challenging life experiences and specific behavioral health needs of female clients who have perpetrated sexual crimes, providers reported experiencing significant barriers to the therapeutic process. Barriers to the therapeutic process represent the second sub-theme among the cyclical nature of therapeutic provider experiences. Participants identified gaps in the field of female sexual offending, a lack of evidence-based and standardized treatment materials, nonexistence gender specific risk assessment tools, stigma, and limited community resources as primary barriers to their experiences when delivering behavioral health care services to female sexual offenders. The therapeutic treatment of challenging client life experiences, in combination with barriers related to behavioral health treatment services, resulted in negative emotional responses among therapeutic providers and push the cycle of therapeutic provider experiences to the third sub-theme capturing the essence of provider experiences when delivering care to the female sexual offender population.

Third, when treating challenging client life experiences and encountering treatment barriers, therapeutic treatment providers experienced negative emotional responses of vicarious trauma, emotional stress, burnout, and dangerous world views. Despite experiences of negative emotional responses, barriers to the therapeutic process, and the treatment of challenging client life experiences, providers emphasized rewarding and worthwhile experiences that motivate them to remain in the field. Within sub-theme four, participants endorsed experiences of professional development, opportunities to help others, client growth, decreased recidivism, and improved community safety as rewarding interactions while treating this population. These

rewarding and worthwhile experiences inspired therapeutic providers throughout their work with the female sexual offender population and motivated them to remain in a challenging profession, overcome barriers to treatment, and continue their efforts towards client growth, development, and making the world a safer place. As such, therapeutic provider experiences involving challenging client life experiences, treatment barriers, negative emotional responses, and rewarding and worthwhile experiences created and maintained a cyclical nature of therapeutic provider experiences in the field of providing behavioral health care services to the female sexual offender population.

Theme Two: Experiences- Female Sexual Recidivists

In the current study, therapeutic behavioral health care providers are experiencing female sexual recidivists throughout their career. While not as board and inclusive as theme one, provider experiences with female sexual recidivists captured the second major theme presented in this study. Nine out of ten participants identified experiences in which they provided mental health care services to women who have perpetrated multiple sexual crimes. When asked to describe their experiences working with and providing therapeutic care to female sexual recidivists, providers commented on additional experiences of treatment complexities and experiences of failure and reduced professional competence regarding this specific population.

Additional Treatment Complexities

The behavioral health care of female sexual recidivists presented as a specific challenge to therapeutic providers in the field. Participant Seven specifically identified female sexual recidivists as a complicated and complex population to serve. Additionally, Participant Seven indicated that providing therapeutic care to repeat female sexual offenders is “really rough. You try to just do whatever you can to help them from offending further.” Participant Seven was not

the only provider to comment on the difficult aspects when delivering therapeutic services to female sexual recidivists. Participant Two expressed:

> I can think of one experience treating a female with multiple sexual crimes. … That was one of my harder cases. [There was] a lack of accountability for their behavior and actions. A minimization of the harm caused by sexual offense behavior. An unwillingness to engage in therapy and relapse prevention methods. They didn't think they had done anything wrong. I tried to improve motivation and personal accountability. Ultimately, I don't feel I was very successful. In this case, I faced multiple treatment barriers. Poor client motivation, offense supportive attitudes, minimization, significant substance abuse concerns, poor institutional behavior. A lack of resources. From the therapy angle, a lack of insight. There was no type of guide or resource with treatment strategies. It was a work your way through it type strategy. Try your best and hope something works. I'm not sure how successful I was with this client. I think all these treatment barriers prevented me from providing the most effective and beneficial care that I could have otherwise.

Participant Three also addressed aspects of poor accountability and minimization of offense behavior among the female sexual recidivist population:

> In my experience treating this population, there was a prevalent disregard for the wellbeing of others. Limited accountability for personal actions. Impulsivity. Substance abuse. Minimization of the harm caused by sexual offense behavior. A lot of factors contribute to sexual offending and recidivism. We spent a lot of time addressing empathy and compassion. Really trying to see and understand the perspective of the victims and understanding the harm created through sexual crimes. Trigger and warning sign identification was also a major therapeutic factor. We really tried to understand offense

> patterns and put in place strategies to prevent future sexual behavior. … I remember this being an experience where I had … extra worry. It's rare for females to sexually reoffend. So, the fact that this individual already had, I had extra worry that they would continue to reoffend. I felt extra pressure to provide care to this individual to help them lead a healthy life and make positive and healthy life decisions.

Similarly, Participant Six identified "a disregard for others, limited accountability, and not understanding the harm caused by their actions" as common factors among their experiences providing therapeutic care to female sexual recidivists. Like Participant Two, Participant Three, and Participant Six, Participant Nine commented on experiences involving insufficient accountability among their clients with histories of multiple sexual offenses. Participant Nine described a specific encounter when providing therapeutic care to a female sexual recidivist:

> She had very poor ownership for her actions. Didn't see the behavior as her offense. So, she would just keep doing the same things. She was stuck in the same lifestyle. She had the attitude of what else am I expected to do? She deflected everything on others. Blamed other people for everything. Had no accountability for her own actions. This case was very difficult. I tried to build a sense of accountability. To help the individual see the opportunity for life changes. I was not successful. This individual continued to offend.

The lack of accountability, disregard for others, and the minimization of harm caused by sexual offense behavior contributed to additional complexity when treating female sexual recidivists among therapeutic provider experiences.

Failure and Reduced Professional Competence

Moreover, due to the additional complex and difficult treatment aspects of providing mental health services to female sexual recidivists, therapeutic providers identified experiences

of failure and reduced professional competence when delivering care to this population. Participant Nine directly stated, “I was not successful. This individual continued to offend.” Furthermore, Participant Six reported:

> I feel out of my element with this population. If you are working with a female recidivist, the risk that they are going to offend again increases. I don’t feel competent addressing this population. The stakes are higher and there are no assistive resources. … I worry that this population will continue to offend and engage in sexually deviant behavior.

Providers indicated not feeling successful in the behavioral health care of female sexual recidivists and experienced additional feelings of worry related to the potential for this specific population to sexually reoffend. Overall, findings indicated that therapeutic behavioral health care providers are encountering challenging experiences with female sexual recidivists and don’t feel competent or successful in the behavioral health care of this specific population.

Theme Two: Experiences- Female Sexual Recidivists in Summary

The majority of therapeutic treatment providers in the current study have experienced female sexual recidivists throughout their career. Providers described complicated and difficult experiences with female sexual recidivists that involved additional treatment complexities regarding a lack of accountability, a disregard for others, and a minimization of harm as common characteristics among the female sexual recidivist population. These additional treatment complexities resulted in feelings of failure and reduced professional competence among providers when delivering care to this distinctive population.

Theme Three: Experiences- Coping Skills

To cope with the experiences of negative emotional responses, treatment barriers, complex treatment aspects, and limited assistive resources captured throughout themes one and

two, therapeutic treatment providers are using coping skills as a primary method to assist them in the therapeutic care of a challenging population. Within this third identified theme of coping skill experiences, treatment providers identified coping skills involving self-care, boundaries, persistence, and supportive colleagues as strategies to overcome barriers and reduce the negative emotional responses resulting from treating the challenging client life experiences common among the female sexual offender population. The coping skill strategies of self-care, boundaries, persistence, and supportive colleges represent four core sub-themes which captured the essence of coping skill experiences among behavioral health care providers when working with the female sexual offender population.

Self-Care

Therapeutic treatment providers identified self-care as a personal coping strategy when providing therapeutic behavioral health care to female sexual offenders. Participant One provided an inclusive account that summarized the experiences of self-care identified by most treatment providers:

> Any provider in the mental health field will stress the importance of self-care. I am no different. In the mental health field, self-care is a must. If I'm feeling tired, I make time for rest. I cope by making time for myself and the things I enjoy. This helps me recharge. I cuddle my puppy. I take walks. I make dinner for my family. I socialize with family and friends. I take care of myself first.

Similar to Participant One, Participant Three further described the importance of engaging in self-care strategies and making time for themself in order to cope with negative emotional experiences when treating the challenging life experiences of females who have engaged in sexually deviant behavior. Participant Three expressed:

> I made time for the things I enjoy. The things that brought me peace. I made time for walks throughout the day. I planned vacations. I stepped away from the office when I needed to. … Providing care to sexual offenders is a difficult job. Its stressful and emotionally heavy work. I had to take care of myself and make self-care a priority. Otherwise, I could not have been a compassionate and skilled provider.

Participant Nine identified additional personal self-care strategies involving yard work and long drives home. Participant Nine reported, "This is time to let it all go. So, I don't take any of the emotions home with me." Participant Four also stressed the importance of practicing self-care:

> I practice self-care. That's something that I really learned with this job. I learned that if I need a day for some reason, I just need a day. Sometimes, I wake up and I know that today is not the day. I know that I am not in the best place mentally. I know that I need to check myself and make sure I am able to bring my best self forward. I know that I need to spend some time taking care of myself. I will go work out. I try to do activities on the weekend that are fun. I really have to take care of my mental health because some of the things that I hear, it can be disturbing.

Furthermore, Participant Seven recognized the importance of identifying negative emotional responses when providing behavioral health care to female sexual offenders and incorporating self-care strategies as personal coping resources. Participant Seven stated:

> Protect yourself. Don't allow burnout to creep in. Watch for it and prevent it when you can. I've been in the field a long time. I get burned out sometimes, but I listen to my body and mind when I get this way and I take the time to recharge. Everyone should take that time for themselves.

