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Evaluations of Sexual Offenders:

How Stereotypical Bias may Affect Assessments of Risk and Treatment Need

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Abstract

Traditional sex role attitudes and gender bias may be affecting not only the identification of female sexual offenders but also the development of gender specific risk assessment tools and treatment interventions. This papers aim is to explore whether stereotypical attitudes exist among trained professionals in Sweden, or if a specialized training is a protective factor concerning discriminative tendencies if existing in society. Treatment providers from the Swedish Correctional Services were asked to asses risk level and treatment need on a vignette character, either male or female, described as having committed a sexual offence against a minor. The test subjects were compared with two control groups; college students and social workers. A total of 161 participants completed the assignment.
Results showed that all three groups tended to over rate the risk of the offender and only minor non significant differences between the test group and the control groups were found. The lack of significant differences could be explained by small power but also raises the question about alternative stereotypical beliefs. The study highlights scarcity of knowledge in the field of female sex offending and more research is warranted to reduce sexual harm.

Keywords: Stereotypical beliefs, sex offenders, risk assessment, treatment interventions.

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Introduction

In the process of working with male sex offenders within the Swedish Correctional System it is fairly common to come across clients who self report sexual experiences with adult women during their childhood or early adolescence. The men often refer to these experiences as consenting and that they themselves have initiated the contact or seduced the women, somewhat proud of being sexually mature at an early age. As a treatment provider in a forensic setting and with a treatment goal to stop abusive and criminal behaviour, the interpretation of these actions differs from the clients' point of view.

Sexual acts between a child and an adult are illegal and are considered sexual offences, no matter of the gender of the perpetrator or the victim. This should be the view shared by most people but due to differences in how society at least historically views female and male sexuality, female sexual aggression is rarely disclosed or sanctioned. Having said this there is no evidence supporting the idea that women sexually offend at the same extend as men do, quite the opposite female sexual aggression is quite rare. Since there are a vast number of undetected sexual crimes being committed though, the actual percentage of female sex offenders could differ from the official statistics. It is plausible that offences perpetrated by females not only is considered or perceived as "non-offences" by the victims but also by the police, courts, treatment providers or persons assessing risk.

Focusing on the differences between males and females is important in the aim to develop gender specific treatment for various problems that might occur in the correctional service systems, but it is also important not to overlook the similarities. One issue that might affect how female perpetrators are assessed in reference to risk and need, and therefore also affect the current research status, could be the attitudes that professionals have on female sexual offenders. Research suggests that once a female perpetrator is identified it appears that society attributes more negative responses towards her than on a male counterpart (Sahlstrom K. J. & Jeglic E. L., 2008).

Prevalence of female sexual offenders

According to the Swedish National Board of Health and Welfare it is estimated that roughly eight percent of women and up to three percent in men have been sexually abused on at least one occasion during their childhood or adolescence. The perpetrators are mainly male but between 5-15% of all offences on children or adolescence are believed to be committed by

female sex offenders (Wigzell, 2001). The suspected under reporting of female sexual abuse is somewhat confirmed in a recent study by Kjellgren, Priebe, Svedin, Mossige, and Långström, (2009) when a Swedish subsample of the "Baltic Sea Regional Study on Adolescent Sexuality" showed that in the total sample of adolescent females and males who admitted a sexually coercive behaviour 19% where girls. Among adolescents who were reported to the police or social service because of sexual coercion one to two percent was girls, indicating a considerable difference.

In the official statistics of sexual crimes committed in Sweden approximately four to five percent was perpetrated by a female. In a study by Fazel, Sjöstedt, Grann and Långström (2008) they found that 37% of the women convicted of sexual crimes between the years of 1988 and 2000 had been admitted to psychiatric hospitals and 8% had a diagnosis of psychotic disorders. When compared to non-sexual violent offenders there were no significant differences in the proportions of psychosis or substance abuse suggesting that the two groups were equivalent in theses aspects. Compared to the general population there were significant differences and it showed an increased risk of a psychiatric disorder in the female offender population than among the non-offending women.

Like male sexual offenders, female sexual perpetrators often self report having experienced severe adversities in their developmental years like physical abuse, sexual abuse, emotional abuse and neglect. In light of those reports it is not surprising that some research suggests that female sexual offenders suffer from a range of mental health problems like bipolar disorders or schizophrenia, but the relation between mental illness and sexual offending is problematic. For one it is more likely that a sexual offender with a mental illness will be apprehended by the authorities and secondly due to the lack of adequate comparison groups it is not possible to do valid conclusions as to how the relation between female sexual aggression and mental illness is construed (Cortoni & Gannon, in press).

Cortoni and Gannon (in press) referers to research by Finkelhor et al. (1990); NSPCC (2007); Adshead et al. (1994) and Cortoni et al (2009) to name a few, and stresses the difficulty in establishing an actual prevalence number of female sex offending when using prevalence statistics or incidence statistics (self reports of victimization versus official crime records). However, although the prevalence numbers is fluctuating depending on the methods and samples used, they conclude that there still will be a sizeable number of victims and offenders in need of clinical intervention. (Cortoni & Gannon, in press).

Along with low reported rates of female sexual assaults, societal myths and taboos seem to support the idea that sexual crimes are only committed by males and this,

contributing to the low detection rate of female sexual offenders. One hypothesis therefore is that male offenders are supervised more intensively than female and are thus more likely to be disclosed if they reoffend in any crime whereas female offending or reoffending remains unknown to authorities. Although, according to Center for Sex Offender Management (CSOM, a Project of the Office of Justice Programs, U.S. Dept. of Justice) the rate of known sexual offenses committed by women increased dramatically from 1% to 8% of all sexual assault arrests between the years 1994 through 1997, indicating that increased knowledge of female sex offences might affect the attitudes among the general public and among the professionals who register the offences (Freeman & Sandler 2008). In the CSOM report of 2007 they note that the registered arrests of adult female sex offenders has decreased but the offences committed by adolescent female perpetrators has increased, specifically between 1997 and 2002 juvenile cases involving female-perpetrated forcible rape rose by 6%, other violent sexual offences by 62% and non-violent sexual offences by 42% (Center for Sex Offender Management, 2007)

Social cognitions and gender bias

In an attempt to understand why sexual offences committed by female perpetrators are underreported to a larger extend than offences committed by male offenders it is suggested that many victims do not report these offences in fear of being disbelieved, in particular if the victim is a male. There appears to be some evidence to support the fear and assumption expressed by victims of a female offender. Denov (2003) demonstrated in her research on a clinical sample that professionals were perceived negatively by the victims when the disclosing of a sexual abuse included a female perpetrator. The victims where met with distrust and minimization by professionals not only from the police authorities, also psychiatrists and therapists were three times more likely to believe that stories of female sexual abuse was fabricated than if the suspected offender was a male.

