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Diversified forms of therapeutic and social rehabilitation actions applied to male and female perpetrators of sexual abuse against children

Abstract: The aim of this study was to present the specific risk factors that differentiate the male and female perpetrators of child sexual abuse, and to discuss the therapeutic effects applied to women and men who perform such acts. In particular, the conditions of application of the two therapeutic models MBT and FBT as well as the gender blind and gender bias therapy are highlighted.

The differences in both the risk factors and the specifics of acting of male and female perpetrators of sexual abuse justify the need for different therapeutic and social rehabilitation treatment of both categories. Traditional and stereotypical treatment of women involved in sexual violence as victims and subjecting them to therapies for victims is in many cases not justified, nor is the application of standard solutions typically used against male perpetrators. The actions taken towards female perpetrators require taking into account not only the specificity of their life situation, their social roles but also the complex consequences of the process of primary and secondary victimization. The actions taken against male and female perpetrators of such acts, both in isolation and outpatient settings, should not be profiled in terms of the stereotypical perception of a woman and a man entangled in sexual violence. It is therefore necessary to go beyond this stereotypical pattern and to use non-standard solutions.

Keywords: Child sexual abuse, clinical profile, risk factors, therapy, social rehabilitation.

Introduction

The issue of violence, and sexual violence in particular, can be considered on several levels. The first of these is the diagnostic level within which findings are made about the specificity of behavior related to sexual violence or factors predisposing to the role of both perpetrator and victim. In this area the crime as well as victimization thread is clearly outlined, emphasizing the possibility of copying violent experiences in subsequent episodes of life. The second research level includes the search for therapeutic solutions addressed both to the perpetrators (and in this case therapeutic actions may be associated with social rehabilitation actions) and to the victims. Regardless of the adopted perspective on the analysis of the phenomenon, it is worthwhile to refer to the gender criterion as a factor differentiating both etiological, phenomenological and, finally, therapeutic and rehabilitation aspects, although some authors (e.g. Finkelhor, Hotaling, Lewis, Smiths, 1990) consider the issue of the perpetrator's gender to be secondary, as the most important is the fact of sexual contact between the perpetrator and the child or the age difference between the perpetrator and the victim (cf. Condy, Timpler, Brown, Veaco 1987).

In many scientific studies dealing with the issue of violence, a woman involved in this type of events used to be and still is seen as a victim rather than the initiator. In particular, when the deliberations are transferred to the plane of sexual violence, a woman and a child are treated as victims of these experiences. The consequence of this approach is the widespread application of victim therapy to women and children.

When we are dealing with a woman acting as the perpetrator of sexual violence against a child, a clear cognitive dissonance appears. Woman, naturally acting as a caring nanny, becomes a sexual assailant, a sexual aggressor. The clash of these behaviors seems almost unlikely. However, numerous studies (including Gannon, Rose, 2009; Ford 2010; Denov, 2004) indicate that such events are not isolated. However, with regard to this type of female perpetrators, it is easier to accept the victim option (forced by the partner, under pressure to cooperate with the perpetrator). As a result, female perpetrators are more often treated and are usually subjected to therapy in the same way as victims of sexual violence. However, it cannot be ruled out that a significant number of female perpetrators act not under pressure, not as accomplices, but as independent initiators and perpetrators of sexual violence, guided by specific sexual preferences, specific traumas, personal experiences or personality disorders. In such a situation, the lack of a precise diagnosis of the phenomenon generally leads to a uniform perspective on the perception of sexual violence, which leads to an equally unified treatment of men and women who have committed sexual abuse against

children. Such an approach does not take into account the specificities of the male and female perpetrators' acting profiles, individualized risk factors and personal experience. The different attitudes of both genders towards therapists, the need to maintain a relationship with loved ones, and the perception of one's role in the relationship are not taken into account. Therefore, the use of a single therapeutic formula, without taking into account gender-specific needs, may not be an effective solution.

