Forensic Psychology: Preparing Female Clinicians for Challenging Offenders

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Preparing female clinicians for the emotional and psychological demands of forensic work with violent and/or sexual offenders is imperative. Stereotypical gender scripts, such as the expectation that females must empathize with victims, result in stigmatization of female clinicians. Biases that women are less capable of handling such offenders contribute to increased difficulties within the field. Preparing female trainees for counter transferential issues, de-feminization, and the potential for vicarious traumatization will serve to help female clinicians continue to thrive in the field of forensic evaluation and treatment; thereby benefitting treatment and the field in general.

KEYWORDS clinical training, female clinicians, forensic psychology, offenders, preventing burn out

Forensic psychology is defined as the intersection of psychology and the law. Forensic psychologists are asked to address legal rather than clinical questions—such as whether a defendant is competent to stand trial or assessing their state of mind at the time of the offense (insanity). Forensic psychologists are also asked to provide sentencing and court mandated treatment recommendations, to introduce mitigating factors that may cause the judge or jury to look differently at a crime, to evaluate the credibility of
a witness, or to assess the risk that a convicted person may commit a similar crime in the future (recidivism).

Media and television dramas have more recently focused on issues involving criminal behaviors, which have increased awareness of and interest in the field of forensic psychology. Despite this increase in awareness, women are still a minority in the field and face implicit biases. Since the forensic population presents unique risks (e.g. aggression, violence, or sexually deviant behaviors), there is an assumption that men are better equipped to manage and treat this population. Although the number of women in the field is growing, little attention has been given to how to adequately train and supervise females in this context. Though the field of forensic psychology is broad, the scope of the current article will be limited to a discussion of violent or sexual offenders. Gender roles significantly impact how clients, supervisors, and society perceive female clinicians working with violent or sexual offenders. Therefore, the purpose of this article is to raise awareness of and prepare females for the feelings, experiences, and difficulties involved in working with these challenging populations.

STIGMATIZATION

Gender stereotypes and biases impact how females are perceived in the field of forensic psychology. According to stereotypical gender scripts, females are expected to empathize with victims, who are often children or women. Female clinicians involved with the defense counsel representing an individual charged with a violent sexual offense (not yet convicted), face stigmatization from the community who may believe they are “supporting” the alleged sexual offense (Lea, Auburn, & Kibblewhite, 1999). When those cases involve child molestation, clinicians who work with or represent the alleged perpetrator are perceived as “heartless” or unsympathetic to children who have been abused. Similarly, clinicians who advocate for treatment or emphasize the capacity for sex offenders to change are perceived as endorsing sexual offending behaviors (Lea et al., 1999). This societal response can be difficult for women to manage, as the clinician’s intent is to uphold the defendant’s constitutional rights and present objective psychological data about the defendant. Reactions to this stigmatization should be discussed in supervision in order to normalize a supervisee’s feelings of anger, confusion, and/or shame that may emerge from their work with these offenders.

Even in promotions and employment within the field of forensic psychology, gender discrimination often exists. Women may be passed up for a position working with dangerous offenders under the pretense that it is for their physical and psychological safety. Gender stereotypes suggest that women are less capable or more fragile than men. Reacting against this stereotype of implied fragility, female clinicians often avoid seeking help and
support in an attempt to prove that they are indeed competent in this difficult field of work. This is evident in female supervisee’s lack of willingness to ask for advice from their supervisors in difficult clinical situations, including ones where clients have acted inappropriately with them—sexually or otherwise (Hartl et al., 2007). Fear of confirming stereotypes creates situations in which women are more susceptible to burn out and vicarious traumatization.

Female discrimination is less evident in other arenas of forensic psychology, such as in family courts. Women are seen as quite capable, and even favored to their male counterparts in this court setting (Arrigo & Shipley, 2004). This favorable bias is likely due to societal beliefs that victims require a nurturing, caring approach, whereas perpetrators only deserve to be punished. However, the involvement of female clinicians can be very beneficial to the treatment of offenders. Interacting with a woman provides the opportunity to challenge the offender’s distorted views of women (i.e., that they are powerless or rejecting). Thus, treatment that includes both male and female clinicians can maximize the effectiveness of therapeutic interventions.