Therapeutic treatment providers are using experiences of self-care as a personal coping skill to manage negative emotional responses and treatment barriers when providing behavioral health care services to the female sexual offender population.

Boundaries

In additional to self-care, treatment providers are establishing strong boundaries as personal coping skills when providing behavioral health care to females who have engaged in sexually deviant behavior. Participant Two identified strong boundaries as their primary means for coping with the challenging treatment aspects of providing therapeutic care to the female sexual offender population. However, Participant Two was not the only provider who commented on the importance of boundary setting as a personal coping skill when treating female sexual offenders. Participant Seven expressed, "I maintain good boundaries. I stay focused on the job. I remind myself of why I do the job that I do." Similarly, Participant Five stated:

> I know that I have a job to do and that my personal feelings can't affect the job that I have in front of me. I am able to remain professional, keep my personal feelings separate, and handle the job ahead of me.

Additionally, most providers identified boundaries related to establishing a sturdy work life balance as a personal coping skill when specializing in the therapeutic treatment of female sexual offenders. Participant One indicated:

> As a provider, I know I have a job to do and I want to do it well. I account for any [negative emotional responses] and prepare for them. Over the years, I've gotten pretty good at establishing a healthy work life boundary. I'm able to take care of myself and my clients.

Participant Six also stressed the importance of establishing a strong work life balance. Participant Six expressed, “I try my best to have a really strong work life balance. I try to leave work at work. It’s not always easy, but it’s of great importance when you work with this population.” Like Participant Six, Participant Three also emphasized the importance of leaving work at work. Participant Three stated, “I made sure to set a strong home/work life balance. I did not bring work home and mentally did my best to leave things at the office.” In order to set a sturdy work life balance Participant Eight stated, “I compartmentalize. I separate work from my personal life. I set internal and external boundaries, I keep my emotions in check, and I make a constant effort to maintain all boundaries.” Creating and maintaining strong boundaries, specifically boundaries related to establishing a healthy work life balance, presented as a personal coping skill experience for therapeutic treatment providers in the field of female sexual offending.

Persistence

Therapeutic treatment providers in the field of female sexual offending also endorsed qualities of persistence as a coping skill experience when providing behavioral health care services to such a challenging population. When asked how they overcome any challenging treatment experiences or barriers to the therapeutic process, providers identified individual characteristics of persistence as personal coping strategies and adaptive resources when treating the female sexual offender population. Participant Two stated, “Hard work and grit. I’m persistent. I don’t give up. I try to be flexible. I try to keep a good outlook and attitude. I just keep going.” Similarly, Participant Eight expressed, “I just keep pushing. I remind myself that I have a job to do, and I just keep going.” Additionally, Participant Five commented, “I just keep working and pushing through. I’ve always been a persistent individual and I use this persistence to overcome the challenges of working with female offenders.” Furthermore, Participant Six

reported, “I just keep at it. I work hard. I see as many people as I can. I network and try to inform others. I just keep working.” The collective therapeutic provider voice captured experiences which demonstrate characteristics of hard work, personal drive, and endurance throughout the therapeutic process. With these personal characteristics, therapeutic treatment providers represented a persistent group of individuals striving to overcome adversity in their chosen professional field. Strong qualities of persistence served as a personal coping skill and adaptive resource for treatment providers delivering behavioral health services within the challenging field of female sexual offending.

Supportive Colleagues

Lastly, therapeutic treatment providers identified experiencing support from their colleagues as a primary method of reducing negative emotional responses and overcoming barriers and complexities to the therapeutic process when providing behavioral health care services to the female sexual offender population. Simply stated by Participant Six, “My supervisors and colleagues in the field have been the biggest types of support I have encountered.” Likewise, Participant Nine expressed, “Sharing things with coworkers is the biggest type of support. Sharing war stories.” Participant Three also identified colleagues in the field as their main coping resource for overcoming barriers within the therapeutic treatment process in the field of female sexual offending:

> Colleagues and coworkers are a great support. They understand the field, know how hard it is, and just have insights on the topic in general. My peers are what I have found to be the most supportive and helpful resource. … I consult my supervisor and seek feedback from my peers. I look for additional resources or techniques to try. … The main resource has been other providers in the field. I turn to their expertise and guidance.

Participant Two echoed similar experiences:

> The most support I have found has been provided by my coworkers and supervisors. It's an unspoken bond of sorts. We know that it's hard and difficult work at times. That support is needed. So, my coworkers and supervisors have been that listening ear. Someone you can emotionally vent to, treatment plan with, and just get general feedback from. They have been a true team.

Participant One further identified the supportive aspect of consulting colleagues in the field and also commented on the importance of teamwork within the profession:

> The best support comes from my colleagues. I am grateful that I have always had a supportive team around me. … And I have had some extremely wise and supportive supervisors. The opportunity to collaborate, vent, brainstorm, and treatment plan together. That's been the best and most helpful support. A collaborative team must be a priority when you work with this population.

Participant Nine depicted a sentimental experience regarding supportive colleagues in the field of female sexual offending, "I met some great people in this field, and I learned a lot from them. I wouldn't be the provider that I am today if I didn't have their support." Therapeutic treatment providers identified the supportive aspects of collaboration, shared understanding, and guidance from colleagues as a fundamental emotional support and assistive coping resource in the field of female sexual offending. Furthermore, providers indicated that experiences of support from their colleagues is a primary means of overcoming barriers to the therapeutic process as well as any reducing negative emotional responses when providing behavioral health care to the female sexual offender population.

Theme Three: Experiences- Coping Skills in Summary

To cope with the negative emotional responses, treatment barriers, complex treatment aspects, and limited assistive resources captured throughout therapeutic provider experiences, treatment providers are using coping skills as a primary method to assist them in the therapeutic care of a challenging population. Therapeutic treatment providers identified coping skills involving self-care, boundary setting, persistence, and supportive colleagues as strategies to overcome barriers and reduce the negative emotional responses resulting from treating the challenging client life experiences common among the female sexual offender population. Coping skill experiences among providers served as an adaptive resource for treatment providers delivering behavioral health services to females who have engaged in sexually deviant behavior.

Theme Four: Experiences- Professional Need

Despite experiences utilizing coping skills, therapeutic treatment providers are lacking overall assistive resources in the field of female sexual offending. When asked to describe any types of support for therapeutic treatment providers who offer care to female sexual offenders, providers noted experiences in which overall assistive resources are lacking. Participant Nine provided a simple statement that captured the general experience of all providers within the study, “There are no supports really.” Participant Ten further emphasized, “Coming from whom? Maybe treatment providers getting together for coffee. Seriously, there is nothing like that.” Additionally, Participant Two indicated, “I haven’t really encountered any supports specific to those who care for female sexual offenders.” Overall, therapeutic treatment providers conveyed experiences in which access to overall assistive resources in the field of female sexual offending are lacking.

In addition to a lack of overall assistive resources for professionals in the field, therapeutic treatment providers identified experiences of minimization surrounding the topic of female sexual offending and requested improved awareness and resources for the subject. Participant One expressed, “female sexual perpetrators are generally ignored and not addressed within the general public. It’s something nobody wants to think about.” Additionally, both Participant Six and Participant Five, endorsed the perspective that female sexually deviant behavior is not a topic taken seriously within society. While society may minimize the topic of female sexual offending, women willingly engage in sexually deviant behavior and perpetrate sexual crimes. Therapeutic treatment providers in the field of female sexual offending recognized the importance of the topic. Participant Two simply stated, “It’s a much needed field.” Additionally, Participant Seven indicated that they are glad the topic of female sexual offending and provider experiences with this population are being explored:

> A lot of this type stuff is kept secret and not talked about. Most people don’t consider females as being sexual offenders, but it does happen. Women engage in sexually deviant behavior. I hope this research study sheds light on this topic and helps providers to effectively treat these women. It is a field that needs to be explored. It is such an important topic. Society needs to be aware so that victims of female perpetrated sexual crimes have less barriers to overcome when reporting. So that victim experiences are validated and not ignored. And so that female sexual perpetrators can receive the mental health services to aid in reducing recidivism and living healthy offense-free lives. To protect others and prevent harm.

Therapeutic treatment providers with experience in the field of female sexual offending stressed the importance of the topic and requested improved awareness and professional assistive

resources within the field. Their experiences involving societal minimization and a lack of available assistive resources for professionals in the field indicate a clear need for advancement and research development surrounding the topic of female sexual offending.

Experiences of professional need captured the fourth and final major theme of the research study. Specifically, treatment providers requested more training and education opportunities, easier access to mental health services for female sexual offenders, female specific treatment materials to aid clinical practice, and trauma based therapy resources for providers when delivering care to female sexual offenders. Most providers identified a mixed request of all specified improvements regarding professional assistive resources in the field.

Training and Education

When asked to describe what types of support for female sexual offenders or therapeutic providers they would like to see more of, participants provided thoughtful and genuine responses. Participant Three emphasized, “More training [and] more education.”, Similarly, Participant Six expressed, “Trainings and education. More providers who specialize in treating this population.” Furthermore, Participant Two provided a knowledge focused depiction:

> More education and training opportunities for providers. … knowledge sharing basically. A way to learn and share experiences. I know education and training would help me to feel more competent in my skills. It would give me a guide or strategies to use. Increase my skills base. Perhaps help me to be more effective in treating this population. We need effective, skilled, and highly trained professionals.