Similarly in a study by Hetherton and Beardsall (1998) attitudes on how policemen and social workers rate the sexual harm by male and female offenders showed that the gender of the offender would be of importance in accounting for decisions following a report of a sexual offence. If the offender was female rather than male the case registration and imprisonment of the offender would be considered less appropriate than if the offender was male by both policemen and social workers. Also among the social worker group the male participants considered that their involvement and investigation in the case would be more appropriate if the offender was male than if female, which suggests not only is the offender

viewed more seriously if male but also that the harm given the victim is considered less serious if the offence is conducted by a female thus limiting the amount of interventions made by the social services.

When a similar gender attitude study, conducted on undergraduate students, on adolescent sex offenders was construed by Sahlstroem and Jeglic (2008) the findings where somewhat different. They found that if the victim were of opposite gender than the juvenile offender, respondents were more likely to assess the crime as more serious and damaging if the offender was a female adolescent than if the same act was committed by an adolescent male. Compared to research where female offenders are viewed as less responsible and less guilty than male offenders, this suggests that although traditional sex role attitudes may contribute to the lack of recognition of female sex offenses once a female was apprehended as an offender she would be judged more harshly than her male counterpart.

Swedish gender studies on attitudes concerning sex offenders has not yet been found but a recent Swedish study by Yourstone, Lindholm, Grann, Svenson, (2008) with the attempt to establish if there might be a gender bias existing in Swedish forensic psychiatric assessments, the results on non-sexual violence was similar to the conclusions on sexual crimes attitudes by Denov (2003); Freeman and Sandler (2008) and Hetherton and Beardsall (1998). Results suggested that the gender of a perpetrator of a violent crime (homicide) would indeed affect the assessments. Psychology students and forensic psychiatric clinicians would interpret information given as more indicative of legal insanity if the perpetrator was female than male. Judges on the other hand were more likely to assess the perpetrator as legally insane if the gender of the perpetrator was the same as their own than if the gender differed. Consequently male violent offenders would less often be considered legally insane than female offenders of the exact same crime. In practice this would result in mentally ill perpetrators having a greater opportunity to get psychiatric treatment if the perpetrator were female, on the other hand it would also indicate that female perpetrators are less likely to be considered responsible for their behavior than male perpetrators reflecting conservative societal myths on how women are considered incapacitated compared to men.

In a Swedish study on gender differences in treatment of alcohol abuse (Palm, 2007) some differences were found in how male and female staff rated male and female clients. It seemed that the men were more gender neutral in reference to treatment views and female treatment providers more gender specific. The differences within the treatment providing group were not alarming though and may be explained by other factors than gender. Interestingly, the clients' different needs as perceived by the staff when compared to the

clients self report of issues and needs didn't always correlate. For instance, the assumption that women experience more shame in regard to the alcohol abuse than men was actually not supported when the same question was answered by the clients, implying that there were no gender differences in this area. Palm (2007) argues that some gender differences are actually constructs that may serve in the interest of individual clients but also may be problematic for some clients who do not comply with the concurrent beliefs.

The mechanisms of gender bias are explained by research in the field of social cognition. In the work of Macrae and Bodenhausen (2000) it is suggested that categories such as gender, age and race seem to create fundamental dividers in the world because they are presumed to be robust foundations. The activation and application of such boundaries differs between and within such categories and may also have important implications for social perception, memory and judgments. Social categories serve as short-cuts in everyday life and are functioning as a way of making sense of the complexity that social context contains, facilitating but also limiting the interpretations and judgments people make about their surroundings. The assumption though that categorical activation is an unconditional automatic process that cannot be controlled does not seem to be accurate. Certain conditions ease the controllability and some undermine it. It is believed that certain stimuli can trigger the activation of the categorical thinking processes but there are individual differences in how prone people are to activate these processes. Stereotype activation is also dependent of the amount of attention-resources available to the person and the level of involvement that a person has to the target objective (Macrae & Bodenhausen, 2001).

Discriminating views on gender are not always easy to obtain in professional settings such as among therapists or other treatment providers. Early attempts on finding evidence of discrimination based on gender-differences or sexism in clinical psychology (Stricker, 1977; Voss & Gannon, 1978) found that it was less likely that discrimination or sexism would occur when assessments were made on individuals and more likely when ratings were conducted on generic groups. It seemed that the gender of the therapist wasn't important when it came to reducing or maintaining discriminative attitudes, but knowledge and skills to integrate both psychological and sociological factors were important. Educational level and professional experience therefore seem to be mediating factors in reducing sexism.

As presented, research on women with sexually abusive behaviour is not as comprehensive as the research on male sexual offenders, not surprisingly, since there are few subjects to research on but also due to that the reported rate of relapses in sexual offences among women are almost non-existing. Compared to the male population of sexual offenders

women who seemingly have the same risk profiles and risk levels actually relapse at a much lower rate than the men. Why this is the case is not yet established but clearly there are problematic issues that needs to be addressed when it comes to women who sexually offend.

Assessment/recidivism

When it comes to relapses, reconvictions in sexual offenses are much less occurring than reconvictions in general criminality and there have been great efforts to study and gain an understanding of the factors relating to sexual recidivism among male perpetrators in an aim to reduce harm even further. In the area of female sexual offending the research is yet quite new as pointed out earlier and in the field of assessing risk of reoffending there is no difference. However, in all efforts being done so far the results seem to be pointing in the same direction which is that compared to male sexual offending women rarely get reconvicted for sexual reoffenses at all.

In a report by Cortoni and Hanson (2005) they found that the *sexual* recidivism rate for female sexual offenders of 1.0%. The rate of any *violent* recidivism (including sexual) was 6.3% and the rate of *any* recidivism (including violent and sexual) was 20.2%. The average follow-up period was five years. In comparison to studies of male sexual offenders, the equivalent numbers would be expected to be 13%-14% for sexual crimes, 25% for any violent crime, and 36%-37% for any new crime.

The gender differences in sexual reconvictions was also found in the study made by Freeman and Sandler (2008) where the reconviction rate for males were significantly higher for both non-sexual offenses and sexual offenses compared to the female offenders (28.97% vs 21.28% for non-sexual offenses and 5.38% vs 1.54% for sexual offenses) (Freeman & Sandler, 2008).

In a survey investigation on variations of assessment and management of female sex offenders in England and Wales it was found that out of 98 cases of female offenders of child sexual abuse 31 cases received no risk assessment at all, mainly explained by the lack of proper validated assessment tools for female perpetrators (Bunting, 2007). The assessment tool referred to was the Risk Matrix 2000 which, like the Static 99 and Static 99-R, is not recommended by the authors to be used on young adolescent offenders or female offenders (Risk Matrix 2000; STATIC 99). Thus the Bunting report not only highlights the need for filling void of validated assessment tools for female perpetrators but also show that despite of the lack of specific tools for women, assessments are still being done. In this report 67 female sex offenders where being assessed, most likely with the RM 2000, which may implicate that

approximately two thirds will receive improper risk management due to faulty use of assessment tools.

