I, Mardi K Fallon, hereby submit this original work as part of the requirements for the degree of Doctor of Education in Counselor Education.

It is entitled: Treatment Providers' Perceptions of Treatment Effectiveness with Female Juvenile Sex Offenders

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with Female Juvenile Sex Offenders

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Abstract

This study investigated how treatment providers working with juvenile sexual offenders perceive treatment effectiveness of current treatment modalities for juvenile female sexual offenders. According to the Federal Bureau of Investigation statistics from 2008, juvenile offenders, particularly juvenile female sexual offenders, are rising in numbers (FBI, 2009). The majority of the research regarding juvenile sexual offenders has focused on adolescent males and little is known about whether treatment for juvenile offenders, generally without differentiation between genders, are working for female sexual offenders. The female juvenile sex offender is under identified, inadequately studied, and underserved. This study aimed at gaining information about treatment providers’ perceived effectiveness of common treatment modalities on juvenile female sex offenders.

Sixty-four helping professionals who work with sex offenders in the Midwest region participated in this study. The results indicated that, out of 55 treatment modalities for sex offenders, 23 treatment modalities were in the range of effective to mostly effective; 12 were in the range of somewhat effective to effective; and 12 were in the somewhat effective category; and 8 treatment modalities, all being in the Pharmacological Methods, were in the not effective to somewhat range. For the 35 treatment modalities in the range from somewhat effective to mostly effective, Communication Skills, Assertiveness Training, Psychodrama, Individual Counseling and EMDR were found to be perceived as more effective treatment modalities for juvenile female offenders compared to juvenile male offenders. Anger Management, Social Skills, Fantasy Work, Assault Cycle and Journaling were perceived to be effective for juvenile male offenders. However, 29 out of 55 treatment modalities (52.73%) were found to be perceived as equally effective to either female or male offenders. It is also found that none of the
treatment modalities in the category of Cognitive Behavioral or Behavioral were perceived to be more effective for female offenders.

While some treatment modalities were perceived as significantly different in treatment effectiveness when comparing juvenile females with juvenile males, more than half of the 55 treatment modalities were identified as being equal for both genders. The findings of this study might lend insights to helping professionals working with juvenile sex offenders to be mindful of differentiated treatment methods for juvenile female and male offenders. Future research is needed to clarify why some treatment modalities are equally effective for juvenile males and females, and the reasons for some treatment being more effective to either gender.
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Chapter 1 - Introduction

Problem Statement

Formal research regarding sexual offenders has increased over the past twenty years. Most of this research has focused on adult male offenders. While much has been discovered about male sexual offenders throughout this period, it is not clear how much can be generalized to apply to female sexual offenders. Understanding how female sexual offenders differ from male sexual offenders has important implications for how this population is managed, assessed and treated (Miller, et. al., 2009).

Juvenile female sexual offenders have been even less researched and understood than their male counterparts. According to the US Department of Justice (2009), juveniles commit more than one third of known sex offenses against minors. Juvenile female sexual offenders tend to be younger than male counterparts, tend to have more victims, co-offenders, and to have family members as victims. While juvenile female sexual offenders represent only 7% of juvenile sexual offenders, indicating that males comprise 93% of that group, they do commit a significant number of offenses across the United States and need to be fully understood (US Department of Justice, 2009).

Since the number of juvenile female sexual offenders has always been very low, courts, detention facilities and treatment programs have focused on male offenders and tailored interventions to the specific needs of this population instead of addressing the needs of juvenile female sexual offenders. The difficulties inherent in studying female sexual offenders, have potentially deterred some researchers from studying this population (Center for Sex Offender Management, 2007).
Research regarding female offenders has been hampered by research designs of many studies where female offenders were excluded from the study, or there was no distinction made between male and female offenders when gathering data. Some studies also included operational definitions of sexual behaviors that are specific to male behavior and not female behavior (such as penile penetration), which assumed that all of the offenders in a study were male. Other studies posed questions with assumptions that males were offenders and female were victims (Anderson, Struckman-Johnson, 1998; Hunter & Mathews, 1997).

While they are less common than male sexual offenders, female sexual offenders continue to commit crimes and need to be further understood. Since the current method of working with sexual offenders is to provide mental health treatment, understanding what methods of treatment work best with female sexual offenders would be helpful both in the treatment of female sexual offenders, in general, and potentially, in making a safer society. This study investigated how treatment providers perceive the effectiveness of treatment with juvenile female sexual offenders as compared with juvenile male sexual offenders in an effort to better understand the treatment needs of the juvenile female sexual offender.

**Purpose**

Since the juvenile female sexual offender is under-identified and studied, research needs to explore how treatment providers working with juvenile offenders view the treatment needs of female juvenile sexual offenders. This would add to the understanding of treatment of this population and identify treatment modalities that might be more effective when working with female juvenile offenders.
The purpose of this study was to increase knowledge about the treatment of female sexual offenders by researching how treatment providers view effectiveness of various treatment modalities for juvenile female sexual offenders. This study examined the perception of treatment providers regarding which of 55 treatment modalities, which are currently in use in the treatment of sex offenders, might be more or less effective with juvenile female offenders when compared with juvenile male offenders. The list of 55 treatment modalities was obtained from the study by Tuell (2003).

**Research Question and Hypothesis**

The main question that this study seeks to answer is: For each of a set of commonly used treatment modalities, do sex offender treatment providers perceive a difference in each modality’s effectiveness when male and female juvenile sex offenders are compared? If the research indicates that female sex offenders behave differently than male sex offenders, have different kinds of histories than male sex offenders, and have different motivation than male sex offenders, then it stands to reason that they have different treatment needs. If female sex offenders do have different treatment needs from male sex offenders, then what treatment modalities would be most effective for them?

The hypothesis for this study is that there will be a significant difference between sex offender treatment provider’s effectiveness ratings for each of a set of treatment modalities when male and female target recipients of the treatment are compared. In other words, it was expected that some of the 55 treatment modalities will be identified as being more effective for female juvenile sexual offenders than for males, while some treatment modalities will be identified as more effective for male juvenile offenders as opposed to female juvenile offenders. The null
hypothesis is that there will be no significant difference between sex offender treatment provider’s effectiveness ratings for each of a set of treatment modalities when male and female juvenile sex offender recipients of the treatment are compared.

Understanding the treatment needs and effectiveness of treatment modalities for the female sexual offender is a way to increase the likelihood that treatment interventions are more effective. If female sexual offenders can get more effective forms of treatment, then they are less likely to re-offend.

**Rationale and Background**

Despite the small numbers of juvenile female sexual offenders, there is a need to understand how to treat them and reduce recidivism. According to the FBI (2006), juvenile females committed 22 forcible rapes and 318 sexual offenses, compared to 949 forcible rapes and 4,162 sexual offenses by males of the same age in 2005. More recently, the US Department of Justice (2009) identified juvenile female sexual offenders as committing only 7% of juvenile sex crimes. There is also reason to suspect that female sexual offending is actually higher than reported because they are less often identified than male sexual offending.

In 1993, 10% of juvenile sex offenders from thirty states were female according to Lane and Lobanov-Rostovsky (1997). A more recent study of 2,123 juvenile sex offenders from 2001 to 2006 identified 5.6% of the offenders as female (Florida Department of Juvenile Justice, 2007).

The true number of juvenile female sexual offenders remains unknown. However, estimates have varied from 5% to 10% of juvenile sex offenders (Roe-Sepowitz & Krysik, 2008). If juvenile female sexual offenders can range from 5% to 10% of the overall population of
juvenile sexual offenders, then greater understanding of treatment effectiveness is necessary to better help this group of offenders. Better understanding of their needs might lead to better identification and treatment, which in turn, promotes decreased repeat offenses and a safer society.

Vandiver and Teske (2006) and Roe-Sepowitz and Krysik (2008), have indicated that juvenile female sexual offenders are different from their male counterparts. For one, they are often victims of sexual abuse themselves. They typically come from highly unstable and dysfunctional homes, have a co-occurring psychiatric disorder, tend to victimize small children that are known to them, and will sexually offend against both male and female victims. Juvenile female sex offenders tend to act alone and often target small children that they are caring for (Bumby & Bumby, 2004; Hunter, 2006; Robinson, 2006).

Understanding how female sexual offenders are different or the same as their male counterparts affects treatment and treatment effectiveness. More responsive and effective treatment would help juvenile female offenders to stop offending sexually and reduce recidivism (re-offense and returning to the Justice system). Currently, many sex offender treatment programs have been created to address juvenile male offenders and have not addressed how female offenders might be different or have different treatment needs (Mathews, et al., 1989; and Wood, et al., 2000). Since treatment effectiveness, itself, is not typically studied for female sexual offenders, this study sought to focus on how those who actually provide treatment to juvenile sexual offenders perceived the effectiveness of various treatment modalities for male and female juvenile sex offenders.
Chapter 2 - Review of the Literature

This chapter provides an overview of the current state of understanding and research regarding juvenile female sexual offenders. The following topics are reviewed and discussed: historical background, female sexual offenders and treatment.

