Risk and Treatment Assessment for Women Who Have Sexually Offended

DAWN M. PFLUGRADT, PSY.D. &
BRADLEY P. ALLEN, PH.D.

1

Who is this Presentation About?

1. Women who have committed a sexual act on another person against the person's will (or against a person unable to consent).
2. Women who use or produce child abuse images.

We are not talking about women who commit prostitution offenses.

2

Offender Characteristics

Younger (Average age 26-32)
Mostly Caucasian
Poor mental health?
Difficulty coping with stress (including AODA)
Maladaptive personality characteristics
Isolation & lack of social support
Problematic/chaotic family environment
Abusive experiences

3

General Offense Characteristics

Most offenses are against adolescents/children

Are more likely to have a co-offender (as compared to males)

Are often in a care giving role to the victim

Engage in less penetration of the victim

4

Women and Adverse Childhood Experiences

- 50.3% of community females report 1-3 ACEs
- ACEs have been shown to contribute to a variety of health & social problems
- In general, the more ACEs one has the poorer the outcome.

(Levenson et al., 2014; Pflugradt, Allen, & Zintsmaster 2018)

5

ACEs in Women who Commit Sexual Offenses

- Women who commit sexual offense have:
- Three times the odds of child sexual abuse;
- Four times the odds of verbal abuse;
- Three times the odds of emotional neglect and having an incarcerated family member.
- Only 20% endorsed zero ACEs (compared with 35% of the general female population)
- 41% endorsed four or more ACEs
- Higher ACE scores were associated with having younger victims

6

ACEs in Women who Commit Sexual Offenses

Multiple maltreatments often co-occurred in households with other types of dysfunction, suggesting that many female sex offenders were raised within disordered social environments by adults with problems of their own who were ill-equipped to protect their daughters from harm.

As ACEs increased, level of violence also increased

7

Victim Impact

Both male & female victims report the same long-term effects

- Substance abuse
- Self-injury
- Suicidal ideation
- Depression & anger
- Problematic relationships
- Difficulties with sexuality and sexual identity issues
- Deemed more psychologically harmful due to the relationships/nurturance provided by the perpetrator (Cortoni, 2018)

8

Societal Responses Harm Victims Further

- Societal responses to victims often re-victimize them
- Disclosure by victims often met by disbelief and ambivalence by therapists, family, & police
- Victims are sometimes told that they must have wanted it, imagined things, misinterpreted their caregiver's intentions, or were dreaming/fantasizing
- Hetherton (1999) termed this as "secondary abuse"

9

Female Perpetrated Sexual Offense Prevalence

Official rate = 2% (Taken from official reports)

Victimization rate = 12% (Taken from reports of victims)

Current Stats under-report offenses committed by female sexual offenders at a similar rate to male perpetrators of sexual offenses.

Approximately 20% of female sexual offenses are officially reported.

(Cortoni, Babshichin, & Rat, 2017)

10

Does Gender Matter?



11

Yes! Gender Matters

Research shows us that being gender responsive gets better outcomes than being gender neutral.

Women who perpetrate sexual offenses should be viewed from a gendered perspective.

12

Gendered Approach

- Steffensmeier and Allan (1996) proposed a gendered theory of female offending behavior. Gendered theories do not assume that causal patterns for female criminality are either the same or distinct from those for identified for men. Rather, gendered theories take into account how gender in combination with differing life experiences influence the behavioral manifestations of criminal behavior.
- Thus the gendered perspective considers the unique life experiences of women who commit sexual offenses, how these experiences influenced or were associated with dysfunctional relationships/ criminal behaviors, the association between offender's criminogenic/ relational characteristics and manifestation of sexually assaultive behaviors and the relevant social/contextual factors.

13

A Gendered Perspective Should

1. Explain how social norms, identities, arrangements, institutions and relationships transform gender into something physically and socially different;
2. Account for gender differences in type and frequency of crime as well as differences in the context of offending;
3. Consider the ways in which the pathways to crime for women differ from those of men;
4. Explore the extent to which gender differences in crime derive not only from social, historical, and cultural factors but also from biological and reproductive differences.