This study addresses this very problem. The study will aim to identify specific and differentiating risk factors for male and female perpetrators, their modus operandi, and to discuss the therapeutic effects applied to women and men who commit sexual violence against children. In particular, I would like to draw attention to the conditions of application of gender blind and gender bias therapies and MBT and FBT approaches in the therapy of the analyzed categories of perpetrators. Indication of differences both in terms of risk factors and specificity of action will allow to justify the need to use different forms of therapeutic and social rehabilitation interactions depending on the nature of the diagnosed problems occurring in the life situation of the perpetrators and taking into account the specificity of gender.

Risk factors associated with the actions of male and female perpetrators of sexual violence¹

Committing sexual abuse of a child leaves no doubt as to the need to take therapeutic and/or rehabilitation measures against the perpetrator. Basically, such actions are determined by the juridical category of "sexual offense", sometimes with a clinical indication suggesting its specific character (e.g. pedophilic act). Meanwhile, the adoption of such a general benchmark for the proper design of corrective actions raises a number of questions. Behind every act there is a perpetrator whose clinical profile may suggest the need for specific, individualized actions as standard unified procedures may prove ineffective. This problem is best reflected in the conditions for the application of the FBT and MBT approaches, which will be addressed later in the study. To properly address sex offenders, it is necessary to collect clinically relevant information in order to detect possible areas of problems, difficulties and disorders that will provide a reference base for the proposed impact strategies. It is equally important to estimate the current level of risk of criminal behaviors, which is important in deciding on preventive

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¹ A more detailed description of the risk factors relating to female perpetrators of sexual violence is provided in the article *Kobiety wykorzystujące seksualnie dzieci. Geneza i możliwości resocjalizacji* [Women who sexually abuse children. Genesis and possibilities of rehabilitation], "Resocjalizacja Polska" 4/2013

measures. Clinical diagnosis usually covers many areas that will be important for taking appropriate actions. As T. Ward (2000) points out, the findings usually concern factors directly related to the commission of sexual offenses: sexual preference disorders, distortions of thinking, empathy deficit, deficits of social skills and problem solving (Ward, Nathan, Drake, Lee, Pathé, 2000, p. 251). No less important for the development of an adequate impact strategy may be the gender-specific differences in the psychological profile of perpetrators of sexual violence.

According to Ward et al. (2000), most modern therapeutic programs based on a cognitive-behavioral strategy are based on the relationship between the diagnosed deficits, needs or problems of the perpetrator and the type of therapy undertaken. When a perpetrator is found to meet the criteria of a sex offender, he/she is referred to a treatment program focused on eliminating the problems diagnosed in him/her, directly related to his/her crime. On the other hand, it is not clear whether, when taking actions towards sex offenders, one should be guided primarily by their needs, problems and hypothetical risk factors, or rather act on the basis of a specific diagnostic strategy, which means categorizing the perpetrator as a sex offender of a specific type (or subtype, e.g. due to specific pedophile preferences), which is in fact based on a precise description of symptoms and revealed psychological problems rather than clinical ones (Ward, Nathan, Drake, Lee, Pathé, 2000, p. 252).

Many studies (cf. Denov, 2004) also highlight the significant differences in this respect between men and women who commit the same juridical kind of acts, namely sexual violence against children. These differences justify the use of different impact strategies against perpetrators of different genders.

One of the most characteristic features of the profile of female perpetrators of sexual violence are mental disorders and previous sexual victimization. They are much more common than in male perpetrators. According to M-M Rousseau and F. Cortoni (2010), about 1 in 10 convicted women had been under psychiatric care before going to prison, and 1 in 8 women revealed emotional disorders while in prison. Women who have committed sexual violence have been diagnosed with severe mental disorders, in particular mental illnesses, personality disorders, psychotic episodes and psychoses, problems resulting from the traumatic relationships in which these women functioned and the sexual violence they have experienced. As Rousseau and Cortoni (2010, p. 74) emphasize, the problem of determining the extent of mental disorders and illnesses in female perpetrators of sexual violence encounters many methodological problems. The issue of the “prevalence” of mental disorders in women who have committed sexual violence against children may be artificially exaggerated, as a significant fraction of female perpetrators are recruited from environments burdened with numerous manifestations of pathologies that may contribute to the appearance of various mental problems. Another factor, also interfering with the true image and