Participant Five also commented on the need for “more available trained professionals” and further identified a personal willingness to attend training and educational resources regarding the field of female sexual offending. Therapeutic providers in the field of female sexual

offending recognized experiences of professional need and requested improved training and education opportunities to improve clinical skill and competence when delivering behavioral health care to the female sexual offender population. Furthermore, providers displayed a willingness to share their experiences and attend educational training opportunities in the field.

Easier Access to Mental Health Services

Not only are therapeutic providers requesting training and education opportunities for professionals in the field, but they are also requesting easier access to mental health services for female sexual offenders. Participant Three expressed, "access to more resources … easy access for offenders." Similarly, Participant Six reported, "Easier access to services would be great." Furthermore, Participant Two provided an inclusive depiction of requested resources for female sexual offenders:

> Really just more support in general. Across the board. For female offenders … more providers willing to work with [them]. Easier access to mental health treatment services. Less barriers and stigma to mental health care. … greater [access to] treatment resources and materials. Just increased availability of mental health care services in general.

Providers indicated that female sexual offenders have a difficult time finding readily available mental health resources and noted experiences of professional need regarding easier access to mental health services for this population.

Female Specific Treatment Materials

Therapeutic providers identified female specific treatment materials as a significant professional need within the field. Participants suggested that female specific treatment materials would aid them in the therapeutic care of this distinct population. Participant One directly stated:

> We need more treatment tools and resources for females. Assessment measures would be great. Screening tools. Female specific psychoeducational materials. Things that are gender specific and can directly address the precise needs of the female sexual offender population. These type things are currently not available. … across the board there are a lack of resources for the treatment and assessment of female sexual offenders. We need female specific treatment materials and resources to help guide us when caring for female offenders.

Therapeutic providers with the study indicated experiences in which they are lacking guidance in the behavioral health care of females who have perpetrated sexual crimes. To improve the effectiveness of the therapeutic care provided to this population and guide clinical practice, providers are requesting female specific treatment materials for the field.

Trauma Based Therapy

In addition to more training and education opportunities for providers, easier access to mental health services for female sexual offenders, and female specific treatment materials to guide clinical practice, participants also identified the professional need for additional outlets for the providers who work with the female sexual offender population. Participant Eight, Participant Nine, and Participant Four suggested that trauma based therapy resources and education would likely provide additional outlets for the therapeutic treatment providers who specialize in the field of female sexual offending. Participant Four provided a thorough description that also captured the experiences of Participant Eight and Participant Nine:

> I would like to see vicarious trauma … training for providers. It's very emotional work. Providers need to learn about vicarious trauma and secondary trauma. There needs to be more counseling options for therapists. It can make a therapist hard. There is a lot that

goes on in the mind when you are treating sexual offenders. It would be helpful for providers to be able to talk about these things sometimes, like how it's actually affecting you and get some support.

Trauma based therapy resources for providers may aid in the management of negative emotional responses experienced when treating the challenging life experiences of the female sexual offender population and assist providers in managing any aspects of vicarious trauma among their professional or personal experiences.

Theme Four: Experiences- Professional Need in Summary

Therapeutic treatment providers in the field of female sexual offending experienced a lack of overall assistive resources when delivering therapeutic care to females who have perpetrated sexual crimes. In addition to the lack of overall assistive resources, therapeutic treatment providers identified experiences of minimization surrounding the topic of female sexual offending and requested improved awareness and resources for the topic. Treatment providers in the field of female sexual offending specifically requested more training and education for therapeutic providers, easier access to mental health services for female offenders, female specific treatment materials to aid and inform clinical practice when delivering care to this distinct population, and trauma based therapy resources for providers. Improved resources are likely to address the distinct needs of the female sexual offender population and guide therapeutic treatment providers in experiences of delivering effective behavioral health care services to females who have engaged in sexually offensive and deviant behavior.

Chapter Five: Discussion

Synthesis of Findings

Theme One: Experiences- Cyclical Based within Social Exchange Theory

A comprehensive essence of therapeutic provider experiences captured an inclusive depiction of experiences that are cyclical in nature. Therapeutic treatment providers identified a cycle of four core sub-themes regarding their cyclical experiences when providing behavioral health care services to the female sexual offender population. To summarize the complete essence of all four core sub-themes of the cyclical nature of therapeutic provider experiences, when faced with providing behavioral health care services to a population marred by challenging client traumatic life experiences, unhealthy interpersonal relationships, mental illness, and distorted and harmful ways of thinking providers identified virtually no gender specific treatment resources or assistive guidance in the field. The captured experience of limited resources and significant barriers within the therapeutic process, in combination with the emotionally heavy aspects of treating challenging client life experiences within the female sexual offender population, created experiences involving negative emotional responses among therapeutic treatment providers. Therapeutic treatment providers with experience in the field of female sexual offending recognized negative emotional aspects of vicarious trauma, emotional stress, burnout, and dangerous world views specific to providing behavioral health care to the female sexual offender population. Despite the challenges and negative emotional responses encountered when providing therapeutic care to female sexual offenders, providers emphasized rewarding and worthwhile experiences that motivate them to remain in a challenging career. The identified provider experiences of professional development, opportunities to help others, client growth, decreased recidivism, and improved community safety pushed providers to continue

delivering mental health care services to the complex and challenging female sexual offender population. Thus, capturing the repetitious cycle of therapeutic treatment provider experiences when delivering behavioral health care services to individuals who have perpetrated sexual crimes.

While the individual four core sub-themes (challenging client life experiences, treatment barriers, negative emotional responses, and rewarding and worthwhile experiences) regarding therapeutic treatment provider experiences in the field of female sexual offending align with previous research, one unique aspect not previously identified by scholars in the field emerged throughout the current research study. This study captured the essence of the clinical experiences encountered by treatment providers offering therapeutic care to female sexual offenders. This captured essence revealed the unique cyclical nature of therapeutic provider experiences not previously discussed among literature in the field of female sexual offending.

This research study used provider perspectives to capture the essence of the clinical experiences encountered by treatment providers when offering therapeutic care to female sexual offenders and revealed a large-scale depiction of the cyclical nature of therapeutic provider experiences not previous captured among the literature. Previous literature examined individual aspects of each of the four core sub-themes identified by providers within this study. However, by examining and focusing on each core sub-theme individually, prior research has not captured the complete portrayal of therapeutic provider experiences in the field. To grasp a complete picture of provider experiences when delivering therapeutic behavioral health care services to females who have perpetrated sexual crimes, one must take a step back and consider all provider experiences as a whole. The large-scale, inclusive, and overarching view of the current study combined and exposed a complete cyclical nature of therapeutic provider experiences.

Therapeutic treatment providers encountered a repetitive cycle of four core experiences when offering behavioral health care to the female sexual offender population. The uncovered cyclical nature of therapeutic provider experiences captured a comprehensive essence of provider experiences not formerly established among scholars in the field. Moving forward, the discovered cyclical nature of therapeutic provider experiences is helpful in exploring and developing a deep understanding of the phenomenon of female sexual offense behavior and therapeutic provider experiences in the field.

While a constructivist worldview was used to highlight the perspective of therapeutic treatment providers in the field of female sexual offending in which to capture the essence of their unique experiences, social exchange theory may provide an explanation for why the cyclical nature of therapeutic provider experiences in the field of female sexual offending occurred. Social exchange theory is defined as an exchange of activity between two parties (Cook et al., 2013). Social exchange theory suggests that behavior is determined based on individual perspectives in which activity is deemed as either costly or rewarding. Cook et al. (2013) indicates that social exchange theory operates under principles of reinforcement and punishment in which behavior or activity perceived as rewarding is continued and behavior viewed as costly is terminated.

In the field of female sexual offending, providers experienced a host of costly activity exchanges when delivering therapeutic care to females who have perpetrated sexual crimes. The therapeutic treatment of challenging life experiences, barriers to the therapeutic process, and negative emotional responses experienced by providers throughout the cyclical nature of therapeutic provider experiences represented aspects of punishment and costly activity among providers. Despite the emotional cost of delivering therapeutic care to female sexual offenders,

treatment providers make the daily decision to stay in a challenging profession. Social exchange theory suggests that treatment providers remain in the field because the rewards outweigh the punishment. In the case of cyclical provider experiences, therapeutic treatment providers identified rewarding and worthwhile experiences of professional development, opportunities to help others, client growth, decreased recidivism, and improved community safety that inspire and motivate them to remain servicing a challenging and complex population.

Theme Two: Experiences- Female Sexual Recidivists and Reflective Practice

In the field of female sexual offending, therapeutic behavioral health care providers are experiencing female sexual recidivists. Nine out of ten participants in the current research study identified experiences in which they provided mental health care services to women who have perpetrated multiple sexual crimes. Previous literature in the field of female sexual offending indicated female sexual recidivism rates of less than 3% and suggested that once female sexual offenders have been detected by the criminal justice system, they are not likely to reengage in sexual offense behavior (Cortoni et al., 2010). While previous research suggests that it is unlikely for females to engage in multiple sexual crimes, 90% of therapeutic treatment providers in the current study experienced female sexual recidivists.