**BOUNDARIES**

Clinical supervision ensures that counter transference and other boundary issues can be addressed properly, which is especially important for women, who may be perceived as more easily intimidated or manipulated (Mothersole, 2000). The supervisor should model setting boundaries so the trainees can observe an appropriate way to maneuver the new environment, which can be intimidating and overwhelming at times. One component of setting boundaries has to do with the amount of personal information shared with offenders. Acceptable boundaries range among clinicians from willingly sharing general details of their life (i.e., personal interests) to sharing absolutely nothing about themselves. Considering the prevalence of manipulative tendencies and personality disorders (e.g., Antisocial or Borderline Personality Disorders) among offenders, the supervisor should prepare trainees for clients’ attempts to deliberately break boundaries. Trainees should be encouraged to decide where they want to set their own boundaries. Furthermore, supervisors are encouraged to advise trainees to seek resources in order to process triggers and discuss their comfort level of continued work with violent or sexual offenders.

**DE-FEMINIZATION**

In a forensic setting, being a woman and a forensic psychologist may not feel fully congruent, as embodying one role may discount the other. Female clinicians need to be vigilant about their appearance and be aware of how it may
impact the client. This is due to the objectification of women and negative connotations associated with women among offenders, as well as the prevalence of paraphilias among offenders that can be easily triggered by visual stimulus. Female clinicians report having to ‘de-feminize’ themselves in order to avoid potential advances or inappropriate behaviors from offenders and to ensure that the focus remain on the clinical material. Thought is given to the type of shoes worn (i.e., no heels or open toed shoes), perfume, jewelry, or any clothing that might remind the offender that the clinician herself is a sexual being (i.e., cleavage, displaying legs or toes, etc.). Since female clothing is often more form fitting, it is common practice to purposely wear loose clothing to de-accentuate femininetrails (Dean & Barrett, 2011), as well as to avoid attracting attention or focus on a particular body part. Because male attire is traditionally looser fitting and covers more of the body, this issue is typically more unique to women. This form of de-feminization is important to explore in the supervisory relationship, as it may feel like the trainee’s identity as a woman is compromised in order to competently do her work.

When clients do exhibit inappropriate behaviors, women are more likely to make attributions about themselves in order to explain such inappropriate behaviors (Hartl et al., 2007). If a client winks or makes a suggestive gesture towards them, female clinicians often wonder, “What was I doing to invite such a gesture?” “Did I lead them on?” or “Did I not uphold my personal boundaries?” These difficult questions should be addressed and discussed in supervision, yet too often are avoided within supervision (Hartl et al., 2007). The potential pitfall of not disclosing or processing these breaches in boundaries to one’s supervisor or colleague results in the internalization of these thoughts as truth—“I must have done something to elicit my client’s inappropriate behavior.” Further, the female clinician may become hypervigilant about her contact with her clients, constantly self-questioning how her behaviors and mannerisms may be interpreted. Although some level of vigilance or awareness is critical in this type of clinical work, excessive vigilance inevitably impacts the quality of treatment.

Discussing inappropriate client behaviors has been established as a crucial aspect of supervision (Heru, Strong, Price, & Recupero 2004). However, less than two-thirds of clinicians will actually raise these issues with their supervisor, which are often sexual in nature (Morgan & Porter, 1999). Females in general have more rigid boundaries regarding self-disclosure within supervision (Heru et al., 2004). Supervisees are hesitant to raise certain issues with their supervisors for fear that they will be deemed ‘irrelevant’ or ‘unimportant’ (Hartl et al., 2007). Ladany, Hill, Corbett, and Nutt (1996) suggest that trainees fear that they may be unsupported, ‘laughed off’, or that they will jeopardize their training evaluation and/or future career if they bring up these concerns. Furthermore, trainees may worry that their supervisor will frame the inappropriate behaviors as a lack of skill/competence or poor personal boundaries, rather than exploring the
emotional impact of clients’ inappropriate behaviors (Hartl et al., 2007). Ultimately, females may worry that a disclosure of inappropriate behaviors directed toward them may result in restricted access to such offenders in the future, as some may mistake the client's sexual inappropriateness as evidence that the trainee cannot handle working with clients in this population.

EXPOSURE TO DEVIANT SEXUAL CONTENT

Preparing new clinicians for work with sex offenders is imperative due to the psychological effects and emotional responses such sexualized environments elicit. Clinicians working with sex offenders are expected to delve into the depths of the client’s sexual world in order to better understand and treat deviant sexual behaviors. In this role, the clinician is exposed to vivid images of the sexual offenses and/or sexually deviant fantasies and behaviors, which can impact the clinicians’ own psychological and sexual functioning. For example, clinicians have reported being fascinated by and attracted to the offenders’ deviant sexual behaviors (Ellerby, Gutkin, Smith, & Atkinson, 1993; Erooga, 1994). Of note, however, is that little research has explored differences between female and male clinicians in this regard. Regardless of gender, this fascination often results in voyeuristic tendencies to uncover more details than necessary for an evaluation or treatment, due to the thrill derived from hearing the sexual account (Mothersole, 2000). In these cases, a supervisor may explore with the supervisee the clinical merit of eliciting such detailed accounts. Once there is an understanding of why, the supervisor can assist the trainee in developing and utilizing necessary therapeutic tools that are beneficial for treatment goals.

