

Female sex offenders: A literature review

Compared with men, very few women are convicted of sex offences (except those connected to prostitution) and a substantial proportion of those convicted are convicted as the accomplices of men. Just 2% to 5% of all sex offenders are women.⁽²⁾

Female sex offenders have commonly been physically and/or sexually abused as children. They are most likely to be young, of low socio-economic status, poorly educated, have few social supports, and be "willing to do anything to belong."⁽³⁾

Female sex offenders are less likely than male sex offenders to be predatory or to use violence. Few use force, and those who do use less than their male counterparts.

Female sex offenders are less likely than male sex offenders to deny what they have done and tend to take responsibility earlier. They are also more angry at themselves, and are much more likely to engage in self-destructive behaviour.⁽⁴⁾

Finally, female sex offenders usually victimize female children they know - male victims, and female infant and adult victims are rare.⁽⁵⁾

This article reviews the current literature on female sex offenders. The above information provides a snapshot of the basic overall characteristics of these offenders. The remainder of the article will examine the characteristics of, and potential treatment responses to, various types of female sex offenders. Theory There is no coherent theory of female sexual offending, probably because female sex offenders are so rarely studied. There is, however, a consensus that male models do not apply to female sex offenders. Treatment focused on deviant sexual preferences, reducing denial and minimization, and relapse prevention are generally viewed as less relevant than an exploration of the woman's past.⁽⁶⁾

Most female sex offender treatment uses a victimization model and emphasizes the relationship between the offender's own sexual and physical abuse experiences and her abusive behaviour.

The goal is to ultimately reduce recidivism by allowing the offender to express her feelings about her victimization and to develop healthier ways to cope with its negative effects. Relapse prevention components alone are not considered enough.

One exception to this view is a Missouri Department of Corrections program that focuses on the offence rather than personal victimization. The program does acknowledge that female sex offenders have often been abused as children and/or adults, but does not consider problems associated with childhood abuse to be a primary treatment need.⁽⁷⁾

Virtually all female sex offender treatment programs combine elements of both approaches.

For example, a Minnesota program uses group therapy relapse prevention goals similar to those used with male sex offenders. However, treatment providers also emphasize the importance of the offender's

own history of abuse, and address related treatment issues such as reducing shame and self-loathing.⁽⁸⁾

Programs vary in the emphasis they place on each component, but a personal victimization focus is most common. Unfortunately, there are no available data on the relative effectiveness of these approaches or their combination. Typologies Few North American institutional or community female sex offender programs use standardized assessments, so the only typological schemes have emerged from unstructured clinical observation. This makes it difficult to compare women across different programs. The typologies that do exist are based on small samples of mostly adjudicated adults. Teacher/lover sex offenders Teacher/lovers initiate the sexual abuse of an adolescent (usually male) from a position of power obtained through either age or status as mother, aunt or guardian. These offenders are not likely to have been sexually abused as children, but have often experienced extra-familial sexual abuse and substance abuse as adolescents.⁽⁹⁾

Few teacher/lovers can be found in federal offender populations, probably because they are rarely reported by their male victims and, if reported, usually receive short sentences.

Although teacher/lovers are often unaware that their behaviour is inappropriate, they can be treated relatively easily by targeting cognitive problems and increasing victim empathy, self-confidence, and social skills and support.⁽¹⁰⁾

Supervision of teacher/lover sex offenders is less critical because of their low risk of recidivism. However, if substance abuse is identified as a criminogenic factor, their abstinence or controlled use must be monitored. Communication with child protection agencies is also recommended, as any recidivism may be responded to by community, rather than correctional, agencies. Male-coerced sex offenders Male-coerced sex offenders are induced or forced into sexual abuse, usually of their daughters. They usually resist at first, but eventually become passive partners in the abuse as a result of physical punishment or intimidation. These sex offenders tend to be of low intelligence, underassertive, dependent on men, desperate to maintain a relationship, and willing to participate and even initiate sexual relationships to please a male partner.

This group of female sex offenders is very heterogeneous. At one end of the continuum are women who committed sex offences only as a result of coercion by a male partner, have worked to repair the relationship with their victim, express remorse, and have ended their relationship with their co-accused. These women probably need only community-based supportive counselling. At the other end of the continuum are women with criminal sentiments who blame their child victim and support their co-accused. These women obviously require more intense treatment before community release.

At both extremes of the continuum, these women need help in developing independence from their abusive male partner. They also need to develop empathy for their child victim, who is often angrily perceived as the focus of attention and responsible for the abuse.