Researchers of recidivism among female sexual offenders are being aware of both static and dynamic risk factors but so far there has been no research establishing what dynamic factors that is related to recidivism among women, sexual or non-sexual (Cortoni & Gannon in press). Among the static variables there is enough research to allow cautious conclusions about what factors seem to predict relapses in sexual offending. Four variables present to be more predictive of sexual rearrests than other potential variables; number of prior sex offence arrests, number of prior child victim offences, number of prior supervision violations and offenders age of registrable sexual offence arrest. Because of the classification schemes that are developed from male samples, Freeman and Sandler (2008) point out that the risk of over classifying female sex offenders is notable. They suggest that research on other variables for female offenders such as psychological and victimization histories would to be considered in creating more conclusive risk assessment tools for women (Freeman & Sandler, 2008). Looking at static variables used to asses a male sex offender population the factors associated with increased risk are; young age at time of release, previous sex offenses, amount of previous sentencing dates, non-sexual violence in previous and index sentences, any hands-off sexual offence, unknown victim or distant relation to the victim, any male victim and whether the offender ever has been in a live-in sexual relationship for a longer period of time (Static 99).

Dynamic risk factors are unlike static risk factors amenable for interventions. Stable dynamic factors are related to personality traits, psychological and emotional functioning and should be targeted in treatment. Acute dynamic factors are more circumstantial factors that are fluctuating and labile by nature and therefore not primary treatment targets but of interest for community supervision since they are predictive of when a potential relapse might occur. For male sex offenders factors related to risk with empirical support are; deviant sexual arousal, sexual preoccupation, using sex as coping, non compliance with supervision, factors related to intimacy deficits, general self regulation and social influences (Hanson, Harris, Scott & Helmus, 2007).

Although equivalent research on dynamic risk factors related to female sexual offending is scarce it is suggested that; relationship problems, attitudes and cognitions related to sexual offending behavior, use of sex to regulate emotions, and emotional dysregulation problems are common among the female sex offenders. It also seems that sexual gratification, desire for intimacy or instrumental goals (such as revenge or humiliation) are associated to

female sexual offending and that engagement in other criminal behaviors should also be considered (Cortoni & Gannon in press; Gannon et al 2008).

Treatment programs, pharmacological treatment and implementation

The fact that potential gender differences would affect assessment and treatment in clinical practice is probably not a controversial issue, although differences has been overlooked when it comes to research and develop gender specific treatment programs or assessment guides. Differences between males and females are typically minimized in various types of treatment conducted by both health care and forensic settings, mainly because of research in general are made on a male population and similarly the lack of research on female counterparts. Consequently women are going through treatment programs designed to target specific treatment needs of a male population.

Correctional Service Canada (2009) has developed a CBT based treatment program designed to target sexual abusive behaviour which has been reported to have good treatment-outcome for male sexual offenders. This program is also translated and adapted in the Swedish Correctional Services *Relations- och Samlevnadsprogrammet, ROS* (Kwarnmark & Hasselrot, 2005), but has yet to date not been evaluated for effect sizes. The program includes topics such as; cognitive distortions, empathy and victim awareness, sexuality, intimacy and relationships, deviant thoughts/fantasies and self-management (Correctional Service Canada, 2009). The current Women's Sex Offender Program in Canada is adapted from the men's sex offender programs by Dr. Sharon Williams in 2001 prior to that they didn't offer sex offender specific programming to female offenders. According to their website the CSC is currently developing a gender specific program for this group of offenders (Correctional Service Canada, 2007; Correctional Service Canada, 2009). In Sweden there is no treatment program designed to target the specific needs of female sexual offenders.

Since there is little understanding to this date on female sexual offending there are little evidence that supports that practitioners truly addresses the relevant targets that is related to female sexual aggression. To achieve the main goal, which is to develop alternative prosocial behaviors to obtain ways to meet the needs that the sexual behavior has fulfilled, it is advocated by Cortoni and Gannon (in press) that treatment should focus on five areas that include; cognitive and emotional processes, intimacy and relationship issues, sexual dynamics and social functioning.

Pharmacological treatment is not typically used in sex offender treatment and is not without controversy. Among the high risk population of sex offenders it has been indicated

that it can be useful when combined with other treatment interventions such as psychotherapy. Anti-androgens or hormonal agents are being used successfully but because of the reducement of the global sex drive and not only reduces the sexual deviance; treatment compliance may arise as an issue that needs attention. SSRI:s are also being used in some cases with promising results and as the side effects are less aversive they pose less of a problem when dealing with treatment adherence (Chow & Choy, 2002; Cohen & Galynker, 2009).

The implementation of treatment programs should be considered due to gender differences in relation to communication styles and relationships needs. Typically treatment programs are offered in a group format and research has shown that men talk more and interrupt more than woman in these settings. Also there is a difference in what men and women listen to in a conversation where the men tend to focus on "the bottom-line" and women are more attentive to details. Women tend to be in need of a more extensive supportive social network than their male counterparts to improve their general community functioning but also as an important part in the ability to deal with stress. So an important factor in working with female sexual offenders and female offenders in general is to strengthen their ability to and maintain stability in life without the dependency on others (Cortoni & Gannon in press).

Modus operandum and its' implications on risk assessment and treatment interventions

Female sexual perpetrators has shown to be a heterogeneous group and professionals has tried to manage this dilemma by categorizing this in to subgroups of different typologies based on type of offence, choice of victim and motivational factors (Vandiver & Kercher, 2004; Sandler & Freeman, 2007). These subcategories of female sexual perpetrators are often missing information on the relation to possible co-offenders though and as pointed out by Cortoni and Gannon (in press) provides little guidance in how to assess or treat these women.

In treatment of male sexual offenders one key element is to examine the offence process, that is, what sequence of events that lead up to the offence using the perpetrators offense narratives. By analyzing how and what may have preceded the offence(s) the differentiation may affect the assessment of risk and treatment need when a clinician is planning for what issues must be targeted and how to intervene. An offender with a high degree of planning and cognitive resources will be assessed and treated differently than an offender that is very impulsive and has lower cognitive skills. The offense pathway model has been especially useful in the work of relapse prevention as it discloses both the *modus operandum* and what underlying needs and goals that effected the chain of events (Ward,

Louden, Hudson, & Marshall 1995; Kwarnmark & Hasselrot, 2005). A similar model has been developed for female sexual offenders – the Descriptive Model of the Offence Process for Female Sexual Offenders (DMFSO) – by Gannon, Rose, & Ward, (2008). According to Gannon et al. there was evidence that female perpetrators followed one of two main pathways to offending; the Direct-Avoidant or the Explicit-Approach. There where also indications of a third pathway referred to as the Implicit-Disorganized.

The first subgroup describes the female offender as someone who molests children to avoid negative affects; they typically offend with a co-offender in fear for their own lives or to obtain intimacy with the male co-offender. This category of female offenders is often unaware of, or very passive to, the early stages of planning the offence. The second group are abusive to either or both children and adults and they appear to use more elaborate planning to achieve their goals whether it being intimacy with the victim, sexual gratification or money. These perpetrators seem to experience positive affects, like excitement, in the offence process. The third group appears to offend in an impulsive and unplanned manner against either children or adults, and the offences are associated with either positive or negative affects (Gannon, Rose & Ward in press; Courtoni & Gannon in press).