Historical Background

Initially, research focused on adult male offenders then shifted focus to adult female offenders and juvenile male offenders. While the formal study of sexual offenders began approximately sixty years ago, the study of juvenile male sexual offenders has developed mostly over the past twenty years, with even less time spent on understanding female juvenile sexual offenders. Before serious focus was given to sexual offenses by male juveniles, it was thought that they were just being typical boys. The concept that female juveniles were also committing sexual offenses was unthinkable.

In the past, when the issue of juvenile sexual offending became a matter of note, male juvenile offenders were seen as experimenting and being a bit more aggressive due to lack of experience rather than any intention to offend. At the same time, female juvenile offenders were seen as either innocent or confused victims, themselves (Finklehor, et al.,1997; Ryan, et al., 1996).

Later, juvenile sexual offending was reinterpreted as a sign of social decay or poor parenting rather than a criminal offense or mental health issue. In the past, little was known or
understood about child/adolescent sexual development. This has been particularly true for female juvenile sexual offenders (Marshall et al., 1991).

Awareness of the extent of male juvenile sexual offending began to develop in the early 1990’s, when there were estimates that between 2% and 4% of juvenile males had committed a sexual offense (Ageton, 1993). Other studies from the same era estimated that as many as 20% of all rapes and between 30% to 50% of child molestation cases had been perpetrated by male juvenile offenders (Becker and Hunter, 1997). In a similar vein, studies with adult male sexual offenders found that as many as half of adult males reported engaging in sexual offenses when they were adolescents, suggesting that adolescent sexual offending is a precursor to adult sexual offending (Abel, et al., 1985). Once it became apparent that juvenile males were committing so many sexual offenses, professionals began to look more closely at female sexual offenders.

Female Sexual Offenders

Characteristics

Developing an understanding of the characteristics of female sexual offenders provides the opportunity to develop strategies to identify, manage and treat such offenders with the goal of avoiding or limiting any sexual offending behavior. Therefore, studies have been conducted to develop a fund of knowledge and understanding about this population. One factor that appeared to affect why some females become sexual offenders is early childhood abuse and exposure to abuse.

Friedrick, et al, (1997) found that children that had been sexually abused had significantly more sexual behaviors than peers without an abuse history and that they had significantly higher scores on the Child Sexual Behavior Inventory. Burton et al (1997) found
that parental history of abuse, chemical dependency and the relationships between parent and child were important factors in the understanding of juvenile offending behavior.

A common theme across studies of female sexual offenders is a history of abuse, particularly sexual abuse, as children. Depending on the study cited, between 46% and 100% of female sexual offenders have stated that they were sexually abused as children (Grayston and DeLuca, 1999; Kaufman et al., 1995). Male sexual offenders have had lower claims of a history of sexual abuse, with from 18% to 20% stating that they were molested as children (Kaufman et al., 1995; Rudin, Zalewski and Bodmer-Turner, 1995).

Not surprisingly, given that abuse is a factor in many sexual offenders’ histories, social/emotional reciprocity and empathy also have been identified as being under-developed or missing with many sexual offenders. Hudson and Ward (2000) found that social skills deficiencies were related to the development of sexually aggressive behavior. They suggested developing empathy for the victim and exploring issues of attachment and intimacy as important to treatment. The connection to social and attachment issues was also explored by Chorn and Parekh (1997) who identified approach-avoidance behavior and the separation-individuation process as important in the understanding of why people sexually offend.

Other studies have identified a variety of characteristics that they have identified as peculiar to female sexual offenders. As stated before, many studies have indicated that female sex offenders tend to have more severe and long-lasting histories of abuse. Adult female offenders are more likely to co-offend with an adult male and also more likely to offend sexually against young children in their care. Meanwhile, adolescent female offenders are more likely to offend against both genders than male offenders. Female offenders do not typically engage in
acts of rape, but, when they do, their victim is more likely to be female (Becker, et al., 2001; Davin, Hislop, and Dunbar, 1999; Grayston and DeLuca, 1999; Nathan and Ward, 2001; and Vandiver, 2006).

A review of the literature indicates that female sexual offenders are very different in both motivation and precipitating psychosocial stressors than male sexual offenders. Specifically, female offenders tend to sexually abuse to meet emotional needs (Faller, 1995 and Kaufman et al., 1995), are more likely to co-offend with a male taking a dominant role (Grayston and DeLuca, 1999 and Kaufman et al., 1995), and have more severe incidents of mental illness, chemical dependence and histories of family violence than male offenders. According to Grayston and DeLuca (1999), female offenders also do not fit the classical model of a pedophile, defined, according to the DSM IV (APA, 1994), as having recurring, intense sexual fantasies, urges or behaviors involving a sexual activity with a prepubescent child. Instead, female offenders reported that they were thinking of adult males while they molested children.

Supporting the argument that female sexual offenders have different motivations, Faller (1995) found female offenders would often sexually abuse in order to meet emotional needs due to a lack of healthier sexual outlets. Faller also found higher rates of mental illness, mental retardation, and substance abuse in female sex offenders when compared with male sex offenders.

Similarly, Kaufman et al. (1995) found that female sexual offenders were less intrusive abusers and that they often acted with a male co-offender (which the victims often perceived as being aggressive and dominant). They also found female offenders to have higher rates of alcohol abuse, histories of physical abuse as a child and spousal abuse. Female sexual offenders
were also found to be more likely than males to exploit their child victims by “sharing” them with others. While male and female sexual offenders varied little in type or severity of abuse, females tended to offend in order to meet emotional needs while males tended to offend in order to obtain sexual gratification.

**Typologies**

In an effort to understand the female sexual offender, researchers have turned to the development of adult female sexual offender typologies as a useful tool. Mathews et al. (1989), proposed three typologies for adult female sexual offenders. They are: the male-coerced offenders, who are females who are passive and dependent, with histories of sexual abuse. These women allow themselves to be pressured into co-offending by a male partner rather than to risk abandonment. The predisposed offender includes women who have been the victims of incest. These women have mental health issues and sexually deviant fantasies. They act alone and tend to offend against their own children or other young children who are family members. The teacher/lover offender involves women with poor peer relationships who regress into a sexual relationship with an underage adolescent victim. This type of offender will see her offending behavior as romantic and not perceive her behavior as being criminal.

Vandiver and Kercher (2004) developed six categories for adult female sexual offenders using a population of 471 female sexual offenders in the State of Texas and using hierarchical log linear modeling and cluster analysis to assess the relationship between offender and victim characteristics. The first subtype, heterosexual nurturers had an average age of 30, and targeted only male victims with an average age of 12. The second subtype, noncriminal homosexual offenders, had an average age of 32. Ninety-six percent of
their victims were females with an average age of 13. This subtype may have co-offended with a male.

The third subtype identified by Vandiver and Kercher (2004) is the female sexual predator, with an average age of 29. Sixty percent of their victims were males with an average age of 11. The fourth subtype, the young child exploiters were the youngest offenders. Their average age was 28 and they were the most likely to commit sexual assault. Their victims were from the ages of 7 to 11 and most often, the victims were related to the offender. The fifth subtype, the homosexual criminals had an average age of 32. Seventy-three percent of their victims were female with an average age of 11. This category was more typically criminal and tended to engage in crimes that provided economic motives, such as prostitute the child. Finally, the sixth subtype, the aggressive homosexual offenders were older (between 33 and 78). Eighty-eight percent of their victims were female and had an average age of 31. This group tended to commit sexual assaults against their victims.

More recently, Wijkman et al (2010) studied 111 cases of adult female sex offenders in the Netherlands from 1994 to 2005. They identified four typologies. The young assaulters were women who were 18 to 24 year olds, independent, and with no noted mental health issues. They offended sexually through fondling or oral sex, often with children in their care. The victim was often a male relative. These women tended to use violence while offending. The next group was identified as the rapist. These women carried out serious crimes involving sexual intercourse and penetration, and usually targeted older victims. They tended to have no preference for male or female victims and would offend against people outside of their family. These offenders were often sexually abused as children by a person outside of their family.
The third group identified by Wijkman et al (2010) was the psychologically disturbed co-offender. This group comprised women who were older, an average of 30 to 35 years old, who had a serious mental health issue. They tended to commit sexual offenses with others and either had been sexually abused as a child by someone within their family, or not to have been sexually abused at all. The fourth group was identified as passive mothers. This group tended to be over 41 years old and to either watch a child being sexually abused by another, or to provide the opportunity for a child to be abused by another. They would take no active role, but the children abused tended to be their own children or stepchildren who were younger than 11.

Finally, Elliott et al. (2010) developed a typology based on a sample of 43 adult female offenders from the United Kingdom, who were found guilty of sexually offending children. Their study also divided the women into four typologies. The lone offender with a victim under the age of 12, tended to be more likely to abuse children within the family (which might be repeating the abuse they experienced as children). The lone offender with a victim over twelve, tended not to see their victim as a child and interpreted their victim as being willing to engage in sexual activity. Both of the lone offender groups tended to engage in cognitive distortions such that they believed that children were sexual creatures and that it was not harmful to engage in sexual behavior with them.