Furthermore, when providing behavioral health care services to female sexual recidivists, treatment providers in the current study identified additional complexities related to poor accountability, disregard for others, and minimization of the harm caused by sexual offense behavior as common psychological characteristics among the female sexual recidivist population. The complex psychological characteristics and arduous treatment aspects of providing mental health services to female sexual recidivists, as well as limited assistive resources when providing therapeutic care to repeat female sexual offenders, resulted in

identified provider experiences of failure and reduced professional competence when delivering therapeutic care to this distinctive population. Therapeutic providers indicated not feeling successful in the behavioral health care of female sexual recidivists and experienced additional feelings of worry related to the potential for this specific population to sexually reoffend. Contrary to previous research indicating low percentages of female sexual recidivism, the current research study indicated that therapeutic behavioral health care providers experienced female sexual recidivists throughout their career and expressed additional difficulty and concern when treating this specific population.

The theory of reflective practice within the field of female sexual offending may improve provider experiences when delivering behavioral health care services to female sexual recidivists and boost feelings of professional competence among therapeutic providers. Therapeutic treatment providers who engage in reflection regarding clinical practice and their experiences providing care to the female sexual recidivist population may be able to make changes in their actions and experiences to best meet the specific needs of the client and feel competent in the decision making and clinical care of a challenging population. Scholars of reflective practice identify the healthcare setting as a complex system (Kinsella, 2010). The complexity of healthcare systems spans to the challenging behavioral health care of female sexual recidivists. Within the theory of reflective practice, practitioners are identified as instrumental problem solvers who are most capable of applying professional skill and knowledge to any challenging situation within their field (Kinsella, 2010). Furthermore, reflective practice scholars suggest that knowledge is created in the midst of clinical experience and through reflection of this experience practitioners can shape and construct intelligent action to best serve the individuals in their care (Kinsella, 2010). The therapeutic providers who have experience treating female sexual

recidivists are experts in their field and their experiences hold the solutions to the additional difficulties and complexities identified when delivering behavioral health care services to this specific population.

Under the framework of reflective practice, therapeutic providers with experience in delivering behavioral health care services to repeat female sexual offenders are the individuals most capable of solving problems and meeting the female specific treatment needs of female sexual recidivists. A framework of reflective practice encourages therapeutic providers to reflect on professional experiences of poor accountability, disregard for others, and minimization of the harm caused by sexual offense behavior when delivering therapeutic care to the female sexual recidivist population. Through the reflection of these experiences, providers can construct treatment plans and behavioral health service options to meet the needs of female sexual recidivists. Their experiences can guide and inform future practice, promote wisdom, and support colleagues in the field. With guiding assistive resources established from reflective practices, providers can feel competent in their care of a challenging and complex population.

Theme Three: Experiences- Coping Skills, Reflective Practice, and Communal Coping

The inability to identify, monitor, and manage the personal impact of providing therapeutic care to female sexual offenders could dampen objectivity, damage the therapeutic relationship, and reduce the effectiveness of therapeutic services provided to the female sexual offender population. The utilization of coping skills is necessary to mitigate the challenges of working with the female sexual offender population. To cope with negative emotional responses, treatment barriers, and complex therapeutic aspects when providing behavioral health care to female sexual offenders, therapeutic treatment providers within the current study are using coping skills to assist them in the therapeutic care of a challenging population. Treatment

providers identified the establishment of self-care strategies, boundary setting, and persistence as personal coping skills when providing therapeutic behavioral health care services to females who have engaged in sexually deviant behavior. Providers who engage in self-care strategies seem to recognize the importance of provider well-being, make time for enjoyable activities, and strive to prevent burnout within their profession. Additionally, the establishment of boundaries as a personal coping skill were indicated through provider experiences involving emotional detachment and a sturdy work life balance as coping techniques when specializing in the therapeutic treatment of female sexual offenders. Furthermore, therapeutic providers within the study expressed qualities of persistence as additional strategies to reduce the negative emotional responses resulting from treating challenging client life experiences. Therapeutic treatment providers represented a hardworking, driven, and persistent group of individuals striving to overcome adversity in their chosen professional field.

To overcome adversity within the field of female sexual offending, the theory of reflective practice may also improve coping skill experiences among therapeutic treatment providers. Therapeutic providers who engage in reflection regarding their psychological well-being and their use of coping skill strategies such as self-care, boundary setting, and persistence to manage any negative emotional responses when delivering care to female sexual offenders may be better equipped to identify, monitor, and manage the personal impact of providing therapeutic care to female sexual offenders. With reflective practices, therapeutic providers may be able to identify and strengthen current coping skill experiences while also making any changes among their actions to eliminate any unhelpful or ineffective coping strategies. Reflective practice among providers may also highlight personal areas of need in which providers can begin to implement and practice new techniques for coping that may improve

experiences of psychological well-being, increase personal insight, prevent burnout, and enhance provider retention in the field.

Not only did providers identify coping strategies involving self-care, boundaries, and persistence, but treatment providers also identified support from their colleagues as a primary coping method for overcoming barriers to the therapeutic process as well as reducing negative emotional responses when providing behavioral health care services to the female sexual offender population. Supportive colleagues in the field offered providers experiences of teamwork, guidance, and emotional support throughout the care of a challenging population. This finding supports previous research which identified supervisory support and task assistance from colleagues as crucial strategies to aid providers in managing and resolving negative emotional experiences throughout their work (Dean & Barnett, 2011; Willis et al., 2018).

The identification of colleagues as a supportive coping resource among therapeutic providers aligns with and supports the theoretical model of communal coping. Research suggests that communal coping improves health and strengthens communities who may frequently experience stressful conditions (Afifi et al., 2020). Communal coping suggests that a team of individuals work together to appraise and proactively engage with a stressor (Afifi et al., 2020). Furthermore, communal coping has the ability to move individuals towards improved psychological well-being and positive adaptation through social connection, shared resources, and alternative perspectives (Afifi et al., 2020). The therapeutic providers who have delivered behavioral health care services to the female sexual offender population represent a community of individuals who frequently experience stressful conditions and negative emotional responses. Communal coping, or turning to colleagues in the field for support, may allow providers to feel connected to their peers and remind providers that they are not alone in their experiences while

treating female sexual offenders. Additionally, by seeking support from colleagues, providers may be able to share resources and receive guidance and support for both personal coping strategies and clinical practice within the field. Under stressful situations, providers who turn to their colleagues for support are likely to experience improved well-being, reduced experiences of negative emotions, and strengthened connections to colleagues in the field.

Theme Four: Experiences- Professional Need Addressed Through Self-Authorship

Therapeutic treatment providers within the current study conveyed experiences in which overall professional assistive resources in the field of female sexual offending are lacking. This finding aligns with the minimal literature discovered designated to the study of the behavioral health care providers with experience in the field of delivering therapeutic treatment services to the female sexual offender population. The lack of professional assistive resources identified by therapeutic treatment providers confirm the extensive gaps in the field of female sexual offending that have impaired understanding of female perpetrated sexual crimes and hindered advances to guide, support and inform behavioral health clinical practice.

Therapeutic treatment providers also identified experiences of minimization within the field of female sexual offending and requested improved awareness and professional resources for the topic. Like prior research has suggested, therapeutic treatment providers in the current study also noted experiences of minimization within the field due to societal and professional biases in which female sexual offending is ignored, not taken seriously, and minimized. Despite the general minimization within the field of female sexual offending, therapeutic providers within the current study stressed the importance of the topic and requested improved awareness and professional resources within the field. Specifically, treatment providers requested more training and education opportunities, easier access to mental health services, female specific

treatment materials to aid and guide providers in clinical practice, and trauma based therapy resources for providers when delivering care to this challenging population.

Providers in the current study are not the first group of professionals to request aspects of professional development as a means of improving awareness and resources within the field of female sexual offending. Prior scholars have also stressed the importance of continuing education, training opportunities, and dissemination of research regarding the topic of female sexual offense behavior as strategies to reduce minimization within the field and improve the quality and consistency of therapeutic care among providers (Jahnke, 2018; Jung et al., 2012; Levenson et al., 2017; Christensen, 2021). Christensen (2021) suggests that if therapeutic providers are more informed regarding the topic of female sexual offending, they will experience more confidence in their professional decision making, be more open to the recognition and discussion of female sexual offense behavior, and more likely to overcome gender stereotypes. Despite years of recognized need for improved awareness and treatment resources for the female sexual offender population, little advancement in the field has occurred. Providers have continued to request more training and education opportunities, easier access to mental health services, female specific treatment materials to guide clinical practice, and trauma based therapy resources for providers. If developed, improved resources are likely to address the distinct needs of the female sexual offender population and aid therapeutic treatment providers in establishing experiences of delivering effective behavioral health care services to females who have engaged in sexually offensive and deviant behavior.

Addressing professional need through the theory of self-authorship is one strategy to encourage therapeutic providers to think critically, evaluate personal experiences, and make effective decisions regarding both their own professional needs and the needs of their clients.

Self-authorship suggests that individuals experience adaptive challenges in which the solution is not always clearly defined (Magolda, 2014). Furthermore, Magolda (2014) suggests that adaptive challenges are solved among the process of working through challenges and changing the ways in which individuals make sense of knowledge, identities, and relationships. Self-authorship offers a smooth blend with the constructivist worldview guiding the current study. Both frameworks recognize the importance of constructing meaning which is shaped through individual perspective and interactions, cultural context, and environmental systems. Throughout their experiences, therapeutic providers in the field of female sexual offending are on a journey of self-authorship. Self-authorship promotes critical thinking strategies, problem solving abilities, supportive relationships, and leadership abilities in order to navigate life's challenges (Magolda, 2014).