14

A Gendered Perspective Considers That:

It is not possible to separate offense factors or behavioral manifestations from the social context (Pflugradt & Cortoni, 2014).

Relational factors are a major component when looking at offending behaviors in females.

15

ASSESSMENT WITHIN A RNR CONTEXT

16

RNR: Core Aims and Assumptions

- Primary aim of correctional intervention is to reduce harm inflicted on community
- Most important treatment targets are those empirically associated with reduced recidivism rates
- Clients should be treated humanely, with research and treatment delivered in an ethically responsible manner
- Client rights trumped only by community needs

• Bonta & Andrews, 2017

17

Treatment Context: What Works

01

Risk: Match level of services to level of risk

02

Need: Target criminogenic needs

03

Responsivity: Use empirically supported approaches; also specific responsivity

18

Assessment of Recidivism Risk

19

Sexual Recidivism

Sexual recidivism is low unless there is a stated intent to reoffend.

In a sample of 471 women, recidivism rates over a 18.83 period:

- 7% for new sexual offense
- 52% for any new general offense (Vandiver et al., 2018)

In a sample of 2,490 women, recidivism rates over a 6.5 year period were:

- 1.5 % for new sexual offense
- 6% for new violent offense
- 20% for any new general offense (Cortoni, Hanson & Coache, 2010)

20

Sexual Recidivism Static Risk Factors

There is only one known static factor associated with female sexual offending:

Prior convictions for child abuse (any type) offenses

Two Theories:

- 1. Women are primary caregivers; they are more likely to come to attention for nonsexual abuse as well.
- 2. Sexual abuse of children, for certain women, is part of a broader pattern of abuse against children.

21

Static Factors for Sexual Recidivism

There are currently no validated Static risk assessment tools.

Do not use the STATIC-99R, STATIC-2002R or ISORA for women.

Static risk factors are different than those found in males and these risk instruments will over estimate risk (Marshall et al., 2020).

22

Dynamic (Changeable) Risk Factors

There are no empirically derived dynamic risk factors related to sexual recidivism in women.

It is inappropriate to apply dynamic risk factors demonstrated for males to female offenders (ex: Mann et al., 2010).

Do not use VRS-SO, SOTIPS, SRA-FV, or STABLE-2007.

23

Assessment of General Risk

Why? Research tells us that women who perpetrate sexual offense(s) are more likely to re-offend non-sexually. That is, the available empirical research tends to indicate that women who perpetrate sexual offenses have a higher risk for general criminal recidivism. Therefore, evaluators need to identify their risk and needs for general offending as well as sexual offending.

Use tools designed for women:

Women's Risk Needs Assessment (WRNA)

Level of Service Inventory-Revised (LSI-R)

24

Non-sexual Criminal Recidivism

Gender neutral risk factors: Youth, Prior criminal history, Antisocial Attitudes, Antisocial Associates, Substance Use/Abuse, Recent Substance Use.

Gendered: Housing Safety, Employment/Financial, Educational Needs, Anger/Hostility, History of Mental Illness, Current Symptoms of Anxiety and/or Depression, History of Abuse/Trauma, Family Conflict, Relationship Difficulties, & Parental Stress.

(Ashley Bauman, presentation 06/17/2021)

25

Risk Assessment Considerations for Women

Identify risk factors related to general criminal recidivism.

Sexual recidivism is low unless stated intent to reoffend.

Research also does not support a nexus between diagnoses and sexual re-offending/offending.

Assessments of female offenders require specific training, practice, and clinical experience.

DO NOT apply male based risk assessment practices to women.

After risk assessment identify treatment needs, which we will discuss next.

26

Assessment of Sexual Recidivism Risk: Primary Assertions Derived from Research

- Women who perpetrate sexually harmful behaviors are a low recidivism risk/high need population.
- Women with high needs are at greater risk of general recidivism.
- It is asserted that women at greater general recidivism are also at greater relative risk of sexual recidivism.
- "Needs" are not the same as "dynamic factors." Rather needs are those areas of a woman's life over which she has little to no control. These need areas may be categorized as intrinsic (cognitive, emotional), extrinsic (sexual dynamics, social) or a combination of both.