The other two groups identified by Elliot et al (2010) are co-offending groups. The male-associated group, tended to abuse children with a male co-offender who was much older, implying a power imbalance between them where the male could engage the woman in a sexual offense against a child without violence. The fourth group was the male-coerced group, which comprised women forced into sexual offending by a male co-offender. Reportedly, this last group had a noted lack of empathy for their victim. In all four groups, histories of child abuse
and attachment issues regarding their parents were common. However, the lone offenders with victims under age 12 group had more significant histories of trauma, sexual abuse and domestic violence.

**Juvenile Female Sexual Offenders**

The literature regarding juvenile female sexual offenders suggests that they are often the victims of sexual abuse themselves. They typically come from highly unstable and dysfunctional homes and have a co-occurring psychiatric disorder (Grayston and De Luca, 1999 and Kaufman et al., 1995). This category of sexual offenders tend to victimize small children that are either family members or that they are familiar with and tend to sexually offend against both male and female victims. They tend to act alone and often target small children that they are responsible for caring for (Grayston and DeLuca, 1999; Rudin, Zalewski and Bodmer-Turner, 1995).

Vandiver and Teske (2006) conducted an analysis of sexual offenders that were juveniles. Out of 29,376 overall sex offenders who were registered as of April 27, 2001 in the State of Texas, 61 were juvenile females and 1,879 were juvenile males (the rest were adult offenders). Their analysis found a significant difference between the ages of the juvenile male and female offenders. Nearly one half of the female offenders were between the ages of eleven to thirteen at the time of arrest, while nearly one half of the male offenders were fourteen to sixteen years old at the time of arrest. Significant difference was also discovered regarding the age of the victims. The average age of the female offender’s victims was around seven and a half while the average age of the male offender’s victims was almost eight and a half. They found that 33% of the females were more likely to offend against children who were five or younger when only 22% of the males chose these victims. Conversely, 24% of the males offended against victims in the twelve to seventeen age group when only 14% of the females chose victims in this age range.
Finally, males were found to be more likely to sexually offend females while females tended to offend against both males and females (70% of the males preferring female victims compared to 59% of the females preferring female victims).

Finally, Roe-Sepowitz and Krysik (2008) examined the case histories of 118 juvenile female sexual offenders. They found that juvenile female sex offenders are not a homogenous group. For example, they found that those juvenile females who did suffer some abuse had a higher incidence of mental health issues, and higher levels of significant bouts of anger/irritability and depression/anxiety. Their study suggested that treatment interventions should combine treatment for the sexual offending as well as their own abuse histories to help the juvenile offenders to work through their mental health issues and trauma histories. This study also suggested that interventions for female sexual offenders should consider gender issues such as self-esteem, self-image, physical and sexual development, the development of intimacy, social skills, impulse control and social expectations of girls to take care of others.

**Treatment**

The current focus of treatment for sex offenders is to keep them from offending in the future. Other treatment goals, such as improving the quality of life or improving self-esteem have been of secondary concern (Miller et al, 2009). Treatment for female sexual offenders often has been based upon already existing programs for male offenders.

The Center for Sex Offender Management (2007) identified guidelines for the understanding and treatment of female offenders. According to the Center for Sex Offender Management, female sexual offenders have been identified as needing to develop trusting relationships. They need to be able to develop independence and self-sufficiency. They have a
greater need for a more positive self-concept, social skills development and the ability to be assertive than do male offenders. Female offenders often require help with managing their emotions, avoiding self-injurious behaviors and developing healthy sexual behaviors and boundaries. These guidelines have been developed with the understanding that the majority of female offenders have been sexually assaulted themselves and have come from histories of abuse and trauma (Center for Sex Offender Management, 2007).

Research suggests that current treatment programming focuses on treating male and female sexual offenders equally, with either identical or very similar programming based on theories of treatment that do not include the identified differences between female and male populations. The Center for Sex Offender Management (2007) indicated that treatment programs with females needed to be less focused on behavioral techniques and more on using expressive and experiential treatment to explore relationships and family issues such as art and drama therapy.

Given the different dynamics among sexual offenders (Wood, et. al, 2000), it is reasonable to question whether or not different treatment modalities should be used with male and female populations. According to the literature, five distinct treatment modalities have been used historically in the treatment of all sexual offenders. These approaches tended to mirror the development of treatment modalities within the field.

The goals of Cognitive-Behavioral therapy have been to decrease or eliminate inappropriate sexual thoughts, address cognitive distortions, develop the understanding that sexual offenses are harmful to the victim, develop social skills, learn how to control sexual urges
and behaviors, and understand the role of sexual behavior in one’s life (Dombrowski, et al., 2011).

Psychodynamic therapy uses counseling techniques to develop greater awareness in the client. Group therapy is a common method used to treat sexual offenders. In the group milieu, offenders are given opportunities to develop self-esteem and interpersonal skills. However, offenders are also able to challenge each other if they perceive that a group member is denying the offense or minimizing their behavior. Within group, participants will engage in activities such as role playing, journaling and sharing personal histories (Dombrowski, et al., 2011).

Behavioral approaches seek to reduce deviant sexual behaviors. For example, verbal satiation is a technique where the offender is encouraged to talk about a deviant sexual fantasy over and over until it becomes boring and no longer stimulating. Masturbatory training is another technique where the offender is taught to masturbate to more socially accepted sexual stimuli instead of deviant stimuli or fantasies (Dombrowski, et al., 2011).

Psycho-educational approaches are typically conducted within a group therapy setting. This approach seeks to teach offenders more socially appropriate skills sets. For example, offenders might be taught proper social skills or get information about sexual behavior in an effort to encourage them to act in a more prosocial manner (Dombrowski, et al., 2011).

Pharmacologic interventions use medications to alter or change some aspect of the offender’s mood or physiologic state. For example, an anxious offender could benefit from some form of tranquilizer. Other drugs, such as anti-androgens like Lupron or Provera, can affect the testosterone level in an offender, decreasing the sex drive (Barbaree and Marshall, 2008).
Treatment modalities for juvenile sexual offenders have common goals of reducing recidivism. They also typically encourage the offender to accept responsibility for the offense, develop some understanding of their offending pattern, and create a way to prevent re-offending. Juveniles are encouraged to learn more appropriate social skills, develop some empathy for their victim(s), address any deviant sexual arousal for the individual offender, address any history of abuse of the offender, and address family issues with an overall goal of developing a more appropriate understanding of sexual behavior (Ryan 1996).

**Treatment Effectiveness**

There are several issues which affect the ability to determine treatment effectiveness for juvenile sexual offenders. Recidivism rates (committing another sexual offense) are typically used to assess treatment. The premise is that treatment is effective if an offender does not repeat a sexual offense. Recidivism rates are determined by police records of charges, arrests and convictions. This may underestimate the reality of repeat sexual offenses because the offenders may go on offending for many years before being caught (Furby et al., 1989). When recidivism rates are obtained from personal reports (such as self-report of the offender or report by victims) instead of official arrest records, however, these sources tend to indicate a higher re-offense rate (up to 2.5 times higher) (Marshall & Barbee, 1988).

Identifying treatment as the only variable affecting recidivism does not take into consideration a host of other variables that might affect re-offense rates (Prentky, et al., 1997; Hunter, 2006 and Hanson et al., 1998). Studies of treated and untreated sexual offender re-offense rates indicated a good deal of variability in the findings. Meyer and Romero (1980) found that those with a low rate of prior arrests for sexual offenses had lower recidivism rates
than did offenders with higher rates of prior arrests. Marshall and Barbaree (1988) found recidivism rates of 12.5% after a 0 to 2 year follow up, 38.5% after a 2 to 4 year follow-up and 64.3% after a 4 to 10 year follow-up. Meanwhile, Alexander (1999) found a recidivism rate of 7% for sexual offenses after five years for juvenile sexual offenders treated with cognitive-behavioral/relapse prevention treatment.

Borduin et al., (1990) investigated the effectiveness of intensive family and community-based treatment (involving family, school, peer and neighborhood influences) called Multisystemic Therapy (MST), compared with individual therapy in an outpatient program with sixteen juvenile offenders. Effectiveness was measured by a three year check of arrests for sexual and nonsexual offenses. Those juveniles who had MST had a recidivism (re-offense) rate of 12.5% for sexual offenses and 25% for nonsexual offenses compared with those juveniles who had individual therapy, with a recidivism rate of 75% for sexual offenses and 50% for nonsexual offenses. Factors affecting recidivism were identified by Barbaree and Marshall (1989) to include whether there was a history of severe offenses, multiple victims, offenses involving intercourse, a prior history of being identified with deviant sexual arousal, a low IQ and a low socioeconomic status. In general, the more serious the offense or severe the condition of the offender was, the more likely it was that the offender would re-offend. Other factors identified by Rice (1991) were mental illness, a history of incarceration, a history of sexual offenses, never being married and being identified as having a personality disorder.

A meta-analysis of nine studies regarding juvenile sexual offender treatment effectiveness as measured by recidivism (Reitzel and Carbonell, 2006) found sexual recidivism rates of 7.37% for juvenile sexual offenders receiving treatment as compared to 18.93% for
juvenile sexual offender controls who did not receive treatment. These results indicated that some form of treatment does appear to affect sexual re-offense rates. One surprising finding is that Cognitive-Behavioral treatment (which has been identified by many studies to be most effective) was not found to be more effective than other treatment modalities.