Summary

The issue of gender bias in evaluating the prevalence of sexual offences has affected not only the detection of female sexual offenders but also the development of gender specific risk assessment tools and treatment interventions. Through an increased awareness of offences conducted by female perpetrators research has started to take small but important steps to fill the void of knowledge concerning this client group in the forensic setting. Some similarities with male sexual offenders has been found but also some differences, but what has been especially apparent is the need to do even more research in the field of sexual offending to be able to stop further victimizing whether the offender is male or female. In addition to proper risk assessment tools and treatment programs with or without the assist of pharmacological treatment and exploring the effects of various treatment interventions, clinicians has also been trying to develop different typologies to differentiate between sub-groups of sexual offenders (male and female) to further assist in the goal of stopping abuse.

Object of this study

The aim of this paper is to explore if attitudes expressed among the public concerning sex offenders, that might reveal sex role stereotypical beliefs, also may exist among trained

professionals, or if a specialized and formalized training is a protective factor concerning discriminative tendencies if existing in society. Aided by the theoretical framework that has been presented the following questions will be attempted to be answered:

Will the gender of a hypothetical offender affect the judgments when assessing risk and need of professionals with trained in the Swedish National Sex Offenders Treatment Program (for men), "Relations- och Samlevnadsprogrammet" (ROS)?

Will professionals with trained in "ROS" differ from the general public (i.e. control-groups) concerning assessing risk and need on a male respectively a female sexual offender?

Method

Participants

Treatment providers from the Swedish Correctional Services, both from prison settings and community services, were asked to asses a written vignette describing a sexual offence case against a minor. In addition to the treatment providers, who all had been trained in the accredited sex offender program for male perpetrators, the same vignettes was distributed to two control groups; one consisting of college students (teacher students and preschool teacher students) and one of social workers from three different offices.

A total of 161 participants completed the assignment: 61 individuals from the treatment provider group, 42 women and 18 men (one person did not provide gender information). The 61 participants were relatively equally divided across age groups (ages18-27 years 3.3%; 28-37 years 31.1%; 38-47 years 24.6%; 48-57 years 18.0%; 58-67 years 21.3%; one missing) Most participants had limited experience from working with sex offenders; 59.0% had worked less than four years with this population, 21.0% had worked between four and seven years with treatment or assessing sexual offenders and 10.0% had longer experience. The control group consisting of social workers contained 43 participants of which five were men and in the control group of 57 students there were 45 women and 12 men. Age distributions in these groups were somewhat different than in the sex offender professional group; social workers (ages18-27 years16.3%; 28-37 years 9.3%; 38-47 years 41.9%; 48-57 years 16.3%; 58-67 years 11.6%; two missing) and the students (18-27 years 73.7%; 28-37 years 19.3%; 38-47 years 7.0%; none missing). The reason for choosing control persons from two different areas is two-fold; for one both sub groups has not received any training in treatment of sexual offenders which make them a good comparison group to the trained professionals when trying to explore potential differences between those who has

received training and those that has not. When computed as a single control group the statistic power in that group is larger than if split to the sub group level. Secondly the two sub groups by them selves are different since the social worker group is working in a setting where they may have to form decisions concerning sexual offence cases. For instance; if a child has a perpetrating parent the Social Services has to evaluate if the child can continue to have a live-in relation with the offending parent or if it and other siblings still may be at risk of being victimized by that parent. With those types of tasks in everyday work, the experience level of assessing risk varies compared to the student group, even though none of the groups has received formal training in risk assessing of sexual reoffending. This enables the comparison not only in relation to formal training, but also to professional experience although the smaller group sizes reduce the statistic power. Among the trained professionals 13.1% had less than 4 years experience in their profession; 21.3% between 4-7 years; 18.0% 8-11 years; 13.1% 12-15 years; and 34.4% had longer experience. The corresponding numbers from the social workers were; 27.9% with less than 4 years of work experience; 23.3% had 4-7 years; 18.6% 8-11 years; 2.3% 12-15 years; and 18.0% had more (9.3% missing).

Material

The vignette contained information about the offender in reference to stable risk factors indicating risk level, and dynamic risk factors indicating treatment targets and needs. The case was based on two authentic sexual offence cases described by an experienced forensic psychiatrist and presented information that was aggravating, neutral or mediating in reference to risk and needs. For instance would statements indicating deviant sexual interests point towards higher risk levels, statements that presented the offender as a diligent person who was well liked would be mediating and statements like that the person is stuttering and is overweight is considered neutral. When constructing the case and the questionnaire special considerations was taken to ensure that the description would be applicable to both a female and a male offender. A small pilot study of six persons (three men and three women) preceded the final study to ensure that the design was functional.

Procedure

Two versions of the vignette were distributed randomly to the subjects, both identical with the exception of the gender of the sex offender. In the trained professional group 44.3% received a female vignette character and 55.7% a male vignette character,

among the social workers the corresponding numbers were 51.2% vs 48.8% and among the students the numbers were 49.1% and 50.9% respectively.

The vignettes were accompanied by a questionnaire in which the participants were able to rate assumed risk and need level for the assigned vignette as well as responding on how well they agreed or disagreed on the relevance of possible risk items and treatment targets on a five point Likert scale ranging from “of little importance” to “of great importance” (from 1-5). To rate the levels of risk and need the participants was instructed to estimate levels of risk and need on an unmarked scale ranging from 0 to 100 with verbal anchors at the endpoints indicating “low risk” respectively “low need” to “high risk” respectively “high need”. The entire scale was 100 mm long and when computed the cut of scores was divided into quartiles each corresponding the risk levels “low”, “medium-low”, “medium-high” and “high”.

The reason not using risk specific labels in the questionnaire was two-fold; for one the treatment providers had been trained at different times whereas some were used to only rate in three levels of risk or need (low, medium or high), secondly there might be biased results in the total test population where participants perhaps less secure in how to rate would have a tendency to rate “high” to be ensured of not “being to lenient”. A common problem in risk assessment is excluding the “false negatives” (people up grading level of risk for fear of missing out on potential hazards) or “false positives” (people down grading the risk level based on positive impressions from the assessed client or other non-specific factors). In addition to this the participants would choose their two preferred interventions used in treating this particular client between eight specified intervention options, such as individual therapy, group therapy, abuse treatment, pharmacological treatment or family treatment.

The participants received the vignette and associated questions along with a written informed consent form that was distributed through assigned supervisors. The supervisors was told to distribute the cases on their regular supervising meetings and allow approximately 20 minutes for the complete exercise (when tested on the pilot group the average time to complete was 15 minutes) before collecting them. They were also instructed that the participants weren’t allowed to discuss the cases among them and to inform them of their voluntary participation and anonymity guaranteed. The information that the participants were given was that the study was aiming to see how professional’s asses risk and needs in different clients.