One treatment approach is to provide cognitive-behavioural therapy in a group setting.⁽¹¹⁾ This approach attempts to reduce denial and minimization through peer confrontation. Once an offender has taken responsibility for her offences (official and nonofficial), she must discuss how she chooses and grooms

her victims, and forces compliance. Once this has been accomplished, personal victimization can be discussed in therapy.

Within this approach, women who raise victimization experiences early in therapy are redirected - their abuse is validated, but they are challenged to work on their offending. This contrasts with other programs⁽¹²⁾ where accepting responsibility is the final therapy step.

Supervision is extremely important with these sex offenders because any contact with abusive males places them at risk. When the victim is a daughter, she may choose to return to the offender's guardianship. However, in such a case, it is important to maintain contact with the victim (or her therapist) to supervise the offender. Should co-accused offenders choose to continue their relationship, then all children must be removed from the homes of both offenders. Predisposed sex offenders Predisposed female sex offenders usually victimize their own children, without male accomplices. These offenders have often been extremely abused by family members, acquaintances and/or strangers throughout their lives. Although they do tend to extricate themselves from their abusive family, they then tend to become involved with abusive male partners. Most of these women believe that abuse is the price of acceptance and human contact.⁽¹³⁾

These women sometimes reveal sadistic fantasies triggered by anger, as well as concern about their ability to control the urge to act on these thoughts. They are frequently self-injurious and chronically suicidal, and their offences are more likely to be violent or bizarre, and to involve children younger than six. Typical offences involve oral sex upon, and/or penetration of, a young daughter - usually carried out in anger and often causing pain. These offenders also frequently neglect and physically abuse their victims.⁽¹⁴⁾

Predisposed sex offenders are difficult to treat because of the extent of their emotional problems. It is considered important to eliminate their deviant sexual fantasies and to treat the repercussions of their childhood abuse, which often manifests itself as anxiety or dissociative disorders.⁽¹⁵⁾

It is important to ensure that these offenders have absolutely no contact with children or other potential victims, such as adult female lovers. Apart from this, supervision largely depends on the offender's willingness to self-report deviant fantasies. If dissociation is diagnosed, then it is also important to monitor this symptomatology (such as headaches or short-term amnesia). Mentally disordered sex offenders It is difficult to group female sex offenders by their mental health problems because of the variety of assessment procedures and criteria across studies. Some researchers have, however, found a higher incidence of schizophrenia and developmental delay among female sex offenders than among male sex offenders.⁽¹⁶⁾ It is clear that a small minority of teacher/lover and male-coerced sex offenders are developmentally delayed.

Sex offenders of borderline intelligence are usually found in the criminal justice system. These women need education and basic skills training. They should be released to a well-structured environment with practical and emotional support. Supervision is needed to monitor compliance with non-association and substance use conditions.

It is likely that many predisposed sex offenders would meet the criteria for personality disorder and, under extreme stress, may experience what appear to be brief psychotic episodes.⁽¹⁷⁾ However, few female sex offenders suffer from schizophrenia, bipolar affective disorder or hypomania.⁽¹⁸⁾ Further, those who are psychotic at the time of their offence are usually diverted to the health system, keeping the number of psychotic female sex offenders in correctional systems low.

Offenders suffering from mental disorders often require medication, support and education about their sexual behaviour. Supervision should include monitoring medication use and any required non-association with potential victims. Discussion From a correctional perspective, the greatest weakness of the female sex offender literature is the lack of attention paid to matching offender characteristics to level of risk and supervision needs. The treatment and supervision of female sex offenders depends on their personal characteristics, the nature of their sexual offending and their unique release plans. Effective treatment depends, therefore, on the accuracy of the match between the chosen intervention and the specific needs of the offender.

It is important not to overlook issues such as substance abuse, dissociation, self-injury and inappropriate sexual attitudes that may arise from victimization experiences. The treatment of sexual abuse survivors incarcerated for a sex offence(s) requires specialized knowledge and should not be undertaken without proper training and supervision.

(1)40 Sir John A. Macdonald Boulevard, P.O. Box 515, Kingston, Ontario K7L 4W7. Please note that assessment guidelines are available in J. Atkinson, *The Assessment of Female Sex Offenders* (Kingston: Correctional Service of Canada, 1995).