Since there is evidence to support the use of treatment to reduce recidivism rates in juvenile sexual offenders, it is logical to question which treatment modalities are most effective. Therefore, in order for treatment to be effective in reducing sexual offending behaviors among female juvenile offenders, there needs to be a greater understanding of how female offenders differ from male offenders and how these differences impact treatment. More effective use of treatment for juvenile female sexual offenders would promote both their welfare and a safer society.
Chapter 3 - Method

This chapter presents information on research methodology applied in this study to address the research question. It explains how the survey was developed and how the survey was distributed. This chapter also describes the sampling plan, including how subjects for the study were identified and approached, data collection procedure, and data analysis strategies.

Foundation for Research Design

This study used a survey developed by Tuell (2003) for providers of juvenile sexual offender treatment, which was developed by using components of offender treatment identified by the National Task Force on Juvenile Sexual Offending (1993) and Barbaree (1991). Tuell utilized a sample of providers of juvenile sexual offender treatment in the State of Ohio.

In Tuell’s dissertation (2003), providers of treatment for juvenile sexual offenders in the State of Ohio included counselors, therapists, social workers and psychologists. A variety of treatment venues were also sampled, such as outpatient, residential and correctional programs. The providers of treatment had a variety of education and experience as well (varying from an undergraduate degree to a doctorate and from initial professional licenses to independent licenses).

Tuell (2003) obtained demographic information on each provider through a demographic questionnaire which also identified aspects of the various treatment venues (such as type of program, number of offenders in the program, and average length of stay). These demographics were obtained in order to assess any possible relationship between demographic information and the provider’s perception of which treatment methods were most effective. Information was also collected about the population treated (such as ages and gender), what type of program the
provider worked in (nonprofit, private, etc.), and a general description of the program (which could range from a prison-based program to a hospital program to an outpatient, community-based program).

This study used the survey developed by Tuell (2003) in order to assess how treatment providers view treatment effectiveness for female juvenile sex offenders. Tuell (2003) did not include a means to differentiate between male and female offenders regarding perceptions of treatment effectiveness for different treatment modalities. This study sought to obtain more explicit information regarding how treatment providers view treatment effectiveness for the juvenile female sexual offender population.

The independent variable in this study is the gender of the juvenile sex offender. Respondents were asked to rate the treatment effectiveness of a set of treatment modalities for male juvenile sex offenders and then for female juvenile sex offenders. The dependent variables are their ratings of perceived treatment effectiveness.

It is expected that treatment providers will identify certain treatment modalities as more effective for female juvenile sexual offenders. This is based on the literature, which suggests that female sexual offenders have different treatment needs than male offenders (Bumby and Bumby, 2004; Hunter, et al., 2006, and Robinson 2006).

Two sections were developed for the survey. The first included the Demographic questionnaire (see Appendix A) and the second included the survey questions about treatment modalities. This is what the participants saw when they opened the link to complete the survey.
Participants

Population

The population for this study was defined to include treatment providers for juvenile female sex offenders within the United States. The population was broadly defined to include practitioners with varied educational and professional histories. Adult, male and female providers from various racial and ethnic backgrounds where included. The population was, however, restricted to those who provided treatment for just juvenile sex offenders, with no restriction placed on those who work just with female juvenile sex offenders.

Sample

The sample included providers from five Midwestern States which had approved lists of sex offender treatment providers. To increase the number of potential respondents, two additional states that bordered the Midwest region were also included.

The participants for this study were providers of sexual offender treatment to juvenile offenders. The sample used providers from a list of five Midwestern States (all the stated that had approved lists of sex offender treatment providers) as well as two other states that bordered the Midwest region in an effort to gain as many participants as possible. In the original study, only 56 providers in the State of Ohio responded. In this study, treatment providers were identified through various databases of juvenile sexual offender treatment providers for five Midwest states.

A list of juvenile sexual providers was obtained through the Minnesota State Department of Corrections website and the Minnesota Sex Offender Treatment and Supervision Directory

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The list for Ohio providers was obtained through the Ohio Department of Rehabilitation and Corrections (2009) list of certified juvenile sex offender programs. A list of programs/providers in Michigan was obtained from the Michigan Department of Human Services website (Michigan, 2006). A list for Nebraska was obtained through the Department of Health and Human Services website in Nebraska (Nebraska, 2008). The Illinois list was obtained through the Illinois Sex Offender Management Board website (2011). The list of Wisconsin providers was obtained through the Wisconsin Juvenile Sex Offender Provider Directory. The list for Idaho was obtained through the Idaho State website (2011). The list for Missouri was obtained through a government website (2011). Finally, the Safer Society Foundation (Safer Society Foundation, 2009) also provided names from all of the States in the Midwest. A list of 318 email addresses was obtained from these sources. In order to increase the number of responses, 56 additional emails were obtained for the States of Colorado (Colorado, 2011) and Arkansas (Arkansas, 2011) since they bordered the Midwest region.

The reason only Arkansas and Colorado were added to the list is that these states provided the most easily available list of viable email addresses that was large enough to use. Identifying viable email addresses was labor intensive, since many of the treatment providers listed were identified with phone numbers or addresses instead of email addresses. Therefore, time was spent looking up the various names and treatment centers to find viable emails. Adding the lists from Colorado and Arkansas was an expedient way to obtain more emails as well as to stay close to the target area of the Midwest.
**Independent Variable**

There was one independent variable, which is gender of the juvenile sex offender targeted to receive the treatment modality being rated. The treatment providers that responded to the survey were asked to rate each treatment modality for effectiveness in treating both male and female juvenile sex offenders with a goal of seeing whether the ratings for male juvenile offenders differed from those ratings given for female juvenile offenders.

**Dependent Variables**

The dependent variable is perceived treatment effectiveness by sex offender treatment providers, as measured on a four point Likert scale. Perceived treatment effectiveness was rated by the providers for each of the 55 treatment modalities under male offender and female offender conditions. A list of the 55 treatment modalities in five categories is included in the Appendix B. The list used in the survey is based on a study by Tuell (2003).

**Instrument**

The instrument used in this study was based on an instrument created by Tuell (2003). This instrument featured a list of 55 sex offender treatment methods that were rated on a five point Likert scale (1 = not effective, 2 = somewhat effective, 3 = uncertain, 4 = mostly effective, and 5 = effective). Tuell’s list of treatment modalities represented five therapeutic orientations. They are Psycho-educational, Behavioral, Psychotherapeutic, Cognitive-Behavioral and Medication. Treatment methods such as Sex Education, Anger Management and Social Skills Training were in the Psycho-educational category, with Psychodrama Therapy, Empty Chair, and Hypnosis were included in the Psychotherapeutic category. For the Medication section, there were items such as Buspar, Lithium Carbonate and Androcur while the Behavioral section had
items such as Impulse Control, Biofeedback, and Aversive Techniques. Finally, the Cognitive-Behavioral section had items such as Relapse Prevention, Thinking Errors, and Reality Therapy.

The items in Tuell’s survey were originally developed using various sources on sex offender treatment modalities (Tuell, 2003). The survey items were developed by Tuell using a variety of current professional sources identifying treatment modalities then in use with juvenile sexual offenders. While this original study is now nine years old, the same treatment modalities are still in use with juvenile sexual offenders, and still identified within the literature.

To test the homogeneity of his treatment modality categories, Tuell (2003) computed Cronbach’s (1951) coefficient alpha for each category (Psychotherapeutic, Psycho-educational, Behavioral, Medication, Cognitive Behavioral). The results indicated alpha levels of .80 for Psycho-educational and Behavioral, .74 for Cognitive-Behavioral and .66 for Psychotherapeutic, as well as .94 for Medication. Scores with alpha levels of .60 or higher are considered to be internally consistent.

The same set of 55 treatment modalities were used in this study. However, the Likert scale used was altered to eliminate Tuell’s middle, or neutral option. The new scale is: 1 = not effective, 2 = somewhat effective, 3 = mostly effective, and 4 = effective Providers were asked to rate the effectiveness of each treatment modality first for use with female juvenile sexual offenders and then with male juvenile sexual offenders (see Appendix B for a copy of the scale used).

**Procedure**

The survey was emailed to all listed providers with a solicitation email requesting them to participate in the study to further the understanding of treatment for female juvenile sexual
offenders. The solicitation email (see Appendix C) went: “You have been identified as a person who provides treatment to juvenile sex offenders. As such, you are being asked to take ten to fifteen minutes of your time to assist in a survey which is part of a dissertation study at the University of Cincinnati. I would appreciate your completion of the online survey. Please proceed if you are willing to participate in this study. If you do not wish to participate at this time, two more requests will be sent. There is no obligation to participate”. Participants were informed that participating in the survey would imply consent and given contact information to ask further questions or to make comments.