In addition to being fascinated by deviant sexual behavior, research has shown that clinicians can become sexually aroused by the content of the sexual offense (Bengis, 1997; Ellerby, 1997; Gerber, 1995; Gil & Johnson, 1993; Hackett, 2002; Ryan & Lane, 2007). Sixteen percent of female clinicians admitted to being sexually aroused by the offenders' retelling of their deviant sexual behaviors (Ellerby et al., 1993). Furthermore, clinicians in general have reported experiencing sadistic sexual fantasies (Gerber, 1995) as well as impulses to act out in deviant, sexual ways (Bengis, 1997). This interest and arousal results in significant counter transference issues for clinicians, as they may experience a range of emotions, such as “confusion, anxiety, helplessness, guilt, rage, protectiveness and even sadism” (Chassman, Kottler, & Madison, 2010). Processing emotional and sexual responses with supervisees is imperative to prevent distress and internalization of blame. Certainly un-examined counter transference issues, such as unwelcome sexual arousal by deviant behaviors, will likely negatively impact a clinician’s work (i.e., avoiding sexual material required for a thorough evaluation or treatment session).
Though some clinicians become fascinated by deviant sexual behaviors, others may be repulsed or horrified by offenders’ behaviors. Offenders have been charged with or committed illegal acts, including murder, rape, or child molestation, and it is a natural human response to experience some fear and/or disgust in their presence, especially in a one-to-one therapeutic relationship. Supervision (in early training) and consultation with colleagues provide a critical place to examine one’s counter transference and the impact it has on an offender’s treatment. Within a supervision context, it is important to decipher whether a fear response is a result of manipulation or inappropriate behaviors on the offender’s part. If so, the focus of supervision should be on re-establishing boundaries and respect for the therapeutic relationship. However, if the clinician’s response of fear is related to a personal trigger or the offense hits too close to home (i.e., treating a pedophile who abused a 7-year-old boy and the clinician is a mother), then the focus of supervision should be on processing the difficulties in maintaining objectivity between the professional demands and one’s personal experiences. In such cases, it is critical to explore and process the supervisee’s emotional response to their client, as it will not only impact the supervisee personally, but also impact the effectiveness and success of treatment. While supervision provides a context to explore counter transference as it relates to treatment, supervisors may need to recommend individual therapy as a context where supervisees can further explore the emotional impact of working with these forensic clients.

Exposure to deviant sexual content and inappropriate behavior can lead to changes in sexual intimacy in the clinicians’ personal life. Clinicians working with this population have reported avoiding sexual contact altogether as well as becoming distracted during sex and/or ending sexual contact prematurely within their own personal lives (Ellerby, 1997). This impact on sexual intimacy is often not addressed or acknowledged by clinicians in the field. However, supervisors should educate trainees on this potential influence on their sexual intimacy in order to empower them to seek resources to manage this sensitive topic (i.e., couples or family therapy).

COUNTERTRANSFERENCE

Females who work with offenders face unique challenges in regards to counter transference, especially when clients have committed sexual abuse or violence. Often, working with these populations increases the female clinician’s awareness of the potential for victimization or trauma in her own life (Schauben & Frazer, 1995). Though men may also be victimized, the statistics reveal that this risk is substantially greater for women, as 1 in 5 will be raped sometime during her life (Koss, 1993) and 25% of females are sexually abused (Rowan & Foy, 1993). Furthermore, because a large percentage of females in general experience victimization, it is not surprising that many clinicians have similar
A. L. Ermshar and A. M. Meier

backgrounds. Schauben and Frazier (1995) found that 70% to 83% of female clinicians working with victims of sexual abuse or violence reported a history of their own victimization (i.e., rape, attempted rape, incest/child sexual abuse, sexual harassment, and/or other sexual assault). A staggering 37% of those who had experienced one of these forms of victimization actually had a history of two or more forms of victimization. Despite these statistics, overall, clinicians with a history of victimization were not more distressed by their work with abuse victims than clinicians without this history (Schauben & Frazier, 1995). However, it is important to educate supervisees that offenders can trigger intense personal feelings and traumatic memories, especially if the supervisee has her own personal history of victimization (Mothersole, 2000).