(2)A. O'Connor, "Female sex offenders," *British Journal of Psychiatry*, 150 (1987): 615-620. See also A. N. Groth, *Men Who Rape* (New York: Plenum, 1979). And see L. Song, R. Lieb and S. Donnelly, *Female Sex Offenders in Washington State* (Washington: Washington State Institute for Public Policy, 1993). And see L. M. McCarty, "Mother-child incest: Characteristics of the offender," *Child Welfare*, 65 (1986): 447-458. And see G. E. Davis and H. Leitenberg, "Adolescent sex offenders," *Psychological Bulletin*, 101, 3 (1987): 417-427.

(3)J. K. Matthews, "Working with female sexual abusers," *Female Sexual Abuse of Children*, Michele Elliot, Ed. (London: Longman Group, 1993): 57-73. See also K. C. Faller, "Characteristics of a clinical sample of sexually abused children: How boy and girl victims differ," *Child Abuse & Neglect*, 13 (1987): 281-291. And see F. A. Wolfe, *Twelve Female Sex Offenders*, Presentation to Next Steps in Research on the Assessment and Treatment of Sexually Aggressive Persons (Paraphiliacs), St. Louis, 1985. And see McCarty, "Mother-child incest: Characteristics of the offender." And see R. Mathews, J. K. Matthews and K. Speltz, *Female Sexual Offenders: An Exploratory Study* (Orwell: The Safer Society Press, 1987).

(4)J. Marvasti, "Incestuous mothers," *American Journal of Forensic Psychiatry*, 7 (1986): 63-69. See also Matthews, "Working with female sexual abusers." And see R. Mathews, *Preliminary Typology of Female Sex Offenders* (Minnesota: PHASE and Genesis II for Women, 1987). And see R. L. Johnson and D. Schrier, "Past sexual victimization by females of male patients in an adolescent medicine clinic population," *American Journal of Psychiatry*, 144, 5 (1987): 650-652. And see Wolfe, *Twelve Female Sex Offenders*. And see Mathews, Matthews and Speltz, *Female Sexual Offenders: An Exploratory Study*.

And see M. E. Brown, L. A. Hull and S. K. Panesis, *Women Who Rape* (Boston: Massachusetts Trial Court, 1984).

(5) Mathews, Matthews and Speltz, *Female Sexual Offenders: An Exploratory Study*. And see Brown, Hull and Panesis, *Women Who Rape*. And see Faller, "Characteristics of a clinical sample of sexually abused children: How boy and girl victims differ." And see F. H. Knopp and L. B. Lackey, *Female Sexual Abusers: A Summary of Data from 44 Treatment Providers* (Orwell: Safer Society Press, 1987).

(6) Matthews, "Working with female sexual abusers." See also N. R. Lawson and S. R. Maison, "Psychosexual treatment program for women sex offenders in a prison setting," *Acta Sexologica*, 1, 1 (1995): 81-113.

(7) M. Clark, Personal communication, 1995.

(8) Genesis II program, J. K. Matthews, Personal communication, 1995. See also R. Mathews, *Female Sexual Offenders: Treatment and Legal Issues* (Orwell: The Safer Society Press, 1987).

(9) Matthews, "Working with female sexual abusers." See also Wolfe, *Twelve Female Sex Offenders*. And see Mathews, Matthews and Speltz, *Female Sexual Offenders: An Exploratory Study*.

(10) J. K. Matthews, Personal communication, 1995. See also Larson and Maison, "Psychosexual treatment program for women sex offenders in a prison setting."

(11) M. Clark, Personal communication, 1995.

(12) Larson and Maison, "Psychosexual treatment program for women sex offenders in a prison setting." See also Mathews, Matthews and Speltz, *Female Sexual Offenders: An Exploratory Study*.

(13) Mathews, Matthews and Speltz, *Female Sexual Offenders: An Exploratory Study*.

(14) Mathews, *Preliminary Typology of Female Sex Offenders*. See also Mathews, Matthews and Speltz, *Female Sexual Offenders: An Exploratory Study*.

(15) Matthews, "Working with female sexual abusers." See also Larson and Maison, "Psychosexual treatment program for women sex offenders in a prison setting."

(16) J. F. Harper, "Incestuous families: A comparative study of prepubertal male and female victims," *Australian Journal of Marriage and Family*, 14 (1993): 81-87. See also Mathews, *Preliminary Typology of Female Sex Offenders*.

(17) S. Travin, K. Cullen and B. Protter, "Female sex offenders: Severe victims and victimizers," *Journal of Forensic Sciences*, 35, 1 (1990): 140-150.

(18) Faller, "Characteristics of a clinical sample of sexually abused children: How boy and girl victims differ." See also Travin, Cullen and Protter, "Female sex offenders: Severe victims and victimizers."