The providers were informed that the study had been through IRB approval at the University of Cincinnati. If the provider decided to take the survey, they clicked the link to actual survey on the Survey Monkey (an Internet survey program that allows one to develop a survey and send it out to large numbers of potential respondents) and started to take the survey. Part of the email also informed them that their decision to go to the link to the survey implied consent to participate in the study. All surveys were confidential, so no specific information identifying the participant was obtained in the study. If the participants wanted further information or had any questions, contact information of both the researcher and the dissertation committee chair was provided in the orientation email.

Each person on the list of providers was sent an initial email with a link to the Survey Monkey site for the survey itself. If they followed that link, they initially saw a letter of confidentiality, clarifying that they were not under obligation to participate and that this was a study for dissertation credit through the University of Cincinnati. They were then sent on to the demographic questionnaire. Once they completed the demographic questionnaire, they were to push a button to go on to the survey itself.
Reminders were sent out the first week of the initial email to participate and, again, the second week of the study. Since there was no way to track who had already responded, reminder emails were sent to everyone. The reminder email is in Appendix D.

The responses to the survey were automatically recorded on the survey monkey website under the researcher’s account. Out of an initial 374 requests sent out, 84 were received. In an effort to obtain more responses, 56 more requests were sent out, and 9 responses were received. All of the surveys were sent out to a general pool of juvenile sex offender treatment providers as identified by a reliable, official source. There was no bias in how the providers were chosen for this list and there is no clear reason why some of the providers either did not respond to the survey or did not complete the survey.

Each set of requests were given two weeks to respond with two reminders given. Thus, out of a total of 430 invitations, 93 individuals (21.63%) responded to the survey. Of these, only 64 were usable (14.88%). Twenty-nine respondents answered the demographic questionnaire but failed to answer the survey questions.

Data Analysis

The main goal of this study was to explore if there is a treatment modality that works better with juvenile female sex offenders than for juvenile male sex offenders. The hypothesis was that there would be a significant difference between sex offender treatment provider’s effectiveness ratings for each of a set of treatment modalities when male and female target recipients of the treatment are compared. The null hypothesis for this study was that there would be no significant difference between sex offender treatment provider’s effectiveness ratings for each of a set of treatment modalities when male and female target recipients of the treatment are
compared. A series of t-tests was performed to test this hypothesis for each of the 55 treatment modalities.
Chapter 4 - Results

This chapter presents the results of the study. It includes the summary of the demographic background of the participants, descriptive statistics of the variables, and the results of hypothesis testing. A summary of hypothesis testing is also provided in this chapter.

Participants

Out of 374 initial survey requests sent, only 84 (22.46%) were received. Responders were given two weeks to do the survey, with two reminders given in that time period. Due to the low initial response rate, a further 56 survey requests were sent out to providers in Colorado and Arkansas. Colorado and Arkansas were included because they were adjacent to the Midwest states studied and had an available pool of email addresses for juvenile sex offender providers. This obtained a return of 9 more surveys (16%). The same procedure was followed in both cases. Providers were given two weeks to respond, with reminders in the first and second weeks.

A total of 93 surveys (21.6% of the total number of invitees) were obtained after the efforts made as stated above. Out of these, only 64 responders actually completed the survey (69% of the responders 13.7% of the total number of invitees). The rest only answered the initial demographic questionnaire and did not complete the actual survey questions. All respondents who just completed the demographic form and did not complete survey questions were dropped from the study.

For those respondents who did answer the survey, more participants consistently answered the male side of the survey than the female side of the survey and many participants did not respond at all to some questions. For example, 55 participants answered the female part of the Social Skills items while 62 responded to the male part. This was the usual pattern, except
for items that could be expected to be less familiar to treatment providers such as the Androcur item, where 32 providers responded to the female section and 36 responded to the male section. The response rate for Androcur was the lowest, however. Most items had a response rate of between 55 and 64 treatment providers responding. This missing data was treated by finding the average for each condition (Male and Female) and substituting the mean for any missing data.

A similar demographic profile was found in this study when compared with the original Tuell (2003) study. In the Tuell (2003) study, out of 56 respondents (which were all treatment providers to juvenile sex offenders in Ohio), 18% had undergraduate experience, 56% had graduate experience and 25% had post-graduate experience. None of the respondents had only High School experience. Nearly 40% had worked with sex offenders from 5 to 10 years, 28% less than five years, 24.5% from 11 to 15 years and 7 % 16 or more years. The respondents in the original study found 45 % of the respondents were licensed Social Workers, 30% licensed Counselors, 9% licensed Psychologists and 9% had no license. The overwhelming majority of respondents in the original survey were Caucasian.

In this study, participants were sexual offender treatment providers working with juvenile sexual offenders within the Midwest (defined as being Illinois, Indiana, Iowa, Kansas, Michigan, Minnesota, Missouri, Nebraska, North Dakota, Ohio, South Dakota and Wisconsin) or Arkansas and Colorado (Arkansas and Colorado were added to obtain more respondents). Providers from each state were surveyed.

Out of the 64 who did complete the survey, there were 35 male respondents and 29 female participants. The respondents had an average age of 45.95 (with a standard deviation of 11.73). The median age was 48. Most of the respondents were Caucasian (N=59) with a few
African Americans (N=3) and one Hispanic and one Native American respondent, each. All of the participants had at least an undergraduate education with 31 claiming a graduate degree, 18 some form of post graduate training and 10 with doctorates (refer to Table 1 for more demographic information).

The participants had varied experience working in the field with sex offenders. Only 10 had 1 – 5 years of experience in the mental health field, while 13 had 6 – 10 years, 17 had 11- 15 years and 23 had more than 16 years in the field (one declined to say). Forty-six of the respondents had experience working with female sex offenders, while 16 did not (and 2 declined to say). Meanwhile, 19 respondents indicated that they had prior training in female sex offenders, while 42 did not (with 4 declining to say). Finally, those who did have experience working with female sex offenders had an average of 9.15 years spent working with this population (with a standard deviation of 6.92).

Table 1. Demographic Results

<table>
<thead>
<tr>
<th>Gender</th>
<th>Race</th>
<th>Education</th>
<th>Yrs. In Field</th>
<th>Work w/ FSO's*</th>
<th>Train w/ FSO's*</th>
</tr>
</thead>
<tbody>
<tr>
<td>Male</td>
<td>White Afr. Am.</td>
<td>Undergrad</td>
<td>4 1-5 yrs.</td>
<td>10 Yes</td>
<td>46 Yes</td>
</tr>
<tr>
<td>Female</td>
<td>Afr. Am.</td>
<td>3 Graduate Post Master</td>
<td>31 6-10 yrs.</td>
<td>13 No</td>
<td>16 No</td>
</tr>
<tr>
<td>Hispanic Native Am.</td>
<td>1 Doctorate</td>
<td>10 16+ yrs.</td>
<td>23</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Missing (No Response)</td>
<td>1</td>
<td>1</td>
<td>2</td>
<td>4</td>
<td></td>
</tr>
<tr>
<td>Total</td>
<td>64</td>
<td>64</td>
<td>64</td>
<td>64</td>
<td>64</td>
</tr>
</tbody>
</table>

*Female Sexual Offenders
Results of Descriptive Statistics

All 55 treatment modalities were divided up into five groups that were based on treatment method. For example, the Psychotherapeutic group included items such as Individual Counseling, Hypnosis, EMDR and Journaling. The Pharmacologic group included items such as Lupron, Androcur and Lithium. The Psycho-educational group contained items such as Social Skills Training, Anger Management, Conflict Resolution and Vocational Training. The Cognitive Behavioral group contained items such as RET, Assault Cycle, Reality Therapy and Thinking Errors. Finally, the Behavioral group contained items such as Impulse Control, Minimal Arousal, Behavior Modification and Biofeedback (see Appendix for a complete listing for each group). All of the original items were used in this study except one. Instead of Plethysmograph (which is specific to males), the item Measurement of Arousal was included in order to be less gender specific.

Hypothesis Testing

For each of the 55 treatment modalities, the significance of difference between the mean for practitioner ratings on effectiveness for the male and the female juvenile sex offenders was tested using a t-test for paired comparison. The t-test for paired comparisons was used to compare the means since the participants rated the effectiveness of each treatment modality for both females and males, therefore, one sample was tested for two conditions. Therefore, it meets the criteria for paired t-test, which compares the mean differences between two variables for each case. The other assumption for paired-t test is the normal distribution of the responses. A frequency test with distribution check was run for all 110 items, i.e. the treatment methods perceived for both males and females. The results showed that overall all the items were found
to have normal or close to normal distribution, based on the frequency check on normal
distribution.