Due unknown reasons these conditions was only applied in the control groups, in the actual test group the vignettes were distributed but most of the subjects were told to send them

in at a later date instead of being collected at the same occasion. Because of this only a limited number of cases were available when the original time limit was set. To be able to get access to a larger number of participants the supervisors were told to remind their subjects to send in their contributions if they had not done this already as soon as possible within the following three weeks. The gathered material was calculated in SPSS.

Results

Assessment of risk and need level of a female versus a male offender.

Within the group of professionals working with treatment and assessment of male sexual offenders in Sweden the average risk level for the male vignette character was rated "high" (mean: 7.9 sd: 1.5[1]). For the female character the rated level of risk was on the border of "medium-high" and "high" (mean: 7.6 sd: 1.6). The assessed the average need level for the male vignette-character was "high" (mean: 8.4 sd: 1.2). For the female character the level of need was assessed also as "high" (mean: 8.3 sd: 1.4). Analyzing for significance between the results using independent t-test, there were no significant difference in how professionals rated the vignette character based on the characters' gender. The gender of the rater did not show any significant differences either when comparing the ratings of a female or a male offender when using independent t-test. (see Appendix A *Table A*)

Analysing for differences between trained in ROS and not trained.

When comparing the average risk and need level as assessed by the professional group and the full control group (social workers and students) with independent t-test there was no significant difference in how participants had assessed either risk level or the treatment need based on gender of vignette-character. The mean level of risk was 7.8 (high risk) sd: 1.5 among participants who had received training and 7.9 (high risk) sd: 1.5 in the comparison group. As for treatment need assessed level was among trained professionals m: 8.4 sd: 1.3 (high) versus m: 8.5 sd 1.2 (high) assessed by participants with no training (see Appendix A *Table B*).

Comparisons between professions

[1] Values of risk categories are provided in cm as measured on the rating scales ranging from 0-10.0 cm.

To compare whether there would be any differences between the three groups univariate of analysis (2 ways ANOVA:s) was made on whether they rated risk levels and need levels differently on a male respectively a female vignette offender. This comparison was conducted to control if the social workers group might resemble the trained professionals and therefore excluding the need in formal training in ROS. If assumed that trained professionals and social workers rate equally and students differs from the former groups, the ROS training explicitly might not be the cause of gender similar ratings rather professional experience or formal training in occupations like psychologists or social workers may be sufficient enough to mediate gender stereotyping. The results showed that students was more resembling to the trained professionals in rating risk of both female and male sex offenders where the two groups had a slightly lower risk level on the female character than the male (medium high vs high) and the social workers had less of a difference between the two subjects (high vs high) and overall higher ratings than both trained professionals and students. The differences, though, was not significant.

When the same comparison was made of treatment need the differences in how the three groups rated the female vs male character showed that there was a tendency to make gender differences in the student group assessing the male character in a higher treatment need than the female equivalent. All three groups rated the treatment need as "high" for both the female and male character and none of the differences was significant between the groups or between the ratings of the vignette characters (see Appendix A *Table C*).

Treatment targets

The choice of what important treatment topics would be the most important did not show any significant differences whether the professionals had a female or a male sex offender using an independent t-test to compare differences. Equally there were no significant differences in what the trained professionals emphasized compared with the total control group. Comparisons between the three groups was not made since data so far has showed that the groups are too small to give enough power to show any significant difference. None of the topics was considered unnecessary in the treatment but topics; deviant sexuality, sexual preoccupation, relapse prevention, victim empathy, cognitive distortions and development of self esteem were viewed as somewhat more important than other topics, no significant differences was found though. For a display of mean and medium ratings of the treatment topics as rated by the trained professionals, see last page of the appendices (Appendix E).

Treatment interventions

The participants had an option of marking two types of treatment interventions to achieve treatment goals from a total of eight alternatives. All groups marked individual the most appropriate way to intervene, generally combined with group therapy combined with one other option such as work training or education, family treatment, working with social network or abuse treatment. In the professional group no participant marked abuse treatment or pharmacological treatment as an appropriate option, but pharmacological treatment was suggested in one control group by a small minority. Among the social workers this option received the most attention (6 persons out of 43, equally suggested for female respectively male offender) (see Table 1).

Table 1. Percentage of participants' choice in treatment interventions per group.

	Individual	Group	Abuse	Network	Pharma	Work/ edu	ART	Family
Trained professionals	49%	37%	0%	15%	0%	11%	1%	1%
Social workers	36%	7%	5%	11%	8%	8%	5%	5%
Students	49%	28%	12%	1%	0%	9%	4%	8%

Degree of engagement and difficulties to relate to the case

On average trained professionals reported a medium level of difficulty relating to the case and degree of involvement in the assignment. Computing with a 2-way ANOVA there were no differences found based on character gender. When compared to the control groups there were no differences found in relation to degree of difficulty or level of engagement. Equally there were no differences found depending on the character's gender (Table 2; also see Appendix B).

Table 2. Participants' rating of difficulty and engagement relating to the assignment

Gender of vignette character	Degree of difficulty[2]		Degree of engagement	
	Male	Female	Male	Female
Trained professionals	2.67 (0.97)	3.18 (1.07)	4.15 (0.79)	3.96 (0.70)
Social workers	3.42 (1.12)	2.63 (1.04)	4.23 (0.70)	4.18 (0.73)
Students	3.17 (1.51)	3.35 (1.25)	4.06 (0.92)	4.00 (0.91)
All	3.03 (1.23)	3.09 (1.16)	4.14 (0.81)	4.03 (0.75)

Positive correlations was found in the trained professional group between treatment need and assessed risk, and degree of engagement in the assignment (0.32**[3]) when computed using Spearman's rho. Negative correlations was found between "difficulties relating to the assignment" and treatment need (-0.25**) vs risk level (-0.22**). Also a small correlation was found between age of participant and degree of difficulty (-0.170*). There were no correlations found in level of engagement or difficulty depending on the gender of character (see Appendix C).

When files were split between professions i.e. three groups there were similar correlations found in the social workers group, but also there was a small correlation between difficulty in the assignment and the gender of offender (0.36*). Correlations was found among the students between engagement and treatment need (0.32*) plus the expected correlations between engagement and difficulty (-0.34*) and risk and need (0.56**) (see Appendix D pgs 1-3).

Discussion

Through the results of the survey conducted amongst treatment providers in the Swedish Correctional Services there were no differences found on risk and treatment need assessed that was based on the gender character, preferably this would be explained by the specialized training they had received on sexual offending, but formal training must be ruled out though since gender stereotyping weren't found amongst the control groups either. In fact, on a whole there were only minor differences between the test group and the control groups and none of the differences can be explained by gender stereotyping. The lack of variance can

[2] Mean rating, standard deviation in parenthesis

[3] ** Correlation is significant at the 0.01 level (2-tailed).
* Correlation is significant at the 0.05 level (2-tailed).

be explained by small power in the researched data, a larger sample of participants may have given a different result. Also given that the original instructions of group testing weren't followed there might be biased results due to uncontrolled test situations. Although, questionnaires filled in by students was performed during optimal conditions and other than the slight (non-significant) variation in how they estimated treatment needs there were no observable effects that related to the gender stereotyping of the vignette character.