27

RNR with Low Risk Individuals?

- See Carr & Willis, 2021
- Focus on individualized approaches to meet needs
- If incarcerated, focus on release planning

28

Gendered Treatment Assessment

29

Strength Based Gendered Assessment & Treatment

The following information comes from these papers and our clinical experience with women who have committed sexual offenses:

Pflugradt, D., & Cortoni, F. (2014). Women who sexually offend: A case study. In D.T. Wilcox, T. Garrett, & L. Harkins (Eds.), *Sex offender treatment: A case study approach to issues and interventions.* John Wiley & Sons.

Pflugradt, D.M., & Allen, B.P. (2019). The application of the good lives model to women who commit sexual offenses. *Current Psychiatry Reports, 21*, 119.

Pflugradt, D.M., Allen, B.P., & Marshall, W.L. (2018). A gendered strength-based treatment model for female sexual offenders. *Aggression and Violent Behavior*, 40, 12-18.

30

31

32

Pathways to Offending

33

Offense Styles/Pathways

In contrast to typologies, there has been research to indicate that offense styles or pathways are useful in understanding female offending. Most females tend to follow one or two main pathways to sexual offending, while a few follow a third pathway.

34

Offense Styles/Pathways

Research utilizing pathways for female offenders:

- Recognizes that the previous classification literature has limited clinical utility.
- Acknowledges the complex and contextual nature and process of sexual offending.

35

Three Main Offense Pathways

1. Directed-Avoidant
2. Explicit-Approach
3. Implicit-Disorganized

(Gannon et al., 2013)

36

Directed-Avoidant

The primary characteristics of this pathway include:

Sexual Avoidance

Negative Affect

Women in this pathway often live in either extreme fear for their lives or desire intimacy with a co-offender.

Women in this pathway are often oblivious or passive in planning abuse initiated by their co-offender.

37

Explicit-Approach

Offenders in this pathway experience positive affect & excitement in anticipation of offense

They plan the offense to reach specific goals

- Sexual gratification
- Intimacy with victim
- Financial reward

38

Implicit-Disorganized

Most Uncommon/Rare pathway

The primary characteristics of this pathway include:

Minimal planning, disorganized offense characteristics

Can be associated with positive or negative affect

Adult or child victim

39

Treatment Assessment/Need Factors

Generally grouped in five domains with a sixth domain used to identify unique individual characteristics. These overlap and cannot be separated out from a women's overall life

- Intimacy & Relationship Issues
- Cognitive Processes
- Emotional Processes
- Sexual Dynamics
- Social Functioning
- Assessment of Unique Characteristics

(Pflugradt & Cortoni, 2014)

40

Cognitive Processes

41

Cognitive Distortions

Research on male sexual offenders has frequently addressed cognitive distortions related to sexual abuse perpetration and criminal thinking.

Significantly less research has addressed the thinking patterns of women who perpetrate sexual offenses.

42

Offense Supportive Cognitions

Gannon & Alleyne (2013) looked for offense supportive cognitions in women who perpetrate sexual offenses. They conducted a systematic review of research and identified 13 studies which examined offense supportive cognitions. The studies cam from the U.K (7 studies); U.S. (4 studies); Nordic Counties (1 Study); Netherlands (1 Study). Most participants were incarcerated or court referred.

43

Implicit Schemas/Beliefs Supporting Child Sexual Abuse

Generally supported

- Uncontrollable
- Antisocial attitudes
- Dangerous world (males are dangerous, contact with children is less threatening)
- Entitled (viewed men in co-abuse as entitled)
- Children as sexual beings (Caution-not generalized beyond victim)
- Nature of harm (abuse by men more harmful)
- Lack of accountability, blame
- **Lone abusers have more distorted cognitions than co-abusers

44

Sexuality Beliefs

Assess and capture the meaning and role of sex in the woman's life.