**Paired t-test Results**

The Results of the paired t-test did indicate some significant differences in how treatment
providers perceived treatment effectiveness when females and males were compared. An alpha
level of .05 was used in order to avoid the possibility of Type II error, in which the null
hypothesis is accepted when it is, in fact, false. The detailed results are as follows:

**Psycho-educational Methods**

In general, Psycho-educational Methods were perceived as being in the “mostly
effective” range for both males and females (males had a median rating of 3.00 and females had
a median rating of 2.92). The absolute mean difference obtained between male and female
categories were small and ranged from .19 to .35. Out of the twelve treatment modalities in the
Psycho-educational category, only four indicated a significant difference when comparing
practitioner’s ratings on effectiveness for male and female offenders. Social Skills Training (t = -
2.22, p = .03) and Anger Management (t = -4.34, p = .001) were identified as more effective for
male offenders while Communication Skills Training (t = 2.38, p = .02) and Assertiveness
Training (t = 3.24, p = .002) were identified as more effective for female offenders. None of the
other treatment modalities in the Psycho-educational Methods were found to have a significant
difference when comparing relative treatment effectiveness for male and female juvenile
offenders.
Behavioral Methods

Behavioral Methods were rated in the “somewhat effective” range (with males having a median rating of 2.10 and females having a median rating of 1.91). The absolute mean difference between male and female offenders ranged from .01 to .41. The treatment modalities of Impulse Control (t = -2.822, p = .006), Measurement of Arousal (t = -5.204, p = .000), Verbal Satiation (t = -2.004, p = .049), Masturbatory Satiation (t = -3.440, p = .001), Orgasmic Reconditioning (t = -2.243, p = .029), Minimal Arousal (t = -4.675, p = .000), Masturbatory Training (t = -2.512, p = .015) and Aversive Techniques (t = -2.246, p = .028) were identified as more effective with males than females. None of the other treatment modalities in the Behavioral Methods were found to have a significant different when comparing relative treatment effectiveness for male and female offenders.

Cognitive Behavioral Methods

Cognitive Behavioral Methods tended to be rated at the “somewhat effective” to “mostly effective” level (with a male median rating of 2.84 and a female median rating of 2.83). The absolute mean difference between males and females ranged from -0.19 to 0.11). The treatment modalities of Fantasy Work (t = -2.225, p = .030) and Assault Cycle (t = -2.071, p = .043) were identified as being more effective with males than females. None of the other Cognitive Behavioral treatment modalities were found to have a significant difference when comparing relative treatment effectiveness for male and female juvenile offenders.

Psychotherapeutic Methods

The Psychotherapeutic Methods were rated in the “somewhat effective” range (with a median rating for males of 2.40 and a median rating for females of 2.41). The absolute mean
The difference between males and females ranged from -0.03 to 0.21. The treatment modalities of Individual Counseling \( (t = 2.191, p = .032) \), Psychodrama \( (t = 2.374, p = .021) \) and EMDR \( (t = 3.730, p = .000) \) were rated as more effective with females, while Journaling \( (t = 3.947, p = .00) \), was identified as more effective with males. None of the other Psychotherapeutic treatment modalities were found to have a significant difference when comparing relative treatment effectiveness for male and female juvenile offenders.

**Pharmacologic Methods**

The Pharmacologic Methods were rated in the “not effective” range (with a median rating for males of 1.46 and a median rating for females of 1.43). The absolute mean difference between males and females ranged from -0.31 to 0.09. The treatment modalities of Provera/Depo Provera \( (t = -3.783, p = .000) \), Androcur \( (t = -2.890, p = .005) \) and Lupron \( (t = -5.550, p = .000) \) were rated as more effective with males while Minor Tranquilizers \( (t =3.158, p = .002) \), Buspar \( (t = 3.244, p = .002) \), Anafranil \( (t = 2.611, p = .011) \), Major Tranquilizers \( (t = 3.996, p = .000) \) and Lithium \( (t = 3.40, p = .001) \) were rated as more effective with females. None of the other Pharmacologic treatment modalities were found to have a significant difference when comparing relative treatment effectiveness for male and female juvenile offenders.

**Table 2 Paired t-test Comparisons for Males and Females**

<table>
<thead>
<tr>
<th>Psycho-educational Methods</th>
<th>Male M</th>
<th>Male s</th>
<th>Female M</th>
<th>Female s</th>
<th>Difference</th>
<th>t (paired)</th>
<th>p</th>
<th>More Effective For</th>
</tr>
</thead>
<tbody>
<tr>
<td>Social Skills</td>
<td>3.28</td>
<td>0.74</td>
<td>3.14</td>
<td>0.82</td>
<td>-0.14</td>
<td>-2.221</td>
<td>0.030</td>
<td>M</td>
</tr>
<tr>
<td>Communication Skills</td>
<td>3.24</td>
<td>0.80</td>
<td>3.43</td>
<td>0.68</td>
<td>0.19</td>
<td>2.377</td>
<td>0.021</td>
<td>F</td>
</tr>
<tr>
<td>Assertiveness Training</td>
<td>3.01</td>
<td>0.78</td>
<td>3.23</td>
<td>0.68</td>
<td>0.22</td>
<td>3.238</td>
<td>0.002</td>
<td>F</td>
</tr>
<tr>
<td>Conflict Resolution</td>
<td>3.22</td>
<td>0.83</td>
<td>3.12</td>
<td>0.83</td>
<td>-0.10</td>
<td>-1.259</td>
<td>0.213</td>
<td>---</td>
</tr>
</tbody>
</table>

35
<table>
<thead>
<tr>
<th></th>
<th>Mean</th>
<th>SD</th>
<th>Min</th>
<th>Max</th>
<th>Value</th>
<th>p-value</th>
<th>M</th>
</tr>
</thead>
<tbody>
<tr>
<td>Values Clarification</td>
<td>2.84</td>
<td>0.86</td>
<td>2.86</td>
<td>0.79</td>
<td>0.02</td>
<td>0.343</td>
<td>0.733</td>
</tr>
<tr>
<td>Sex Education</td>
<td>3.02</td>
<td>0.90</td>
<td>3.11</td>
<td>0.87</td>
<td>0.09</td>
<td>1.398</td>
<td>0.167</td>
</tr>
<tr>
<td>Dating Skills</td>
<td>2.70</td>
<td>0.82</td>
<td>2.65</td>
<td>0.75</td>
<td>-0.05</td>
<td>-0.647</td>
<td>0.520</td>
</tr>
<tr>
<td>Anger Management</td>
<td>3.27</td>
<td>0.75</td>
<td>2.92</td>
<td>0.73</td>
<td>-0.35</td>
<td>-4.336</td>
<td>0.00</td>
</tr>
<tr>
<td>Sex Roles</td>
<td>2.65</td>
<td>0.86</td>
<td>2.66</td>
<td>0.82</td>
<td>0.01</td>
<td>0.139</td>
<td>0.890</td>
</tr>
<tr>
<td>Positive Social Sexuality</td>
<td>2.98</td>
<td>0.77</td>
<td>2.92</td>
<td>0.75</td>
<td>-0.06</td>
<td>-0.819</td>
<td>0.416</td>
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<tr>
<td>Vocational Training</td>
<td>2.65</td>
<td>0.91</td>
<td>2.54</td>
<td>0.84</td>
<td>-0.11</td>
<td>-1.267</td>
<td>0.210</td>
</tr>
<tr>
<td>Job Seeking Skills</td>
<td>2.61</td>
<td>0.90</td>
<td>2.55</td>
<td>0.88</td>
<td>-0.06</td>
<td>-0.793</td>
<td>0.431</td>
</tr>
<tr>
<td>Median</td>
<td>3.00</td>
<td>0.83</td>
<td>2.92</td>
<td>0.81</td>
<td>---</td>
<td>---</td>
<td>---</td>
</tr>
</tbody>
</table>

**Behavioral Methods**

<table>
<thead>
<tr>
<th></th>
<th>Mean</th>
<th>SD</th>
<th>Min</th>
<th>Max</th>
<th>Value</th>
<th>p-value</th>
<th>M</th>
</tr>
</thead>
<tbody>
<tr>
<td>Impulse Control</td>
<td>3.14</td>
<td>0.90</td>
<td>2.91</td>
<td>0.88</td>
<td>-0.23</td>
<td>-2.822</td>
<td>0.00</td>
</tr>
<tr>
<td>Measurement of Arousal</td>
<td>2.30</td>
<td>0.96</td>
<td>1.89</td>
<td>0.77</td>
<td>-0.41</td>
<td>-5.204</td>
<td>0.00</td>
</tr>
<tr>
<td>Verbal Satiation</td>
<td>1.96</td>
<td>0.87</td>
<td>1.84</td>
<td>0.76</td>
<td>-0.12</td>
<td>-2.004</td>
<td>0.04</td>
</tr>
<tr>
<td>Masturbatory Satiation</td>
<td>2.02</td>
<td>0.92</td>
<td>1.76</td>
<td>0.83</td>
<td>-0.26</td>
<td>-3.440</td>
<td>0.00</td>
</tr>
<tr>
<td>Orgasmic Reconditioning</td>
<td>1.86</td>
<td>0.79</td>
<td>1.68</td>
<td>0.77</td>
<td>-0.18</td>
<td>-2.243</td>
<td>0.02</td>
</tr>
<tr>
<td>Minimal Arousal</td>
<td>2.10</td>
<td>0.85</td>
<td>1.73</td>
<td>0.71</td>
<td>-0.37</td>
<td>-4.675</td>
<td>0.00</td>
</tr>
<tr>
<td>Masturbatory Training</td>
<td>2.10</td>
<td>0.79</td>
<td>1.92</td>
<td>0.73</td>
<td>-0.18</td>
<td>-2.512</td>
<td>0.01</td>
</tr>
<tr>
<td>Aversive Techniques</td>
<td>1.93</td>
<td>0.92</td>
<td>1.74</td>
<td>0.73</td>
<td>-0.19</td>
<td>-2.246</td>
<td>0.02</td>
</tr>
<tr>
<td>Behavior Modification</td>
<td>3.03</td>
<td>0.82</td>
<td>2.96</td>
<td>0.76</td>
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**Cognitive Behavioral Methods**