size of these disorders in female perpetrators may be the not entirely objective information from the subjects themselves. However, it cannot be ruled out that the over-exposure of possible mental disorders by female perpetrators may be a form of defense and explanation of their criminal behaviors with mental disorders and thus leading to a reduction of responsibility for the committed violence. Similar behaviors are also quite often observed among male aggressors (Gannon, Rose 2009). Another important factor to take into account when analyzing the psychological-personal profile of female perpetrators of sexual violence against children is the physical, mental and sexual victimization they experienced during their childhood or adolescence. J. Saradjian (1996) suggests that this problem affected between 50 and 80% of female perpetrators. This does not authorize an unambiguous statement that the problem of victimization does not affect male perpetrators or it does in only a small percentage. The nature of these experiences may turn out to be more significant. In the case of women, it is indicated that they have experienced particularly drastic, prolonged and cruel acts causing great suffering. The nature of these experiences influenced their psyche in a special way. Many women, who were subjected to sexual violence in childhood, exhibit symptoms of chronic trauma as well as cognitive, emotional and behavioral disorders that reveal in adult life (cf. Eldridge, Saradjian, 2000. p. 402-426). From the perspective of the analyzed acts, the differences in the diagnosis of sexual preferences, and pedophilia in particular, are very important. Although women who have committed sexual violence against children are generally not diagnosed with pedophilia, some researchers indicate that clinical observations may suggest the occurrence of certain symptoms of pedophilia without fixation on the child (cf. Nathan, Ward, 2001, after Ford, 2010). Although, compared with men, women are much less frequently diagnosed with pedophilia (especially fixation pedophilia), this obviously does not rule out the possibility of deviant sexual fantasies of pedophilic nature or sexual arousal induced by this matter in female perpetrators of sexual violence. The research by Natan and Ward (2002) shows that almost half of the women surveyed by them who have committed sexual violence (41.6% of the respondents) claimed that they were motivated to take such actions by a deviant sexual arousal associated with a child (Nathan, Ward as cited in. Ford, 2010). Therefore, it cannot be ruled out that also in women, sexual arousal caused by pedophilic content and the pursuit of sexual satisfaction may play an important role in the profile of their sexual behaviors (although, as one may think, much smaller than in men with clearly diagnosed pedophilia), so it is important to determine whether deviant sexual preferences will motivate violent behaviors against children. On the basis of research findings, Gannon et al. (2008) concluded that deviant sexual arousal is important in the case of women acting alone or women who abuse adolescents, i.e. those who choose victims according to their sexual preferences and perceive them as a substitute for a mature partner. However, in women acting under pressure from their partner,

deviant sexual arousal does not occur (Gannon et al. 2008). Research conducted on deviant sexual preferences in women may suggest that the emergence of sexual fantasies with pedophile content will be a significant motivating factor for deviant sexual behaviors and, as with male perpetrators, may be treated as a risk factor for sexual assault on children (Rousseau, Cortoni, 2010, p. 76). Nevertheless, the mere confirmation of deviant fantasies and sexual behaviors among women does not explain whether the nature of these paraphilic preferences among women is the same as in men. The claim that some women who have committed sexual violence against children reveal deviant sexual fantasies does not authorize to diagnose pedophilia or other deviant behaviors in them that may occur in men who commit similar acts. Despite the much smaller incidence of paraphilia in women, according to clinicians, these behaviors in female perpetrators of sexual abuse should not be underestimated, as this may help to establish etiological findings and to plan an appropriate strategy of therapeutic impacts (Rousseau, Cortoni, 2010, p. 77). As the problem of deviant sexual inclinations is significant in the male population of sex offenders and is clearly related to the acts committed, therapeutic impact strategies focus on solving these problems. Therefore, the application of the same forms of therapeutic impacts to men and women who commit sexual violence is not a good solution.