When compared with the literature there would be an expected difference in how the subjects would assess the two characters based on their gender. Although none of the referred literature or research data of gender stereotyping in regards to sexual predators in this paper is calculated on a Scandinavian population, so there might be cultural differences involved affecting the outcome of this research. Gender equality questions have a strong tradition in politics and media reporting so there would be a high degree of awareness of discrimination issues in the tested population, especially since the vast majority is or have been involved in higher education and therefore have assessed related topics through their studies. What contradicts the glorifying hypothesis of a non-discriminative population is the fact that the participants weren't comparing two offenders, they had only one offender to assess and where told that all participants had different cases and that the survey was to explore how trained professionals working with sexual offenders rate compared to people without formal training.

One alternative explanation might be that the diagnosis "pedophile" might construe a social category in itself independent of other fundamental dividers like age or gender. Macrae and Bodenhausen (2000) explained fundamental categories as usually linked to biological features and different diagnostic labels are sometimes strongly linked to more robust features like personality traits or sexual orientations. This brings up the philosophical question of man's ability to change. Is it possible to change sexual orientations or deviations, or is this a biological thus unchangeable trait? The answer is much depending on what theoretical orientation is used. Some might argue that sexual orientations are learnt behaviors and can therefore be "un-learned" and some argue that it is inherited or permanent and that although a persons sexual behavior may stop or change the orientation will always exist. A perceived permanent condition may prone an assessor to be more inclined to view future risk of sexual reoffending more negatively than if the condition is thought to be reversible. If a diagnosis of pedophilia is in fact a separate social category one might wonder why it, as in this case, override gender?

It is possible that the term pedophile triggers scripts and related aspects of human survival or protection of offspring. To be able to ensure of continued existence humans must

be aware of any threat that may compromise our offspring's survival and therefore it automatically prepare us for judgments what potential threats might be. It is possible that through the years of media attention people have been made aware of child sexual offenses to a greater extent than ever before and therefore have adapted social constructs to "modern" hazards. The "offender script" activated then functions as a signal to the reader to take precaution and be prepared. To protect the innocent the internal alarm signal would be on alert for "any risk at all" and transforming it to "high risk" immediately and scripts of how to protect ourselves would set off, no matter of gender aspects.

What contradicts the diagnosis pedophile of being gender neutrally charged is that reports of *female* offenders are very rare and unique in media which affects the degree of nuances the reader will have of who a sex offender is and therefore automatically links the description of a pedophile or a child molester to already existing scripts, only confirming a prejudice image and not challenging it. The portrayal of a child molester given by media is often depicting an elaborate planning and cunning *male* offender much alike the offence-pathway label "the Explicit-Approach" used on female and male perpetrators' described by Gannon et al. (2008) and Ward et al. (1995). Consequently all sex offenders are at risk of being stereotyped in a predominately male "offender script", not gender neutral or flexible to individual variances but gender specific and rigid, thus triggering the reader to view the perpetrator as a monstrous character, no matter of actual gender or offence pathway.

Generally the participants overrated the sex offender character based on the given information. Only looking on the static risk factors mentioned in the text the offender would get a risk level of medium. The dynamic risk factors involved added up to a high risk or need level, which weighted together would result in a level of "medium-high" on risk to reoffend if left without treatment. Although there was no significant difference based on characters' gender among the trained professionals, the mean level of risk when the character was female was lower than if male, which would be more accurate when compared with research on sexual offending. Macrae and Bodenhausen (2001) argued that social categories may be more or less prone to be activated depending on individuals' amount of attention resources available to the person and the level of involvement in the target objective. Since this test situation differs immensely from an actual risk assessment in a forensic setting, it is not clear if these results would reflect how a male or a female offender would be assessed in the clinical world. Reading a vignette is more resembling of reading a minor psychiatric evaluation since there is no actual client that can influence the assessor, positively or negatively, so there is no room for interaction with the client. The words and formulations in

the vignette text appeals to the readers internal scripts that forms the foundation of which our actions will occur. One might wonder how the result would be if the diagnosis pedophile was cut from the vignette and the participants would have read the text without this social category in it. Would the remaining information still be as profound if the offender character didn't have a label other than his or her name?

The result may also reflect the need to use structured and validated assessment tools. Lack of proper assessment tools results in use of clinical judgments that is, at best slightly worse than chance. Although 61 subjects out of a total 161 were trained in and had more experience of assessing and treating sexual offenders, some even great experience, the group as a whole did not differ significantly from the control group in any way. Given that, the void in assessment tools made for female offenders of sexual crimes difficult to accept since the procedure of assessing risk is intended to give an advantage in the aim on reducing possible sexual reoffending versus not knowing anything at all. Not considering assessment tools specific for the female offender is disregarding her potential future victims too.

There are differences and similarities between male and female sexual perpetrators in a variety of aspects but in terms of the victim perspective there are more similarities than differences. The degree of intrusiveness or use of violence is not significantly different and the affect on the victim is that of extreme stigma, shame and isolation whether the offender is female or male. Since most victims of child sexual abuse are in close relation or dependency of the perpetrator the most likely female offender would be the victim's natural caregiver or nurturers. When sexual offences are committed by a caregiver, especially a mother, it is believed that the traumatisation could be even graver than if the offences are committed by someone else (Wigzell, 2001). Since the natural relationship between a mother and a child gives ease of accessibility, permits early onset and longer duration with the risk of increasing severity in the offences these relations also are increasing the risk of later psychological disturbances in the victim. There is also some evidence that maternal sexual abuse in male victims may increase the risk of sexual offending in adulthood (Bunting, 2007).

Both differences and similarities should be considered in deciding on appropriate treatment for women and men. Cortoni and Gannon (in press) recognizes that there are problems related to simply using a program designed for a male population and offer it to women since it might fail to consider gender specific elements. For one, the role and presence of a co-offender which is common among female sex offenders but not typically found in the male population. Another example is differences in the patterns in cognitive distortions where it is common that the women with a co-offender also take responsibility for their offending

partners' behaviour, quite similar to how offence victim often feels responsible and exhibits guilt for the offence itself. There are also different perspectives on the importance of intimate relationships, whereas the men tend to disregard it and woman overemphasizing its importance often due to their own dependency issues (Cortoni & Gannon in press).

This study has shown, despite lack of significant differences, that there are people who are engaged in cases such as this one and that they have ideas on what would reduce further harm made by an offender. These ideas are supported, on a whole, by research as important in assessing risk or targeting treatment interventions. It would have been nice to know that these participants are a valid reflection on society's assets in human resource, because then society has a good foundation in preventing and stopping sexual abuse in all stages of the human life span. A foundation found in the good hearts of social workers, future teachers and people working in the Swedish Correctional Services.