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**Psychotherapeuetic Methods**

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<td>0.91</td>
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Empty Chair  2.14  0.80  2.21  0.82  0.07  1.404  0.165  ---
Psychodynamic Therapy  2.04  0.76  2.13  0.81  0.09  1.946  0.056  ---
Family Systems  2.83  0.79  2.80  0.80  -0.03  -0.466  0.643  ---
Median  2.40  0.83  2.41  0.82  ---  ---  ---

Pharmacologic Methods
Provera/Depoprovera  1.60  0.63  1.43  0.54  -0.17  -3.783  0.000  M
Androcur  1.29  0.36  1.21  0.29  -0.08  -2.890  0.005  M
Lupron  1.59  0.66  1.28  0.44  -0.31  -5.550  0.000  M
Major Tranquilizers  1.33  0.52  1.42  0.52  0.09  3.996  0.000  F
Minor Tranquilizers  1.40  0.54  1.46  0.53  0.06  3.158  0.002  F
Lithium  1.56  0.65  1.65  0.63  0.09  3.400  0.001  F
Anafranil  1.36  0.40  1.41  0.40  0.05  2.611  0.011  F
Buspar  1.52  0.59  1.59  0.63  0.07  3.244  0.002  F
Median  1.46  0.57  1.43  0.53  ---  ---  ---

Summary

Of the five treatment methods, Psycho-educational Methods (with a male median rating of 3.00 and a female median rating of 2.92) and Cognitive Behavioral Methods (with a male median rating of 2.84 and a female median rating of 2.83) were rated in the “somewhat effective” to “mostly effective” range for treatment effectiveness for both genders. Psychotherapeutic Methods were in the middle “somewhat effective” range (with a median rating for males of 2.40 and a median rating for females of 2.41). The least effective treatment categories were the Behavioral Methods at the low end of the “somewhat effective” range (with males having a median rating of 2.10 and females having a median rating of 1.91) and the Pharmacologic Methods which were ranked in the “not effective” range (with a median rating for males of 1.46 and a median rating for females of 1.43).

In summation, out of 55 treatment modalities, 26 were identified by the treatment providers in this study as being more effective for either males or females. Eight Behavioral treatment methods were identified as more effective for males (Impulse Control, Measurement of
Arousal, Verbal Satiation, Masturbatory Satiation, Orgasmic Reconditioning, Minimal Arousal, Masturbatory Training and Aversive Techniques), while none of the Behavioral treatment modalities were identified as more effective for females. Two of the Psycho-educational treatment methods were identified as more effective for males (Anger Management and Social Skills Training) and two were identified as more effective for females (Communications Skills Training and Assertiveness Training). Only two of the Cognitive Behavioral methods were identified as more effective for males (Assault Cycle and Fantasy Work), while none were identified as more effective for females. However, three Psychotherapeutic methods were identified as more effective for females (Individual Counseling, Psychodrama and EMDR) while only one was identified as more effective for males (Journaling). Finally, out of the Pharmacologic methods, three were identified as more effective for males (Provera, Androcur and Lupron) while five were identified as more effective for females (Major Tranquilizers, Lithium, Minor Tranquilizers, Lithium, Anafranil and Buspar).

The results obtained suggest that Behavioral interventions and Pharmacologic interventions are not very effective for males or females, given median scores in the “not effective to somewhat effective” levels. Psychotherapeutic interventions appear to be equally effective for males and females, being in the “somewhat effective” to “mostly effective” levels. Cognitive Behavioral interventions were identified as being more toward the “mostly effective” level for both males and females while Psycho-educational Methods appeared to be at the “mostly effective” level for both conditions.
Chapter 5 – Discussion

This chapter provides a discussion of the results of the study. It includes a brief overview of the background of the study, the major findings of the study, its limitations and implications for future research.

Brief Overview of the Study Background

Previous literature has indicated that female sex offenders are different from male sex offenders on several counts. Vandiver and Teske (2006) and Roe-Sepowitz and Krysik (2008) found that juvenile female sex offenders are often victims of sexual abuse, come from dysfunctional homes, have a co-occurring psychiatric disorder, tend to victimize small children that are known to them, and will sexually offend against both male and female victims. Female offenders are more likely to sexually offend against smaller children in their care and adolescent female offenders are more likely to offend equally against male and female victims. They are more likely to offend with another person, and not alone. Finally, they do not tend to commit rape, but, when they do, the victim is more likely to be female. (Becker, et al., 2001; Davin, Hislop and Dunbar, 1999; Grayston and DeLuca, 1999; Nathan and Ward, 2001; and Vandiver, 2006).

The literature also suggests that female sex offenders commit offenses for different reasons than male offenders. For example, female offenders tend to report offending sexually to meet an emotional need more often than males (Faller, 1995 and Kaufman et al., 1995). Similarly, female offenders tended to report thinking of adult males when they offended against children, thus not fitting the typical characteristics of a pedophile (Grayston and DeLuca, 1999).
Since female sex offenders have been found to have different reasons for offending, more extensive histories of being abused, more trauma in their lives, and higher incidence of mental illness or chemical dependence, it is logical to question whether treatment effectiveness would be different for female than male sex offenders.

To explore the differences between treatment effectiveness for juvenile male and female offenders, this study investigated perceived treatment effectiveness of offenders among treatment providers. The study used a survey developed by Tuell (2003) who conducted his dissertation study about juvenile sex offenders without distinction between male and female offenders. Using the survey developed by Tuell (2003), this study surveyed treatment providers working with juvenile sex offenders to determine which of 55 treatment modalities were perceived to be more effective for female juvenile sex offenders.

**Major findings**

Sixty-four treatment providers were asked to rate 55 treatment modalities for effectiveness for male and female juvenile sex offenders. Out of 55 possible treatment modalities, 23 were identified as being in the effective to mostly effective range, 12 were identified as being in the somewhat effective to mostly effective range, 12 were rated as being in the somewhat effective range and 8 modalities, all in the Pharmacologic Methods section, were identified as being in the not effective to somewhat effective range.

Slightly over half of the treatment modalities (52.73%) were identified as equally effective for both male and female juvenile offenders. Also, none of the Behavioral or Cognitive Behavioral treatment modalities were identified as more effective for females than males.
When the mean median responses for each treatment modality are placed in rank order and compared for both males and females, then the treatment category that is considered to be the most effective for both males and females is the Psycho-educational Methods category. The median response for males in this category is 3.00 and is 2.96 for females. Out of 12 treatment modalities within the Psycho-educational Method, 8 were rated as being equally effective for both males and females. Two treatment modalities were identified as being more effective for females than males. These were Communication Skills and Assertiveness Training. The two treatment modalities that were identified as being more effective for males than females, were Anger Management and Social Skills training.

These results are supported by the literature. The Center for Sex Offender Management (2007) recommended treatment for female sex offenders include assertiveness training. Also, Hudson and Ward (2000) and Roe-Sepowitz and Krysik (2008) recommended interventions for female sex offenders which help them to understand sexual development, address social skills deficits, and promote understanding of social expectations of female behavior, each of which are addressed by Psycho-educational Methods.

Cognitive Behavioral Methods are next in rank for both genders. The mean median response for males in this category is 2.84 and is 2.83 for females. No Cognitive Behavioral treatment modalities were identified as being more effective for females, but Fantasy Work and understanding the Assault Cycle were identified as being more effective for males. Otherwise, ten treatment modalities within this category were identified as being equally effective for both males and females. While Hudson and Ward (2000) supported using Victim Empathy with female offenders, Cognitive-Behavioral Techniques are not typically identified as being gender specific interventions, which was seen in this study.
Next in the rank order, in the somewhat effective to mostly effective range were the Psychotherapeutic Methods. The mean median response for males in this category is 2.40 and the mean median response for females in this category is 2.41. Three of the treatment modalities were identified as being more effective for females. They were Psychodrama, Individual Counseling and EMDR. Only one was identified as being more effective for males. This was Journaling. The rest of the 8 treatment modalities were rated as equally effective (but closer to the somewhat effective range) for males and females.

The literature supports these findings for females. McGrath (2003) recommended that treatment for females focus on expressive and experiential techniques and mentioned drama as well as art as useful with this population. Meanwhile, Hudson and Ward (2000) as well as Chorn and Parekh (1997) suggested interventions that address issues of attachment and intimacy (which are often addressed in Individual Counseling). The literature (Grayston and De Luca, 1999; Kaufman et al.;1995, and Vandiver and Kercher ,2004) suggests that female sexual offenders have more extensive histories of mistreatment and abuse, have been sexually abused as a child, are more extensively mentally ill and have more impairments than male sex offenders. Therefore, it seems logical that female sexual offenders would respond more favorably to those treatment modalities that would address histories of trauma and abuse (Dombrowski, et al., 2011 & Roe-Sepowitz and Krysik, 2008).