A very important point of reference in the therapeutic impacts on perpetrators of child sexual abuse is the shaping of a level of empathy towards the victims. However, there is little research on the level of empathy towards victims in women who have committed this type of act. It is indicated that both women and men may lack empathic feelings towards the victims. Fromuth and Conn, among others, stated that 2/3 of female perpetrators of child sexual abuse examined by them were convinced that the consequences of their actions for the victims would not be significant and only 1/3 considered that there were negative experiences for the victims (Fromuth, Conn, 1997). It is also worth noting that women who had originally perceived the victim as a sexual object and women whose sexual assault was motivated by a desire for retaliation, had a small sense of harm done to the victim and were convinced that the victim experienced positive feelings. In contrast, women who were forced by men to engage in this kind of behavior stated that they did not think about it or put aside negative thoughts about violent behaviors. It can be assumed that in this category of women more diverse empathy towards victims emerged (Ford, 2010, p. 106).

In this context, the issue of choosing the victim is also worth mentioning. Both men and women who sexually abuse children generally choose the victims to whom they have easy access for various reasons. Often the victims of sexual abuse by women are children who remained under their care. Thus, the perpetrators are usually mothers, carers, nannies, women related to the child, whose close relationships with the victim does not arouse surprise and are not treated as something unusual. For this reason, it is also more difficult to diagnose the existence of sexual abuse.

The multitude and complexity of risk factors that may be associated with committing sexual offenses against children confirms the need to seek effective therapeutic and rehabilitation solutions addressed to different categories of perpetrators – both gender-differentiated and situated in different clinical and even psychological categories.

MBT and FBT approach in the treatment of sex offenders

The choice of the right form of therapy should depend on a number of factors, among which clinical picture and gender should play a crucial role. However, many programs are based on a similar pattern of impacts and are aimed at cognitive restructuring, modifying sexual behaviors, developing empathy, interventions, shaping social skills, developing the ability to establish and maintain socially valuable contacts, controlling emotions and training to prevent relapses of criminal behaviors. Of course, there may be some modifications in the form of additional impact elements, but the scheme remains essentially unchanged (Ward, Nathan, Drake, Lee, Pathé, 2000, p. 252). Diagnostic errors may also be a problem in the individualization of impacts (apart from high costs). Constructing a case diagnosis requires a number of clinical assessments including identification of the perpetrator's (client's) problems, determination of the significance of each of them, diagnosis of the problems, the relationship between these problems and finally determination of their causes and possibilities for modification (Ward, Nathan, Drake, Lee, Pathé, 2000, p. 252). These difficulties, however, must not overshadow the fundamental objective that is a comprehensive understanding of the functioning of perpetrators through a thorough diagnosis of their needs and problems. It will be required in particular when the perpetrator experiences multiple problems, mainly related to victimization or relating to specific sexual preferences or personality profile, when there is a dissonance in therapeutic relationships or when standard interventions bring no effect (Ward, Nathan, Drake, Lee, Pathé, 2000, p. 252). In such cases, these specific characteristics and problems of the clients (e.g. related to pedophilia, psychoactive drug addition or aggression control problems) should become the focal point of the therapeutic impact.

Two approaches can be used in therapeutic and social rehabilitation practice: FBT (based on an individualized approach to the patient) and MBT (based on standard procedures). FBT is more flexible and therefore offers more possibilities to individualize the impacts and includes more possibilities of clinical references taking into account individual predispositions, patient preferences or his/her non-specific needs. MBT, on the other hand, is a more unified impact model and relies less on clinical assessments.

According to T. Ward, the use of the standard approach, i.e. MBT, has a number of advantages and is more common, however, in several cases the use