Female sexual offending is a field in which the solutions to therapeutic provider experiences of treating a challenging and complex population are not clearly defined. Despite the difficulty of the topic, behavioral health care providers are requesting more training and education opportunities, easier access to mental health services, female specific treatment materials to guide and inform clinical practice, and trauma based therapy resources for providers. The professional need for these assistive resources was established through the provider evaluation of their own professional experiences in the field. Therapeutic providers have experienced the minimization and lack of assistive resources within the field of female sexual offending, and they are beginning to think critically regarding their experiences and look for solutions to meet their own professional needs and the needs of the female sexual offenders under their direct care. Perhaps if professional assistive resources are to be obtained, leaders among therapeutic providers in the field of female sexual offending will have to create them. On

the journey to self-authorship, therapeutic providers must take it upon themselves to lead the way, think critically, and use their experiences to create the training and educational opportunities, mental health services, gender specific treatment materials to guide clinical practice, and trauma based therapy resources requested by most behavioral health providers in the field of female sexual offending.

Limitations

As with most research related to the field of female sexual offending, limitations were present in the study. Primarily, the study incorporated in-person and virtual interviews to collect data related to the topic. These interviews depend on participant self-report and work under the assumption that therapeutic treatment providers will be completely honest and disclose all relevant information during the interview process. Treatment provider honesty and disclosure cannot be guaranteed. Participants may be vulnerable to impression setting, therefore responding in biased directions to achieve social desirability or perceived social gain. It is also possible that some participants may have simply forgotten relevant information throughout their years in clinical behavioral health practice. As such, these limitations may have impacted the findings of the study and should be considered.

Additionally, the researcher's positionality and interest in the field of female sexual offending may present as a limitation within the current research study. The researcher has professional therapeutic experience in the field of female sexual offending and purposefully selected participants who also have experience in delivering behavioral health care services to females who have engaged in sexually deviant behavior. In order to purposefully select therapeutic treatment providers with experience in the field, the researcher consulted professional contacts gained through the attendance of continuing education trainings, professional

conferences, and experience within the mental health field. These resources were used as a first line recruitment strategy. It is possible that the researcher may have held a prior professional relationship with participants. This professional relationship may have impacted how participants responded or expressed their experiences throughout the study. Steps were taken throughout the methodology of the study to address the researcher's positionality and reduce potential bias. These steps can be examined in chapter three and include aspects of researcher reflexivity, bracketing, thick description, and ethical principles.

Implications and Future Research

The mental health professionals with experience in treating the female sexual offender population offer unique insight into the phenomenon of female sexual offending through their focused behavioral health provider lens. Their lived experiences can be used to further advancement in the minimally explored field of female sexual offense behavior as well as promote knowledge regarding the treatment providers who have offered therapeutic care to this distinctive population. The findings represented in the current research study support previous literature within the field and present several implications related to the phenomenon of female sexual offending, the therapeutic providers who have treated this population, and future research to guide and inform clinical practice in the field. Specifically, the findings presented in this study represent an essence of provider experiences when delivering therapeutic care to female sexual offenders. The essence of these experiences captured an overview of offender life experiences, barriers to therapeutic treatment, and provider responses when treating such a challenging population. Capturing the essence of therapeutic treatment provider experiences when working with female sexual offenders established a foundation of knowledge in the field. Furthermore, the essence of these treatment provider experiences may set the stage for future research and

suggest implications for understanding female perpetrated sexual crimes, identifying therapeutic needs and treatment resources, and support for the providers specializing in the care of this population.

Implications to Inform Clinical Practice among Providers

Throughout this study, therapeutic treatment providers were directly asked to identify what types of support for female sexual offenders or therapeutic treatment providers they would like to experience. Their responses provide a useful strategy for guiding future research in the field of female sexual offending. Therapeutic treatment providers requested improved awareness regarding the topic of female sexual offending and improved resources for the field. Specifically, treatment providers requested more training and education, easier access to mental health services, female specific treatment materials to guide clinical practice, and trauma based therapy resources for providers. Treatment providers in the current study are not the first group of professionals to request aspects of professional development as a means of improving awareness and resources within the field of female sexual offending. Prior scholars have also stressed the importance of continuing education, training opportunities, and dissemination of research regarding the topic of female sexual offense behavior as strategies to reduce minimization within the field and improve the quality and consistency of therapeutic care among providers (Jahnke, 2018; Jung et al., 2012; Levenson et al., 2017; Christensen, 2021). Christensen (2021) suggests that if therapeutic providers are more informed regarding the topic of female sexual offending, they will feel more confident in their professional decision making, more open to the recognition and discussion of female sexual offense behavior, and more likely to overcome gender stereotypes.

Despite years of recognized need for improved awareness and treatment resources for the field of female sexual offending, little advancement has occurred. Therapeutic treatment providers have continued to request more training and education opportunities, easier access to mental health services, female specific treatment materials to guide and inform clinical practice, and enhanced trauma based therapy resources. If developed, such requested resources are likely to address the distinct needs of the female sexual offender population and aid therapeutic treatment providers in their experiences delivering effective behavioral health care services to females who have engaged in sexually offensive and deviant behavior. The resulting implications of the current study may offer guidance and direction for providers in their experiences delivering therapeutic care to the female sexual offender population.

The strongest implications of the current study resulted from the captured therapeutic provider experiences of complex and challenging life experiences common among the female sexual offender population. Challenging client life experiences have been well documented throughout the literature. This primary finding established the foundation upon which provider experiences when treating female sexual offenders are formed. Through their lens, therapeutic providers recognized challenging client life experiences of trauma, unhealthy interpersonal relationships, mental illness, and distorted and harmful ways of thinking as distinct characteristics and treatment needs that must be addressed among the female sexual offender population.

The essence of therapeutic treatment provider experiences captured in the current research study, identified the relationship between traumatic life experiences, unhealthy interpersonal relationships, mental illness, and distorted and harmful ways of thinking as likely contributing factors to deviant female sexual behavior. Considering these factors, therapeutic

providers are developing treatment plans to meet these gender specific needs. However, providers are experiencing significant difficulty acquiring professional resources to aid and inform the clinical care of this distinct population. Findings indicate that therapeutic treatment providers in the field of female sexual offending are consulting and altering treatment materials and resources designed with the focus of treating male perpetrators. These treatment models focus solely on deviant sexual desire and relapse prevention techniques that may not be as effective for the female population. The existing relapse prevention models frequently used for male offenders and adapted by treatment providers for use with female perpetrators, will likely fail to address the history of trauma, unhealthy relationships, mental illness, and cognitive distortions that providers identified as contributing factors to female sexual offense behaviors.

When addressing the distinct treatment needs of female sexual offenders, treatment provider experiences indicated that providers should focus on therapeutic interventions designed to explore the relationship between traumatic life experiences, unhealthy relational patterns, mental illness, and cognitive distortions in the decision to engage in high-risk deviant sexual behavior. Willis and Levenson (2016) suggest therapeutic techniques such as trauma informed care and schema focused therapy may aid and guide therapeutic providers in clinical strategies to best address the treatment needs of female sexual offenders. Elements of trauma informed care stress the establishment of a safe and empowering therapeutic environment. Willis and Levenson (2016) suggest that a safe therapeutic environment based on empowerment, empathy, and respect will allow women to explore the role that traumatic life experiences play in the adoption of deviant sexual behavior, unhealthy interpersonal relationships, and distorted belief systems common among the female sexual offender population. Additionally, Schema focused therapy incorporates a variety of therapeutic modalities in order to identify and amend maladaptive

schemas, belief systems, and emotional experiences that contribute to sexually offensive behavior among the female population (Willis & Levenson, 2016). Cortoni et al. (2010) also recommends the use of treatment procedures designed to specifically address overcoming trauma histories and establishing strong social skills and boundaries within interpersonal relationships within the female sexual offender population. Trauma informed care, schema focused therapy, and interpersonal skills are therapeutic techniques which may aid, guide, and inform behavioral health providers throughout their clinical experiences in the therapeutic care of the challenging and complex population.

Low rates of sexual recidivism among female sexual offenders and under-reporting due to social stigma and bias have made the development of female risk assessment tools difficult. No therapeutic treatment provider in the current study was able to identify any female specific risk assessment measure or treatment tool available to guide their experiences when treating female sexual offenders. Furthermore, upon review of the literature, no assessment instruments have been developed specifically for the use of female sexual offenders (Brayford, 2012; Comartin et al., 2021; Cortoni et al., 2010; Pflugradt & Allen, 2014; Vess, 2011). Therapeutic provider experiences within the current study indicated that risk levels for female sexual offenders are estimated by clinical judgement. Additionally, therapeutic provider experiences of the current study indicated that providers are altering resources designed for male sexual offenders for use in the clinical care of female offenders. Cortoni et al. (2010) suggests that risk assessment measures designed for the male population are likely to overestimate the recidivism risk of female sexual offenders. Therefore, assessment tools cannot provide accurate risk measurements for the female sexual offender population and should not be used in decision making regarding recidivism risk. Until risk assessment tools are designed specifically for use in

the female sexual offender population, accurate measures of risk are difficult to assess, and providers are experiencing significant barriers and lack of professional resources in their efforts to treat this distinct population.

Therapeutic treatment providers throughout the current study indicated that the lack of gender specific assessment tools have presented a major barrier when assessing risk and establishing treatment planning for female sexual offenders within their professional care. Future research should focus on designing specific tools and risk assessment procedures to generate accurate measures of risk and protective elements for female sexual offenders in which to guide and inform clinical practice among therapeutic providers. Thus, reducing the therapeutic treatment barriers identified and experienced by providers throughout their professional work.