The Behavioral Methods were identified as being in the not effective to somewhat effective range for treatment effectiveness of both males and females. The median response for males in this category was 2.10 and for females, was 1.91. Dumbrowski et al. (2011) indicated that Behavioral Methods were used to decrease deviant sexual behaviors. In this study, 8 out of 12 Behavioral treatment modalities were identified as being more effective for juvenile males
than juvenile females, while none were identified as more effective for juvenile females. These results suggest that juvenile females have emotional needs that motivate their sexual offending behavior while juvenile males act out of needs for power and control when they sexually offend; therefore treating from behavior perspective are not necessarily effective.

The Pharmacologic Methods were rated as the least effective treatment category for both juvenile males and juvenile females. The median response for males in this category was 1.46 and the median response for females in this category was 1.43. Interestingly, males were identified as responding more effectively to medications that affect hormonal levels (such as testosterone levels) while females were identified as responding more effectively to medications that affect mood and anxiety (such as Lithium & Buspar). Barbaree and Marshall (2008) indicated that medications could be used to calm down anxious offenders as well as to decrease male hormonal levels, so these findings are reflected in the literature.

Limitations of the Study

The sample size is small in this current study. The limitation of having such a small sample size would lower statistical power. The low statistical power of a small sample affected the results for effectiveness for juvenile males and juvenile females because the statistical significance found in the study is more likely subject to error. Therefore, any statistical significant results found in the study should be interpreted with caution.

Another limitation is that this survey was based on self-report data. As any self-reported survey, the response might be biased due to participants’ factor. While some of the respondents to this survey might have sufficient training to respond adequately to the survey, some may not be equipped to answer the questions with good faith. The participants may have personal
philosophy about female sex offenders that could lead them to believe in effectiveness of certain
treatment modalities regardless the actual outcome of the treatment. They may respond to
certain questions under the influence of social desirability as well. As a human being, the
participants may simply make errors, so random error could occur.

Along the same line, the treatment providers might not have been familiar with certain
treatment modalities (such as EMDR and Hypnosis, which require specialized training, or
Measurements of Arousal and Verbal Satiation, which are not as widely used) and increased the
likelihood of measurement error. Also, some of the treatment providers might not have felt as
comfortable or knowledgeable about female sex offenders, and have either avoided some of the
female sections. It is also possible that treatment providers do not see any differences between
the populations, treating both equally as sex offenders. Finally, since none of the Pharmacologic
Methods were identified as being effective for either males or females, it is possible that the
treatment providers in this study did not believe by their professional affiliation that using
medication as a good treatment option for these populations.

The response rate was very poor, with only 93 people responding out of a total pool of
430 surveys sent out. Out of the 93 who responded, only 64 actually went on to complete the
survey. Due to the very low return rate and the sample being small, the sample in this study may
not represent the population of sex offender treatment providers well. There were several reasons
for the low response rate. In an effort to maintain confidentiality, respondents were not tracked,
so there was no way to identify who responded and who did not. Therefore, it was unknown how
those who responded might be the same or different from those who did not respond. Another
problem with the response rate was the difficulty obtaining viable emails for all treatment
providers as identified by legitimate sources such as the Safer Society Press and Sex Offender
Management Board for a particular State. Since many of the lists provided only phone numbers or addresses instead of viable emails, much time was spent looking up individual names and treatment centers in order to obtain legitimate emails. The original pool of treatment providers was therefore much larger than the list of providers with email addresses.

Out of the list of 430 providers finally identified, 29 emails were unable to be sent out due to an error in the address. Out of the emails that did go out or had viable addresses, some messages were received that the provider was out on vacation, that the provider did not want to participate in the study, or that the provider no longer worked in the field. Out of 93 providers who did respond, only 64 actually went on to complete both the demographic questionnaire and the survey.

The low return rate indicates that the sample in this study might be less representative of the actual population. The combination of small sample size and low return rate of the survey limits the findings of this study to external generalizability. Interpretation and application of the study results should be cautious too.

To gain better representative sample in the future study, one should consider emailing the survey to those with viable emails and mailing the survey to those who did not. This would have resulted in a higher response rate. The future study should design a user-friendly online survey to prevent low completion rate as found in this study.

**Implications for Research and Practice**

The results of this study add to the existing literature about juvenile female sex offenders by changing the focus from identifying and categorizing offenders to looking at how they respond to treatment modalities. While prior research focused in large part on identifying
characteristics of juvenile female offenders, this study focused on treatment effectiveness as perceived by those who actually provide treatment to this population.

The results of this study suggest that, while some of the treatment modalities were identified as being significantly different in treatment effectiveness for juvenile female sex offenders when compared to male peers, over half of the 55 treatment modalities were identified as equally effective for both. Future research is needed to explore these findings and to identify what factors contribute to the differences in treatment effectiveness for male and female juvenile sex offenders.

While it is helpful to understand how treatment providers view the effectiveness of their interventions, further research would be needed to identify whether these perceptions are true. In other words, is there an actual difference in treatment effectiveness for juvenile female sex offenders among the various treatment modalities?

As for implications for practice, the results of this study found that use of Psycho-educational and Cognitive Behavioral practices were effective for both genders. However, communication skills and assertive training were more effective for females. It might be helpful to emphasize the development of relationships and social skills for female clients. Then, emphasizing the development of Communication Skills and Assertiveness Training would be more beneficial for the group participants. If possible, treatment for females should consist of Individual Counseling and, if there is a trauma history, then the use of EMDR could be beneficial.

Counselors working with juvenile sexual offenders can utilize the results of this study about the similarities and differences of treatment effectiveness for female and male juvenile
offenders in their treatment plans. For instance, Psycho-educational and Cognitive Behavioral treatment modalities appear to be useful for all, as well as more beneficial than Psychotherapeutic treatment modalities in general. Behavioral Modalities may be effective with male juvenile offenders. Pharmacologic Modalities may be used differentially for females to address emotional/anxiety issues and for males to address hormonal levels.

**Conclusions**

Developing a greater understanding of juvenile female sex offenders is important in the development of treatment modalities that meet their treatment needs. This study investigated how those who are actively providing treatment to juvenile sexual offenders perceived the effectiveness of various treatment modalities for juvenile males and females. The results of this study find that treatment effectiveness as viewed by sex offender treatment providers as equal across genders. However, there are some differences in treatment effectiveness where females were identified as responding more favorably to Communication Skills training, Assertiveness training, EMDR, Individual Counseling and Psychodrama.

An issue that arose from this study is whether or not the treatment providers accurately perceived treatment effectiveness. It would be helpful to have a large and more representative sample to explore whether the same findings would be obtained. Future research is also needed to clarify why some of the treatment modalities were identified as equally effective for both male and female juvenile sex offenders while other treatment modalities were identified as being more effective for either gender. Further, the perceived effectiveness should be tested through treatment outcome evaluation studies.
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Joseph Peters Institute.


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Appendix A

Demographic Information

The following information will assist in this researcher’s understanding of these data obtained for this research. Please circle or add your response. Feel free to add any additional comments that you feel will assist in this research.

Your Gender: ______________ Your Age: ________________ Your Race: ____________

1. Years working with the offender population: 1-5 5-10 11-15 16 +
2. Education: High School Undergraduate Graduate Post-graduate
3. Highest Degree: _____________________________________
4. Licensure: No License Counselor Social Worker Psychologist Other __________
5. Have you had experience working with female sex offenders? Yes ____ No ____
6. If yes, how many years of experience have you had? __________
7. Where you specifically trained in the treatment of female sex offenders? Yes__ No__
8. If yes, where did you get that training? ______________________________________

Please include any other relevant material regarding training and qualifications for the treatment of sexual offenders and/or female offenders:

______________________________________________________________________________
______________________________________________________________________________
______________________________________________________________________________
______________________________________________________________________________

By completing this questionnaire, I indicate my consent to participate in this study.
Appendix B

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KEY:
1 = Not effective 2 = Somewhat effective 3 = Mostly effective 4 = Effective
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Appendix C

University of Cincinnati
Department of Counselor Education
Principal Investigator: Mardi Fallon, MEd
Faculty Advisor: Mei Tang, PhD

Dear Colleague:

You have been identified as a person who provides treatment to juvenile sex offenders. As such, you are being asked to take ten to fifteen minutes of your time to assist in a survey which is part of a dissertation study at the University of Cincinnati. I would appreciate your completion of the online survey. Please proceed if you are willing to participate in this study. If you do not wish to participate at this time, two more requests will be sent. There is no obligation to participate.

Thank You,
Mardi Fallon, MEd
Appendix D

Second reminder email:

Dear Colleague:

This is a second request to participate in the survey sent to you last week. Please complete the attached online survey. If you do not wish to participate, there is no obligation to go further. However, since responses are confidential, another reminder will be sent to you in a week.

Thank You,
Mardi Fallon, MEd

Final reminder email:

Dear Colleague:

This is the final request to participate in the survey sent to you two weeks ago. Please complete the attached online survey. If you do not wish to participate, there is no obligation to go further. No other reminders will be sent to you.

Thank You,
Mardi Fallon, MEd