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Appendix A

Table A. Analysis of differences in rating risk and need within trained professionals' group.

	level of risk		level of need	
Gender of vignette character	Male	Female	Male	Female
Male rater	7.26 (2,10)	7.32 (2.11)	7.43 (2.21)	8.10 (1.77)
Female rater	8.19 (0.95)	7.68 (1.45)	8.59 (0.82)	8.55 (0.88)

Mean rating, standard deviation in parenthesis

Table B. Mean risk- and needlevels as assessed by trained professionals (ROS) and comparison group.

	level of risk	level of need
Trained in ROS	7.75 (1.53)	8.37 (1.28)
Comparison group	7.90 (1.48)	8.48 (1.24)

Mean rating, standard deviation in parenthesis

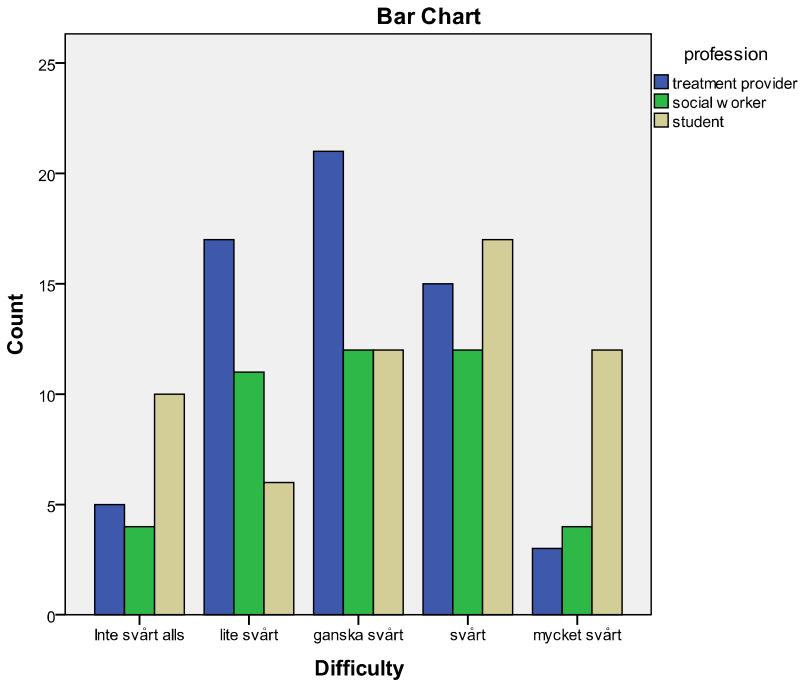
Table C. Analysis of differences in assessed risk and need level of the offender.

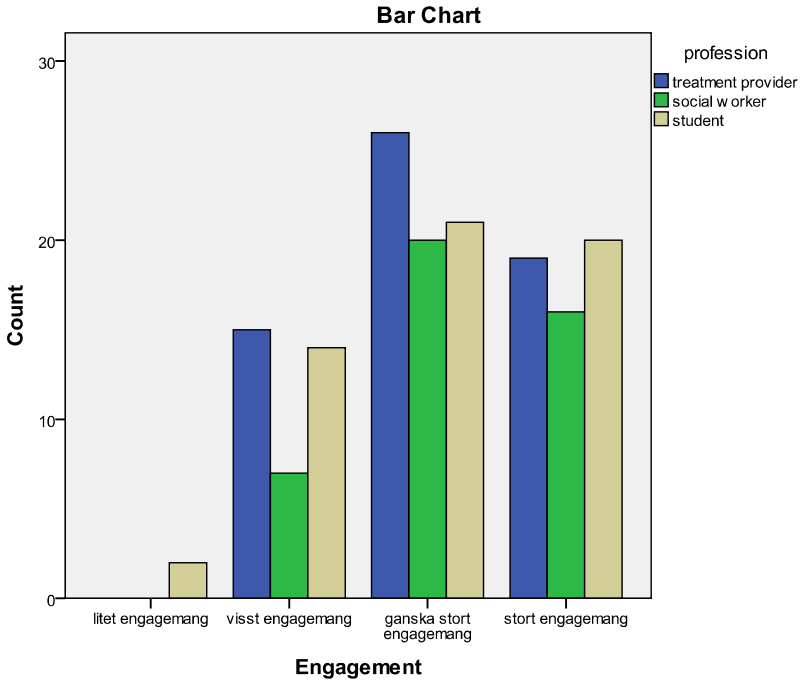
	Level of risk		Level of need	
Gender of vignette character	Male	Female	Male	Female
Trained professionals	7.87 (1.47)	7.58 (1.62)	8.44 (1.23)	8.28 (1.36)
Social-workers	8.26 (1.17)	8.23 (0.96)	8.62 (1.02)	8.70 (1.09)
Students	7.71 (1.98)	7.56 (1.38)	8.71 (1.05)	7.97 (1.58)
All	7.92(1.59)	7.76 (1.39)	8.57 (1.12)	8.28 (1.39)

Mean rating, standard deviation in parenthesis

Appendix B

Participants' reported levels of difficulty and engagement to the assignment.





Appendix C

Correlations table of relations between: Age of participants; years trained in ROS (Swedish national sex-offender treatment program); how difficult participants perceived the assignment; how their engagement to the assignment was; and how risk and treatment needs were assessed; and any relations to whether the vignette character was male or female.

		Difficulty	Engagement	Age	Yrstrained	Needlevel	risklevel	Male/ Female off
Difficulty	Correlation Coefficient	1.00	-0.25**	-0.17*	-0.08	-0.25**	-0.22**	-0.01
	Sig. (2-tailed)	_	0.00	0.03	0.30	0.00	0.01	0.88
	N	161	160	158	161	134	151	161
Engage-ment	Correlation Coefficient	-0.25**	1.00	0.04	-0.12	0.32**	0.31**	0.08
	Sig. (2-tailed)	0.00	_	0.60	0.12	0.00	0.00	,34
	N	160	160	157	160	134	150	160
Age	Correlation Coefficient	-0.17*	0.04	1.00	0.34**	0.12	0.13	-0.01
	Sig. (2-tailed)	0.03	0.60	_	0.00	0.19	0.12	0.95
	N	158	157	158	158	131	148	158
Yrstrained	Correlation Coefficient	-0.08	-0.12	0.34**	1.00	-0.05	-0.01	0.03
	Sig. (2-tailed)	0.30	0.12	0.00	_	0.57	0.94	0.73
	N	161	160	158	161	134	151	161
Needlevel	Correlation Coefficient	-0.25**	0.32**	0.12	-0.05	1.00	0.68**	0.08
	Sig. (2-tailed)	0.00	0.00	0.19	0.57	_	0.00	0.36
	N	134	134	131	134	134	133	134
risklevel	Correlation Coefficient	-0.22**	0.31**	0.13	-0.01	0.68**	1.00	0.10
	Sig. (2-tailed)	0.01	0.00	0.12	0.94	0.00	_	0.22
	N	151	150	148	151	133	151	151
Male vs Female offender	Correlation Coefficient	-0.01	0.08	-0.01	0.03	0.08	0.10	1.00
	Sig. (2-tailed)	0.88	0.35	0.95	0.73	0.36	0.22	_
	N	161	160	158	161	134	151	161

** Correlation is significant at the 0.01 level (2-tailed).

* Correlation is significant at the 0.05 level (2-tailed).