Until such risk assessment tools and evidence-based treatment modalities are developed, therapeutic providers should focus on understanding female sexual offenders on an individual level. Treatment providers should address individual factors that contributed to past sexual offending and identify current personal and environmental conditions experienced by the individual when designing treatment plans throughout the therapeutic process. Therefore, clinicians can create an individualized risk profile and address the individual specific treatment needs of each offender. Addressing the individualized treatment needs of each offender may offer therapeutic providers a sense of guidance throughout their clinical experiences treating the female sexual offender population that is currently lacking.

Another strong implication in which to guide and inform clinical practice among therapeutic providers relates to therapeutic treatment provider experiences with female sexual recidivists. While previous literature suggests that it is unlikely for females to engage in multiple sexual crimes, 90% of therapeutic treatment providers in the current study experienced female

sexual recidivists. Furthermore, treatment providers identified experiencing additional complexities related to offender characteristics and limited assistive resources when providing behavioral health care services to women who have engaged in multiple sexual crimes. Sexual offense recidivism in the female population presents a sizable gap in the field and is in need of future study. Provider experiences with female sexual recidivists indicate clear need of advancement to best support those who deliver therapeutic care to this population.

Considering female sexual recidivists, therapeutic treatment providers identified experiences involving poor accountability, disregard for others, and minimization of the harm caused by sexual offense behavior as common psychological characteristics among the female sexual recidivist population. The complex psychological characteristics and arduous treatment aspects of providing mental health services to female sexual recidivists, as well as limited assistive resources when providing therapeutic care to repeat female sexual offenders, resulted in identified provider experiences of failure and reduced professional competence when delivering therapeutic care to this distinctive population. Therapeutic providers indicated not feeling successful in the behavioral health care of female sexual recidivists and experienced additional feelings of worry related to the potential for this specific population to sexually reoffend.

Contrary to previous research indicating low percentages of female sexual recidivism, the current research study indicated that therapeutic behavioral health care providers experienced female sexual recidivists throughout their career and expressed additional difficulty and concern when treating this specific population. This finding may suggest that female sexual recidivism is more prevalent than currently understood, the specific treatment needs distinctive of this population are not being met, and therapeutic providers are experiencing a sense of failure in the professional care of female sexual recidivists. Future research related to female sexual recidivism

is needed to expand upon the understanding and knowledge in the field. Additionally, advanced study focused on the therapeutic treatment needs of individuals who have engaged in multiple sexual crimes is necessary to strengthen support and guidance for therapeutic providers delivering care to this distinctive population and establish experiences of professional competence in the field.

According to the theory of reflective practice, therapeutic providers are experts in their field. While they may not always experience professional competence in their skills, they have the knowledge and experiences in clinical practice to effectively treat the female sexual offender population. Therapeutic treatment providers should make the time to reflect upon their professional experiences, change any techniques they don't find to be effective in treating female sexual offenders, and incorporate and strengthen effective clinical practice techniques. Future research study should specifically focus on gaining a complete grasp of provider experiences and knowledge in the behavioral health care of the female sexual recidivist population to create available resources and treatment materials for providers in the field.

With their clinical experiences, therapeutic behavioral health providers are well-informed individuals capable of working together, collaborating towards shared goals, and enhancing rewarding experiences of professional development, helping others, client growth, decreased recidivism, and improved community safety. With these rewarding experiences outweighing the costs to providing therapeutic care to female sexual offenders, social exchange theory suggests that providers will remain in the profession for many years to come.

Implications for Provider Well-Being and Longevity

Social exchange theory suggests that providers will remain in the profession as long as the rewards outweigh the costs of providing behavioral health care services to individuals who

have perpetrated sexual crimes. Therefore, psychological well-being must be a priority for therapeutic providers in the field. Addressing significant client life experiences of trauma, unhealthy interpersonal relationships, mental illness, and distorted and harmful ways of thinking throughout the therapeutic process, in combination with encountering significant treatment barriers, is professionally and personally challenging for therapeutic treatment providers in the field. Within this study, therapeutic treatment providers identified experiencing negative emotional responses of vicarious trauma, emotional stress, burnout, and dangerous world views. If left unchecked, these negative emotional responses resulting from the emotionally heavy and demanding therapeutic aspects required when providing behavioral health care services to the female sexual offender population are likely to harmfully impact provider well-being and damage the therapeutic process. Reduced psychological well-being among treatment providers and impaired behavioral health services would likely reduce the effectiveness of therapeutic care provided to female sexual offenders and provide the opportunity for future sexually deviant behavior to occur, further damaging and reducing experiences of professional competence among providers.

To manage the negative emotional responses resulting from providing behavioral health care to the female sexual offender population, therapeutic treatment providers are using coping skills to assist them in the therapeutic care of a challenging population. Within the current study, treatment providers identified experiences of self-care, boundary setting, persistence, and supportive colleagues as strategies to reduce the negative emotional responses resulting from treating challenging client life experiences and overcoming barriers to the therapeutic process. Future research to determine strategies for strengthening and developing experiences of self-care, boundary setting, and persistence would be beneficial in aiding therapeutic treatment providers

in reducing experiences of negative emotional responses throughout their career. Furthermore, future research is needed to determine how to best link therapeutic treatment providers with supportive colleagues in the field. Specifically, research pertaining to strengthening aspects of communal coping may benefit the entire community of behavioral health care providers with experience treating the female sexual offender population. The establishment of strong coping skills and communal support may provide a buffer when treating the challenging and traumatic life experiences common among female offenders, improve provider well-being, prevent burnout, prevent adverse treatment outcomes, and expand treatment provider longevity in the field.

While not a topic explored in this study, future research may also benefit from exploring therapeutic provider experiences and retention in the field under the lens of social exchange theory to determine when the balance between cost and rewards among provider experiences are no longer symmetrical. It is possible that when the rewards no longer outweigh the costs, therapeutic treatment providers may leave the field and focus on the behavioral health care of alternative populations. A greater understanding of emotional costs and rewards when delivering therapeutic care to female sexual offenders may promote strong psychological well-being among therapeutic providers and aid provider retention in the field.

Conclusion

Limited research in the field of female sexual offending has impaired understanding of female perpetrated sexual crimes and hindered the development of female-specific treatment interventions and resources to guide, support, and inform behavioral health clinical practice. Pertinent gaps in the study of female sexual offense behavior and the behavioral health care providers who specialize in treating this specific population remain. The behavioral health care

providers with experience in the therapeutic treatment of female sexual offenders represent a vital vocation and offer unique insights and experiences related to the field. Advanced study through the therapeutic provider lens, is one strategy to bridge the gap in the literature and expand knowledge in the field of female sexual offense behavior and the experiences of the providers who have delivered therapeutic care to this distinctive population.

Guided by constructivist theory and phenomenological research design, this study captured the essence of the clinical experiences encountered by behavioral health treatment providers with experience offering therapeutic care to female sexual offenders and explored how providers experience the world in order to establish an advanced understanding of the nature and meaning of everyday life experiences in the field of providing behavioral health care to female sexual offenders. This study used the lens of therapeutic provider experiences to build a foundational overview of the topic of female sexual offending, expand knowledge related to the field, and develop insight into the providers who have treated this focused population. Future research is needed to extend beyond these experiences to improve understanding and awareness within the field of female sexual offending, develop gender specific treatment interventions, enhance resources to better support treatment providers, and establish practices to effectively meet the needs of the female sexual offender and therapeutic treatment provider population.

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Appendix A

Initial Participant Recruitment Script: Initial Phone, Email, In-Person Communication

Dear provider,

You are being invited to take part in a research study examining the perspective of individuals who provide therapeutic care to women who have engaged in sexual crimes. Your unique experiences and perspectives offer a useful tool in advancing knowledge of sexually deviant behavior in the female population, increasing awareness of gender-specific distinctions, and enhancing insight to better support therapeutic providers who specialize in treating female offenders. Please read this form carefully before deciding whether to participate.

The purpose of this study is to utilize the lens of therapeutic provider experiences and perspectives to build a succinct foundational overview of the topic of female sexual offending, expand knowledge related to the field, and develop insight into the providers who specialize in treating this focused population. Specifically, the study is guided by the following research question:

1. What are the experiences of treatment providers working with female sexual offenders?

Participation in this study is voluntary and will involve open-ended, semi-structured interviews taking approximately one hour to complete. You are free to not answer any question or to withdraw from participation at any time without penalty. If you are interested in participating in the study, and would like to establish a time to discuss a thorough informed consent and begin the interview process, please contact the researcher via email or phone.

Thank you for your time and consideration,

Jalie Adams, LPA
[redacted]

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Appendix B

Female Sexual Offending: The Experiences Identified by Treatment Providers Subject Informed Consent

Introduction and Background Information

You are invited to participate in a research study. This form contains information that will help you decide whether to participate in the study. The study is being conducted by Dr. Grant Smith and Jalie Adams. The study is sponsored by Annsley Frazier Thornton School of Education, Bellarmine University. The study will take place at a time and place convenient to you and may occur in-person or virtually based on your personal preference. Approximately 5-10 subjects will be invited to participate. Your direct participation in this study will last for approximately one hour.