VICARIOUS TRAUMATIZATION

Given the significant impact of this work on their psychological, social, and sexual functioning, it is not surprising that clinicians who work with violent and sexual offenders experience high levels of burnout (Farrenkopf, 1993; Hackett, 2002) and are susceptible to vicarious traumatization (Moulden & Firestone, 2007; VanDeusen & Way, 2006; Way, VanDeusen, & Cottrell, 2007). However, it is not clear how women are specifically impacted by this work, as research has not investigated gender specific differences. Though evidence has found any risk for traumatization can be mitigated by supervision, clinicians who work with offenders and have limited opportunities for supervision have reported higher levels of distress and burnout than those who have supervision readily available (Ellerby, 1998).

Though research has focused on clinicians' work with victims of sexual abuse, those who work with perpetrators are also at risk for vicarious traumatization. Vicarious traumatization has been described as “a process by which therapists' experience of themselves, others, and the world around them is negatively affected as a direct result of an empathic connection with clients' traumatic material” (Kadambi & Truscott, 2003, p. 217). This process can result in changes in world view, identity, issues surrounding safety and trust, as well as intrusive visual images and painful affect (McCann & Pearlman, 1990). Farrenkopf (1992) found that 25% of professionals who worked with sexual offenders reported high levels of stress, exhaustion, depression and burnout. Furthermore, in his research, 33% of these professionals experienced symptoms of vicarious traumatization, including hyper vigilance, suspiciousness and fear for the safety of loved ones (Farrenkopf, 1992). Fitzgerald (2009) described her difficulty and eventual burnout from working with sexual offenders: “I couldn’t get to sleep at night. Images flashed—no, crashed—before me, of the things I had read or heard that day: X touching the nine-year-old girl; Y masturbating in front of his two
boys … I began suspecting every man I knew. I wanted to know why they helped out at Scouts or offered to babysit … They had skewed my world, polluted me.” The issues Fitzgerald (2009) highlights are common and contribute to burnout. However, acknowledging a possibility of negative outcomes and providing adequate attention to these issues in supervision can stave off the ramifications of exposure to such a challenging population. Vicarious trauma can also occur and may even be more intense in the supervisor, who hears about the trauma or offense secondhand and has no working relationship with the client. As a supervisor, it may be more difficult to think of either the victim and/or the offender as whole persons when there is no working relationship with either. As such, it will be important for supervisors within this context to seek their own consultation and support for these difficulties.

Chassman and colleagues (2010) found that seeking supervision and/or individual therapy helps clinicians more effectively manage their feelings and prevent burnout. Furthermore, clinicians who experience sexual arousal in working with sex offenders should work on managing and setting their own boundaries. In order to minimize the chance of vicarious traumatization and to manage potential sexual arousal, substantial thought should be given by the clinician as to how much detail of their clients’ sexual and/or violent acts they are willing and able to handle (Chassman et al., 2010). Coping techniques can be utilized to prevent vicarious traumatization and burnout, such as focusing on the clients’ narrative rather than visualizing the behaviors being described (Chassman et al., 2010). Though clinicians who work with violent and sexual offenders have an increased susceptibility to burnout and traumatization, it is important to note that the majority of clinicians who work in this area are coping relatively well with no signs of any drastic changes in emotional or psychological functioning (Ellerby, 1998; Ennis & Horne, 2003).

CONTINUING SUPERVISION

Although the concept of supervision is often regarded as solely for those in training or early in their career, it should be viewed as a career-long tool to be utilized by all. Once out of training and post-licensure, supervision is often coined “consultation” or “peer supervision.” Colleagues have been cited as the most frequently used method of coping with the nature of forensic work (Jackson et al., 1997). As illustrated throughout the article, the benefits of continued consultation with peers even post-licensure include a) greater objectivity for clients, b) increased insight into clinical blind spots or personal triggers, c) support for difficult cases, and d) mitigation of burnout. When working with violent and/or sexual offenders, consultation with peers is even more critical than in other clinical settings, since the topics discussed
in treatment and the offenders themselves often take a much larger toll on clinicians.

CONCLUSION

Preparing new clinicians for the emotional and psychological demands of forensic work with violent or sexual offenders is imperative. As illustrated throughout the article, supervision is crucial to adequate adjustment to this field, especially for female trainees and the unique challenges they encounter. Stereotypical gender scripts, in which females are expected to empathize with victims, result in stigmatization of those working with offenders because it is seen as evidence for supporting or excusing their behaviors. Considering these examples, the attitude and atmosphere towards women in forensic psychology serves as a self-fulfilling prophecy setting women up for increased difficulties in the field, as they strive to prove that they indeed can handle it without seeking support or help, hastening their burnout levels. Preparing female trainees for counter transference issues, de-feminization, and the potential for vicarious traumatization will serve to help female clinicians continue to thrive in the field of forensic evaluation and treatment; thereby benefitting the offender’s treatment and the field in general.

REFERENCES