of the individualized approach (FBT) is indispensable – when we are dealing with a system of non-specific features of the perpetrator which require special treatment rather than standardized treatment, when other forms of impact used have failed and when there are specific indications of the need for a special, close therapeutic relationship (Ward, Nathan, Drake, Lee, Pathé, 2000). It can therefore be assumed that this approach may be more applicable to women. The FBT approach emphasizes that the effectiveness of the impact on sex offenders depends on identifying and understanding the sources of their problems and deficits. Thus, three stages of acting can be distinguished, including clinical diagnosis, determination of the genesis of the problems and deficits found and indication of interactions between mental mechanisms and manifestations of dysfunctional behavior and deviations of thinking. The clinical picture of the patient, including individual sexual problems, deficits and personality profile, established in the first phase becomes the subject of etiological investigations in the next phase. The probable genesis of the identified disorders and deficits is established by identifying the psychological mechanisms underlying these problems (e.g. the image of oneself and the world and the resulting behavior). It may be helpful in this respect to refer to the knowledge of psychopathology, as it helps to narrow the search for causal factors to the most reliable ones. The final stage is to link the causal mechanisms and consequences in the form of the perpetrator's behavior and to create a coherent concept explaining the complexity of a given patient's situation. Demonstrating individual cause-and-effect relationships allows not only to understand the essence of the patient's problems, but also to develop a formula of impacts to deal with his/her dysfunctions. Thus, individualized strategies of therapeutic impacts will be applied to different people. Even if the diagnosis indicates similar problems or even a similar cluster of difficulties in two different perpetrators, this does not necessarily mean that they were caused by similar mechanisms. It would therefore also not be justified to use the same forms of impact. Only such a therapy plan is applied to the perpetrators that can remove the specific problems diagnosed in him/her. Thus, if the perpetrator does not have dangerous deviant sexual preferences, which may be directly related to the commission of sexual offenses, then the therapeutic plan does not include interference in this sphere of behavior. Likewise, if the perpetrator is fully aware of the harm he/she has done to the victim, there is no need to include in the therapeutic plan actions aimed at raising the level of empathy (Ward, Nathan, Drake, Lee, Pathé, 2000, p. 253–254). This strategy also allows to individualize the relationship between the therapist and the perpetrator. If the offender participating in the therapy is extremely distrustful, the therapist can take more time to build a proper relationship and break through resistance or distrust.

The MBT model, on the other hand, can be treated as a standard therapy scheme. Treatment is time-consuming, structured and includes unified forms of

intervention. The individual intervention packages are generally consistent. In the MBT model, all participants in the therapy are subjected to the same procedures. Therapeutic groups consist of people who are diagnosed with similar problems or clusters of disorders (Ward, Nathan, Drake, Lee, Pathé, 2000, p. 255). Since similar impact schemes associated with their main problem (e.g. pedophilic tendencies) are applied to all individuals, there is no justification for making an accurate clinical diagnosis defining the genesis of these problems (cf. Wilson 1996, after Ward, Nathan, Drake, Lee, Pathé, 2000). However, MBT does not exclude the possibility of using different forms of interventional impacts tailored to the specific problems of the patient, but the main objective is to determine in which diagnostic category a person “falls”. This is done by describing the main problems and disorders occurring in the client, which is the basis of the diagnostic (classification) decision (Ward, Nathan, Drake, Lee, Pathé, 2000, p. 256). Therefore, the main difference between the MBT strategy and the above-described FBT is that when the MBT strategy is applied to each client classified in a particular diagnostic category, identical impact procedures or treatment programs are used, while the use of the FBT model suggests the need for tailor-made solutions for each client. The FBT approach in therapeutic programs takes into account not only the diagnosed deficits, but above all the relationships between psychological mechanisms and problems revealed by the client. Both these therapeutic models can be applied to clients with different problems, while from the point of view of the issues addressed, the most important are the possibilities of using these impacts against sex offenders. It is a specific category of people with whom therapeutic actions often do not bring the desired effect. The most common forms of cognitive behavioral therapy (CBT) are those that arouse a lot of controversy in the context of their effects. It cannot be denied, however, that compared to many different treatments used for this category of perpetrators, the effects of CBT therapy are quite promising, although it is difficult to clearly determine whether all actions used in typical cognitive behavioral therapy are necessary to achieve the desired effects. The basic “package” of impacts used in modern therapeutic strategies, not excluding CBT, psychodynamic or family therapy includes the development of empathy, cognitive restructuring, modification of deviant sexual preferences and behaviors, development of social skills, control of emotions, shaping relapse preventing skills (Marshall et al., 1998, as cited in Ward, Nathan, Drake, Lee, Pathé, 2000). Since there are many reasons to believe that the use of the indicated components together brings the desired changes in sex offenders closer to the desired ones, the “package” should therefore be treated as a correlated impact strategy in its entirety, rather than implementing only selected components of these impacts which therapists believe may be useful to the offender. As Ward et al. rightly note (2000), although it is not known whether all sex offenders need a full “package” of impacts, there are no convincing results