Purpose

The purpose of this research study is to utilize the lens of therapeutic provider experiences and perspectives to build a succinct foundational overview of the topic of female sexual offending, expand knowledge related to the field, and develop insight into the providers who specialize in treating the female sexual offender population. Specifically, this research study is guided by the following research question:

1. What are the experiences of treatment providers working with female sexual offenders?

Procedures

In this study, you will complete in-depth, open-ended, semi-structured interviews to gather information and engage in conversation about your unique experiences providing therapeutic care to female sexual offenders. The interview will be completed at a time and place convenient to you. Interviews will last approximately one hour. During any portion of the interview process you may decline to answer any question that makes you feel uncomfortable or that may render you prosecutable, without incurring any penalty. Should you decide to withdraw consent prior to interview completion, any audio recording or transcription data will be destroyed immediately by the researcher.

Potential Risks

There are risks associated with the open-ended, semi-structured interview process. Throughout the interview, you will be asked to discuss and interpret potentially sensitive and personal material regarding your experiences when providing therapeutic care to female sexual offenders. Therefore, you may experience potential risks related to emotional discomfort at times. Should the need arise, you will have access to psychological resources and services provided by the Crisis Hotline using talk, text, or chat #988 for behavioral health needs. Furthermore, during any portion of the in-person interview or research process, you are able to decline to participate or answer any question posed by the researcher, without incurring any penalty. Should you decide

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to withdraw consent prior to interview completion, any audio recording or transcription data will be destroyed immediately by the researcher.

Benefits

The possible benefits of this study include the opportunity to share your insights, experiences, and perspectives regarding the therapeutic care of the female sexual offender population. Sharing your lived experiences will aid in capturing the essence of the experiences encountered by treatment providers offering mental health care and treatment services to female sexual offenders. Your specialized therapeutic provider lens may assist in expanding knowledge in the field of female sexual offense behavior and the experiences of the clinicians who specialize in providing therapeutic care to this distinctive population. The data collected in this study may not benefit you directly. However, the information learned from this research may be helpful to others in the future. The information gathered from this study may improve understanding of the experiences when treating female sexual offenders and provide a useful tool in advancing knowledge of sexually deviant behavior in the female population, increasing awareness of gender-specific distinctions, and enhancing insight to better support therapeutic providers who specialize in treating female offenders.

Compensation

No form of financial or external compensation will be provided for participation in this study. Your participation in the study is voluntary and you may choose to discontinue participation in the study at any time, without incurring any penalty.

Confidentiality

Although absolute confidentiality cannot be guaranteed, confidentiality will be protected to the extent permitted by law. If you report the following information, the researcher is mandated to report this information to the appropriate authorities:

1. Threats to harm yourself or others
2. Information indicating that another person is being abused, neglected, or endangered

The study sponsor or the Institutional Review Board may inspect your research records. Should the data collected in this research study be published, your identity will not be revealed. To maintain the privacy of participants, the researcher will refrain from providing any identifying information in reports or documentation. No identifying names or locations will be provided. Pseudonyms will be assigned to each participant and any identifying names or information delivered through participant experience or report will be changed to protect the anonymity of providers and their clients. Furthermore, interview audio recordings and transcriptions will be maintained on password protected computers in password protected cloud locations. Transcriptions will be completed within 48 hours of interview completion and identifiable information removed. Once participant interviews are transcribed by the researcher, the audio recordings will be destroyed.

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Potential Future Research Statement
Your provided identifiable private information or biospecimens collected as part of this research, even if identifiers are removed, will not be used or distributed for future research studies.

Voluntary Participation
Your participation in this research study is voluntary. You may refuse to participate or withdraw your consent at any time without penalty or losing benefit to which you are otherwise entitled. Should you decide to withdraw consent prior to interview completion, any audio recording or transcription data will be destroyed immediately by the researcher.

Your Rights as a Research Subject and Contact Persons
If you have any questions about your rights as a research subject, you may call the Institutional Review Board Office at 502.272.8032. You will be given the opportunity to discuss any questions, in confidence, with a member of the Board. This is an independent committee composed of members of the University community and lay members of the community not connected with this institution. The Board has reviewed this study.

You acknowledge that all your present questions have been answered in language you can understand. If you have any questions about the study, please contact the Principal or Co-Investigator.

Principal Investigator: Grant Smith
[redacted]

Co-Investigator: Jalie Adams
[redacted]

Consent
You have discussed the above information and hereby consent to voluntarily participate in this study. You have been given a copy of this consent form.

_____ _____
Signature of Subject or Legal Representative Date Signed

_____ _____
Signature of Investigator Date Signed

_____ _____
Signature of Person Explaining Consent if other than Investigator Date Signed

Appendix C

Female Sexual Offending: The Experiences Identified by Treatment Providers

Semi-Structured Interview Protocol

Interviewee:

Date:

Location- in-person/virtual:

Job Title/Certifications:

Clinical Field/Educational Background:

Age:

Ethnicity:

Gender:

Number of years' experience in the mental health field:

Tell me a little about the work that you do in your current employment role:

What have been your experiences working with sexual offenders?

What type of mental health services or programming did/do you provide to sexual offenders?

Years' experience specifically working with sexual offenders:

If past experience, how long removed from the field?

What emotions, feelings, or images emerge when you are providing care to sexual offenders?

What are your initial emotions when you consider therapeutic care for the female sexual offender population specifically?

Do these emotions, feelings or images feel different than when you work with male offenders? If so, in what ways?

How do you cope with these emotions?

Do these emotions impact your ability to treat sexual offenders? If so, please describe how:

Do these emotions or experiences impact the care that you provide to clients who do not have histories of sexual offense behavior? If so, please describe:

How does providing treatment to female sexual offenders impact you internally? Externally?

Do you experience any moral or ethical dilemmas? If so, what is your experience?

What types of differences have you encountered when providing care to female versus male offenders, if any?

Describe any unique experiences when working with female offenders?

How do you think female sexual perpetrators are portrayed to the general public?

What types of commonalities or characteristics have you noticed among the female offender population?

What factors do you believe contribute to female sexual offense behavior?

How do you address any of these unique experiences or common female offender characteristics within the treatment milieu?

What have been your experiences working with female sexual recidivists?

From your experiences treating female sexual recidivists, what factors do you think contributed to reoffending?

How do you incorporate these factors into the therapeutic care you provide these women?

What types of community supports have you found available for women who have perpetrated sexual crimes? Please describe a little about these supports:

Have you encountered any types of support for therapeutic treatment providers who offer care to female sexual offenders? If so, please describe them:

What types of support for female sexual offenders or therapeutic providers would you like to see more of?

- How would these supports be beneficial?

What have been your experiences when situations occur in which you are required to discuss with others (the community/friends/family) the type of work you provide?

- What information do you provide about your work with female sexual offenders?
- How do others typically respond to this information?
- What are your emotional reactions during these situations?

What specific difficulties, if any, have you encountered when working directly with the female sexual offender population?

Have you faced any treatment barriers when providing therapeutic care to female offenders? If so, please describe:

How do you challenge or overcome these difficulties and barriers?

Have you come across any female specific treatment tools or resources? If so, what are these tools and resources?

- What have been your experiences with these tools or resources?
- What tools or resources have been the most beneficial and why?
- If you had access to additional tools or resources, what would you choose?

What is your motivation for work in the field of female sexual offending?

Describe any rewarding experiences you have encountered in the field?

- What are your greatest accomplishments in the profession?

What wisdom would you impart to clinicians working with female sexual offenders?

Do you have any final comments regarding your experiences when providing therapeutic care to the female sexual offender population?

Appendix D

Sample of Field Notes and Observations

Notes	**Interview Observations**	**Thoughts and Ideas**
• In-person interview • Thoroughly discussed consent form • Provided time to ask/answer consent questions-no questions • Signed consent • Discussed pseudonym selection-participant has no preference • Participant declined audio recording • Interview length=1 hour and 20 minutes • Handwritten detailed notes taken by researcher throughout interview	• Participant appeared engaged throughout the interview • Appropriate eye contact • Open and warm body language • Appeared reflective and thoughtful when responding to questions • Knowledgeable and insightful regarding the topic • Current and up to date in the field- Identified and quoted current research and statistics • Home warm and inviting • Sees clients from home-has a space set up for this purpose- interview was completed in this home office-space is warm and comfortable- books on table related to understanding culture/CBT therapy/assertiveness skills. • No personal pictures present • Separate entrance for clients • Appeared excited about discussion the topic	• Seeing clients from home-concerns for safety? • Maintaining boundaries? • Provider concerns or worries? • Stays up to date in the field-resources/motivation-suggestions for staying current? • Networking • Linking providers together- important? • Mentioned ACEs-Trauma- very important-mentioned a lot- common among all participants so far • Coping skills- strong-helps to stay well-lengthen longevity in the field- how to strengthen? • Caring-providers really care/compassionate/want to help • Client growth-investigate further-making a difference • Sense of pride?

Appendix E

Analytic Memo

Emerging Thoughts and Ideas Throughout Research

Researcher Reflection

*Reminder*Research question-data alignment

*Purpose=capture essence of provider experiences

1. What are the experiences of treatment providers working with female sexual offenders?

[As a mental health professional, I have had the opportunity to work with a variety of client populations. For years my work involved the specialized treatment of sexual offenders within the correctional setting. I have provided therapeutic care to both men and women who have committed sexual crimes. Through my work, I realized that research and data regarding female sexual offenders was severely limited. I strongly feel that this impacted and reduced the effectiveness of the care I was able to provide these women. For this reason, I wanted to further explore the field of female sexual offending and potentially contribute to building the knowledge base within the topic.]