1. Does she has negative feelings about sexual relationships in general?
2. Does she experience a lack of fulfillment in her sexual relationships?
3. Are their cognitive distortions related to intimacy or power/control?

**It is important to assess how the woman's experience as a female has interacted with social, historical, and cultural factors to shape her beliefs and views of sexuality.

45

Cognitive Domain-Lack of Information

Women who perpetrate sexually abusive behaviors reported less clarity about sexual values, understanding physiological sexual responses, and sexual satisfaction.

Offenders showed less positive attitudes toward contraception use than non-offenders.

Offenders tended to lack information related to appropriate sexual norms/boundaries and at times healthy sexuality.

Offenders have more difficulties with perspective taking than non-offending controls.

46

Intimacy & Relationships

47

Intimacy & Relationships

- Intimacy Deficits
- Dysfunctional Relationships
- Partner Coercion & Dependency

48

Intimacy & Relationships

- Women are particularly vulnerable in this area and are often disenfranchised.
- How does this woman relate to the world and what do we need to do to improve her functioning?
- Women often have very limited social networks and supports.
- Histories often include patterns of relationships that were characterized by abuse.
- May have negative feelings and/or experiences about sexual encounters with adults (both male and female partners).

49

Intimacy & Relationships-What Do We Look For?

- History of short-term relationships
- Same age friends/family support
- Acquaintances (Antisocial peers/co-offenders)
- Isolated (Barriers to interactions)
- Abuses History

Lacking intimacy?
- Physical
- Emotional

50

Emotional Processes

51

Emotional Processes-What Do We Look For?

- MMPI or MCMI is helpful here
- Looking at overall mental health and well-being
- This is often relationship to intimacy/relationship issues
- Substance use/abuse
- Depression and or any other mental health dx
- Coping with body-image, self-esteem (see next slide)
- A big factor to assess is self-regulation & coping

52

Self-Esteem

- Seek poor quality partners and are content in unhealthy relationships
- Expect people not to like them
- Have poor relationships with others
- Experience frequent emotional distress
- Underestimate their abilities
- Expect to do poorly and fail
- Set lower goals for themselves

(Marshall, 1996)

53

Anxiety

Research has demonstrated that incarcerated women have anxiety related to institutional release. For all female offenders, their anxiety increased as they got closer to release. Younger offenders tended to have more anxiety than older offenders.

Demonstrates need for assessment and intervention to prepare for successful community re-entry and possibly also increase desistance to criminal activity.

(Pflugradt, Allen & Butler, accepted in The Prison Journal)

54

Sexual Dynamics

Deviant Sexual Interests
Sex as Coping
Healthy Sexuality Knowledge

55

Sexual Dynamics

56

Sexual Dynamics

Deviant Sexual Interests
Sex as Coping
Healthy Sexuality Knowledge

57

Sexual Dynamics

- Women's arousal patterns are different than males and are more fluid (Chivers et al., 2004).
- The role of paraphilic disorders in female sexual offending is unclear. DSM-5 does not quite fit for women. There is also no evidence to support a nexus between paraphilic disorders and re-offending.
- Paraphilic disorders do exist in women but their manifestation is different than in males
- Sexual arousal during the offending process itself is more related to emotional arousal and less to sexual preference and in some cases sexual arousal (Pflugradt & Allen, 2012).

58

Sexual Deviance

Most common paraphilic disorder in women is exhibitionistic disorder. Is this really most common or is it because it fits the DSM or social norms?

Be careful about applying Pedophilic Disorder to women based on crimes alone. Even if she meets DSM criteria, it is truly the disorder or a way to meet other needs? Remember research on female sexual fluidity.

59

Sexual Sadism

Although rare, research exists that looks at sexual sadism in women.

A study looked at incarcerated women diagnosed with Sexual Sadism Disorder. These women were generally young (21-33 years), mostly Caucasian, had 10.8 years of education, and tended to offend with a co-offender (male & female)

They assaulted the victim(s) over the course of days, weeks, or even years. Assaults included both physical and psychological torture that occurred within the guise of nurturing. Cognitive distortions from the offenders included: Victim deserved it; denial; and concrete thinking.