of research on the effectiveness of particular elements of impacts. It therefore seems unjustified to practice selective elements of therapy for this category of perpetrators. According to Ward et al. (2000), this argues in favor of applying the MBT model to the category of sex offenders, as it includes the described standard, structured elements of therapeutic impacts. If there are no clinical indications of specific causal mechanisms underlying the problems and deviant behavior of the perpetrator which should be treated in an individualized manner, the use of standard, cognitive behavioral therapeutic impact strategies may be the most justified and effective (cf. Ward, Nathan, Drake, Lee, Pathé, 2000).

To sum up, the characteristics of the MBT and FBT models presented above may suggest that the solutions contained in the MBT model are more effective towards male perpetrators of sexual offenses, as opposed to female perpetrators. Women who commit child sexual abuse are diagnosed, as shown in the previous section of the article, with a greater accumulation and variety of causal factors associated with their acts. In particular, their history of victimization is more dramatic and complex, and psychological and emotional disorders may occur with greater intensity, which may also be a distant result of victimization experiences. Therefore, for many female perpetrators of sexual violence against children, the standard procedures of the MBT model may not be effective. In this situation, it is advantageous to refer to individualized impacts, designed to neutralize the causal factors identified, i.e. the use of the FBT model.

Gender blind and gender bias therapy for male and female perpetrators

Taking into account the criterion of individualization or standardization of therapeutic procedures allowing to separate the model of MBT and FBT therapy is not the only solution allowing to take into account during therapy the differences between male and female perpetrators of sexual offenses. Taking into account the criterion of the gender of the person undergoing therapy, two main directions of impacts can be distinguished. The first one is the gender-biased direction which indicates the fundamental differences between the perpetrators of sexual abuse of both genders, which suggests the need to take different actions against women and men. In this respect, the therapeutic impacts on women focus on the process of earlier victimization and developed defense mechanisms that may be related to the subsequent perpetration of acts of violence against children. The second direction called gender-blind assumes that all perpetrators of sexual abuse, regardless of gender, require a similar therapeutic approach. The gender-biased direction, taking into account the complex system of causal factors differentiating the perpetrators of both sexes, is close to the FBT model as it assumes the individualization of therapeutic impacts. In this case, the gender specificity is the

key factor². Experience with social rehabilitation and therapeutic work aimed at women who sexually abuse children has been limited so far. However, it should be believed that such actions should be focused on the specifics of the life situation of female perpetrators. For these reasons, it is not clear which form of therapy – individual or group – will be most desirable for women. However, the range of problems diagnosed in female perpetrators suggests that, in contrast to the group therapy preferred to men, an individual approach is recommended for women who commit sexual violence. When organizing therapeutic groups, it should be taken into account that many women who commit sexual abuse find themselves in therapy with their own traumatic experiences of sexual violence, which have been perpetrated by men, while others are accomplices who had been induced to sexual abuse by their current partners. These circumstances call for the abandonment of the creation of mixed therapeutic groups as they may lead to the danger of perpetuating a tendency to reproduce violent relationships (Ashfeld, Brotherstone, Eldridge, 2010, p.164). The same circumstances should be taken into account when choosing a therapist. Violent experiences which appear in the victimization history of perpetrators suggest that in case of female perpetrators, it will be more desirable if therapy is conducted by women. According to Briere (1996), for some women who have been sexually abused by men (e.g. fathers, partners), emotional exposure by revealing these facts to a male therapist overwhelms them and embarrasses them by intensifying the process of re-victimization. Similar caution is also desirable in the selection of the therapist for those women who have been abused by women. Due care should be taken when trying to establish a proper relationship with a male/female therapist. The therapeutic experience described by Ashfeld (2010) shows that female perpetrators are particularly sensitive to seeing seemingly insignificant things like being late for a therapeutic session or last-minute changes to an appointment, which they read as indicators of rejection or disregard. Such behavior may also confirm the perpetrators' personal experiences of rejection, disregard and violence and perpetuate reduced self-assessment. It is therefore an important indication for therapists who want to create the right relationships with female perpetrators that it is important to pay close attention to the way specific information is communicated, even if it concerns the most routine behaviors.