The study of female sexual offending is a difficult topic for research. I quickly realized and faced similar challenges that other researchers have faced before me. As a researcher, how do I gain access to study this population? I cant, there are too many barriers. However, the providers with experience treating this population have a very specialized lens. Their experiences could really improve insight and awareness in the field. Other therapeutic providers who specialize in treating this population could also provide a significant contribution to research in the field. By studying the clinical experiences of providers, I could begin to capture the essence of these unique experiences and use them to offer therapeutic suggestions and techniques to support and inform practice when treating female sexual offenders. Therefore, potentially contributing to increased understanding of female-specific treatment interventions, resources to better support treatment providers, and development of practices to decrease recidivism and enhance community safety.

Mental health providers with experience offering care to female sexual offenders would present a population that could be studied to assist with building knowledge in the field of female sexual offending. A selection of providers with experience working with female sexual offenders in would provide the sample sizes needed for reliable and valid research. Pull all professional contact info possible for potential participants. To begin the study, I needed to create a solid understanding and knowledge base of female sexual offending. I reviewed the scant literature related to the topic and established an extensive literate review covering female specific characteristics, offense motivations, risk factors, treatment needs, and provider considerations. Establishing this knowledge base would assist the reader with understanding female sexual offense behavior and provide a means of comparison when evaluating and interpreting the

provider experiences being studied. I also anticipated that clinical providers might provide additional insights and areas of consideration for future study and development. Specifically, I wanted to explore the research questions:

1. What are the experiences of treatment providers working with female sexual offenders?

To collect this data, I created a semi-structured interview designed to capture the essence of provider experiences. Establishment of the semi-structured interview was a difficult process and required several revisions. It was a challenge to create questions that would completely capture the essence of the phenomenon. Ultimately, I created a semi-structured format that I believe is effective in capturing the essence of providing therapeutic care to female sexual offenders. Audio recording of the interviews was also helpful in transcribing and reviewing data for the interpretation and analysis process.

During the data collection process, it became clear that provider experiences aligned with previous research in the field. Almost all participants commented on the extensive trauma and abuse histories experienced by females who have committed sexual crimes. Also addressed were distorted attachment, unhealthy relationships, mental illness, and harmful thinking common among this population. All participants commented on the lack of research and limited resources when treating this population. [This strengthened my concern that the specific treatment needs of the female sexual offender population are not being addressed effectively due to limited research, data, and resources.] Initial emerging data seem to suggest that for women, it is important to address unique trauma histories, healthy relationship establishment, mental health concerns, and harmful ways of thinking. I plan to spend more time here during data interpretation to fully expand upon the unique treatment needs of female sexual offenders.

Through data collection, I am beginning to notice patterns and themes endorsed by providers. Participants expressed common experiences of negative emotional responses, vicarious trauma, stress and burnout. [My initial impression is that these negative responses are likely due to the trauma needs and emotional toll of treating sexual offense behavior in the therapeutic setting.] Additional exploration is needed here during the data interpretation process to further build upon these possible connections.

[I hold the belief that a knowledgeable, compassionate, and supportive therapeutic provider can make a difference in the lives of their clients. I believe that providers can help individuals learn, grow, and develop as individuals. I hold these same beliefs when treating the female sexual offender population. I believe that is it possible for females who have perpetrated sexual crimes to live an offense free and healthy life. Participation in mental health care is one aspect to assist female sexual offenders with the growth and development required to live an offense free life and reduce the potential for recidivism. I believe that a provider who is experiencing significant and frequent negative emotional responses and burnout cannot provide the best care to their clients and effectively meet the specific treatment needs of the female sexual offender population.]

Initial review of data seems to suggest that other providers experience similar beliefs. Professional providers appear to recognize the potential for stress, vicarious trauma, and burnout when providing care to female sexual offenders. With this knowledge, all participants stressed the importance of self-care, boundary setting, strong coping skills, and social support to assist them with becoming the best providers for their clients. I plan to further examine and identify these common themes in order to offer therapeutic suggestions and techniques to support and inform practice. Therefore, potentially contributing to increased understanding of female-specific

treatment interventions, resources to better support treatment providers, and development of practices to decrease recidivism and enhance community safety.

Other things emerging from the data that need to be investigated:

- Experiences with repeat offenders
- Additional complexities
- How to best link providers with other resources/colleagues in the field
- Resources
- Materials and ax procedures
- Stigma

I need to spend more time with the data. Use more focused and pattern coding procedures. Really gear down on using the participant voice to construct the final themes. [It is my ultimate hope that this research contributes to improvements in the understanding of female-specific treatment interventions, resources to better support treatment providers, and development of practices to decrease recidivism and enhance community safety.]

Appendix F

Focused Coding Sample from Field Notes and Observations

Field notes and observations:	Emerging themes:
-Focused coding of possible emerging themes gathered from field notes and observations -For comparison to interview transcripts/participant voice	**Therapy is hard because:** Trauma Emotionally heavy Are providers ok? Well-being and negative impacts Unhealthy relationships Abuse hx **Providers at times are:** Stressed Worried Exhausted Angry Burned out They want to make a difference Protection and safety **No support/how to support them:** Coworkers/insight Dive into coping skills **Boundaries and safety:** Where to see clients? In home? Safety Caution Fear?

Appendix G

Sample of Coding Cycles among Colaizzi's 7-Step Approach to Data Examination

*Numbers to the side of codes represent the frequency of occurrence in participant report

First Cycle: Descriptive and In Vivo Coding	Second Cycle: Focused Coding	Third Cycle: Pattern Coding
Trauma-11 ACEs **Dependency**-6 **Poor Boundaries**-4 **Unhealthy attachments**-7 **Mental illness**-6 Substance abuse-4 **Dist. & harmful thinking**-6 Misplaced feelings **Emotional immaturity**-5 **Poor self-esteem**-4 Poor self-worth **Unhealthy relationships**-4 Lack of assertiveness-1 Poor impulse control-1 **Lack of accountability**-4 **Minimization**-4 Manipulation-2 Blame-1 Victim attitude-1 Disregard for others-1 IQ-3 Poor trust Complexity-1 Difficult Complicated Power and control Emotional Fragile Denial Poor job skills-1 Sadness **Anger**-3 Tired-1 Fear-1 Child safety Difficulty trusting Guarded-2	**<u>Challenges/Client Life:</u>** **Trauma** Dependency- (representative of unhealthy relationships-group together) Unhealthy attachments-(representative of unhealthy relationships-group together) Poor boundaries-(representative of unhealthy relationships-group together) **Mental illness** **Unhealthy relationships** **Distorted & harmful thinking** Limited resources No tx materials Stigma **<u>Emotional Responses:</u>** Draining Exhaustion Emotionally heavy Stress Worry Burnout Anxiety Guarded Difficulty trusting Fear Intrusive thoughts Caution Emotional work Heavy **<u>Positive Experiences:</u>** Pride/Proud Help people	**1) <u>Cyclical Experiences</u>** **A) Challenging Client Life Experiences:** • Traumatic Life Experiences • Unhealthy Interpersonal Relationships • Mental Illness • Distorted and Harmful Ways of Thinking **B) Barriers to the tx process:** • Gaps/limited research • Lack of tx materials • No risk ax tools • Stigma/limited community resources **C) Negative Emotional Responses:** • Vicarious trauma • Emotional stress • Burnout • Dangerous world views **D) Rewarding Experiences:** • Professional development • Help others

Intrusive thoughts Draining-2 **Exhaustion**-2 **Emotionally heavy**-2 Worry-2 Stress-2 Doubt-2 **Burnout**-3 Hard Secrecy-2 Avoidance-1 Embarrassment Anxiety Responsibility Thinking Jaded-1 Disbelief Caution-1 **Stigma**-6 Pressure Poor confidence Imposter Overwhelming-1 Hyper vigilant Disturbing-1 Emotional work-1 Low tolerance Heavy Lack compassion Stories stay Empathy-1 Secondary stress/trauma Irritation Pride/Proud-3 **Help people**-11 **Meaningful**-1 **Positive difference**-3 **Learn/grow**-7 Make world better-1 **Rewarding**-2 **Professional growth**-2 Impact Positive client interactions-1 Enjoy work **Protect community**-2 Gratifying	Meaningful Positive difference Learn/Grow Rewarding Make the world better Professional growth Positive client interactions Protect the community **<u>Coping:</u>** Self-care Work life balance Boundaries Hard work Grit Don't give up Persistence Colleagues Talk **<u>Needs:</u>** Training Education Easier access to services Dealing w/ secondary stress Outlets Trauma based therapy Resources Tx materials **<u>Female Sexual Recidivists</u>** Lack of accountability Disregard Minimization Failure Reduced competence	• Client growth • Decreased recidivism • Community safety **2) <u>Female Sexual Recidivists</u>** • Lack of accountability • Disregard for others • Minimization of harm • Failure • Reduced professional confidence **3) <u>Supportive Colleagues and Personal Coping skills</u>** • Self-care • Boundaries • Persistence • Supportive colleagues **4) <u>Needed Resources</u>** • Training and Education • Access to mental health services • Female specific tx materials • Trauma based therapy resources for providers

Care **Self-care**-6 **Colleagues**-14 **Work life balance**-5 **Boundaries**-10 Research **Hard work**-3 **Persistence**-4 **Grit**-2 **Don't give up**-2 Flexible Positive attitude Workout **Talk**-3 Humor Remember why I do the job-2 Professional judgment-1 **Training & education**-4 **Easier access to services**-3 Treatment materials-2 **Deal w/ secondary stress**-3 Outlets **Trauma based therapy**-3 **Gaps**-3 **Limited Research**-4 **No resources/tx materials**-11		