60

Sexual Sadism

- Some of the sexual arousal appeared vicarious (i.e., the female perpetrators' arousal resonated off the arousal of the co-offenders).
- Victims were chosen for their psychological vulnerabilities rather than physical weakness.
- Perpetrators created emotional dependence in their victims.
- Control was more sexually arousing to the subjects than inflicting pain.
- Control was a central theme which involved not only controlling the victim but also the co-offenders.

(Pflugradt & Allen, 2012; 2013)

61

Sexual Dynamics

In addition to deviant arousal, you also must assess:

- Knowledge of sexuality in general
  - Are they able to recognize their own sexual needs?
  - Do they know how to meet those needs in a healthy manner?
  - Do they understand needs for intimacy and sexuality and how those differ?
  - Do they have the basic sexual education and understand how the female body works (reproduction, etc.).

62

Social Functioning

63

Social Functioning

*Women do not function well in isolation. Sexual offending is often an unhealthy way to meet needs for social interaction.

*Being part of a community and socially integrated aids in desistence from criminal activity.

*By assessing this category, the clinician is able to obtain an understanding of who the client is and how she interacts and fits in with the world.

64

Social Functioning

Assess

•Social Support/Influences

•Social Difficulties/Isolation

65

Social Functioning

•Female offenders usually require much more social support than male offenders

•Female offenders cope better with adversity and stress when support is available

•Female offenders have the need for healthy connections to others.

66

Social Functioning

- How well does she relate to other adults?
- Role as caregiver?
- Is she able to generally function in day to day life or does she need assistance?

Generally socially appropriate?

Mature? Childlike? Understand Boundaries? Experience with healthy relationships? Desires adult interaction (Related to lack of resources)?

67

Personal/Unique Characteristics

68

Unique Characteristics

- Lack of resources/isolation
- Low educational attainment leads to fewer job opportunities
- Still expected to parent despite difficulties (or want to parent and not allowed)
- Trauma (Levenson et al., 2015; Pflugradt et al., 2018)
- Substance Abuse History
- Homelessness & Food insecurity

69

Responsivity Factors

70

Responsivity Factors

Evaluators also need to assess responsivity factors in order to understand how to best meet a woman's needs.

71

Responsivity Factors

- Assess intellectual and academic functioning (esp. reading comprehension)
- Language barriers
- Hearing impaired
- Unstable psychological or psychiatric status
- Learning or Intellectual disability
- Attentional Deficits
- Evidence of serious social skill impairment due to developmental or psychological concern
- Neurocognitive disorder
- Other condition(s) that may affect treatment responsivity

72

Strengths that May Assist with Desistance from Criminal Behavior

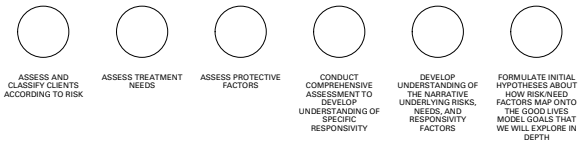
There are protective factors listed in the literature for general female offending. No protective factors have been directly identified for female sexual offenders.

Protective Factors for General Female Offenders:

Educational Assets, Relationship Support, Parental Involvement, Family Support, Relationship Satisfaction, and Self-Efficacy

73

Putting It All Together



74

Treatment

Women who perpetrate sexual offenses are generally a low risk/high need population

So why should we provide treatment if they are low risk?

- Overall impact on the community.
- Potential for general recidivism is higher.
- Overall well being of person
- Stigma of person who commit sexual offenses?

75

Treatment

- As proposed by the presenters in various other forums, the most comprehensive and integrated treatment model for women who commit sexual offenses includes a gendered, strength-based approach that also considers social and contextual dynamics.
- We will briefly talk about the theoretical tenets of a Good Lives Model Program (primarily community based tx for women) and then discuss another approach for use with incarcerated/institutionalized women.