Therapy focused on the perpetrator's gender does not clearly define its type. As indicated earlier, the use of cognitive behavioral therapy can be justified by

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² The exact characteristics of the program implemented by the LFF, which is part of the gender bias trend, are presented in the article *Inspiracje dla oddziaływań resocjalizacyjno-terapeutycznych adresowanych do kobiet wykorzystujących seksualnie dzieci* [Inspirations for social rehabilitation and therapeutic impacts addressed to women who sexually abuse children], in: K. Marzec-Holka, K. Mirosław-Nawrocka, J. Mołęda (ed.), *Współczesne uwarunkowania i wzory procesów resocjalizacji, reintegracji, inkluzji* [Contemporary conditions and patterns of processes of social rehabilitation, reintegration, inclusion], Published by Akademii Pedagogiki Specjalnej, Warszawa 2014.

its proven effectiveness in particular in suppressing adverse behaviors, controlling progress and using enhancements that allow to perpetuate appropriate behaviors and encourage further efforts. However, taking into account the fact that many of the female perpetrators are mothers, other forms of therapy such as family therapy or psychodynamic therapy are also possible when strongly blocked emotions are related to the process of victimization which started already in childhood.

Referring to experiences with therapy for men who have committed sexual violence against children, Ashfeld, Brotherstone, Eldridge (2010) have formulated the most important indications that are particularly applicable in the treatment of women who commit similar acts. One of the basic indications related to the course of therapeutic impacts is to acquire the ability to create and maintain appropriate relationships. Understanding the essence of the relationship is facilitated by Miller's concept, according to which men are primarily oriented towards maintaining their autonomy and independence, which are the basic mechanisms of their development, while for women these factors play a much less important role, because, according to the author, creating relationships with others becomes a priority. Miller suggests that for women, mutual, empathic relationships are particularly needed to achieve mental balance and development (Miller, 1996 as cited in Ashfeld, Brotherstone, Eldridge (2010). Disturbed relations in which female perpetrators had functioned (this is particularly noticeable in female accomplices) are very often the result of the process of victimization, which often started already in childhood. However, in adulthood, the perpetrators usually functioned in unsatisfactory relationships, often with a male accomplice of violence. This set of unfavorable factors quite clearly differentiates the situation of female perpetrators and their male counterparts. This also suggests that therapy and social rehabilitation of women who have sexually abused children is more difficult than that of men. The development of interpersonal skills will play an important role in therapeutic impacts. In the course of therapy, emphasis should be placed on the female perpetrators' creation of proper relationships that do not duplicate their experiences of neglect, abandonment and violence. The first step in therapy will therefore be to learn how to build correct relationships with therapists, relatives and children (Ashfeld, Brotherstone, Eldridge, 2010). It is precisely the relationships with one's own children that is another factor that significantly differentiates female and male perpetrators of sexual abuse. Having children and caring for other children can play a significant role in the choice of a particular therapy – whether or not gender-specific. Indeed, some women are seen only as victims and, despite their experience of sexual abuse, are wrongly perceived as not posing any risk related to harming a child. In this case, they undergo the same treatment as is provided for victims of sexual violence. In other cases, behaviors that exceed the tolerated limit of childcare are interpreted as a significant threat that completely excludes these women from having contact with their own children. For many women who are perpetrators of sexual abuse,