Appendix D (pg 1-3)

Correlations after split file between professions are made.

profession			Difficulty	Engagement	Age	Needlevel	risklevel	Male femaleoff
treatment provider	Difficulty	Correlation Coefficient	1.00	-0.25	-0.01	-0.27*	-0.23	-0.23
		Sig. (2-tailed)	-	0.06	0.94	0.04	0.08	0.08
		N	61	60	60	55	58	61
	Engage-ment	Correlation Coefficient	-0.25	1.00	0.06	0.36**	0.28*	0.13
		Sig. (2-tailed)	0.06	-	0.64	0.01	0.04	0.32
		N	60	60	59	55	57	60
	Age	Correlation Coefficient	-0.01	0.06	1.00	0.26	0.12	0.06
		Sig. (2-tailed)	0.94	0.64	-	0.06	0.38	0.63
		N	60	59	60	54	57	60
	Needlevel	Correlation Coefficient	-0.27*	0.36**	0.26	1.00	0.79**	0.05
		Sig. (2-tailed)	0.04	0.01	0.06	-	0.00	0.72
		N	55	55	54	55	54	55
	risklevel	Correlation Coefficient	-0.23	0.28*	0.12	0.79**	1,00	0.09
		Sig. (2-tailed)	0.08	0.04	0.38	0.00	-	0.48
		N	58	57	57	54	58	58
	Male vs Female offender	Correlation Coefficient	-0.23	0.13	0.06	0.05	0.09	1,00
		Sig. (2-tailed)	0.08	0.32	0.63	0.72	0.48	-
		N	61	60	60	55	58	61

* Correlation is significant at the 0.05 level (2-tailed).

** Correlation is significant at the 0.01 level (2-tailed).

Cont.

profession			Difficulty	Engagement	Age	Needlevel	risklevel	Male femaleoff
social worker	Difficulty	Correlation Coefficient	1.00	-0.15	-0.18	-0.42*	-0.31*	0.36*
		Sig. (2-tailed)	-	0.35	0.26	0.01	0.05	0.02
		N	43	43	41	35	41	43
	Engage-ment	Correlation Coefficient	-0.15	1.00	0.03	0.30	0.44**	0.04
		Sig. (2-tailed)	0.35	-	0.86	0.08	0.00	0.82
		N	43	43	41	35	41	43
	Age	Correlation Coefficient	-0.18	0.03	1.00	0.07	0.13	-0.05
		Sig. (2-tailed)	0.26	0.86	-	0.70	0.44	0.77
		N	41	41	41	33	39	41
	Needlevel	Correlation Coefficient	-0.42*	0.30	0.07	1.00	0.63**	-0.12
		Sig. (2-tailed)	0.01	0.08	0.70	-	0.00	0.49
		N	35	35	33	35	35	35
	risklevel	Correlation Coefficient	-0.31*	0.44**	0.13	0.63**	1.00	0.07
		Sig. (2-tailed)	0.05	0.00	0.44	0.00	-	0.66
		N	41	41	39	35	41	41
	Male femaleoff	Correlation Coefficient	0.36*	0.04	-0.05	-0.12	0.07	1.00
		Sig. (2-tailed)	0.02	0.82	0.77	0.49	0.66	-
		N	43	43	41	35	41	43

* Correlation is significant at the 0.05 level (2-tailed).

** Correlation is significant at the 0.01 level (2-tailed).

Cont.

profession			Difficulty	Engagement	Age	Needlevel	risklevel	Male femaleoff
student	Difficulty	Correlation Coefficient	1.00	-0.34*	-0.11	-0.14	-0.13	-0.03
		Sig. (2-tailed)	-	0.01	0.41	0.36	0.37	0.80
		N	57	57	57	44	52	57
	Engage-ment	Correlation Coefficient	-0.34*	1.00	0.02	0.32*	0.27	0.05
		Sig. (2-tailed)	0.01	-	0.90	0.04	0.06	0.71
		N	57	57	57	44	52	57
	Age	Correlation Coefficient	-0.11	0.02	1.00	0.17	0.13	-0.02
		Sig. (2-tailed)	0.41	0.90	-	0.27	0.36	0.86
		N	57	57	57	44	52	57
	Needlevel	Correlation Coefficient	-0.14	0.32*	0.17	1.00	0.56**	0.24
		Sig. (2-tailed)	0.36	0.04	0.27	-	0.00	0.12
		N	44	44	44	44	44	44
	risklevel	Correlation Coefficient	-0.13	0.27	0.13	0.56**	1.00	0.13
		Sig. (2-tailed)	0.37	0.06	0.36	0.00	-	0.34
		N	52	52	52	44	52	52
	Male femaleoff	Correlation Coefficient	-0.03	0.05	-0.02	0.24	0.14	1.00
		Sig. (2-tailed)	0.80	0.71	0.86	0.12	0.34	-
		N	57	57	57	44	52	57

* Correlation is significant at the 0.05 level (2-tailed).

** Correlation is significant at the 0.01 level (2-tailed).

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			Motivational intervention	Deviant sexuality	Affect regulation	Victim empathy	Assertiveness skills	Stress management	Relapse prevention
female	N	Valid	26	27	27	27	27	27	27
		Missing	1	0	0	0	0	0	0
	Mean		3.46	4.52	3.30	4.41	3.44	3.56	4.41
	Median		4.00	5.00	3.00	5.00	4.00	4.00	5.00
male	N	Valid	33	34	33	34	34	34	34
		Missing	1	0	1	0	0	0	0
	Mean		3.88	4.41	3.76	4.53	3.26	3.74	4.35
	Median		4.00	5.00	4.00	5.00	3.00	4.00	5.00

	Sex.	Conflict	Dependency	Abuse/trauma	Rejection	Cogn.	Coping

PST PSYKOTERAPEUTPROGRAMMET

			preoccupation	management	in relations	history	/loss of relations	distortions	with depression /anxiety
female	N	Valid	27	26	27	27	26	27	26
		Missing	0	1	0	0	1	0	1
	Mean		4.41	2.46	2.93	3.89	3.31	4.56	3.12
	Median		5.00	2.00	3.00	4.00	3.00	5.00	3.00
male	N	Valid	34	33	32	34	34	34	33
		Missing	0	1	2	0	0	0	1
	Mean		4.53	2.55	2.78	3.62	3.65	4.50	3.30
	Median		5.00	3.00	3.00	4.00	4.00	5.00	4.00

Appendix E. Trained professionals average ratings on important treatment topics in therapy with a female or a male sexual offender (scale 1-5).