76

Treatment

- Treatment programs for women who perpetrate sexual crimes look very very different than programs designed for males.
- Very little focus on sex offense specific behaviors (makes some providers uncomfortable)
- Shorter duration
- Do not place female sexual offenders in mixed gender treatment groups
- Female perpetrators necessitate a strengths based approach
- Treatment provider/client relationship important

77

Treatment Provider Characteristics

Given the highly contextual and relational nature of female offending, it is hypothesized that clinician characteristics will directly relate to treatment outcome.

Clinicians providing treatment to women should display warmth, empathy, and be non-judgmental. The should also model pro-social behavior as well as display genuineness.

Many women have had negative experiences with men. We have found that by having male and female co-facilitators, a new experience with males can be provided within a safe context.

78

Treatment Provider Characteristics that Inhibit Effectiveness

- Confrontational
- Sarcastic/Rejecting/Not Genuine
- Angry/Aggressive and/or Dismissive
- Discomfort with Silence
- Problems with Boundaries

79

Strength Based Gendered Treatment

The following information comes from these two papers and our clinical experience with women who have committed sexual offenses:

Pflugradt, D.M., & Allen, B.P. (2019). The application of the good lives model to women who commit sexual offenses. *Current Psychiatry Reports, 21*, 119.

Pflugradt, D.M., Allen, B.P., & Marshall, W.L. (2018). A gendered strength-based treatment model for female sexual offenders. *Aggression and Violent Behavior*, 40, 12-18.

80

Strength Based Gendered Treatment Model

Sexual offending for women is an inappropriate way to meet needs.

Treatment should focus on identified clinical needs to improve overall functioning and well-being.

It should also address:

- Reducing or eliminating antisocial attitudes and behaviors while increasing prosocial skills.
- Empowering clients to overcome past traumas and socio-cultural barriers to rehabilitation
- Building and enhancing coping skills and abilities
- Developing relational strengths (healthy relationships, healthy sexuality, interpersonal effectiveness)
- Increasing social supports

81

Strength Based Gendered Treatment Model

Evolving research seems to suggest, for most female offenders, the ability to remain emotionally regulated and to socially connect (in a healthy appropriate manner) with others may be the most important treatment goals.

(Russeau, Pflugradt, & Allen, unpublished dissertation)

82

Good Lives

A basic description of the Good Lives Model (GLM) is that it is "…a strength based approach by virtue of its responsiveness to offenders' core aspirations and interests and its aim of providing them with the internal and external resources to live rewarding and offence-free lives" (Ward, 2010).

Additionally, the GLM differs from other treatment approaches because its central focus is building upon client strengths instead of addressing deficits.

83

Good Lives

The application is comprised of three sets of basic assumptions:

1. All persons strive to meet or acquire primary or basic goods (e.g., health, knowledge, work, happiness). The importance that individuals assign to their specific basic goods reflect their life values and life priorities. Their behaviors are the means to achieve/acquire their desired goods.
2. The second set of assumptions is that all persons organize or, in a sense, create their lives around core values and follow some type of good life plan.
3. It also assumes that the first two assumptions can be applied to direct or inform the treatment of offenders. (Willis et al., 2013)

84

Gendered Supervision

Based on RNR Principles

Individualized

Supervision plan based on criminogenic need and protective factors

85

Conclusions

Current research on female sexual offenders indicates that the content of treatment programs should include RNR within a strength-based, good lives model which includes specific treatment methods (e.g., cognitive-behavioral therapy).

Due to the diverse needs of women who commit sexual offenses, the most efficacious treatment approaches include several different modalities as part of a comprehensive, individualized program.

The Good Lives Model (GLM) and discussed institutional programming both provide a comprehensive conceptual framework to integrate these key or primary elements of gendered-strength based treatment that includes specific treatment needs as well as relevant biological and ecological factors.

86

Conclusions Continued

They also provide the necessary flexibility to address contextual and individually specific factors by facilitating a gendered, strength-based process of self-discovery and personal fulfillment, that is, the pursuit of a good life, free from criminal behavior.

87

Questions/Comments?

88

Thank You!

Dawn Pflugradt
dawnm.Pflugradt@Wisconsin.gov or
dawnb71@hotmial.com

Brad Allen
bradp4508@aol.com

89