identification with the role of the mother, even if they have abused that role, is a turning point in their lives and gives them a new look at their lives. (Ashfeld., Brotherstone, Eldridge,2010). Therefore, including the ability to build the right relationship with the partner and children in the course of therapy can be a very important step in building a new life without violence. The traumatic experiences that started the process of victimization cause these women to lose control, which makes it difficult for them to set clear limits. The result is not only the consolidation of the role of the victim in subsequent episodes of life (e.g. in a relationship) but also unsuccessful attempts at therapeutic intervention due to a disturbed sense of internal and external security. For these reasons, an important element of therapy is to set clear limits at the beginning. Some of the limits set will specifically reflect the legal situation of female perpetrators of sexual violence and refer to the legal control of their actions. Other restrictions include, for example, confidentiality, or may be specific to the situation of the woman concerned (e.g. refraining from verbal and physical aggression).

Another consequence of the trauma associated with sexual abuse in childhood may be a feeling of low self-assessment and low self-esteem, and cause consolidation of inadequate defensive mechanisms. Sometimes in the behavior of female perpetrators, one can see symptoms indicating a strategy of denial or suppression developed by them. The denial or suppression mechanism allows women who have committed sexual violence against children to avoid, as they believe, comparisons with their oppressors (Eldridge and Saradjian 2000). As a result, these mechanisms are very difficult to eliminate. The development of constructive defensive strategies to deal with emotions can be based on the development of a dictionary of terms describing the different emotional states experienced by female perpetrators. For many women, simple techniques such as recognizing physical heralds of various emotions (e.g. anger) associated with exercises on how to control these behaviors help them to become convinced that they are able to control emotions that were originally perceived as getting out of control (Ashfeld, Brotherstone, Eldridge, 2010). Such actions can also be helpful in therapy aimed at male perpetrators.

In cognitive behavioral therapy, it is very important to recognize and maintain the progress that is being made in the behavior of the perpetrator, as this is an important incentive for further efforts. Experience of working with female sex offenders indicates that progress is usually seen later than with men. Since group therapy is preferred for men, while for women it is more common to use individual impacts, it is difficult to assess whether and to what extent gender can influence progress in changing the behaviors of male and female perpetrators. The small steps strategy can lead to discouragement, especially in the case of long-term treatment of women. An important element is the so called homework done by women, the aim of which is to consolidate the skills acquired during the therapy. When women accept the goals they are set, the motivation to achieve

them increases significantly (Ashfeld, Brotherstone, Eldridge, 2010). Special requirements are also placed on therapists who work with female perpetrators of sexual violence. In particular, the ability to adapt easily, which can be of great importance for improving the quality of therapeutic relationships, should be appreciated. It is primarily about the ability to adapt the therapist's style of work not only to the expectations of different clients, but also to the diverse and individualized problems they present and the changes that take place in them at different stages of therapy (Ashfeld, Brotherstone, Eldridge 2010, p. 176).

Given that many of the female perpetrators involved in therapy bring complex life and violence problems, it is important that the therapist has the knowledge and ability to identify and establish appropriate solutions for the individual perpetrators (Ashfeld, Brotherstone, Eldridge, 2010). In this case, the requirements are higher than for male perpetrators because often the current needs of female perpetrators are shaped to a large extent by the external influences of the family and the partnerships which excessively affect the woman's behavior.

Final thoughts

The aim of this study was to demonstrate some of the characteristics differentiating male and female perpetrators of child sexual abuse. These differences are not only in the area of clinical and personality profile, but also in the area of therapeutic and social rehabilitation impacts.

The actions taken against male and female perpetrators of such acts, both in isolation and outpatient settings, are rather profiled in terms of the stereotypical perception of a woman and a man entangled in sexual violence. Going beyond this stereotypical pattern (e.g. an aggressive female perpetrator who sexually abuses a few years old child or a female perpetrator dominated by a man) usually (or exclusively) results in the application of unified solutions, i.e. referral to a therapeutic ward where an identical therapeutic program is carried out for women and men. More effectiveness could probably be expected by implementing an impact strategy with greater flexibility, adapted to both the sex of the perpetrator and his/her clinical profile. The projected impacts should also take into account the roles that are usually played by female perpetrators, in particular partnership and maternal roles, in order to prevent further victimization.

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